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Chair

Mrs. Joy Smith

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● (0900)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, ladies and gentlemen. I want to welcome you to the health committee. We'll have some other members joining us shortly and we'll keep them informed, but I don't want to get behind. I want to make sure we keep up to speed, because we have quite a complement of witnesses today.

I want to welcome you to the Standing Committee on Health. We're very pleased that you could make it and are very pleased to hear what you have to say today.

We are going to begin with the Royal Canadian Mounted Police. We'll begin with Staff Sergeant Murray Brown.

You have ten minutes, Mr. Brown.

Staff Sergeant Murray Brown (Staff Relations Representative, Occupational Health & Safety, Royal Canadian Mounted Police): Thank you, Madam Chair.

Good morning, Madam Chair, committee members, and guests. It's with great pride that I come before you today, and sadly, with great emotion concerning my topic and our force, the Royal Canadian Mounted Police.

I'm a proud member of the RCMP, serving in my 37th year. My service has been in the provinces of Nova Scotia and Prince Edward Island. Like most RCMP members, I began my career in front-line policing at the detachment level. I have done numerous duties in the force, including criminal intelligence, outlaw biker gangs, extensive drug work in many various aspects, including undercover. I spent about ten years on an emergency response team, which resulted in multiple deployments in two capacities, primarily as a marksman or sniper and as an assaulter. These exposures have led to some life-impacting experiences and injuries.

My appearance here today originates from my current duties as a staff relations representative, a labour relations representative who acts on behalf of over 900 members in my division, which is the province of Nova Scotia, but also thousands nationally in my capacity as chair of the SRR, our national occupational health and safety program. This is a responsibility I have held for many years. I've been elected to this position by my peers in caucus and elected divisionally by regular and civilian members of the force to terms now exceeding 14 years.

In the time we have this morning, I want to bring to your attention a critical situation that exists in the RCMP and has reached a crisis. I will try to remain focused on the occupational stress injury component broadly and not just on post-traumatic stress.

Many of you have likely seen the recent SRR publication. Many of you have it in front of you this morning. I would hope you can find some time to give that document a view. The edition has little fluff and lots of facts. The testimonials were sought to emphasize the difficulties encountered by numerous members throughout the country. There were many offers of input, and some were extremely emotional. We chose to concentrate on those individual situations impacted through the circle of care.

Some of you already know that members of the RCMP are excluded from the Canada Health Act, along with new immigrants to Canada and federal inmates. Because of this exclusion, I am not entitled to receive health care in my own province without the approval of my employer. That authority comes under subsection 83 (1) of the Royal Canadian Mounted Police Act and regulations.

The publication provided to you today has also been given wide distribution, including to the Senate and the House of Commons. Features within are impacting articles from affected serving and retired members, treating professionals, families, and others. There were many who wanted to contribute their experiences, but we could not accommodate the demand.

Some of the real thoughts expressed by regular and civilian members when they have been impacted by operational stress injuries include the following:

—It would harm my career, job promotions, advancement.

—Members in my unit have less confidence in me.

—Unit leadership might treat me differently.

—Leaders blame the member for the problem that he or she has become ill, because from a leadership point of view, we're now down a body with no replacements.

—Members are seen as weak—the “suck it up” type of attitude.

—It will be too embarrassing for my family.

—I do not trust the RCMP.

—I do not trust RCMP health services.

— I will get better on my own.

We recently had a serving member of the force sustain major injuries during an international deployment. I received phone calls from various members who were concerned about the medical and support services needed by this severely injured member. My first contact was with one of the presenters here today, Superintendent Rich Boughen. After I discussed this matter with Rich, he immediately went to the member's house and he facilitated some of those needs that the member and the family had.

Many of our support programs that were designed to assist first responders in the field are suffering from a lack of resources and funding. We need help externally to deal with these situations we confront. We need your help to put these medical needs concerning the health of our members in their rightful place—as a true, real priority.

Some members are dealing with medical situations by paying for their own appointments and medications, so that no one will know they're having personal difficulties. In situations such as this, if a regular member goes to pension and makes a Veterans Affairs' claim application upon retirement, there is no medical information contained in the member's personnel medical file to justify the claim. So then the process has to start from a position of pension in which to justify that application.

● (0905)

These are outcomes encountered when members feel that they must keep their condition secret.

Recently, an RCMP veteran who had been retired for six years read some of the SRR work concerning OSIs. During this pension period, he dealt with many personal issues and realized he needed support, so he reached out for help. That help was provided. He was taken to a local VAC office, and he is now in treatment.

We have RCMP members who are self-medicating through drugs and alcohol. This is a short-term fix for a monster that returns even angrier. The RCMP has a growing underground of sick members who do not want to come forward.

We deal with any number of contract professionals who know little or nothing about the policing profession or the lifestyle that we live. They have no introduction to our world. In fact, in my home division right now, we have a contract doctor who is working, I believe, seven days a month. If you happen to get hurt or have a file for review during those seven days, what do you do? Those are the realities we're faced with in my organization through the inability to have the resources to provide the service.

For years, SRRs have been promoting the need to have designated physicians who are educated and knowledgeable about police work. We have a member employee assistance program, MEAP, as a core program that is respected by serving employees for its many successes. But it has been continually crippled by vacancies.

Members often do not go to RCMP health services for referrals, especially for psychological conditions, because they are concerned about their personal and professional situations.

We have had and continue to have members who are not followed in their transfer from one division to another, who ultimately fall through the medical administrative cracks. I would suggest that, more than often, members are not followed up when they come out of northern or isolated posts. This is because of a lack of health care professionals who have an understanding of our world, police work.

Our concern is not for those who are off duty sick as much as it is for the large numbers we have who are working sick, those members who come to work every day until they crash. Our organization cannot tell you how bad the psychological situation is within our organization. We maintain few or no statistics. We are forced to depend on numbers provided by Veterans Affairs Canada. As recently as last night, the closest I can get to those is for last spring, almost a year ago. Remember that VAC only has those numbers after the damage is done.

Our health care program defers to VAC to make decisions on injuries that were sustained during employment, which is another test of our inability to deal with these issues ourselves and then make application to Veterans Affairs.

The RCMP has no in-home care available to our severely injured serving and retired members. Imagine a person being hurt and unable to remain in their own home. Our members serve throughout Canada and the world and show the Canadian flag in more jurisdictions than any other government service. But historically our injured members have been denied the benefits of the veterans independence program. Our battleground is primarily domestic, but we serve abroad as well, in many other countries. Our force has paid a heavy price in supporting our nation, as have our brothers and sisters in the Canadian Forces, who have made the same sacrifices. We are asking for nothing more than to be looked after medically.

First and foremost, we need your help as a health committee. We need A-base funding of our health services requirements so that the money is protected and cannot be extracted for other purposes.

The RCMP needs the resources—trained resources—and funding to provide health care programs that meet the needs of our front line members. These resources must be identified in an organizational chart that does not change frequently. At present, we have the money for 20 positions; we have 40, minus some vacancies, in a workplace that needs every bit of 60 positions. This is a circular response to our situation that you have to know about.

We need a committed, strong MEAP program, fully focused on the mental and physical health of the RCMP. Members trust other members, and this is what allows us to access what we know now. This inherent trust in our members maintaining the MEAP program —knowing who we are, knowing what we do and how we function as a police force—makes this program not only unique but trustworthy from within. In essence, you speak to someone you know who understands what you do, rather than a stranger on the end of a 1-800 number.

It is critical that every employee of the RCMP be given immediate training in OSI.

● (0910)

I've taken enough time this morning. I realize that your time and my presence here today is at a premium. It is one that I will carry through the remainder of my service, and I thank you for the opportunity to come in front of you today.

The Chair: Thank you, Staff Sergeant Brown.

We will now go to Chief Superintendent Alain Tousignant, acting assistant chief human resources officer and chief learning officer.

Chief Superintendent Alain Tousignant (Acting Assistant Chief Human Resources Officer and Chief Learning Officer, Royal Canadian Mounted Police): Thank you. Good morning, Madam Chair and members of the committee. Thank you for inviting the RCMP to appear before you today.

I would like to introduce Superintendent Rich Boughen, acting director general, occupational health and safety, who is with me to answer questions on occupational health and safety. I would also like to acknowledge the presence of Staff Sergeant Murray Brown, who was invited directly by the committee to speak on behalf of the staff relations representative program.

The RCMP is the largest police force in Canada. We employ a workforce of extremely diversified occupations. The bulk of this workforce is composed of police officers who diligently carry out traditional police functions. We also employ a wide variety of specialized officers and civilian members, as well as public servants, auxiliary constables, volunteers, and contractors from all trades and professions, who in all total over 28,000 employees. The RCMP is present in large centres, small communities, northern and isolated posts, and peacekeeping missions across the world.

[*Translation*]

There is no such thing as routine work for a police officer. By nature of their work, RCMP members can be placed in operational situations that can result in physical, emotional and psychological injury and/or illness. They are regularly exposed to traumatic events, tragedies, atrocities, natural disasters and deep human suffering. Operational stress injuries not diagnosed can have a significant impact on the functioning and enjoyment of life within the family, work and social domains without the member or their families understanding the reasons for behavioural changes.

RCMP members are excluded from the Canada Health Act. Health care to our members is provided under the authority of the RCMP Act. Under this authority, the RCMP, through its operating budget, provides all health care benefits for its regular members to maintain and, if necessary, ensure a timely return to good health and fitness for duty.

● (0915)

[*English*]

The occupational health and safety branch establishes policies and programs aimed at promoting a healthy and safe work environment, and collaborates with a network of designated providers and other federal health care partners. The national branch supports regional and divisional occupational health offices by establishing national medical and psychological health standards, which are carried out by the divisional offices.

[*Translation*]

Preventative measures are in place to monitor the health of regular members throughout their career. Divisional physicians evaluate physical and mental wellbeing during a mandatory Periodic Health Assessment. This assessment must take place every one to three years dependent on specialized duty.

Members have access to comprehensive health care through entitlements and benefits. Health care is provided by medical and psychological professionals in the community and chosen by the member, although the RCMP does provide immunization. We strive to meet the health care needs of our members and those of their families and, when necessary, we will transport and may even relocate a member to ensure access to treatment resources.

[*English*]

The federal health care partnership aims to achieve economies of scale while enhancing the provision of care as well as to provide strategic issues leadership. The RCMP is unique among its partners in the FHP, as we do not provide direct health care or treatment to our members and as such we do not encounter the same types of pressures in the recruiting and retention of health professionals.

[*Translation*]

We are pleased with the leadership that the FHP has provided in Privacy, Enterprise Architecture Plan for the development of the Electronic Health Record, Health Services use of Data and Health Claims Processing. We also believe that the departments could further capitalize on the potential economies of scale by the provision of a knowledge base in support of partners in all areas of health care and health care management.

[*English*]

In closing, it's important to note that as our organization matures and changes, so do the needs of our employees. The RCMP is evolving to keep pace. As of April 1, I will be commencing the new position of director general, workplace development and wellness. The creation by our organization of this new role at the assistant commissioner level underscores the importance of wellness at the RCMP. We also continue to be intelligence-led and have engaged experts in the field to shepherd us as we move forward. We will utilize the latest research and best practices to keep our people healthy, fit for duty, fit for life.

Thank you.

The Chair: Thank you very much.

We will now go on to Ms. Paulette Smith, please.

Ms. Paulette Smith (As an Individual): Good morning.

I have provided a photo of my husband, whose suicide was a direct result of the failure within the health service of the RCMP. My husband responded to a move to the north, and at no time during this time was he interviewed psychologically prior to leaving. He responded to an interview. He came home with a transfer paper, and at that time he had been transferred on three separate occasions in his career of 18-plus years, so he knew what a transfer paper was.

He indicated to me that he thought he had been transferred, and I said, “Well, that's not possible, because we both would have had to go through a number of psychological interviews.” I have had friends go to the north as well, since I am an RN. I said, “Make sure that you give me lots of notice, because I too am busy in my work.”

He proceeded to go to the interview and discuss a position that was possibly available. At no time was he interviewed, but he was promoted to go to the north. I was not given a psychological interview at all. As a spouse, I was given a piece of paper and sent home to review it and send it on.

We proceeded to the north. At that time the conditions were unbelievable in the place where we went. Support was minimal in a number of factors. He reached out and said, “I can't do this any more. I don't know what is wrong with me. I don't know what is wrong with me.”

He contacted his division supervisor. We then went to K Division headquarters in Edmonton. We met with psychological professionals and force physicians. The psychological physician was not within the force; she was an outsourced member. During the interview, I was with my husband at all times. I made sure of that. Even if I wasn't invited, I made myself invited.

Paul responded to a question that is mandatory. He was asked if he had any issues with self-harm or harm to others, and his response to the question of suicide was yes. Her response was, “You have a few issues we have to talk about.” He was asked where his family was. He said it was down east in Ottawa and Nova Scotia. She said, “Fine, I'll refer you to Ottawa.”

We went on to Ottawa. It took some time for the appointment to actually get made to go forward. We then went in. The doctor indicated within an hour and a half over a two-day period that nothing was wrong with my husband, but indeed he was going about this blindly. He had not been given my husband's work file, and I said, “Dr. So-and-so, I am a nurse. How can you be evaluating us with no file?”

His response was that it was never given to him. He said this was common. He said, “I go to the north on a monthly basis for a period of five days a month.” He works for three days a week. He is not a member, nor does he know anything about being a member.

● (0920)

Within a two-day period, my husband was told that there was nothing wrong with him. He was told, “You are normal.” He walked out and said, “Dear, I'm normal.”

We were posted to Ottawa. We bought a home, and while signing the papers for the home, we received a call to come and pick up his side arm. Within three days he took his life. We were told that he was normal, that nothing was wrong.

Throughout his career, as you see.... You may not be able to tell from his photo, but my husband was six feet three inches and 265 pounds. He was a gentle giant. He never asked for help until then, and the resources were not there. The people we met were not trained to recognize what was wrong with him. He didn't know what was wrong with him.

When we sat with the Ottawa psychologist, Paul opened up completely. “Okay, just a sec,” he said, “we'll start.” Paul had no issues in opening up and reiterating what was going on, but not necessarily what was wrong with him. To be told by one psychologist that you have a few issues, and to answer “yes” to suicide....

I'm not a member, but I am a member's wife. At no point in time did the psychologist take me aside, for the sake of 15 minutes, and say, “Mrs. Smith, I have grave concern” or “I have concern. These are the things I want you to watch for.” I'm not sure why she didn't, but when the response to a mental health issue and burnout is “yes” to suicide, I don't think it leaves much of a question of diagnosis.

As a nurse, I think we can all identify with someone breaking an arm. We have tools to identify that. We bring you into emergency. We do an assessment. We take photos and X-rays. We determine that the arm is broken, that the bone is fractured. We put on a cast. We assess you. You come back in four to six weeks, and we do another assessment. We have tools to assess for mental health issues as well, and for burnout.

Members, my husband is not the only one. There are many members. As Mr. Brown said, they self-medicate through abuse of drugs and alcohol and through many other ways as well.

Paul didn't choose to do that, obviously. I think his feeling was to suck it up, and that was the feeling that was given to him through the actions and the treatment within the health issues. That was what he was given to deal with this issue. He had none. It was, “Turn around and go out the door. You're fine. Go back to work.” He was told, as I sat in the office, that he was fit for duty. This was from a psychologist who works on contract for three days a week.

I ask you to consider what these men have to say, realizing that first-line personnel—RCMP, firefighters, EMTs, persons of that sort—are all high-stress individuals in high-stress jobs, and not everyone deals with their issues in the same way.

● (0925)

My husband paid the ultimate price. When he asked for help, it wasn't there. It was not provided. I am not quite sure why, in the total sense, but he did everything he could do.

Thank you.

The Chair: I want to thank you very much, Mrs. Smith, and I thank you for sharing that very personal story with our committee.

I would now like to go to the Department of National Defence and Commodore H.W. Jung, director general of health services, commander of the Canadian Forces health services group, Surgeon General, and Queen's honorary physician.

Go ahead, Commodore Jung.

[*Translation*]

Commodore H.W. Jung (Director General of Health Services, Commander of the Canadian Forces Health Services Group, Surgeon General and Queens Honorary Physician, Department of National Defence): Good morning ladies and gentlemen and thank you for the opportunity to address the committee.

I will begin by providing you a brief summary from the Canadian Forces perspective of issues surrounding health personnel and collaborative care that I understand are of interest to the committee.

[*English*]

The Canadian Forces are very much really a separate health care jurisdiction in Canada. While the most tertiary and high-level care within Canada is obtained through civilian jurisdictions, the CF has its own deployed tertiary care and its own training establishment, dental service, public and occupational health agency, pharmaceutical supply system, and research organization, as well as other services. It also maintains nationally unique capabilities necessary to support military operations. Except in very specific authorized circumstances, the military health service is only mandated and resourced to provide care to CF members, but pursues every opportunity to enhance the provision of provincial or territorial care to the families of CF members.

● (0930)

[*Translation*]

The Canadian Forces Health Services experienced severe personnel shortages in the 1990s that seriously affected our ability to support military operations. To address this and other gaps, the Rx2000 project was initiated in January 2000. One of its many components was an Attraction and Retention Initiative to address health personnel gaps.

[*English*]

Our attraction and retention model and strategy had been expected to close some of these gaps, particularly for physicians, which was the first group we targeted. As of January, our total effective strength for uniformed medical officers has been met, and our intake requirement is satisfied up to 2017. These successes are mainly due to competitive recruiting incentives, compensation scales, continuing medical education opportunities, and employment opportunities in other work environments.

[*Translation*]

The successful physician model has been applied to other distressed professions with varying success.

Pharmacists remain a challenge due to shortages in the civilian sector, where salaries are high and the CF is not competitive. Forecasts indicate that most of our distressed occupations will achieve their Preferred Manning Levels within five years if our funding model remains at its current level.

[*English*]

Given the investment required to recruit health care professionals, we try very hard to retain them once they are enrolled. We use a number of incentives, such as professional development programs, maintenance-of-competency programs, incentive allowances, professional advancement opportunities, and so on.

The importance of recruiting and retaining enough health professionals is only expected to increase as the implementation of the Canada First defence strategy progresses. Since it takes many years to educate and train health professionals, their attraction and retention must remain the subject of constant effort and vigilance.

[*Translation*]

The CFHS also employs many civilian health professionals. Our ability to recruit and retain them is constrained by disparities between market forces and public service employment incentives.

This has resulted in some staffing gaps and has necessitated a reliance on expensive contracted services. We therefore support efforts to enhance Public Service recruitment and retention.

[*English*]

With the exclusion of the CF members from the Canada Health Act, very much like the RCMP, civilian health care providers and provincial and territorial health authorities may also charge out-of-province, and sometimes non-Canadian, resident rates for health care services to CF members, ranging from approximately 130% to 200% of provincial rates. We would therefore support initiatives to standardize and minimize such cost differentials.

With respect to collaborative health care, the primary care renewal initiative was designed to provide high-quality patient-focused care through collaborative practice, strong continuity of care, and a standardized approach across CF health services, while remaining adaptable to ever-changing CF operational needs.

At the core of our model, our care delivery unit is composed of several types of clinicians supported by a variety of support and population health staff. They work closely together through means such as case conferences to deliver optimal evidence-based care based on best practices and are supported by a variety of mental health centres and clinical and population health specialists. Our lessons learned in all aspects of health care are available to any interested departments. We collaborate closely with many departments, such as Veterans Affairs Canada for the transition of care to CF members leaving the armed forces, VAC and the RCMP for the provision of mental health services, the Public Health Agency of Canada for national public health threats, provincial and territorial authorities for the provision of tertiary care, and many health institutions for health research and clinical training.

We're committed to assisting the federal health care partnership and departments interested in our CF health information system, which is very popular for our clinicians. It would permit controlled electronic access to patient records and link health facilities across Canada and locations outside Canada, such as in Europe and in Afghanistan.

Thank you again for your interest in the health of CF members and for the opportunity to appear before you today. I'd be pleased to answer any questions.

Thank you.

The Chair: Thank you, Commodore Jung.

Now we'll go to the Department of Veterans Affairs, to Ms. Janet Bax, the executive director of the Federal Healthcare Partnership Secretariat.

Ms. Bax.

Ms. Janet Bax (Executive Director, Federal Healthcare Partnership Secretariat, Department of Veterans Affairs): Thank you, Madam Chair.

Honourable members, as the chair has pointed out, my name is Janet Bax, and I'm the executive director of the Federal Healthcare Partnership Secretariat. Accompanying me today is Hillary Flett, who's the manager of the federal health care partnership's office of health human resources.

● (0935)

[*Translation*]

We are very pleased to be with you today to report on the activities of our office since it was created in 2008. We are going to make most of our presentation in English, but we will be pleased to answer your questions in French.

I will begin the presentation. Ms. Flett will follow and will describe the office's achievements and the challenges we are facing. You have the brief in front of you. We do not intend to go through it page by page. We are simply going to give an overview to allow for as many questions as possible.

[*English*]

First, Madam Chair, I'll offer a brief word on the partnership. We are a horizontal initiative of seven partners, including Citizenship and Immigration Canada, Correctional Service of Canada, Health Canada, National Defence, the Public Health Agency of Canada, Veterans Affairs Canada, and the Royal Canadian Mounted Police. We represent over one million clients and an annual expenditure on health services and products of over $2.7 billion.

Established in 1994, the partnership has a mandate to work collectively to obtain economies of scale, as Monsieur Tousignant said, while enhancing health care provisions, and to identify areas of health care that would be susceptible to joint collaboration.

In 2006 partners were facing a serious issue with respect to hiring and retaining positions in the Government of Canada and asked the partnership to work collectively on this issue. The result was a study on recruitment and retention of federal positions, which was published in March 2007, three years ago. I believe, Madam Chair, that the committee has seen and read this report.

The commodore has spoken to you about measures that were and are being undertaken by the Canadian Forces. As Commodore Jung points out, however, many of these measures are not available to the public service, particularly with the introduction of the Expenditure Restraint Act. We are still living in a period of economic restraint. We and our partners are realistic about our ability to propose increases in remuneration in present circumstances.

However, our study also demonstrated there is much that could be done to improve the working environment for physicians and health workers. Madam Flett will take you through those initiatives, and then we would be pleased to answer any questions you might have.

I will now hand things over to Madam Flett.

The Chair: Go ahead.

Ms. Hilary Flett (Manager, Office of Health Human Resources, Federal Healthcare Partnership Secretariat, Department of Veterans Affairs): Madam Chair, as Madam Bax has indicated, the severity of the shortages was documented in the 2007 federal health care partnership study on the recruitment and retention of federal physicians and further revealed in a PCIS, a physician classification information survey, in 2008, which indicated that National Defence had a vacancy rate of 25% of their nursing positions, the correctional services had a vacancy rate of 35% in their psychology positions, and National Defence was, among its indeterminate public servants' positions, grappling with a 90% vacancy rate.

The FHP partner organizations have endeavoured to mitigate these shortages; however, these strategies, including third-party contracts, have led to a significant financial and administrative burden to the departments. As mentioned, the health human resource committee was stood up in July 2006 to develop clear and actionable recommendations that would address the federal physician shortage.

The committee tabled its report in March 2007, highlighting six recommendations: to increase compensation package and salary levels, to be competitive with provinces, territories, and the private sector; to develop an attraction program to attract medical graduates; to establish a partnership network; to focus on the overall change in government culture; to increase liability coverage; and to encourage continuing education.

Over the past three years, the federal health care partnership has moved forward on all six recommendations, including the standing up of a functional community office, the Office of Health Human Resources, in October 2008. The purpose of the office is to undertake horizontal initiatives on behalf of partner organizations and other implicated federal entities, including Transport Canada, Human Resources and Skills Development Canada, and the Public Service Commission.

As its logic model indicates, the long-term objective of the federal health care partnership's Office of Health Human Resources is that the federal government be able to employ the optimal health care provider mix and number.

The OHHR has three key strategies. These are to develop activities to address health service occupational classification and compensation issues, demonstrate the federal government as an employer of choice, and facilitate communities of practice. The benefits of a collaborative approach include alignment with the Privy Council Office direction and with key documents, including the sixteenth annual report to the Prime Minister on the Public Service of Canada and the third report of the Prime Minister's Advisory Committee on the Public Service, which speaks of the importance of facilitating collaborative recruitment, supporting functional community models, and strengthening the public service brand.

In addition, the community approach realizes economies of scale by collaborating on career marketing, learning and development, and enabling infrastructure.

The federal health care partnership office of OHHR is looking forward to continued collaboration with its federal partners and central agencies in addressing the federal health human resource challenges.

Thank you, Madam Chair.

● (0940)

The Chair: Thank you.

We'll now go into our first round of questions and answers. It will be a seven-minute round, for the questions and the answers.

We will begin with Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you to each of the panel members for your testimony.

I want to start with a quick question based on what we were just hearing about the 2007 report on health human resource supply challenges. Has there been any follow-up? That was three years ago. Is there anything saying, here were the recommendations and here is the state of response by the federal government on each of them: what stage they are at, whether we are making progress, and what the areas of concern are?

The Chair: Which one of you would like to take that question?

Ms. Hilary Flett: As I indicated in my opening remarks, we have in fact moved forward on all six of the recommendations.

The first one was with regard to compensation and classification. As Madam Bax mentioned, we are in a situation of fiscal restraint, and so the work the office is undertaking right now is to prepare for collective bargaining in the future. We're undertaking work that looks at current classification standards, recognizing that this really is work to enable us to be situated in the future, when we can consider collective bargaining.

Ms. Joyce Murray: Excuse me.

There's a misunderstanding of my question. I'm not questioning whether the partnership is doing the work that you identify as needing to be done. My question is whether there is a public review or reporting on progress to date, for each of those, that is available to the public, so that people like us, for example, can see that here are all the recommendations, and here is where the partnership is telling us we've made progress, or we haven't made progress, etc.

Ms. Hilary Flett: I apologize for my misunderstanding.

Every year the federal health care partnership puts out an annual report. We have available the annual report for 2008-09. It highlights the work that the office has undertaken and describes how it's meeting and fulfilling the recommendations.

In addition, on a quarterly basis the office puts out a quarterly update, which is public and made available, that highlights the specific activities that we have undertaken.

Ms. Joyce Murray: Madam Chair, I'd be interested in access to a copy of that.

I have a couple of questions with respect to the very difficult testimony by Madam Smith. To take it from the personal story to more of a general question, someone in the RCMP, perhaps, could tell us whether the professional resources—the psychologists who would be trained to work with people, to identify and support people having mental health challenges and post-traumatic stress disorder—are the right kind of resources available. Or is this a general gap, such that there may not be the kinds of professionals who can really assist in a situation like that?

● (0945)

The Chair: Who would like to take that?

Mr. Boughen.

Inspector Rich Boughen (Acting Director General, Occupational Health and Safety Branch, Royal Canadian Mounted Police): Sure, I can take that. Thank you.

Generally, the way the RCMP health services presently works is under an occupational health model. As was said in the opening statement by Chief Superintendent Tousignant, except for immunizations we don't provide direct health care whereby we deal with members who are ill. That is the responsibility of the communities in which they live and of the health care providers within those communities.

We police hundreds of communities—hundreds of aboriginal communities, hundreds of northern, isolated communities—that have issues overall with access to all kinds of medical care, whether it's doctors, nurses, or nurse practitioners, and especially for psychological issues. The way we mitigate those issues, because we don't provide the health care itself, is that we have programs that Staff Sergeant Brown talked about: the member employee assistance program, which can assist people in a peer counsellor role, or by allowing access to different facilities.

For example, in the north over the past couple of years we have approached $750,000 to $1 million in travel expenses for taking our members from isolated communities and providing health care to them at an appropriate location.

Ms. Joyce Murray: Are there trained psychologists in your EAPs?

Insp Rich Boughen: We have trained psychologists in the organization. They are regional or divisional psychologists. They typically don't provide point of care; they don't typically do the counselling. They work with doing psychological evaluations for such things as our child exploitation units, undercover programs, that type of thing.

Ms. Joyce Murray: Are these clinical or organizational psychologists?

Insp Rich Boughen: They tend to be clinical psychologists—clinical or counselling.

Ms. Joyce Murray: One of the things this group has been studying includes the international medical graduates as a potential resource to help with shortages. Has there been any identification of this as an opportunity? I understand you're saying that it's the professionals in the community, but it seems to me that there is a responsibility to support the members in a way such that, if there is an absence in the community, it's not acceptable to just say that the community doesn't have those professionals. That's where the organization would fill in some gaps.

The Chair: Your time is up, Ms. Murray.

Could someone make a comment?

Insp Rich Boughen: I didn't want to leave you with the impression that we leave our membership hanging in isolated communities. When issues are identified, we can either get the assistance they need at another location, or at times transfer them out of the community to a location that's better suited for them, for treatment, or because of the community itself.

The Chair: Thank you.

We'll now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

I would like to thank the witnesses for their presentation.

Going by the very touching testimony given by Ms. Smith and all of the testimony heard, I would say, essentially, that the client groups who are affected by your organizations are special and unique by virtue of their functions and the work they do. In particular, I am thinking of the Department of Veterans Affairs where they work both with a somewhat aging clientele, I'm thinking of veterans of the Second World War and the Korean War, and now with a much younger clientele, thinking of veterans of the Gulf War or more recent conflicts.

As a result, health services have to adapt to these two types of very special client groups. I am wondering whether, to respond to this type of clientele, there have to be tailored services, health professionals who are more specifically familiar with this type of clientele. Is that necessary?

● (0950)

[*English*]

The Chair: Who would like to take on that answer?

Mr. Brown.

S/Sgt Murray Brown: If I may, sir—and I hope I have captured your question correctly—from a point of view of being able to take on these unique services, in fact we haven't. We're floundering in that area. I'm a bit jealous to hear some of the successes on the military achievements medically. When you look at the specialty required, you have to remember that in our service delivery—we are in many places—that even the health services stations or the nurses stations have been closed out. We are all there is in many of those jurisdictions.

As Superintendent Boughen indicates, we have to move them out. The difficulty, though, with not providing that circle of care is that we move them out and then we move them back in with no follow-up or continuation. Granted, now we can do this by video conference. But if you're sick, it doesn't give you much confidence that your medical practitioner is somewhere else in Canada while you're stuck in the community that is sometimes fuelling the difficulty you're having. In our organization—and the commissioner doesn't like me speaking for him, so I will keep his request in mind—we don't, in that context.

I hope I have answered your question. If I haven't, I apologize.

The Chair: Mr. Boughen, did you want to respond?

Insp Rich Boughen: The part of the question that I think you hit on that is so important is that there is a tremendous diversity of experiences. Several years ago the military came upon the term OSI, meaning operational stress injury. We've adapted that because it works for us. Without being military, I don't want to float into a jurisdiction that I'm not versed in, but the experiences of the military in their everyday work are much different from ours. When the military deploy, they are in it for a period of time. They're deployed into a zone, and it might be for six months or three months or a year, depending.

For the policing experience I'll be RCMP-specific, but I think it touches on all policing throughout the world, or in Canada for sure. Every time we put on a uniform, we are at work, so coming across tragic events—car accidents, homicides, child abuse—is a daily occurrence. We have just begun learning in the recent past that those things take their toll. We are learning about things such as secondary trauma, which is viewing things or hearing about things that you can do nothing about. It's the unfixable suffering, the deep pain that we as police officers encounter every day. We're just recognizing that although it might not meet the definition in the DSM of what post-traumatic stress disorder is, the symptoms and symptomatologies are very similar. There is sleep disorder; there is substance abuse; there is anxiety, depression, mood swings, and a whole bunch of behavioural changes.

One of our challenges is finding health care professionals who get that. Quite frankly, I don't think there are a whole lot of what are called trauma psychologists. We are very fortunate in our organization to have Staff Sergeant Jeff Morley, who is in E Division. I work with him, and he is an unusual person in that he is also a registered counselling psychologist. He understands that. We've taken some strides in dealing with the prevention of these types of injuries, and at some point, should it please the committee, I can talk about them.

● (0955)

The Chair: Mr. Jung, I believe you want to make some comment.

[*Translation*]

Cmdre H.W. Jung: I would like to answer you in French, but this is official testimony. So with your permission, I will answer in English, to be sure that what I say is clear and exact.

[*English*]

I very much appreciate that question. Obviously for that very specific reason, the Canadian Forces have their own military health care system. It's not just doctors; we have a complete health care system that is more or less self-sufficient. We have uniformed doctors, uniformed nurses, pharmacists, psychiatrists, and so forth, who provide that very specific health care requirement while knowing and living in and experiencing the same environment that our patients undergo. We understand what they're going through and we deploy with them in that environment.

Obviously we also have civilians working in our system to make sure that when we take our military members out of their base, there's some continuity. Military members, because they're military, do get posted just like any other military members. They get deployed. Therefore to ensure the continuity of care, we have a mixture of military personnel and civilians in our health care facilities, but the majority of the occupational health care and the understanding of the context where the health care issues arise are provided by occupational clinicians, as we call them.

The Chair: Thank you very much.

We'll now go to Mr. Stoffer.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Madam Chair. It's indeed an honour and a pleasure to be on the health committee. I think this is my first time in twelve and a half years.

First of all, Mrs. Smith, our condolences on the loss of your husband. To the RCMP folks, our condolences again on the loss of those two great men in Haiti. To Mr. Jung, our condolences again on the loss of that soldier in Edmonton last week.

All of you have a very tough job, just as tough as it is for the family members behind you who allow men and women to serve our country in a capacity that is unknown to most of us because you see things, hear things, and do things that we only hear about in the media.

I have a couple of basic questions. Mr. Tousignant, you're aware of the VIP program that the military have, correct? Do you believe, sir, that the RCMP should now be included under the veterans independence program?

C/Supt Alain Tousignant: I know there's some work being done. We're working on the VIP program, but I'll defer to Inspector Boughen for the specifics as to where we're at with that development.

Insp Rich Boughen: I'm sorry, could you repeat?

Mr. Peter Stoffer: The veterans independence program is a program that's quite successful with our military. Unfortunately, in my view it's not extended to enough of them, but that's a debatable point. The fact is that for those who do receive it, it's an excellent program. It's administered under VAC. A lot of the RCMP concerns were administered under VAC. For similarities of the concern that Mr. Brown had issued, do you believe, sir, that it's now time for the RCMP and their families to be allowed the services under VIP?

Insp Rich Boughen: We have done a tremendous amount of work over the last several years in forwarding information to government to set out our position as an organization. Right now that's before the commissioner and the minister. We work diligently to try to put into place the regulations that are required to be able to offer certain benefits that are commensurate with the military.

Mr. Peter Stoffer: Are you then saying, sir, that there's a proposal on the table, and it just needs a nod and a wink by somebody to make it happen?

Insp Rich Boughen: I'm not sure about the nod and the wink, but I know there is documentation that our minister has been briefed on. It's with our commissioner as well.

Mr. Peter Stoffer: Sir, do you yourself believe, though, that it should be a good program for RCMP members and their families?

I know I'm putting you on the spot. If you're not permitted to answer, that's fine.

● (1000)

Insp Rich Boughen: In terms of those kinds of benefits that you're talking about, what we've striven for in preparing the documentation is to make the regular member population equal with the rest of Canadians who are afforded similar types of benefits.

Mr. Peter Stoffer: Mr. Brown or Mrs. Smith, do you think it's time now for the RCMP to be under the Canadian health care act, or should it be kept the way it is now?

The Chair: Go ahead, Mr. Brown.

S/Sgt Murray Brown: Mr. Stoffer, I know it's being looked at in different capacities as we speak, but I'm not really privy to the legal work and the consequences in order to answer it.

We are looking at some issues now of being able to have medical cards in certain divisions. For instance, as I mentioned, in Nova Scotia I cannot have an MSI card. My family has them, but in many of the provinces in Canada we do not have them. As we speak, we are running a pilot in Alberta to look at facilitating it.

For me the issue is not really whether we're in or we're out; the issue is that we need the services to allow us to function and be treated like most other Canadians when it comes to health care. I think it's a short way to answer your question, but technically and legally I don't want to touch it.

Mr. Peter Stoffer: That's the thing.

Commodore Jung, you're correct. If you go to the Stad in Halifax, for example, they provide excellent medical care for the serving members. The problem, of course, is that when serving members leave and become veterans, they no longer have access to the Stad. They go into the general system, and that's a problem. Many people in the provincial system don't understand post-traumatic stress disorder. In fact, I would advise this committee—and I'll give the name to the chair later—of Lieutenant Colonel Dr. Heather McKennitt, who gets tremendous numbers of referrals from regular doctors because she understands what it's like to wear the boots, as they say, whereas most provincial doctors do not. That's one of the problems we have. I'd like your comments on that.

Mrs. Smith, to give you the final word, can you make one recommendation that may prevent another RCMP officer from looking at no other excuse but suicide? I know there are many, but which one do you think would be most helpful to help the next person down the line?

Cmdre H.W. Jung: Should I go first?

You've identified a very clear issue in the transition from the military to the civilian sector. Obviously, as I stated in my opening comment, my mandate as the Surgeon General ceases the moment you no longer wear the uniform, so that becomes partly a Veterans Affairs issue, but the member then re-enters the civilian health care system.

I know that Veterans Affairs has taken some great initiatives by publishing instructions, guidelines, and information through the college of family practice journals to inform physicians in the civilian sector about the things they may want to look out for if they have a patient who is ex-military, things such as PTSD and so on. It provides a bit of cultural context on where they're coming from and the types of services they may be able to access through Veterans Affairs, so they are making those linkages with the civilian sector.

Obviously, from a military perspective, once you retire from the military, there's not much I can do in that regard.

The Chair: Ms. Smith, would you like to comment?

Ms. Paulette Smith: Yes, just in regard to the entire membership of the force and what they do. They don a uniform every day, as indicated, and their job cannot be duplicated, even through Canadian Forces. That is a different job, although it's similar in nature in some aspects. But it is a daily exposure to the type of work that these members—male or female—see, and it is over time that issues happen.

If these issues are addressed in a timely manner within the organization, they are treatable and preventable in every way. I am a nurse, but I also see the shortage of doctors within our hospitals. I see the shortage of nurses within our hospitals. What happens is that the patients are the ones who pay the price. In the force, because there are no funds allocated or because organizations may not be set up as such, the members, the people on the ground, are the ones who pay the price. Ultimately, then, the family is left to carry on.

Allow the members the opportunity to speak up without feeling ashamed. Allow the members to realize that what they're going through is part of their job and they are not to be ashamed of how they feel. Allow them to be treated instead of being left untreated and abandoned, which is basically what's happening, because the funding and the understanding through the physicians....

This is a topic that you just can't put your finger on. Everyone is different. Not everyone has the same symptoms and not every patient presents the same. One may present with certain issues that are definitive as to the DSM, but the issue is that not everyone presents the same. In my case, my husband presented as casebook, as textbook.

That was my issue. I don't think that.... We just need more help. We need more help.

● (1005)

Mr. Peter Stoffer: Thank you very much.

The Chair: Thank you, Ms. Smith.

We'll now go on to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to start today by thanking each and every one of you for being here and also by thanking those of you who don the uniform. I come from a family in which my father served in the Canadian Armed Forces for 25 years, and my uncle and my brother-in-law are in the OPP and in the RCMP. I know a little bit from the family side about the commitment you make to your jobs. I think everybody on the committee here wants to thank you for doing those tough jobs each and every day for Canada.

We've been having a lot of interesting meetings here in the health committee about human health resources. We've heard from experts and associations from across the country about the challenges that Canada is having in utilizing our health care resources the best we can, in recruiting, and in maintaining. I think one of the comments about this particular initiative was made by Inspector Boughen and was about "health professionals who get that". With the competition from the private sector, I think it's a real challenge to keep those people in the field who actually do understand, to maintain those people.

I want to ask about the program you mentioned, Superintendent Tousignant. I was quite pleased with how you ended your presentation in stating that as of April 1 you are commencing a new position of director general for workplace development and wellness. It's going to be a new role for you in engaging experts in the field to move forward with—I liked the final line—"fit for duty, fit for life".

Can you explain a little more to the committee what the mandate is of that new position?

C/Supt Alain Tousignant: Certainly. The mandate is evolving as we speak, but listening to Mrs. Smith about the tragedy that she went through, I take your comments to heart. As a husband and as a father, I take your comments to heart. I also listened to Mr. Murray's comments about some of the challenges that we face in the future.

From today, even as my mandate evolves, it really talks about wellness. Comments were made about employees and members feeling ashamed to speak out and feeling worried about their promotions and advancement in the RCMP. I actually see trying to remove those roadblocks as part of my mandate, so that our organization will be one in which our employees and members will feel very free to speak about medical conditions or the challenges they face on a daily basis.

I've been working in the north and have travelled the country. I believe I have a good understanding of the issues. To wrap up what my mandate is, it is to try to build a wellness strategy for the RCMP and really define what it means. Since 2005 or 2006, as Rich Boughen and Mr. Brown explained, we've been starting to grasp what it means and how our employees are affected when they're living in northern communities or are placed in situations in which they see different tragedies day in and day out. It's really trying to develop a strategy that encompasses all this, trying to get to the heart of it. I think we've enlisted some professionals in the business to help us develop our strategy to move into the future.

My biggest obstacle, to come back to what Madam Smith was talking about, is for the members and the employees to feel comfortable and unashamed about saying that they have a medical condition or that they're scared or that things are not working out right now and they need help. If we can get to that point, I think we'll have gone a long way into the future.

● (1010)

Mr. Colin Carrie: I like the idea of wellness and prevention. As Mrs. Smith was saying, the signs were there, and you can prevent a lot of these things by taking that initiative. I want to applaud you for taking that on. I think it's something that's well overdue.

I wanted to ask a question, too, of Commodore Jung, because it does seem that the Canadian Forces have put a real push on for developing a model that works for the Canadian Forces. I wanted to talk to you a little bit about this idea of interdisciplinary teams.

My background is that I'm a chiropractor; I worked in interdisciplinary teams with physicians and physical therapists, and just by using the right professional for the right condition, we saw a lot of efficiencies. I know that in the Canadian Forces there's been talk with nurse practitioners and physician assistants. I think you even have some chiropractors working in the field. What efficiencies have you seen since you have been there and seen how this has been integrated? Are there any lessons you have learned that you could share with other organizations around the table?

Cmdre H.W. Jung: The collaborative care model obviously is very in vogue today, and you hear about the PCR, primary care reform, basically everywhere you go in the health care sector.

The collaboration in the military is nothing new. It's been in existence for much longer than it existed in the civilian system. When I entered the military practice in 1985 I was actually quite surprised at how much collaboration was already in place and how much leveraging of services was already in practice. We were using nurse practitioners before the term was known. We were using pharmacists much more than giving drugs in the civilian sector. We were using physios much more robustly. That collaboration diminished during the nineties during the budget cuts, when we were closing a lot of bases and our services.

When we came back to rejuvenation in the year 2000 through the Rx2000 program, we really re-entrenched the collaborative model through what we call PCR, the primary care reform initiative. This is primary care but it's not limited to primary care. What we're talking about is continuative care whereby you have.... It's a form of capitation where members are rostered to a care delivery unit. In that unit there are physicians, military and civilian. There are nurse practitioners, physician assistants. There are medical technicians. With that core, they look after a group of people. Then we have as primary care providers physiotherapists, where a member can simply access.... If you have an ankle injury over a sports weekend, you don't have to go see a doctor to get a referral. You just go see the physiotherapist and have them look at it. If there are issues that he or she wants looked at, then they refer them back.

If you have some issues about certain self-medication, for example, again you don't have to go see a doctor. You can just go down to our pharmacy. We're one-stop shopping. They can do all of that. If you have some family issues, you can go see a social worker for family issues directly.

That is the core to which then we have secondary and tertiary care. In all of our bases, there are mental health components. Some of the larger bases have a much larger centre, where the core of the primary care is part of the mental health care team so that the communication between the primary care and the mental health is smooth. The mental health itself is not stovepiped. That is a team of psychologists, psychiatrists, mental health nurses, and social workers and pastoral counsellors who work together to look at that patient. If it's a complex one we have case conferences, and that involves not just mental health but there's the primary care team that goes into it.

That kind of stuff actually does play havoc a little bit with so-called efficiency. It takes a lot of people to look after holistically. I don't really want to get down to efficiency in that regard, but rather it is a very effective way to holistically look after the patient who's in the middle and you have the whole team.

The Chair: Thank you, Mr. Jung.

With the permission of the committee, I'd like to ask a question. Is that okay with all of you?

Thank you.

Mr. Brown, I heard you say that things seem to be quite different within the context of the umbrella of the RCMP.

Mr. Jung, when you were talking, it was just amazing to hear of this wonderful support system for our front-line soldiers. I have two questions, Mr. Jung. Is there a designated health care funding for the soldiers, yes or no?

● (1015)

Cmdre H.W. Jung: My budget, the health service budget, is a corporate budget controlled by the senior leadership.

The Chair: Okay.

Mr. Brown, when we're talking about the lack of health human resources, the lack of doctors who are actually understanding what the front-line police officers do, based on what Mr. Jung had to say, do you have any suggestions that might be very helpful for us as the health committee to know?

S/Sgt Murray Brown: I commented earlier about being envious of the military situation. I realize that they pick up and leave and need to be self-contained. I don't think it would ever be practical for us to do that. I think, though, that we have some similar good things happening in our organization. We are here collectively, working for an outcome. I hope that this is witnessed by your committee today. I'm not standing here as a labour person trying to attack the force. I love it dearly.

I would like to start with the budget. We don't have one. We've never had a health care budget allotted at the Royal Canadian Mounted Police. What we do is this: If it cost *x* million dollars last year, that's where we start you this year. What I'm asking is that money be locked in so that no one can come during the fiscal year, based on some other pressure, and extract money that's for the membership. That would be one humongous change.

In relation to the concept of holistic care, I thought we would move a little bit that way with a quarterback, if I may, which is case management. I don't know if we've advanced much as an organization, even within the case management realm. In a recent situation, a member was back to work on a return-to-work program. The person is working one or two hours a day so is no longer a priority with case management. That's tragic. That's what I refer to in my notes as an administrative gap. It's these transitions. Paulette has touched on it tremendously.

When Paul, who I knew during the years before he left Nova Scotia, came through, he fell through some tremendous gaps.

We had an attempted suicide in my division. My health services office didn't even know that the person was in our division. The person had transferred in.

We do a very poor job. I don't mean to be mean or critical. On isolated and remote posts, those men and women should be followed up maybe at six months or a year. Then we can wean them off the corporate eye, so to speak. At least the membership would know that the system has followed them during those experiences. Paulette touched on that when she answered Mr. Stoffer's question.

If we were more attentive, instead of saying that you're one over.... If I sprain my ankle, I can go to a physiotherapist. In my organization, I can go so many times, but if I don't have another injury, I'd better go to a doctor to get a referral. It doesn't have to be so complicated, and in our organization it is. Everything needs permission. We're paying as much now for permission as we are for the service.

Are there possible efficiencies? There are.

I look forward to working with Alain in his new position—with all due respect to the rank—but in all fairness to Alain, he's just been put in that position. Again, this is not a criticism. It's an observation. Now, instead of being able to go directly to the chief human resources officer, I have a stopgap. I will see how well this stopgap works out. Alain and I talked about it this morning. I can't go as high now, directly, but I can go to Alain. We'll see how that position works out. I am optimistic. I'm optimistic because he found the interest and the time to come here today, because he wasn't originally in the program.

I really believe—and I said so to both gentlemen this morning—that we have the occasion to have a fresh start.

I hope, Madam Chair, that this gives you some context.

● (1020)

The Chair: Thank you, Mr. Brown.

We'll now go into our second round of five minutes of questions and answers. We will begin with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thanks very much.

I thank particularly Ms. Smith for really painting a picture of what this is like, and how really helpless you feel when somebody's designated fit to serve and you know that's not true.

I would like to explore how we can do a much better job in terms of wraparound care, first by identifying people at risk and then by providing some sort of continuous support. I don't think somebody who's there three days per week—and if you see a different person each time—is the way we sort this out. In most jobs people have to say "I'm okay, Jack" and get on with it. As a family doctor, you know when somebody is not himself or herself. You actually do need somebody with a continuity of care.

Maybe we should also be exploring how even in Nunavut people are able to do mental health visits electronically. To be able to see the same person each time, even with Skype, would be using the technology that we used in other parts of the services for this most important thing, our health human resources.

Even though, Ms. Smith, you had difficulty in terms of the clinical psychologist, I have to say that after the problem with Colonel Williams at Trenton a great number of my friends commented that we don't as yet have clinical psychologists in uniform in the military. Although you have operational psychologists, without clinical psychologists, who use the kinds of tools Ms. Smith described that we use for broken bones.... There are tools you can use to find out these things. I guess we're the only force without clinical psychologists but we also seem to be unlike the U.S. Air Force. We don't seem to do a pre-psychological assessment of our pilots.

I want to know how we can help. Another piece for which a number of us have been fighting for a very long time is that people are moved all over the country, particularly in the armed forces, and the soldiers receive care but their families do not. In my experience as a family doctor, if I'm not having the wife or the kids tattle on whoever's having trouble, I might not know what's going on.

What would it take, Dr. Jung, for us to be able to provide services of the highest possible quality for the military and their families?

Cmdre H.W. Jung: On the first issue about clinical psychologists, you're right that we do not have them, but we hire them as civilians. One reason is that the requirement to be in uniform is absolutely required for deployment. Because we have psychiatrists, mental health nurses, social workers, and padres on deployment, the unique acute care requirement of psychologists is lacking in the operational theatre. A lot of this has to do with the limits of the size of the force, so that is probably unlikely to change in the foreseeable future, although as I said, we do have civilian psychologists embedded in our mental health teams so that they can provide the same therapy and screening.

Hon. Carolyn Bennett: Are you saying that when somebody is deployed, there's no ongoing surveillance? If somebody has had a bad experience, is there no testing for that until it's time for them to come home?

Cmdre H.W. Jung: No. Number one, if somebody has some kind of illness, whether it's physical or mental, we have—

Hon. Carolyn Bennett: But it's not an illness yet. They've just been put through a terrible situation. It's not an illness until he or she says it's an illness.

We're doing a better job testing when people come back, but actually there in theatre, is there some sort of prevention—anticipatory approach—that could be afforded by clinical psychologists?

● (1025)

Cmdre H.W. Jung: Pre-deployment, everybody is screened to make sure they're both physically and mentally stable to be able to deploy. At every deployment there is a pre-deployment screening that includes a psychological screening.

Hon. Carolyn Bennett: Unfortunately, that's not the case in the RCMP.

S/Sgt Murray Brown: That wasn't the case with Paul Smith and his wife when they went north. Does it happen? Yes, it does happen. We found out a little while ago that officers weren't pre-screened prior to departure. We understand we've closed that gap now. Those are things we worked through, and I can provide the correspondence to senior management at another time.

Hon. Carolyn Bennett: Madam Chair, if I may—

The Chair: Your time is up, Dr. Bennett. I'm sorry.

Hon. Carolyn Bennett: I'm just wondering if Dr. Jung could table what he thinks would be an estimate for the difference in their budget now, just looking after soldiers, and what it would be if they looked after soldiers and their families.

Cmdre H.W. Jung: That would be a very difficult task. There would be an enormous increase. I would guarantee that. You just have to look at the U.S. TRICARE system. It is an absolutely enormous task.

The Chair: Thank you, Dr. Jung.

We will now go to Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I certainly apologize for missing the testimony, and I will read Hansard to make sure I get all the information you provided.

This is one of the things I want to start to focus on. My background is in nursing, and when I was a very young nurse I had the privilege of working with a physician who was no longer with the military. He worked in a rural community and actually used a lot of the concepts he had learned. I would say that was one of the few really strong primary health care teams to which I have been witness. In our conversations and in those with previous witnesses, there has been a lot of talk about physician assistants and perhaps opportunities for physician assistants. I wonder if you could talk briefly about their role and their training. It has been mentioned many times.

Cmdre H.W. Jung: The physician assistant model started in the military in Canada. It's been in existence for over 40 years. It was a requirement that came strictly out of necessity. You could never send doctors everywhere. Ships have a small number of people. We couldn't send doctors there, and of course many of the army units are very far forward. You have to be a soldier also. The term "physician assistant", and for that matter paramedics, came out of the military in the historical sense during the First World War, with stretcher bearers and so on. The physician assistants came out of the military necessity to provide acute care in a setting where there were no physicians and there were no other health care providers available. These were trained by the military using a medical model to be able to have the skills to look after acute requirements to buy time for a patient to then be evacuated back to a facility manned by physicians or to a surgical facility.

That scheme then expanded over time to beyond just simple acute care to doing primary care. Why would we in the military want to have physicians looking after colds and simple sprains and so on when we could spend more time on more complex cases? We simply evolved the physician assistants in the military. Basically you are leveraging physician services so that instead of a physician looking after 100 patients, let's say, with a PA he or she may be able to look after 180 patients with physician oversight.

Then there are nurse practitioners in our clinics who use the nurse practitioner model, but they come from a nursing model, so it's slightly different. They do have a separate origin, but they are both in the same care delivery unit. They provide similar services in different contexts with different backgrounds, but there is enough room in our system for both of them.

Mrs. Cathy McLeod: You talked about perhaps lacking a little in efficiency, but have you actually reviewed it in terms of the primary care team taking care of the sort of "capitation model", as you might put it? Have you done some effectiveness evaluations and some comparisons?

Cmdre H.W. Jung: I want to be clear when I say efficiency is going to go down with the collaborative model. That just means that you cannot churn through patients as fast. That doesn't mean you are providing good care. From an efficiency perspective, we just had our health care budget completely analyzed by government consulting services, and we actually came out per capita, per unit of service, actually more cost efficient than the civilian health care sector using the CIHI data. I just want to be careful about that. The lack of efficiency is that we do not have the revolving door concept. We do look after the patients.

● (1030)

The Chair: You still have a minute, Ms. McLeod.

Mrs. Cathy McLeod: Great.

I appreciate your comments about efficiencies.

I have two more questions. I'll ask them both. One would be about outcomes. Have you done some work on outcomes?

I was recently at a function where I believe you received a mental health award for some of the work that was being done. Is that a new concept? I wonder if you could briefly respond to that.

Cmdre H.W. Jung: The outcome measure, as you know, is a sort of holy grail of the health care sector. Outcome is very difficult to manage. We're going to have a better handle on it as soon as the last phase of our health electronic system is implemented. Then we'll be able to extract data to see whether or not we're making a big difference in hypertension, diabetes, and so on. That is going to be coming.

In terms of the satisfaction rate and basically of feedback from physicians, I think we are having a much greater effect, particularly when it comes to mental health. I think we've made some enormous strides over the last several years in providing good mental health. I would dare to say that I think Canadian Forces is probably in the leadership role in Canada in providing holistic, integrated, multi-disciplinary mental health.

In terms of our model, we look at it as involving a three-pronged approach. You have to have a good and effective mental health care treatment system. If you cannot provide good care, then who's going to come to you? Two, you have to have a good supportive leadership. Leadership in the military in many ways determines the culture of the organization. As you know, we've done an enormous amount of work in education for that leadership. The Chief of the Defence Staff recently launched the "Be the Difference" campaign. Mental health issues are discussed openly, more than ever, I suspect, in any other society in Canada. The third one is aware and engaged members or patients.

You have to have all three—if you like, a three-legged stool, and if one of them is short, it's going to tip. I think we're working on all three facets simultaneously right now.

The Chair: Thank you, Mr. Jung.

We'll now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you, Madam Chair.

First, I would like to thank the witnesses for being here today, particularly the RCMP and the Army for all the work they do. Your presence is invaluable to the committee. I would also like to say special thanks to Ms. Smith, because I know this is not necessarily easy for her.

Since the committee began sitting, we have talked a lot about prevention. I think that is really the key word, when a post-traumatic or psychological problem arises. Obviously, first, there is a shortage of funds and resources, particularly in the RCMP. We may not be giving you all the resources that you need, to be able to put into practice ideas that you consider to be fundamental, or all the resources that might be useful for you.

On that point, I would like to hear Mr. Tousignant—and also, congratulations on your new appointment. Concerning the answer Mr. Brown gave our chair earlier, I would like to know your opinion.

C/Supt Alain Tousignant: We're talking about the budget. In 2008-2009, the RCMP spent approximately $70 million on treatment for employees. That is money we have no control over. It is money used for treatment for all our members. We have a budget that we control a little more at our national policy centre, which is under Mr. Boughen. The centre looks after implementing projects and initiatives to try to meet the needs we are discussing this morning, in relation to both mental health and physical health.

Obviously, if we are talking about the Office of Health, we are really talking about a three-pronged approach: mental health, physical health, and also health in the work environment. These are the three aspects we try to target with the budgets allocated. I can assure you that of the budgets we control, especially internally, all the money is spent; nothing is returned. We try to maximize the initiatives we can deploy with the budgets allocated to us.

Obviously, we are competing with the other RCMP budgets, both for operations and for human resources. It is always a balancing act, dividing up the budgets that will be allocated each year. During the year, we have an opportunity, by doing a business plan, to get funds that may be surplus, but it is still based on priorities and acceptance of the plan. That is kind of how we operate with our budgets.

● (1035)

Mr. Nicolas Dufour: We have talked a lot about prevention. Ms. Smith told us there was a kind of wall of shame to get over, for example, to be able to talk to a psychologist or get access to the tools to get through it. We have talked a lot about barriers. I would like to know, in your opinion, at the RCMP, what do these barriers look like that prevent your members from talking to psychologists.

[*English*]

The Chair: Mrs. Smith, do you want to comment on that, or Mr. Tousignant?

Ms. Paulette Smith: From being a wife and observing my husband—we were married for five and a half years, and obviously I'm not a member—their training makes them so stoic. I think they feel—and I'll use the term Mr. Brown used earlier in his speech—that they must suck it up; that speaking beyond the uniform shows weakness, and that you are maybe not able to handle a situation.

It becomes a little harder when you are six foot three and 265 pounds, versus maybe of smaller stature. As well, your superiors, your staff sergeant, your immediate supervisors, and staff in your detachment maybe go to you a bit more because you are a larger person and you tend to handle things well, versus other members. You seldom complain, because that's not your nature. I'll add that my husband was from a military family. His father was a colonel, so he knew all about what military meant and what the uniform meant. He was very proud to be a member. I know I've never said that, but he really was. Even at the end he still was.

I feel that it's almost in them as members. It's in the training and in what they're presented with on a daily basis. It's just the way the force is. You are to be strong and show strength, because you are protecting everyone else. We're forgetting that the people behind the uniforms are fathers and sons, that they have children and feelings.

They may see a child of 18 months being administered CPR and later dying, and rush the parent through at 150 kilometres per hour on a Sunday evening. But no treatment is given to them; no follow-up. They may pick up a young girl of 19 years of age who was brutally murdered, and put her in a body bag, and for over two years work with a major crime unit when it's not their position to do that—and never receive follow-up. They need help, and we need you to help them. The members are crying in their own way, telling people they need help, and I think the only way to do that is through funding.

They need to feel at ease when they're speaking to their superiors. They need to have conferences where they're told what they may be exposed to, and what they may encounter over their careers. It should be brought down to the ground level when they're training and they should be told, "Guys and girls, this is it. This is the job and what it entails. You will see things that normal people, on an everyday level, will not see. But we will follow through and we will take care of you, as we should. This is what we have in place for you. When you feel something different or wonder why you're not sleeping or eating, feel free to come to us and speak of that. Get it off your chest." That's all it takes. It's prevention.

● (1040)

The Chair: Ms. Smith, allow me for a minute to tell you that your testimony here at this committee is of paramount importance, because it opens up all of our eyes to what happens with police officers, the military, and others like that. I know it's very hard for you, but it's very much appreciated.

We'll now go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair.

I too would like to thank our presenters here this morning and apologize for missing your presentations. I will definitely be checking Hansard, as will my colleague, to make sure that I don't miss anything.

I just want to say this to Ms. Smith. I certainly hear your voice and feel your pain. I lost a very dear and close friend who was a member of the police force and was not getting the attention that he needed. He was dealing with undercover units in a very nasty world, and there needs to be something there.

I also have a husband and a son who are emergency responders in the fire service. I understand some of the tension that families go through and some of the assistance they need, as well, to deal with the issues that our loved ones deal with as a matter of routine, almost.

So I'm certainly glad and thankful that you were able to come here and give your testimony today.

I want to ask a couple of questions to the Department of Veterans Affairs, to Ms. Bax and Ms. Flett, please.

I understand you are part of the federal health care partnership movement, and I think that's great. I want to hear a bit more about it, and I hope I'm not asking for things to be repeated that I missed.

I think the face of Veterans Affairs is changing greatly and changing rapidly. I am speaking of the demographics and what we had traditionally been accustomed to with veterans, and now, with today's world, what we are faced with with the veterans in the demographic area.

I'd like you to address some of the challenges that presents, if you could, please. Are we looking at different shortages, different types of shortages for specific specialties, or are things remaining much the same?

Ms. Hilary Flett: With regard to the nature of shortages, if we compare the study of 2007 and the shortages today, the actual requirements with regard to filling indeterminate, permanent public service positions haven't changed, partly due to how departments are opting to deliver their service, such as the example you raised within Veterans Affairs. They have chosen to go with a third-party contract model for their occupational stress injury clinics. So their requirements, with regard to their medical officers and their district nursing officers, remain the same and their overarching requirement remains the same for indeterminate public servant physicians, and the same applies with the other departments.

So to answer your question, no, the shortages have not changed in the past three years.

Mrs. Patricia Davidson: Okay. Can you elaborate a bit more, then, on how the federal health care partnership has best allowed you to optimize the mix of professionals that you require? How has it been a benefit to Veterans Affairs?

● (1045)

Ms. Janet Bax: Madam Chair, it's very important to point out to the honourable member that while we are housed in Veterans Affairs, we're actually not Veterans Affairs. We are a partnership of seven departments, so we don't actually deliver direct services. What we do is provide the means to work collaboratively. Through the establishment of the Office of Health Human Resources, the issues that all of our partners are experiencing in dealing with the challenges they have of finding physicians, psychiatrists, psychologists, nurses, and so on are brought to the table, so that a good practice that has been adopted and has worked for one partner can work for another. But our raison d'être is economies of scale, so we don't actually deliver the services for the RCMP, we don't actually deliver the services for Veterans Affairs.

I think, Madam Chair, it's important that the honourable members understand the nature of the work of the partnership. So the study that was done in 2007, the work that we continue to do, is aimed at helping departments deal with their challenges.

The Chair: Thank you, Ms. Flett, for pointing that out. Ms. Davidson and some of our members did not get a chance to have the preliminary introduction. That's a very good question and a very good reminder. There are seven partnerships that encompass this health human resource initiative.

Now we'll go with shared time to Ms. Murray and Ms. Duncan, and remember it's five minutes.

Ms. Joyce Murray: Thank you, Madam Chair. I know Ms. Duncan has questions on this very important committee testimony.

I am seeking unanimous consent to propose a motion, which is as follows:

> That, in the opinion of this committee, the government's G8 maternal and child health initiative for the world's poorest regions must include the full range of family planning, sexual and reproductive health options, including contraception, consistent with the policy of previous Liberal and Conservative governments and all other G8 governments last year in L'Aquila, Italy;
>
> that the approach of the Government of Canada must be based on scientific evidence which proves that education and family planning can prevent as many as one in every three maternal deaths; and that the Canadian government—

The Chair: I'd like to stop you right here, Ms. Murray, because—

Ms. Joyce Murray: I'll just finish my motion.

The Chair: No, because you need 48 hours' notice, which is the requirement for a motion, unless we have unanimous consent—

Ms. Joyce Murray: "—and that the government should—"

The Chair: I'm going to ask you to stop. We're going to ask for unanimous consent to go ahead with this motion.

Ms. Joyce Murray: I'll just complete the motion, Madam Chair.

"—that the Canadian government should—"

The Chair: Do we have unanimous consent for this motion?

Ms. Joyce Murray: "—refrain from advancing the failed right-wing ideologies—"

The Chair: Is there consent?

Some hon. members: No.

The Chair: Now we're going to go on with....

Ms. Murray, do you have a question? I'll start your time over.

Ms. Joyce Murray: Thank you.

The Chair: Dr. Duncan, you start, please.

An hon. member: We did not have unanimous consent?

A voice: No.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you all.

I appreciate that Mr. Stoffer recognized everyone.

I'd like to particularly recognize Ms. Smith. You had a very difficult job to do today. It took tremendous courage, and I thank you for sharing about your husband. I will keep his picture—the gentle giant with the beautiful smile. So thank you.

Some hon. members: Hear, hear.

Ms. Kirsty Duncan: I'm really concerned about this issue, and I'd like to ask how many mental health professionals are currently employed by the RCMP.

Insp Rich Boughen: There are approximately 14, one per division, more or less. But again, they're not psychologists who offer treatment. They are people who are more in the area of looking at trends for things like undercover operations, integrated child exploitation units, assessing those particular people in high-risk areas.

● (1050)

Ms. Kirsty Duncan: So 14 psychologists for how many RCMP officers?

Insp Rich Boughen: There are roughly 19,000.

Our treatment needs go out to the community, so we look for both mental health issues and physical health issues to be done at the community level.

Ms. Kirsty Duncan: That's a staggering statistic. How many of those 14 are clinical psychologists?

Insp Rich Boughen: I don't have that information before me.

Ms. Kirsty Duncan: How many OSIs are we looking at per year?

Insp Rich Boughen: We don't have that information presently. As Staff Sergeant Brown said, I can tell you that we have a number of people who have applied for pensions through Veterans Affairs for an operational stress injury, but I don't have the number who are diagnosed with operational stress injuries.

Ms. Kirsty Duncan: Is that being tracked somewhere? What is the trend for that?

Insp Rich Boughen: Presently our systems aren't allowing us to do that.

Ms. Kirsty Duncan: Okay.

Can you take us through the process of someone coming forward and not feeling particularly well? What happens from that point?

Insp Rich Boughen: If a regular member were to come forward, the person could go to his or her MEAP representative in the member employee assistance program, who could allow access to a professional, depending on what the issue was. It could be family counselling or whatever. MEAP representatives have lists of names of providers in the geographic area where they're located. We also have a chaplaincy program.

Depending on the type of issue, if the person who is having the issue goes to a supervisor, he or she might be asked to see the health services officer to be assessed by a designated physician.

Ms. Kirsty Duncan: What are the qualifications of the people doing the EAP process? Are they able to tell the difference between someone who is in crisis...?

Insp Rich Boughen: I'm not 100% sure of what their training consists of today. I went through that process 15 years ago, and it was then a three-day course. It taught you not to be a counsellor. It taught you to actively listen and to be able, in a very primary fashion, to assess the issue and categorize it perhaps as a marital issue, a harm-to-self issue, or a financial issue, and then to be able to have the tools available in that geographic location to give them names or set up appointments.

Ms. Kirsty Duncan: Has a gap analysis been done? Ms. Smith's family went, sought help, and sought help repeatedly. They fell through the cracks. Has a gap analysis been done to ensure that this doesn't happen again, to the best of our ability?

Insp Rich Boughen: To the best of our ability.... Processes and procedures are one thing. What Mrs. Smith brings to the table is the human side of processes and procedures when they are not working as they should. What we have done is reaffirm the reality that all members deploying to remote or isolated areas need to be psychologically assessed by the MMPI-2 and have a follow-up assessment with a psychologist. That applies as well to each adult member of the family who is over 16.

The Chair: Thank you so much.

Thank you, Dr. Duncan, for those very insightful questions.

We'll now go to Mr. Rickford.

Mr. Greg Rickford (Kenora, CPC): Thank you, Chair.

I appreciate the questions of my colleague. I think it's important to understand some of the process and steps that people take.

Just by way of introduction, I spent eight years as a registered nurse living and working in isolated and remote first nations communities across Canada, at the very least northwestern Ontario, Manitoba, Saskatchewan, British Columbia, and across the Arctic. I have a rich understanding of the experiences one goes through in taking an assignment in those communities. I have to say, Mrs. Smith, that I have very close friends who are members, and I share some of your concerns, particularly with the culture of stoicism that you referred to and the fine line between bravery and an ability to come forward with some of the things that you see. In nursing, not unlike the RCMP, we have come into a variety of different things. Of course, there's always a nexus between our personal and professional issues and the counter-transference between those two.

Having said that, my questions may be focused more with Mr. Tousignant around the wellness program. I just want to very briefly talk about what nurses have experienced in the north and how they've come to respond. It seems to me, based on what Mrs. Smith is talking about, there may be some structural defects in how emergencies or traumatic scenarios are dealt with that prevent officers from coming forward. If I can shed a little bit of light on our own experience, it's actually mandatory that we participate in debriefing programs or sessions by phone, or if the situation necessitates it, with a counsellor. Obviously there's a grade on which they're evaluated, but it can be highly subjective and highly individualized based on what the person has seen and how they respond to that.

Furthermore, there are other scenarios that require a mandatory group debriefing, the entire unit in this case. The entire nursing station staff converge on the basis of what transpired. It deals not just with the incident itself but with how the group interacted, things they feel they could have done better. Inevitably, that scenario rises again there or in some other station, and most of us get moved on over the course of our career. I think one of the cornerstones there is that it's built right into our operation.

Another cornerstone would be confidentiality: the real ability of the member, or in this case of the nurse, to be able to go in confidence and actually make disclosures because these kinds of things can sometimes trigger or manifest issues that you have in your other life. As I said, I talked about a nexus between them and prevalences of the use of alcohol—certainly maybe not when you're in the community but binge drinking when you've left the community—or social adjustment disorders with your family or large groups when you get out.

At risk of rambling on here, I'm just wondering whether you've contemplated some of those features in this wellness program, or foundationally speaking, some of these around it. I believe that they are the most important pieces that actually have us come through. I'm not terribly comfortable in a group therapy session, although I have been in one, but for the benefit of my colleagues, I thought of at least one case of a shooting where a murder was the outcome that it was productive for us as a group dynamic, more so than individually. I'll stop there and maybe you could just talk about it.

● (1055)

C/Supt Alain Tousignant: I'll make a few comments, and I'm sure Inspector Boughen will probably give you more details.

There are mandatories. On highly specialized duties there are mandatory sessions that you have to attend during, before, and after. For example, if I go back to some of the tragedies that we faced with some of our members being killed on duty, there is a debriefing that takes place after with the employees who work at the site to try to deal with the issues that you discussed. Definitely, depending on the types of duties you do, there are mandatory steps that you have to take. Presently we are working on a pilot project that Mr. Boughen has initiated dealing with some of the issues you're referring to.

Maybe I'll let Rich provide more details.

Insp Rich Boughen: Thanks.

You're right about the critical incident stress management piece around certain specific instances, such as shootings or whatever, and I think we have a fairly good handle on that. What we don't have the handle on that we need presently, as Chief Superintendent Tousignant mentioned, is the pilot that started in January of this year. Two are going to be running. One that began yesterday is continuing today and tomorrow on Vancouver Island. We look at something Mrs. Smith talked about, the cumulative effect of all the stress and tragedy that we see on a daily basis. During that time there's psycho-education.

One of the terms that I steal from the military is that as we walk through life we pick up all these rocks and put them in our rucksack. At times the rucksack becomes too heavy. Our backpack gets too heavy, so we are trying these programs to get rid of some of these rocks by talking about the specific things in our work world that cause the emotional stuff. We go to tragic events such as car accidents—and as a nurse you would know this—that are absolutely abnormal in our everyday world. However, when we have these normal reactions to them, we think they're abnormal because either we're six feet three inches or we wear a uniform or everybody looks to us for support, so we never allow that to get out. We put a plexiglas wall in front of us when we go to an accident and see death and destruction, whereas the natural response would likely be to sit on the curb and cry with everyone else. However, in our world that's not acceptable. That's not what we're hired for.

● (1100)

Mr. Greg Rickford: Nor is it acceptable for five foot four inch or five-foot-nothing nurses. I think it should be clear, for all of us who may not be—

The Chair: I'm going to have to bring this to a conclusion, because we have another committee coming in to this room.

I know that this is the first time the RCMP have been on the health committee. I thank you for coming, along with the military and the veterans affairs representatives. I think it has been very helpful—more than helpful—to be able to present to this committee the challenges that are there behind the scenes with the military, the RCMP, and others who are in high-risk professions. As a committee, we want to thank you very much for being in attendance today. Thank you.

The meeting is adjourned.

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