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Chair

Mr. Neil Ellis

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● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good afternoon, everybody.

I'd like to call the meeting to order. Pursuant to Standing Order 108(2) and the motion adopted on December 29, the committee is resuming its study of mental health and suicide prevention among veterans.

For the first hour, we have Roméo Dallaire, retired lieutenant-general and senator; Scott Maxwell, from Wounded Warriors; and retired Brigadier-General Joe Sharpe.

We'll start with a 10-minute witness statement and then go into a round of questioning.

Good afternoon, gentlemen. Thanks for appearing today. The floor is yours.

Hon. Roméo Dallaire (Founder, Roméo Dallaire Child Soldiers Initiative): Thank you, Mr. Chair, and ladies and gentlemen, for receiving me in these opulent surroundings. I could barely find my way around the place. I'm very glad for you, in fact. It was high time that it was done. So well done, for bringing you the ability to work with a certain quality of life with your staff to achieve your missions.

I will read a short statement. I hope it's short, or I'll do as my Marine Corps friends have taught me: I'll power talk through it.

I have two colleagues here.

Joe Sharpe and I were intimately involved in the writing of the Liberal Party policy on veterans and have been engaged with veterans for over 10 years in specifics and policy, and also individual cases and the like, and 10 years before that, with the deputy minister at the time, Admiral Murray. He had an advisory committee, chaired by Dr. Neary, who wrote the book on the first Veterans Charter, dated 1943. We spent 10 years working together on that multidisciplinary team. We were also classmates from RMC—but he passed.

Scott Maxwell is the executive director of Wounded Warriors Canada. I am the patron of Wounded Warriors Canada, which, by far, to me, is the body of altruism and philanthropy that is putting so much of its capabilities into the field in the hands of those who are wounded—mostly psychologically. I speak of programs such as animal assistance programs, the equine program, and the veterans training program that we run out of Dalhousie University with my child soldiers initiative, where we train veterans to go back into the field and serve by training other armies on how to handle child soldiers and reduce casualties on the sides of both the child soldiers and us. They take a formal one-month program with us at Dalhousie. We can go into that as we go into the possibility of programs.

I'm going to use as a reference, if I may, my correspondence with the commander-in-chief—that being the Governor General—when I was a senator in the post-time, when I had a number of activities going on with him—his wife was also quite involved—in regard to care and concern for injured veterans, particularly with psychological injuries, as they are quite engaged in that side. I want to use it to give you a feel from there as we move forward.

I'll start by thanking you very much for permitting me and my colleagues to join you today on this matter of suicide prevention in the Canadian Armed Forces and amongst our veterans, both those who serve in the Canadian Forces still—and a large number do—and those who have been released and are in Canadian society. I commend your commitment to the welfare of these individuals and their families, and I am honoured to share my thoughts on how we can make more progress in finding solutions to this problem of people killing themselves because they're injured.

As I mentioned at other times, both publicly and in different forums, I had assembled over the years a team of advisers from diverse backgrounds and with deep knowledge of both the forces and Veterans Affairs. This group of advisers worked to develop policy recommendations and advocacy tools that have allowed us to maintain a well-researched and well-informed outlook on the issues facing our military—especially those who have, in fact, taken the uniform off—particularly related to operational stress injuries. I emphasize that I'm not necessarily always touching on all of mental health; I'm focusing on the operational stress injury part. That is the crux of those who are injured. That is the heart of the problem. That's the operational deficiency that we are seeing right now.

● (1535)

Some of those who are involved—just to get their names out there because they've been so committed—are Sergeant Tom Hoppe and Major Bruce Henwood, both retired; Dr. Victor Marshall; Mrs. Muriel Westmorland; Joe Sharpe, who is here with us; and Christian Barabé. Over the years, they have all been engaged with me in bringing forward the veterans scenario and have also helped me when I was chair of the veterans affairs subcommittee in the Senate.

Our research, thought, and work have led us to the conclusion that operational stress injuries, OSIs, in particular, can be and are too often fatal to those affected. Also, the consequences often last a lifetime for those who do not succeed in trying to kill themselves. From peer support organizations in the past, we've had statistics showing that peers have been able to prevent a suicide attempt a day, through the peer support program, let alone the more formal structures of the medical system.

Of course, this includes the devastating consequences for the families and those affected by OSIs. It is my belief that a comprehensive, whole-of-government approach that is engaged with society can bring significant solutions to this crucial problem of people destroying themselves, and bring them to meaningful progress instead, and, in the long run, give them a decent way of life.

The mental health of veterans and current members of the forces, and also with Veterans Affairs Canada, is a continuum that has been presented as a clinical matter with very little involvement of the overall command structure, that is to say, the essence of what people are used to living, their cultural framework, which is a chain of command and a very structured way of life. The clinical and therapeutic and medical dimensions have taken over the problem of OSI, but have also taken over the potential resolution of conflicts that would bring people to ultimately destroy themselves. The chain of command was left on the sidelines, so it was impossible for it to know what was going on. They would get troops coming back to their units with no information on their state of mind because of confidentiality or not being able to work around the access to information system or the individual's privacy rights in regards to the charter.

Using that to the extent of abuse has disconnected the chain of command from the injured, which is totally contrary to all the education we've received in command. I spent my life in command, from a platoon or a troop of 30, to the 1st Canadian Division of 12,000, in peace and in war. The command is like being pregnant. You are in command all the time, while you have a command function. It's day and night and then, when the baby's born, you're still there, just like in command. Whether you're in garrison or in operational theatres, you cannot divorce the chain of command from the ultimate responsibility of ensuring the well-being of the individuals and the command structure to ensure that the families are integrated within that support structure.

I repeat: the families must be integrated into that support structure. It's not about co-operating with the families or assisting the families, but about integrating them into the operational effectiveness of the forces. Why? It is because the families live the missions with us. In my case, I came back injured. I was thrown out of the forces injured. My family was injured. It wasn't the same family that I had left behind because the media make them live the missions with us.

Therefore, if you employ any of these policies that don't totally integrate families, including policies from DND or the Canadian Armed Forces, for veterans serving, veterans out of service, and through Veterans Affairs Canada, you're going to end up with some of the statistics I mentioned—though still anecdotal.

● (1540)

I was at the last military mental health research forum in Vancouver presenting a paper in which we argued that the families suffering from stresses and strains, families where individuals are suffering from mental health issues, and the individuals involved are not getting the support needed. We're now seeing teenagers who are pushed to the limit in these conditions of extreme stress and who are committing suicide. We have not only the individual members, but we're also now seeing family members who can't live with what they've seen, and in fact are committing suicide.

It is essential that we identify the early warning signs of psychological distress, and that we encourage members to seek help through support programs offered by the military, by Veterans Affairs Canada, by outside agencies like Wounded Warriors Canada and the veterans transition training programs we have. These programs give them gainful employment close to, as much as possible, their background. Why try to convert a person completely when you can build on a person? Why not find gainful employment in, around, surrounding, contractually or otherwise, what veterans have grown up with, what they have given their loyalty to, namely, the armed forces? The uniform is off, but we wear it underneath, and we wear it in our hearts. Why divorce them from that? Why not find programs that bring you much closer?

I'm going to curtail this because of time. My presentation is only to indicate that there are initiatives moving forward. Certainly, the January 2017 CDS strategic directive on suicide prevention has to be the best piece of work we've seen in a long time. He makes it clear that the chain of command is the essence of prevention. However, when you start reading the nuts and bolts, you will see that the medical people have put their finger into the pie and are, I would say, watering it down. What they're supposed to be doing is supporting the chain of chain of command, not creating the chain of command.

I will leave you with the following recommendations so that there is enough time to speak. My colleagues will amplify these and they are free to respond to your questions. I hope you will feel at ease with that.

First, the Canadian Armed Forces directive on suicide prevention strategy has to be funded, implemented, and validated. If necessary, go to what we used after Somalia. Create ministerial oversight committees that report to the minister. We did that for nearly three years. I was ADM of personnel at the time. For three years we had six oversight committees that reported every two months to the minister on how we were implementing this kind of stuff. There's nothing wrong with the political oversight getting closer to the actual implementation when you have a crisis like this.

As for the Veterans Affairs suicide prevention framework and strategy, I haven't seen it. I don't know if it's written. It had better be out there. It is critical, because they have veterans who are outside of the forces, and they have a whole whack of veterans who are inside the forces. That is critical, and it should be funded and implemented.

The third leg of that strategic focus is what is called the Canadian Forces-VAC joint suicide prevention strategy. That's where we want the two departments to come together. Certainly, in the DND one, that's what they articulate. It's what the CAF wants. I haven't seen that one either. That one is going to prevent people from falling through the cracks. That's going to permit the continuum. That's where the loyalty is not lost and where people will continue to commit.

That third strategy has to be out there—implemented, evaluated, but also validated, six months, eight months down the road. That validation has to be of such a nature to hold people accountable. That's why I come forward again with the recommendation that in these oversight committees by the minister there's nothing wrong with bringing that online and helping out.

● (1545)

I think the recognition of casualties caused by operational stress injuries has to be advanced at Veterans Affairs Canada to the level of the 158 who were killed overseas or any of our members who were killed in action. If we prove that an operational stress injury has caused the death an individual, that individual is part of the numbers. We didn't lose 158. We're up to 200-some-odd now. So why not use that number?

Imagine having somebody come back for four years and then losing them. After four years of striving and working hard to save them, you lose them, and you get nothing of any great significance. You don't even get recognition, apart from a medal.

Now that you've moved Veterans Affairs Canada into the military family resource centres, move the families and help the families through those centres too. Reinforce that capability. It's used to taking care of families. Let them take on that angle for both Veterans Affairs Canada and for CAF, because they're already doing it.

Finally, give them gainful employment as close as you can to their history, to their loyalty to the military or military milieu. Why try to change them at a time when they're already in crisis?

Thank you very much.

The Chair: Thank you.

We'll start off the first round of questioning.

We'll start with Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

General, thank you very much for your service and your commitment to this very important issue.

I'd like you to expand a little bit more, if you can, on the chain of command. Can you give us some suggestions as to how we can juggle the challenge the chain of command has? Really, your conversation today is probably the first time we've had someone here at our committee speak about the conflicts between the chain of command and mental illness, the actual clinical presentation. Can you give us some ideas on how we can bring these two together?

Hon. Roméo Dallaire: I'll let my colleagues also intervene.

The immediate response is that the chain of command must be informed. As regards confidentiality, there's no negating that, but you can't let people be handed over to another body, even to the joint support units they were moved to, or sometimes moved back to the unit from. The unit commanding officer, who's responsible for the life of those individuals in the field, is also responsible for command back home. You can't just throw them back without giving them information. They have no idea how to handle them, because they don't know the scale of the injury the individual has.

We all have doctors in our regiments, in our units. Unless there's a means by which those doctors can provide that input, and by which that input can be moved down to the lowest level without offending, but on the contrary, reinforcing, the individual's return, you just have a bunch of walking wounded in a unit. People don't know what the hell to do with them. That isolates them more, and it pushes them more toward wanting to, maybe, end it.

A voice: I agree.

Hon. Roméo Dallaire: Joe?

● (1550)

Brigadier-General (Retired) Joe Sharpe (As an Individual): I would repeat the point that General Dallaire made earlier, that this is a leadership issue, not a medical issue. I think that is a refrain I would come back to over and over again.

Stovepipes, if I can use that term, create barriers to care. That is a major concern here. To use the 2015 numbers, 13 of the 14 suicides in 2015 were by people who had sought care within a year prior to committing suicide, 10 of them within 30 days of committing suicide.

There's a leadership message here. There was an opportunity to intervene, and I think it's an information flow that creates that barrier. Once a member transitions into Veterans Affairs, that's another stovepipe. It's another barrier. It's another obstacle to getting to the bottom of this.

Mr. Robert Kitchen: We're hearing an awful lot about barriers, and that's the biggest thing. There are a number of barriers. Here is another one that we see, or that I'm seeing at least at this point, with the chain of command. As a clinician, myself, how do I protect my Hippocratic oath in dealing with the chain of command? So I appreciate your comments.

General Dallaire, you very briefly touched on the issue of child soldiers. Obviously, that's an important issue. We were both at the CIMVHR conference together. I came away from that conference with a statement that resonates with me to this day. It's basically that what happens to soldiers oftentimes is a violent contradiction of moral expectations. As we deal with the issue of child soldiers, which potentially we could be stepping into again, we realize it's a huge conflict for a lot of our soldiers.

I'm wondering if you could comment on that. I know there's a strategy that's been presented—

Hon. Roméo Dallaire: Yes.

Mr. Robert Kitchen: You've been involved with that.

Hon. Roméo Dallaire: We've been working for two years with the Canadian Army, in particular, and with NATO. We've been in Africa getting research because my institute, the Roméo Dallaire Child Soldiers Initiative, based at Dalhousie University, is field focused. We train armies and police forces in countries to send them —military and police forces—into conflict zones.

We were able to influence the content of the Canadian Army by being the first army in the world to formally put into its new doctrine.... Doctrine is a reference from which you deduce tactics, organization, equipment, and the training you need to do the job, the mission. By creating that doctrine, it is now leading the world in formally recognizing it. We are going start implementing the training of trainers to then bring that forward.

This doctrine is particularly important because there isn't one conflict in the world that is not using children as the primary weapon system. The children may be nine years old, 10, 12, 13, 14, or 15. Every one of those conflicts creates not only an ethical but a moral dilemma for the members. That's what blows us further....

We always thought it was the ambush or the accident that was the hardest point. The hardest one is the moral dilemma and the moral destruction of having to face children.

A sergeant came to me in Quebec City, where I live. He looked good and spoke of five missions, and things were going well. I asked him what his job in the battalion was, and he broke down right there in the middle of the shopping centre. He couldn't talk. He stammered, and he was weak-kneed and crying. I took him aside and so on, and he said, “I was in the recce platoon, and my job was to make sure the suicide bombers didn't get to the convoys”. He said, “You know, I've been back for four years, and I still haven't hugged my children”.

We are taking significant casualties because we don't know how to handle child soldiers. This doctrine will move us a long way that way, and we'll be part of the training program.

The Chair: Thank you.

Ms. Lockhart, go ahead.

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

Thank you, General, for your service and for being here today to answer our questions.

I want to talk about a quote that I read from your book, *Waiting for First Light*. You said:

> No one recognized what I was doing at the time. Not even me. Nobody told me I was injured. I didn't think I was injured, though I felt the weight of having had to ask to be relieved of command. Outwardly, I was still committed, determined, stable. Inwardly, the stresses I was imposing on myself were beating me down, piling up on the stresses at work.

Is there something that Veterans Affairs can do to intervene at this point in a soldier's life and a soldier's mental state that could prevent or stop the progression from this state to suicide?

● (1555)

Hon. Roméo Dallaire: With mental health—and particularly the operational stress injury side of it—you are facing an injury that gets worse with time. If you lose an arm, you know that you've lost it, so the aim is to try to build a prosthesis that will be as effective as possible. If you don't intervene with the same sense of urgency an operational stress injury by recognizing it first and then providing for it, it gets deeper and more difficult to get at and to resolve.

It took four years before I crashed. I lost one of my officers 15 years afterwards and having been treated. So there is a vacuum of how to get at them so that they don't continue to walk around as if they're not injured, without there being a stigma there.

We thought we had broken the stigma by having a veteran armed forces—and we did until not so long ago, but now have a lot more non-veterans in there. We're living what we lived in the fifties. In the fifties we had a lot of veterans, but we had a lot of non-veterans, and there was friction between the two, and they would say, “Oh, I wouldn't be injured like that”. We didn't recognize operational stress injury, so those guys simply drank themselves to death or got out. They were the rubbydubs who died on the streets because we had abandoned them. The exception was the Legion, which did help a lot, but there was also a lot of alcoholism.

We lack the ability to discern them early and to then follow it through in a progressive way.

The first time I went out for treatment, I was given eight sessions. I've been in treatment for 14 years. I still have a psychiatrist and a psychologist. I still take nine pills a day. It keeps me like this.

There are moments, though, like last week. My book was launched in French, and it was catastrophic. Writing those books is like going back to hell. There is no real value to me, but I hope it will be useful to others.

You have to find a way because you need to prevent the injury from getting worse—not just recognizing it, but preventing it from getting worse. Unless you get in there early, it's going to get worse.

Mr. Scott Maxwell (As an Individual): I think there are two things or two competing problems we see at Wounded Warriors Canada. On the one hand, you have the frustration when you're talking to someone who has graduated from one of our programs and you talk to them about their injury.... Here, I just want to add to the general's comments that the vast majority of injuries—when they're comfortable to tell us when they occurred in their mind—happened through an interaction with children in some way, shape, or form.

Second, it commonly took them eight to 10 years after that injury, or the action that caused the injury, before they sought or receive the help they deserved. You can imagine a life like that, the impact on the family of those eight to 10 years before they attempted to deal with their injury.

On the other side of that, a further problem we see after we write about their need to come to get help, to self-identify, to reach out peer to peer, is that because it's a much more commonly understood topic to be discussed and more people are more comfortable coming to get help to address it, we are receiving more and more people seeking help. The problem now is if they do come forward, programs like ours now have wait lists of up to two years. We have a severe access problem in Canada. That is one thing and it's very nice and all well and good if they come forward to seek help, but when they don't get it, you can imagine what that can do to their mental state and overall health care and the impact on their families.

There's a lot at play here and it's extremely serious.

Mrs. Alaina Lockhart: Thank you.

I think that pretty much is my time, but that was great. It was wonderful.

● (1600)

The Chair: Ms. Mathyssen.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair.

Thank you very much for being here. We appreciate your expertise and candour, because this is very important.

We need to get to the bottom of this. We have heard so much and got so much information from veterans that is contradicted by experts or people from VAC or DND, it's frustrating and renders our ability to do the right thing questionable. I want to get down to some brass tacks.

I was with veterans on the west coast over the weekend. They told me that of course they're masking and denying their injury because to admit it means that they're out, that they will be on the outside of a brotherhood or sisterhood, a family that they need to stay connected with.

They also told me that members within the Canadian Forces are suicidal too. It's not just when they're thrown out. They're suicidal too, but all of that information is being managed and they're transitioned out so that if they are going to commit suicide, they're not in the Canadian Forces. They're on the outside and DND doesn't have to account for those deaths.

All of this is frustrating. I'm sure there are various opinions on this, but the point is that the trust has been broken. These were angry veterans and they talked about the triggers, the mountain of paperwork, the fact that they were financially insecure. They left without pensions or financial supports and they didn't know what to do and they felt that the only way out was to end it all, that they were of no use to their families, and they were either hiding in somebody's basement or they were lashing out.

What do we do? It's a catch-22. How do we re-engage those veterans? How do we re-establish that trust?

General, you talked about this study. Is that study available to us, the CDS study, the strategy you talked about? Is that available to us?

You also talked about things that should be happening with mental health and you don't know where they are. All of this combines to make us wonder what is going on, where are the support services, and when can we expect that there will be a genuine response that meets the needs of these veterans.

I know that that's a lot and there's not really a question in there, but please respond.

Hon. Roméo Dallaire: Brevity is not my strength either, so don't worry about it.

Let me put it this way first. We have articulated after years of working on it that unless there is an atmosphere within Canada and the Canadian people, and within government circles—and I speak of parliamentary circles too, which seems to be there, but also within the bureaucracy, which doesn't necessarily seem to be there—such that you feel a covenant, not a social contract because that means you've negotiated stuff, just like the current Veterans Charter….

I'm the one who in a day and a half pushed it through the Senate and I've regretted it ever since, because it didn't reflect the 10 years of work we had done before. It was a bureaucratic piece to try to save cash and it hamstrung the minister with all kinds of regulations. That is a new phenomenon in legislation. Before there weren't many, but now they're throwing a whole whack of them with legislation.

That new Veterans Charter doesn't need a new one. It needs a significant reform. In there you will find in the reform a lot of the answers these guys and girls need in order to get the appropriate responses and a timely response. Until you hit that target deliberately, you're going to have a problem.

The only way you can convince people to go that far is if you actually believe that there's a cradle-to-grave responsibility, not to the age of 65, not with a reduced way of life, but an actual covenant that they have committed themselves to unlimited liability, recognizing that they've come back injured, that their families are being affected, and that some of them are dead and their families are obviously affected, and then you've got them for life.

If you don't sell that, then you will not gain their trust. I'll tell you, it started right rotten with the Gulf War syndrome. We did everything to prevent them from getting anything. Every lawyer in town, every medical staffer, gave us arguments why we couldn't take care of them. That undermines the operational commitment of individuals. Do I want to get injured? It undermines also the families, and they're the ones who are creating a vacuum of experienced people because they're pulling their spouses out.

● (1605)

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): I'm sorry, Ms. Mathyssen.

Ms. Irene Mathyssen: No, no. Thank you. I'll come back.

Mr. Doug Eyolfson: Thank you, Mr. Chair.

Thank you so much for your service and coming here today and talking about suicide. It's an important issue. We have something in common with that. I practised medicine for 20 years and it is a problem in my profession. My medical school had three suicides in a 15-month period while I was a resident. I'm sensitive to professions where this happens.

One of the other things we have in common is that there's a stigma involved in seeking mental help. There's a place in hell for the person who said, “Physician heal thyself”. A lot of damage has been done by that attitude. Soldiers probably deal with that as well.

We do know that there's always a hesitancy to step forward, a stigma of being seen as weak, of not having what it takes. Do you think the stigma of PTSD has been reduced in the military since when you were serving?

Hon. Roméo Dallaire: I'm going to let Joe speak more about that, but I wish only to indicate to you that I consider myself in—because I have a psychiatrist and a psychologist. I'm getting care and I have some peer support. I don't hide it. If you were a doctor who took care of me because I had cancer, I'd talk about you, and I'd say he's a dummy, or he's a very good doctor, I like him, and so on, but we'd talk about those doctors. Why don't we talk about our psychiatrists and our psychologists? They used to in some of the films of the early seventies.

We've got to make that just as honourable as any other injury, and making it honourable will destroy that stigma. We are now seeing friction on the stigma coming back, which we thought we had pretty well with a cultural change, which Joe speaks of, by the non-veterans who feel that, with these very Darwinian, very visible type of people the military are, or any first responders, anybody in uniform—police, fireman, and so on—there's this inability to accept what you can't see. If you can't see it, you can't accept why they can't be 100%.

That, you've got to educate and train.

BGen Joe Sharpe: I'll just add a very quick footnote to General Dallaire's comments.

We were talking earlier today about a young soldier I was working with on Thursday last week, a young corporal, who was telling me very candidly that he suffers from PTSD and is being cared for, but he said, “Sir, you're hearing all the right words from the senior leadership in the organization.” It's an honest commitment coming from the senior leadership of the Canadian Armed Forces. This young lad is an infantry soldier in the process of being released. He said, “On the ground, the sergeants and the warrant officers do not believe a word of that. To them, it's purely BS. If you come forward in your platoon or in your company and ask for help, you are a weak link, and they don't want you there.” That's Thursday of last week that this was described.

Is the stigma gone? Absolutely not. The stigma is still there, but it's because we focus very, very strongly on changing that immediate behaviour. If we caught you, from a leadership perspective, badmouthing these guys, we're all over you. We're worried about behaviour, and we didn't really focus at the belief level that we really needed to focus at, and ultimately to the cultural level below that. It's a long, tough battle to change the culture. I think we were focusing on behaviour, not beliefs and not culture.

Mr. Scott Maxwell: The only other point I'd add is, not from those still in the Canadian Forces, but those who have released and are forming the civilian veteran population. With them, I think things have improved a little bit with regard to the stigma. They're obviously already out so there's a lot less risk, but there's more comfort in talking about their situation. They're comfortable to put themselves out there in a very, very vulnerable position, often among their own peers. It's happening all across the country. As I mentioned earlier, our problem is expanding access to programs, not trying to find ill and injured people to come into our programs. I think that certainly highlights that there is some progress being made for those who have released and for the veterans on the civilian side of the world to come forward, put their hands up, and seek help. There's a little bit of optimism there. The downside, of course, is we've have to make sure we can help them when they come forward.

● (1610)

Mr. Doug Eyolfson: Thank you.

The Chair: Mr. Fraser.

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

Thank you so much, General, Mr. Sharpe, and Mr. Maxwell for being here today.

I want to preface my comments by saying that on Friday night in my riding of West Nova, I was at an event in support of the military family resource centre at 14 Wing Greenwood. It was an excellent event to bring awareness to the issues of mental health and PTSD within our military and veteran community and to raise funds for the military family resource centre.

I was glad to hear you talk about how families can access military family resource centres and how this should be expanded to include veterans' families as well. I wonder if you can expand on that. I know the good work that they do. How do you see that actually taking place? How would it work within DND expanding those services?

Hon. Roméo Dallaire: The VAC has signed an agreement now with the Canadian Forces that we can take care—I say “we”, there you go, proof—

Some hon. members: Oh, oh!

Hon. Roméo Dallaire: —and I say that after 10 years in the Senate—of injured veterans who are no more in the service, and their families.

I would consider that family support centre is one of those pivotal bridges they can cross, and survive, into a new world. The family support resource centres have a lot of the expertise and have access both provincially and locally, let alone within the military and within VAC, to influence the battle and get people more timely support.

However, they're hurting because the money is not going there and they can't hire and veterans can't then get that special support. The horrible scenario that I think is still unresolved is that we are improving the individual members, the forces members who are still serving, and we're improving the case of the veterans who are out there with our different clinics and so on, but we're not improving the case of the families.

You have one half of the problem solved; the other half is not, and that half is hurting. It's going to drag down everything you're doing. Until you look at the family as also deploying.... I would argue that the days are now here when the family is part of the operational effectiveness of the forces, and not just in support of the operational effectiveness of the forces. They're on Skype with them an hour before they go on patrol. Come on, how is it possible to disconnect them?

If the family is intrinsic to the operational effectiveness of the forces, they should have access to the same level of care. That means, yes, more money into VAC and more money into DND to take care of the families. We're already transferring a whack of money to the provinces. We're telling the provinces that we're going to clean up our own mess. We created these injured people and we're going to take care of them. We'll buy the resources from you instead of simply dumping them and having that very serious disconnect.

Mr. Colin Fraser: Yes, Mr. Maxwell.

Mr. Scott Maxwell: I think the other part of it is that they're great hubs, they're physical locations, and they're places for people to go and have that peer-to-peer support.

I would caution, though, that like anything, the issue is so vast and the scale is so large that not one agency, not one MFRC, is ever going to be able to do this on their own. We confront this all the time at Wounded Warriors Canada. If we fund a program, if we make a $375,000 donation to a program to run the program across the country, that's wonderful. However, there are limitations on the ability to help people and get them all in. The goes for MFRC.

One of the things we're working with, and we talk a lot about in this space, is partnerships. We're working with military family services, which administer MFRCs across the country, to allow MFRCs if they identify a couple—in this case, supporting families—to attend one of our programs, to have those costs covered from the referral from the MFRC to a program administered by Wounded Warriors Canada.

You can see how fast this would multiply and duplicate on a national scale, so you don't have this regionalized framework where something is very good out there somewhere, and less so in Esquimalt or wherever the case may be. We have to focus on making sure when we're having these discussions that its implementation is national, because that's where the population is. It's in every corner of the country.

● (1615)

Mr. Colin Fraser: I think you're right. I appreciate that comment. It's really important to recognize that in smaller communities, having this vehicle can be the way to reach out in the community. A trusted facility like that is really important.

Mr. Scott Maxwell: And we wouldn't get them on our own. Let's face it, if we want to run a program, how do we identify the people who need help? We use the likes of OSISS and MFRCs, and we partner with them and military family services more broadly.

You're absolutely right: it's about partnership and linking the information and the tools and ultimately the programs together so if someone does walk into an MFRC and they could benefit from X program, which might not be administered within that MFRC, then at least the MFRC is able to get them the program they deserve to receive.

Mr. Colin Fraser: My time is very limited.

Do you see as well, though, the importance of the family being involved and integrated into the mission is also to ensure that if there is an intervention, it will perhaps be made earlier on? You've got somebody there who can maybe spot some challenges a soldier is facing and maybe be able to identify the problem earlier.

Hon. Roméo Dallaire: Mr. Fraser, you've pulled one of the gems out of this.

If the family feels they are intimately engaged in the operational effectiveness of the forces, they will feel that sense of responsibility of helping the member understand that's part of the exercise of that member re-becoming operationally effective or being adjusted to some other worthy sort of employment.

Right now, you will have members fighting their families to not get support, whereas if the family were integrated into the program, they wouldn't be able to do that; they would be reinforcing each other to get that help. There's the ick; that's the crux.

The Chair: Thank you.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you very much for being here today. This is so helpful.

I want to focus specifically on your first comment regarding the Canadian Armed Forces suicide prevention strategy and how to implement it with ministerial oversight committees. You mentioned Somalia.

I'm very involved with our veterans on the issue of mefloquine. We are still hearing from the powers that be that only one in 11,000 forces members is affected. Our own Minister of Health, as recently as February 22, has written with respect to the continuing use of mefloquine that as a malaria prophylaxis, the department considers the benefits of mefloquine to outweigh its potential risks under the conditions of use described in the CMP.

I'm hearing from veterans from Somalia, Rwanda, Uganda, Afghanistan, and Bosnia who have been taking this that they did not have freedom of choice with its use. Our allies—Germany, Britain, Australia, and the U.S.—have taken steps, and yet our government still doesn't recognize what happened in Somalia and has carried on. It's impacting suicide rates. I know this what I'm hearing directly from veterans.

Can you please talk about this?

Hon. Roméo Dallaire: I was on mefloquine for a year. About five months into it, I wrote the National Defence Headquarters, and I said this thing is affecting my ability to think. This thing is blowing my stomach apart. This thing is affecting my memory, and I want to get rid of it. At the time, the Germans weren't using anything, but then when we lost two people in 48 hours to cerebral malaria, they changed their policy.

I then got a message back, which was one of the fastest ones I have ever got back, which essentially ordered me to continue, and if not, I would then be court-martialled for a self-inflicted wound because that was the only tool they had.

Mefloquine is old-think, and it does affect our ability to operate. Those statistics to me don't—

● (1620)

Mrs. Cathay Wagantall: They are not accurate.

Hon. Roméo Dallaire: —really hold water. Even if it they do, what if it's the commander who's affected by it, which I was at the time? My executive assistant kept an eye on exactly how I was handling mefloquine. There are other prophylaxes that are much better.

Just on the command side, let alone on our ability to respond to the very complex scenarios in which we find ourselves, when you're facing children and so on, and you have nanoseconds to decide whether you are going to kill a child or not to save other people, we don't want to have any booze, and yet maybe we're still being affected by a drug.

Mrs. Cathay Wagantall: What do you say then? Should we be doing studies to determine—

Hon. Roméo Dallaire: I say get rid of it, and use the new stuff.

Mrs. Cathay Wagantall: Thank you. That's the faster route I would love us to take.

Hon. Roméo Dallaire: Yes.

Mrs. Cathay Wagantall: One of the groups that is helping veterans, Veterans Helping Veterans, talked about the need for us to deprogram. We program soldiers. I understand the fight or flight, the get out there attitude, that you think of the other person before yourself, but when you come home, you don't know how to sleep in a normal pattern. Yet, they claim this could be reprogrammed, that you can recreate a proper sleep pattern, with proper food, etc. All of those things are so crucial to health.

I know you have struggled deeply with sleep. Is this something you see as an avenue that could be taken to help our soldiers?

Hon. Roméo Dallaire: I was about to respond by saying, “Read my book”, but I'm not going to say that.

Mrs. Cathay Wagantall: I haven't done it yet. Sorry. You can tell.

Hon. Roméo Dallaire: The difficulty is that when we come back, we're trying to go to sleep in a bed and in an atmosphere that is foreign to us. It's foreign to us because, and I came back and the slaughter of a million people or so didn't count. I was back as deputy commander in the army, and I was told, “Thank God, you're back. You've had your time overseas. Listen, the priority now is the budget cuts.” It was as if it didn't happen.

There is a disconnect in our ability to know that those people exist, know that we haven't finished the job, and know that there have been horrible scenarios played out. Then we come back, nobody gives a damn, and nobody really recognizes.

We have a horrible time adjusting to the opulence, to the pettiness, and to the nature of our societies. What keeps us from being able to handle it is our fatigue, our inability to reason. What does that is the lack of sleep.

Mrs. Cathay Wagantall: Yes.

Hon. Roméo Dallaire: We can't get to sleep because this stuff keeps haunting us and keeping at us. If there are programs to do that —I know there are all kinds of initiatives—fine, but I would argue that we're into two major cultural frictions that are not easy to come to an arrangement with.

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you, and thanks, General Dallaire.

The problems we deal with on the veterans committee originated with the period of active service, so I was impressed with your notion of the joint suicide prevention strategy. Obviously, two different groups are going to have to be working together in order to solve the problems. What would you see in that joint suicide prevention strategy? Are there any guidelines that you're anticipating?

Hon. Roméo Dallaire: In 1998, when I was the assistant deputy minister of personnel, or what they now call CMP or HR, I was able to work out a deal with the ADM, a chap called Dennis Wallace at Veterans Canada, to second a general to Veterans Affairs Canada and create the first joint discussions. Our computers weren't working together—nothing like that worked. We couldn't even talk to each other. So we created a simple office where people had the veterans' files on the veterans affairs side and the forces' files on the other side, and a case would come in and they'd talk to each other and solve it.

There have been a lot enhancements there, but I don't believe it has gone far enough. I don't believe people are comfortable being handed over to another department. I'm glad it's in Charlottetown. People are still very human and not as clinical as Ottawa would be, so you're not treated as a number. And I think that's okay, but the fact that it's a separate department and the fact that you're being moved away.... Take my uniform off, but don't divorce me from the family. Don't move me to somebody else who has a different culture, in maybe a different atmosphere, who's running from a different set of gears in regard to rules and regulations.

I think it is time to look at those countries that have moved their veterans departments over to their national defence departments. They have their budget lines and they have their structures, and they're not tripping over each other. The client is not handed over to somebody else. The client is still in the family. You can do a lot of informal resolution. You can bring a different angle to some of the directives. With the Minister of National Defence versus the Minister of Veterans Affairs, you can give more power to getting in-cabinet changes done, I think, because it has a direct impact on the operational effectiveness of the forces. If you don't treat the injured veteran right, the guy or girl who's going over will realize that if they come back injured they have to fight the second fight, and that's coming home and trying to live decently. If it stays within the structure, you can be very candid and far more accountable.

● (1625)

Mr. Bob Bratina: Thank you.

I wondered, going back to the issue of culture and stigma, what role does a chaplain play?

Hon. Roméo Dallaire: Oh, what a wonderful question. At my child soldiers initiative, we discovered that the threat is obviously to children. During the course we ran last summer for 15 veterans—and we've already deployed some of them to train in Kenya with the Somali people—two of them came forward and said they had killed children. They had never told that to a therapist, never told that to their family, never told that to anybody, but they told it to these guys around them because they were going to be involved with children. They suffered that.

I think that the ultimate pursuit you're looking for is engaging them in...here's where my memory is shot. You take over.

Mr. Scott Maxwell: Did you say it's the chaplain?

Mr. Bob Bratina: Yes.

Hon. Roméo Dallaire: Oh, yes, it's the chaplains, the spiritual side of this thing. We've talked about the moral side. Our moral weaknesses come from the fact that we don't have a spiritual side left, yet in theatres of operation many of those countries still have a spiritual side. It's not purely religious. It's cultural. If you don't have a spiritual side to fall back on, then you're falling into a vacuum, and that makes your recovery that much more difficult. So the padres are very proactive and very effective, I think, in the field, and they're a second chain for resolving problems.

Mr. Scott Maxwell: Yes, our national program director has just retired after 25 years as a Canadian Forces chaplain with a combat engineer regiment in Toronto. Through working with him and with Wounded Warriors, I've interacted with a whole bunch of members of the forces he has assisted over the years. At his Depart with Dignity ceremony especially, I met dozens of them, and we were talking about just that question. What was it about Phil, in this case, that was so helpful?

It was almost, within the regimental family, a place to go if you didn't want to go up the chain of command or tell any of your superiors anything about anything, because you just weren't sure how significant the problem was, or if it was even worth mentioning. It was a safe place within the regimental family to go and at least have that first point of discussion with someone you weren't fearful of, and you didn't fear any repercussions for saying something or asking a certain question.

It had a tremendous impact on how things went for them, from there on.

Mr. Bob Bratina: I take General Dallaire's point.

Hon. Roméo Dallaire: Yes.

BGen Joe Sharpe: I'll make one very quick comment on this one.

The Chair: Could you just make it brief, please?

BGen Joe Sharpe: Yes. I visited a major army base to interview the padres about their role in dealing with PTSD and OSIs. Fourteen of the 16 padres on that base had been diagnosed with PTSD.

So if we're going to use padres—and we need to, as they're a critical part—we have to take care of the padres as well. It's not a "physician, heal thyself" approach.

● (1630)

Mr. Bob Bratina: They must carry a lot, absolutely.

Thank you.

The Chair: Mr. Brassard.

Mr. John Brassard (Barrie—Innisfil, CPC): Five minutes, Mr. Chair?

Thank you. General, it's good to see you again. We saw each other in Barrie at the opening of the École secondaire Roméo-Dallaire. I know the students, staff, and board members were thrilled that you took the time to be there for the opening of a school in your name, so thank you, sir.

Hon. Roméo Dallaire: I'm putting all my artifacts there too.

Mr. John Brassard: I think I had to speak French the whole time I was there.

I want to talk about transitional issues, because we build our soldiers up to fight but we don't—for lack of a better term—break them down to re-enter civilian life. The issue of transition has come up a lot during the testimony. In fact, the DND ombudsman talked about a concierge service for those who are being medically released, to make sure that everything is in place. In fact, this committee issued a report to Parliament reaffirming what the DND ombudsman had suggested.

Scott, I know you were on CP24 three years ago, and you were asked about the issue of transition then. In the short time that we have, if I were to ask all three of you to list three priorities for what we need to do to help with the transitional stressors for those who are transitioning out of the military back into civilian life for the sake of their families, what would those three priorities be right now?

Scott, I'll start with you.

Mr. Scott Maxwell: I wholly support the DND ombudsman's report and recommendations. I have said that publicly for far too long, it feels now, going back to that time, and obviously he has since produced new recommendations.

Mr. John Brassard: He refers to it as a low-hanging fruit opportunity.

Mr. Scott Maxwell: It really is. One of the things in talking about this—and he also references it—is that it's not necessarily a cost change. It's more of a process change. I think that's accurate. If you're going to have the two departments—if it's not going to go the way the general just suggested, despite the fact that maybe it should go that way—we ought to ensure that when forces members are leaving, when they are releasing from one department to the next, that everything we can possibly prepare in advance is done. We ought to ensure that the transition is as smooth and soft as possible, because we know in working with this population that it doesn't take much for them to stop doing things that are going to be beneficial for their well-being, to shut down, and to isolate themselves from everything, including their own well-being.

We see it and hear it far too much. We're an organization that looks at and identifies gaps and tries to fill them. One of the biggest gaps we see continuously is the release gap, the time between departments, where they lose their identity. Their identity is in constant struggle, and they just feel that they have to retell their story too many times to too many people who simply do not care enough to give them the service support and the process support that they require to help them deal with all the questions they're receiving at home from their families, like "what's next for you and us and our life?"

It's serious, and all I can say in short is: adopt the DND ombudsman's recommendations. They do represent low-hanging fruit, but I think it's a very important basis from which to start.

BGen Joe Sharpe: There are a couple of points I would make very quickly. They're very similar to Scott's.

Close the gap. It's a big deal. We've got to bring these two departments closer together, and I think we've got to stop removing the membership from the individual who is leaving. In other words, once you're a member of the Canadian Armed Forces, you remain a member of the Canadian Armed Forces. What we do now is take the cards and cut them up, and you're on your own. You're a different thing.

We've got to remove that transition shock of being rejected from the family, if I can use that term.

Mr. John Brassard: Right.

BGen Joe Sharpe: Secondly, we have to reduce the bureaucracy, the complication of that process of transitioning. We're not going to another country; we're staying in Canada. We're simply transitioning to another government department, but the horrendous bureaucracy that surrounds that transition process is mind boggling—if you're healthy. If you're ill and injured, it's a barrier that's almost insurmountable.

Lastly, I would say remove all the barriers to that transition. Seriously study what constitutes barriers to the member and to the member's family, and target those barriers and get rid of them. We don't need the complication that we have now.

Mr. John Brassard: General, the last word is to you.

Hon. Roméo Dallaire: Get out of the weeds and take a strategic perspective of it, meaning that if we inculcate in these people, from the day they enter, a sense of loyalty to their service.... My Dad told me I entered a service. He said, "Don't expect anybody to say thank you. Expect an interesting career. You'll never be a millionaire." And in those days, he said, "Change your name to Dallard, because with Dallaire, you'll go nowhere." But anyway, that's changed.

Take the high road of remembering that loyalty does not disconnect because of the extraordinary experiences we live, and our interwoven lives; it's there forever. That's the covenant, to serve. And so if it is a covenant, then get rid of these two ways of handling the same problem. I was a veteran serving. Then I was a veteran non-serving, and I went into a whole different set of circumstances—I was not needed.

Part of the strategic perspective is looking at two departments with different regulations for helping the same individual during the same lifespan, or nearly the same.

Secondly, don't build a new charter, but as I've often said in-house, build one based on the covenant of a reformed charter. Get rid of so many of the stupid rules.

And yes, it's going to cost you more. Well, look at the billions we spend in training these people; the billions we spend in equipping them, giving them the ammunition, the food, the medical supplies; the billions we use in getting them into the theatre of operations and doing everything to reduce casualties and win the war, which we do in humongous amounts of money; and then the billions we spend in rebuilding and replacing the equipment and restocking ourselves; and then look at the amount of money we are actually spending on the human beings that have gone through it. It is the most gross disconnect that you can imagine.

Veterans Affairs at $3 billion is inappropriate. It is absolutely inappropriate compared to the scale of the commitment we're putting into every other dimension except the actual human being.

That is the strategic position that should be taken.

● (1635)

The Chair: Thank you.

Ms. Mathyssen, for three minutes.

Ms. Irene Mathyssen: Thank you.

I need so much more, but I'm going to—

Hon. Roméo Dallaire: So do we.

Ms. Irene Mathyssen: I want to go back and underscore everything you've said, because that's exactly what we heard.

This is for you, Scott, and you, General Dallaire. You said that you were in this horrific situation, and you came back to this superficial life where there was no understanding of your experience. How do we change that? How do we make sure that when that member comes back, there is recognition of that experience and what happened out there in that deployment?

Hon. Roméo Dallaire: The crux of that, particularly with reservists, who are all over the countryside and often abandoned.... Remember, this only gets more complicated when you're talking about reservists. It shouldn't be, but it is.

I think the crux is linking them to family. That's your anchor.

Ms. Irene Mathyssen: Okay.

Hon. Roméo Dallaire: For a reservist who's single, it would be his parents. They're part of the forces. And if he's married, it's his intimate family or close family and so on, his children. Bring the human side back to these individuals so they can build on that, and then work from there. We've lost a lot of people because they lost their families and there was nothing left. It was not just losing a job. They lost their families because of that, and they killed themselves because of that.

Try to keep that fundamental element of our society with them, and help them go through the years of difficulty of living with a person like that.

It's based on family, and the tool to make the family available is the family support centres. There is no better expertise than them.

Mr. Scott Maxwell: The one thing that General Dallaire has often talked about in relation to our work is to ensure that they never have to fight again. That is such a powerful line. If they feel as though they are fighting again when they come home in order to access everything that is available to them and their families, it's a huge problem.

When we talk about removing that feeling and how you do that, well, how about starting by making sure they don't have to fight again for everything they are entitled to upon returning from deployment in service to Canada?

● (1640)

Ms. Irene Mathyssen: Okay.

You said something very important, that they tried to save the cash. I have that feeling over and over again, whether it is with the new Veterans Charter, with mefloquine, with the Gulf War syndrome.

This committee some years ago did a study on Gulf War syndrome, and we had mountains of evidence that it was all in their minds, that it was not real, and yet we had veterans coming in without hair, with very clearly disoriented perspectives.

Hon. Roméo Dallaire: We could have given them $70,000, and add to that the fact that we recognize it's an injury. Even if we can't figure out all the legality of it, and even if some of them are going to rip us off, who gives a damn?

What it would have changed would have been the whole attitude that the troops feel regarding coming back injured. If you're undermining their getting injured, you're going to undermine their operational effectiveness and their taking the appropriate risks, and you're undermining the ability of families to handle them when they do come back.

Ms. Irene Mathyssen: It's the same feeling with mefloquine.

I asked directly if troops were advised, if they were monitored, and if anyone took care to know what the effects of these drugs were, and the answer was no. I asked if there were any repercussions for someone saying they choose not to take this drug, and it was, “Oh, no, it comes through the chain of command.”

Hon. Roméo Dallaire: Well, the chain of command will charge you because you're doing self-inflicted wounds because you're going against medical advice that the chain of command has accepted.

Ms. Irene Mathyssen: Even though they were guinea pigs.

The Chair: That ends our time for testimony today by this panel.

We will take a short break.

On behalf of the committee, I'd like to thank all three of you for your service, for what you have done for our men and women who have served.

We'll have a two-minute break and we'll come back to the second panel.

Thank you.

● (1640)

(Pause)

● (1645)

The Chair: I call the meeting back to order.

In the second hour we're going to have to condense a bit of time on this.

We have, from the Quebec association for suicide prevention, Kim Basque, training coordinator; and Catherine Rioux, communications coordinator.

We'll start with 10 minutes of witness testimony.

Roméo Dallaire is going to stay here, probably not to answer questions. He just wants to see how the committee works together.

We'll start with our new panel.

Thank you. The floor is yours.

[*Translation*]

Ms. Catherine Rioux (Communications Coordinator, Association québécoise de prévention du suicide): Mr. Chair, members of the committee and Mr. Dallaire, we want to begin by thanking you for inviting us to participate in this consultation. We know that the Canadian Armed Forces and Veterans Affairs Canada are already working on mental health and suicide prevention. We thank you for your interest in going even further.

For 30 years, our association has been advocating for suicide prevention in Quebec. It brings together researchers, responders, clinicians, survivors of suicide loss, as well as private, public and community organizations.

Our main areas of activity are education, citizen engagement, and training for responders and citizens. As you can see, our association has no military expertise. Our appearance before the committee today stems from our experience in advising various community stakeholders and developing prevention strategies for a wide range of settings. We did that recently for agricultural producers and for detention centres.

How do we reduce the number of suicides among our veterans? What we all know is that there is no simple answer and that a multi-pronged approach is required. The few approaches that we could propose during this hour and that we feel are essential have to do with education, training and the services provided.

I will begin with education, or cultural and mentality changes.

Thanks to repeated awareness-raising campaigns, mentalities have started to change on the issues of suicide and mental health. Taboos are less entrenched and are starting to fade. Unlike 10, 15 or 20 years ago, suicide is no longer seen—or is less so—as inevitable and as an individual problem. People are more aware that it is a collective problem and that prevention is possible.

People talk more about their mental health issues and asking for help is more valued. We have come a long way in this area, but there is still much work to be done. That is why we are here today.

We have a few suggestions to make with regard to education. We are convinced that it should begin with proactive education of active armed forces members, especially those who belong to units at higher risk of suicide, such as combat trades.

There are all sorts of initiatives. For instance, we may be talking about strengthening the cohesion around an individual who is experiencing difficulties or is separated from their unit for health reasons. There are messages reiterating that taking care of our mental health is just as important as taking care of our physical health. There are also campaigns promoting existing help resources.

We must also work on reducing the social acceptability of suicide. That acceptability appears to be stronger among men who conform to the traditional male role. Certain therapeutic approaches are aimed at reducing that acceptability and manage to make suicide less acceptable and to highlight the fact that, by finding other ways to put an end to their suffering, they can become models for their children and models of resiliency for their community.

We firmly believe that suicide must not be an option, on an individual or a collective level. That is why we support messages to that effect inviting people to find other ways to deal with their distress and suffering.

We also believe that, as part of education, society should avoid glorifying individuals who have died by suicide, since that involves a risk of contagion. To avoid that, the media must be educated. I know that is being done already, but the message must constantly be repeated, as newsrooms and journalists are always changing.

● (1650)

We must also educate people in charge of ceremonies when a death by suicide occurs, as well as grieving families. That is a very delicate thing to do, but we must pay attention to that if we want to save the lives of suffering veterans. Some practices can have consequences, such as the erection of monuments honouring military members who died by suicide. We see them as a real risk to veterans who are suffering, who are vulnerable to suicide and who have lost a tremendous amount of recognition and value. Those veterans could see suicide as a way to regain some honour and recognition. Let us be clear: appropriate funeral services must be provided for military members who have taken their lives, just like for military members who died of other causes, but attention must be paid to the potential glorification and contagion aspect.

Ms. Kim Basque (Training Coordinator, Association québécoise de prévention du suicide): To properly evaluate the services and training to be provided, we have to understand the suicidal individual's state of mind.

All suicidal individuals, be they military members or not, believe that they are worthless, that their situation will never change and that no one can help them. In that context, it becomes extremely difficult to seek help, to find it and to take a step toward a resource. It is even more difficult for men who conform to the traditional male role, where physical strength, autonomy, independence and solving one's own problems are valued. For someone who is going through a difficult time in their life when they think that they are worthless, that no one can help them and that the situation will never change, all those obstacles make it extremely difficult and painful to seek help.

However, in spite of their suffering, the individual will always feel ambivalent. This means that a part of them wants to stop suffering, and that is why they think about ending their life, but there is always a part of them that wants to live. That is the part that must be recognized by the individual in distress, and it is the responders' and professionals' job to help that part grow. Every time a suicidal person asks for help and shows their distress, the part that wants to live is expressing itself and continuing to hope.

As for many veterans—who are generally men—the characteristics of their way to seek help must be taken into consideration. That is true for suicide in general, and it is also true in the armed forces. A call for help will not manifest in the same way, and the way services are provided to them must also be adapted.

Research shows that, when a man conforms to the traditional male role, he is five times more likely to attempt suicide than a member of the general population. In the armed forces, a medical release is a failure of the system, but it is also a failure for the man who finds himself in a vulnerable situation. As that perception is generalized within himself and within his unit, he feels shame and has difficulty seeking help, as we were saying. Therefore, going from active military service to civilian life and becoming a veteran is a critical moment when the vulnerable soldier loses the strong and unified network with which he identified and participated in. So that will be an extremely difficult moment that must be anticipated and monitored, and that is why this consultation is important.

As you know, many services are provided by Veterans Affairs Canada. However, is sufficient training provided for the professionals who work in suicide prevention, the responders to whom our veterans can turn? Are they able to recognize signs of distress and act quickly?

A training initiative for Quebec citizens has a proven track record. “Agir en sentinelle pour la prévention du suicide”—acting as sentinels to prevent suicide—is a training initiative that is intended not for professionals but for anyone who wants to play a role in their community, in their spare time, with their work colleagues and their peers. It enables people to be proactive, identify signs of distress, refer the individual to help resources and go with them. That training works. It is effective and has already become entrenched in some military communities. It promotes timely identification and proactiveness.

In civil society as in specific communities, those sentinels must be able to rely on a designated responder. They must be supported in order to play their role and then be able to quickly help the suicidal individual connect with a responder who will provide a full intervention and decide what steps should be taken next.

● (1655)

Suicide prevention training is essential for responders and mental health professionals, as well as for physicians who work with military members and veterans. It should not be taken for granted that a physician, a nurse or a psychologist has received specialized training in suicide prevention. However, that type of training does exist, and it works.

The Quebec male suicide rate decreased significantly in the 2000s specifically thanks to a national strategy with training at its core. So we suggest that you make training a cornerstone of the next strategy for veterans.

Furthermore, we want to draw your attention to three major elements to consider with regard to the current services provided or with regard to what you could implement. General Dallaire referred to this earlier. I am talking about the importance of streamlining the services available to our active military members and veterans. That transition must go as smoothly as possible, so that, ultimately, the suicidal individual or military member who needs services, having successfully asked for help and found someone to help them and guide them in that endeavour, does not have to change responders or treatment teams and does not have to repeat their story, either before or after a suicide attempt.

To avoid that disconnect, we suggest that you consider a consolidation of Canadian Forces operational stress injury treatment centres and veterans centres, so that the treatment team would be the same. The therapeutic alliance is important. Veterans sometimes even go back to the same team and health professionals they dealt with when they were in active service.

We also talked about social support. General Dallaire mentioned that. We are talking about social support from families and peers, but also about support from the unit, as well as gathering around the forces and active military members. That support must be an integral part of care and of what professionals and responders propose to military members.

Men mainly turn to their spouse—sometimes exclusively—when they need emotional support. A separation occasionally occurs when they are not doing well. There may be additional problems, including mental health issues, alcoholism and substance abuse. All that puts considerable pressure on loved ones. That is why it is so important to take into account this reality in order to help military members and veterans recover.

The Canadian Armed Forces are a large and strong family. Each member can count on the others for their survival. The idea is to make sure that this strength and mutual support continue after release, whether that release has to do with medical issues or not.

In addition, we make recommendations when it comes to web-based prevention and online responses. Distress is increasingly manifesting on various platforms. People share their suicidal ideas and their distress on the web. That is especially true in the case of young people and isolated individuals, but that behaviour is becoming more prevalent among a variety of individuals. We feel that suicide prevention strategies must now take into account this reality by including a web component. That would enable people to share prevention messages, identify cases, be proactive and propose full response services online.

In closing, I want to reiterate the required elements of an effective suicide prevention strategy. First, all the stakeholders are concerned. Second, managers at various levels of the chain of command must undergo training, uphold the principle and demonstrate leadership. Third, professionals and responders must be provided with specific suicide prevention training. Fourth, the creation of sentinel networks must be supported. Fifth, strong and widespread social support must be established. Sixth, people must be provided with better education on mental health issues and be better informed on the help that may be provided. Calls for help must be encouraged to ultimately change cultures and mentalities. It is also important to pay attention to the messages and ceremonies, so that they would not increase the social acceptability of suicide. Of course, adequate funding is required to implement the proposed measures. Finally, accessible care adapted to the clientele for which it is intended is obviously required.

● (1700)

Thank you very much.

[*English*]

The Chair: Thank you.

We'll start our first round, and we're going to have to shorten it to five minutes each. I'm sorry about that.

We'll start with Mr. Kitchen.

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

[*Translation*]

Thank you very much, Ms. Rioux and Ms. Basque.

[*English*]

I appreciate your coming here. That's the limit of my French.

Some hon. members: Oh, oh!

Mr. Robert Kitchen:: You both said something that caught my ears, and I've got a very short period of time because I'm going to share my time with Ms. Wagantall.

Ms. Rioux, you commented on the need to avoid glorifying death by suicide. Can you expand on that? What do you mean by that?

[*Translation*]

Ms. Catherine Rioux: By using suicide to put an end to their suffering, a military member may receive honours, attention and recognition. That is what I call suicide glorification. We can glorify the deceased individual or pay tribute to them, but it is important to separate that from their act of suicide. A military member must not think that committing suicide will give them more honour than another soldier who died of a heart attack or another cause would get. Contagion must be avoided, and people must not end up thinking that it's a way to get recognition from the Canadian Forces and society.

● (1705)

[*English*]

Mr. Robert Kitchen: Thank you.

There's that stigma. There's that challenge, that disconnect with the stigma for somebody who maybe has attempted to take their life because of depression, or situations, or whatever it might be, which often gets labelled. Someone says, okay, you're not worthy of anything. I'm trying to wrestle that with your comment about glorifying it and whether someone would actually look at glorifying that, but I appreciate your comments.

Mademoiselle Basque, you talked about suicide prevention training. How extensive is it in your organization?

[*Translation*]

Ms. Kim Basque: It is an extremely important aspect of our organization. The AQPS designs training products with major partners such as Quebec's Department of Health and Social Services, as well as with other organizations with data expertise. We have to be inspired and learn from the research to give our responders and fellow Canadians an opportunity to develop tangible skills that will enable them to play a role in suicide prevention.

The AQPS currently has about 20 different training products. We have trained more than 19,000 responders to use best practices and clinical tools that help them recognize proximal factors of suicide. There are 75 factors associated with suicide, and some carry more weight than others. Some factors are observed very closely when action is taken.

Thanks to the expertise we have acquired and the tools at our disposal, we are improving our responses to ambivalent suicidal individuals to help them reconnect with their reasons for living.

The sentinel training is developed based on a similar model, while of course respecting the role and responsibilities of volunteers in their community. That training will give those people the tools they need to determine if there is suicidal ideation, be aware of resources and guide the suicidal individual toward those resources, as that is often a difficult step for them.

Our training products are complementary and aim to strengthen the safety net around suicidal individuals.

[*English*]

Mr. Robert Kitchen: Thank you very much.

I hope I've left enough time for Ms. Wagantall to ask questions.

Mrs. Cathay Wagantall: As you know, we recently brought into law in Canada assisted suicide and assisted dying legislation. Since then, 800 individual Canadians have chosen that route. With its coming into play, I was very concerned about our veterans, our soldiers, who feel that life isn't worth living anymore and who might see that as an affirmation. In the work that you do, are you seeing a difference at all in response to this?

[*Translation*]

Ms. Kim Basque: It is too early to take stock of the situation or obtain relevant documentation on medical assistance in dying.

That said, we are extremely worried about this. When that legislation was developed, a few years ago now, we participated in the consultations of the parliamentary committee of the Quebec National Assembly to share our concerns with regard to a potential shift in the social acceptability of suicide.

A person at the end of their life feels, rightly or wrongly, that their life is no longer worth living; that is their decision. That is why they want to request medical assistance in dying, resulting in their death. Even in a medical context, we understand why people would want to use that measure.

Our concerns had to do with a way to provide a vulnerable individual who is not doing well—who feels that their suffering is intolerable, who is depressive and suicidal—the same care they should have the right to, without legitimizing a request for medical assistance in dying in a context where it would legally not apply.

We are extremely worried by that. At this time, it is too early to gauge the concrete and documented effects of medical assistance in dying.

● (1710)

[*English*]

The Chair: Thank you for your answer.

Mr. Graham.

[*Translation*]

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Thank you for your comments.

You spoke a lot about training. In the veterans context, I would like to know whom we should train.

Ms. Kim Basque: The health care teams should receive specialized training to be able to intervene in a complete way and properly receive the veterans, taking into account the fact that the request for help from military men does not always present in the same way. Those teams should also use precise clinical tools, as well as ensure follow-up and access to services and resources.

The networks of sentinels we referred to could also be proposed. These sentinels have to be volunteer adults who are already in a role where they have the trust of the person, who can open up and agree to talk about his troubles. The sentinels cannot be members of the health care team. They really have to be people who are involved with the veterans and can have access to them, even if they are not specialists.

If I may, I'd like to make a parallel between veterans and the agricultural milieu. We have created massive sentinel networks there, and we even set up training specifically for the agricultural environment. Agricultural producers are often isolated, and they aren't necessarily part of a network. That said, there are still people who gravitate around them and see them, because they provide services. Those are the people who are trained as sentinels to reach out to farmers.

You could think of setting up a similar system for veterans, that is to say assess where they go, who they see, who they are in contact with regularly in their daily lives. Those people can become sentinels, if they want to, of course. Indeed, that cannot be an obligation. The training of intervenors is central to all of this. The sentinel must himself have access to support and be able to direct the suicidal person to an intervenor 24/7.

Mr. David de Burgh Graham: So we could train family members and other military members.

Ms. Kim Basque: Yes, if the military person is not suicidal himself and if the family itself does not need care and support.

Those close to suicidal individuals have other needs and have to obtain care. They cannot act as sentinels in these extremely difficult moments in their family life. They have to take care of themselves and the other members of the family and know how to support the spouse who is not doing well. We try to avoid training loved ones, especially when they are going through difficult times. Of course at other times, that is possible.

Mr. David de Burgh Graham: You also spoke about avoiding the glorification of the death by suicide of military members.

Earlier we spoke with General Dallaire about the need to include war-related suicides in war deaths.

How can we reconcile those two approaches?

Ms. Catherine Rioux: Would you repeat the question? I want to make sure I understood.

Mr. David de Burgh Graham: We want to avoid glorifying suicide of course, but we also want to recognize veterans who committed suicide because of mental injuries they suffered through their participation in war. We want to acknowledge them, but not glorify suicide. How can we align that?

Ms. Catherine Rioux: Of course they must be recognized as victims who fought. There is indeed a certain risk involved. Certain suicide prevention workers are worried about that parallel; it is a complex question.

We recommend that you take some time and speak with experts on this issue. There are several in Quebec, such as researchers like Brian Mishara. Some intervenors who work in the army are also specialized in this.

We don't have all the answers, but we think it is important to look at this question and find good potential solutions in order to avoid glorification.

Ms. Kim Basque: A nuance needs to be made. Of course you have to collect useful information on the suicide of soldiers and veterans, in order to understand what could have been done to prevent them, and put in place proper services. However, in paying tribute to a person who committed suicide, we must not send the message that we are also paying tribute to the way in which he or she ended his suffering. Nor should we conceal the fact that services needed to be offered to that person, and that a security net needed to be placed around him in order to prevent his act.

That concern exists everywhere. Following a suicide, we talk about post-intervention. That consists in asking ourselves what can be done for the family members and friends, peers and environments who have experienced the loss of one of their members. We are always concerned by the way in which people who have lost a loved one wish to pay tribute to them. We don't want this to send a message of glorification, and we don't want the tribute to be disproportionate. We worry about the risks involved in emphasizing how the person died, that is to say the fact that they committed suicide.

● (1715)

[*English*]

Hon. Roméo Dallaire: I was just asked to reinforce that, Mr. Chair.

The Chair: You'll have to make it very quick. We are running on gas here.

Hon. Roméo Dallaire: Before they commit suicide, the option is to have a system of recognizing them as being injured honourably. If you have a solid way of showing that they've been honourably injured, just like we take care of the guy or girl who has lost an arm or a leg, and they feel that they've been honourably recognized in that way, then you have an equilibrium with those who simply have gone the other route. If you only try to recognize them because they've committed suicide, I agree entirely with them. The onus is on the prior recognition of an honourable injury that they've received and that we've treated them honourably and that their regiments and so on have done the same. Then you have established a balance.

The Chair: Thank you.

Go ahead, Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you.

I'm glad that you made that point, General Dallaire, because PTSD is an injury that has debilitated a veteran in some way.

You talked about people in combat suffering this injury, but we know that PTSD can strike those who are not in a combat role. I'm thinking particularly of a statistic that we received from StatsCan's 2016 survey that found that more than a quarter of all women in the military reported sexual assault at least once during their careers.

Have you looked into military sexual assault—it's not just women, but men too—as an underlying issue with regard to PTSD during combat or non-combat situations.

[*Translation*]

Ms. Kim Basque: To my knowledge, the cause and effect link has not been well established, as is the case for other types of difficulties. I certainly do not want to minimize the effects of sexual assaults, that are horrific both for women and for men, but we can make someone fragile who is not, and make someone who is in distress even more fragile.

Suicide is complex. The factors that make people vulnerable to suicide are also complex. There is no single cause for suicide. I don't know if there are specific data showing a link between sexual assault and the suicide of military people.

[*English*]

Ms. Irene Mathyssen: Okay, thank you.

I wonder if mental health workers should play a more central role during the transition of a veteran. Would a stronger presence of mental health workers make that transition easier, underscore the value of the veteran, and provide recognition that their mental problems are understood by DND and VAC and that there is compassion?

[*Translation*]

Ms. Kim Basque: We suggest that the same health care team follow the veteran, whether he is an active member of the military or a veteran released from the Canadian Forces because of the state of his or her health. Of course that would help the transition. Ultimately, it would in a way eliminate that transition. The same health care team would take care of the same member, whose needs would evolve. Since the request for assistance continues to be fragile among male military members, it is important that it be received with an eye to its particularities. You have to continue to build the trust that was created, rather than changing the caregivers.

● (1720)

[*English*]

Ms. Irene Mathyssen: Thank you.

We know and have heard over and over again how important families are to the overall well-being of the veteran. To what degree does your organization interact with family members? I'm thinking not just about how they support and help the veteran, but also how they survive themselves.

In previous testimony, we heard there's an increase in suicide among the children of veterans, which is very troubling. How do you interact with families?

[*Translation*]

Ms. Kim Basque: Our association does not provide services to citizens who are not feeling well. We have suicide prevention expertise, but we work with several partners who offer clinical services, such as in the suicide prevention centres. Our expertise takes that into account.

In Quebec, the way we intervene has changed. A few years ago, for instance, we mistakenly believed that the fact that the person who was feeling troubled phoned for help himself meant that he would be easier to help. But no research has shown that recovery is easier if the person asks for help himself. What we know about suicide in fact makes that assumption all the more inappropriate.

In Quebec, we have adapted the services provided so that we can provide assistance to family members who ask for help, and of course we support them when they do so, when they express worry over someone else. The services offered by the suicide prevention centres and the integrated health centres take that reality into account.

[*English*]

Ms. Irene Mathyssen: I think this is a very important thing. In Ontario you have to reach out for help yourself. A family can't do it for you. It's extremely frustrating.

You talked about the tools and the outside agencies. We've also heard that there's a real sense of a military family. Are you finding—

The Chair: I'm sorry, we're out of time.

We will have next, Mr. Fraser.

Thank you.

[*Translation*]

Mr. Colin Fraser: Thank you very much, Mr. Chair.

I thank our two witnesses for their presentation, and for having come to speak with us about this highly important topic. The information you have shared with us will be very helpful to our committee.

You spoke about the importance of families and people close to the members in these situations. Can you tell us how, when suicide is a risk, it would be possible to intervene earlier with the help of families and friends? How could we rally these people around the veteran in such situations?

Ms. Kim Basque: Suicide prevention is everyone's business, but it is also the business of the loved ones of the suicidal person. Suicidal people always give clues about their distress. People don't always pick them up. We don't always have access to the total picture. Every individual has a piece of the puzzle, and it is when you assemble all of these pieces that you can understand what state the person is in, what needs have been expressed and what signs of distress we should recognize.

As for the care that needs to be provided to the suicidal person, the family has privileged information. The resources and care we can provide to the loved ones will also help them to get through the crisis, to play their role properly and to become a bit more solid.

● (1725)

Ms. Catherine Rioux: They have to be aware that there are dedicated suicide prevention lines that exist, for instance in Quebec. A Canadian suicide prevention line will be available soon. Pilot projects are being set up. That line will be for the civilian population, but also for military members and loved ones. Indeed, the families are sometimes grappling with enormous issues, they can be worried and in a state of extreme vigilance. So it is important to let the families know that these resources exist and that they can be supported by suicide prevention specialists.

In a suicide prevention strategy, post-intervention is extremely important. If we prepare a strategy we have to think about post-intervention mechanisms. What do you do after someone commits suicide? How do you announce things? How do you protect his environment, his colleagues and his family, among others? We can do prevention work with those people, who are in fact more likely to commit suicide themselves after someone's death.

Mr. Colin Fraser: It is important to include such people in the process. Indeed, the sooner you intervene in a suicide situation, the better the outcome.

Is that correct?

Ms. Catherine Rioux: Yes.

Mr. Colin Fraser: Ms. Basque, I believe you spoke about online services in connection with your organization.

Based on your experience, can you tell me whether persons in crisis use online services? Perhaps they will not communicate by any other means. This is new for some veterans, but it is a modern means of communication. Do you think some people will only use online services?

Ms. Catherine Rioux: Yes, we do. Experiments were conducted all over the world. Some of them were in Canada, but I would say that we are not very advanced in this area. In Quebec we lag behind in this regard. Certain tests have shown that the Web allows us to reach other types of clientele, for instance people who would not go to meet caregivers or who would not use the telephone to ask for help. As we were saying earlier, that is the case for people who are more isolated. Young people today also communicate very little by telephone.

We can offer other means of interaction, such as text and online chat. In certain countries, there are online interventions. In this way we can establish a first contact and then speak on the telephone to create a therapeutic alliance. That can be done online, remotely. For some people it is less intimidating. They will open up more and can choose how often they want to be in touch.

There are all kinds of models that exist currently. In Quebec, the Centre de recherche et d'intervention sur le suicide et l'euthanasie, CRISE, is devoting a lot of effort to studying that.

In short, there are things to explore in this area but unfortunately, we are lagging behind. This lag not only pertains to the military, but also civil society.

Mr. Colin Fraser: Thank you very much.

Ms. Kim Basque: We have to provide the services suicidal people need where they are. If it is the Web, we must be present on the Web. If it is on the phone, we have to be present on the phone. If they are in a physically isolated location, but are nevertheless in touch with someone once a week, that person has to be vigilant and encourage them to request assistance.

Ms. Catherine Rioux: After someone commits suicide, people often discuss the death and express their distress and their disarray on social networks. This is distressing for suicide prevention workers, such as the people who work in schools. People don't know exactly what to do. There are potential solutions that can be proposed. We have to put something in place in order to allow those workers to identify the people who are the most vulnerable in these discussion forums and social networks.

Mr. Colin Fraser: Thank you very much.

[*English*]

The Chair: Thank you.

Unfortunately, that ends our time for testimony today. I do apologize.

I'd like to thank your organization and both of you for all you do for our men and women who have served.

Also, if you would like to add anything to your testimony, please send it to the clerk, who can then get it to the committee.

With that, I will adjourn for one minute sharp and we will then have about five minutes of committee business. I apologize to the committee that I do have to keep you afterwards. Everybody who doesn't need to be here can leave and we'll start the committee business in one minute.

[*Proceedings continue in camera*]