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Chair

Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): I'll call the meeting order.

Today we continue our study of the quality of life in the Canadian Forces, with an emphasis on post-traumatic stress disorder.

We have witnesses today from Veterans Affairs Canada: Kathy Darte and Colonel Don Ethell. Welcome. From the Department of National Defence, we have Major Le Beau, Shawn Hearn, and Cyndi Greene. Welcome to all of you.

I understand, Colonel, that you're going to start with some opening comments. What we usually do is give you the time you need to do that and then we'll open it up for a round.

You're the only witnesses we have today. We have almost two hours. There will be bells ringing at a quarter after five for us, calling us back for a vote, so that will give us lots of time to hear your presentation and get into questions from the committee members.

Sir, the floor is yours.

Colonel (Retired) Donald S. Ethell (Chair, Joint Department of National Defence and Department of Veterans Affairs Operational Stress Injury Social Support Advisory Committee): Thank you, sir, and thank you for the introduction.

Before I give you my introductory remarks, you indicated who the team is. I in fact am not from Veterans Affairs, and I don't work for either department. I'm the volunteer chair. I wish I were from Veterans Affairs, with their wage scale.

The two co-managers on either side of me are from DND and VAC. We have two peer support coordinators. I'll come back to them in a minute. They're the “coal face” people, as we call them, who deal with the peers.

There are some members of this team who have been involved with the operational stress injury social support program from the beginning, and one of us, I believe, will be able to answer any questions you may have once I'm finished this presentation.

I understand you've been given a printed version of the slides. I will not read all of the slides. Rather, I will hit a few of the high points and focus on what's new with the operational stress injury social support program, the key determinants to its success, and the major challenges that face the organization.

I am sure that most of you are familiar with the term “operational stress injury”, or OSI. As you know, OSI is not a diagnostic term but rather a term developed by the OSI social support organization here in Canada to put the focus on the injury and to work toward de-stigmatization of the condition. The term is now in use by most clinicians as a way to encompass all operationally related mental health issues. This includes some elements of the U.S. military.

The presentation package contains some background on the joint DND and Veterans Affairs Canada OSI advisory committee, which I chair. This group, formed in 2002, brings together a group of interested people from Natinal Defence, Veterans Affairs, veterans organizations, the RCMP, and various mental health professions three times a year to provide advice to the two co-managers, Kathy Darte and Major Mariane Le Beau, and feedback from me to the senior management in both sponsoring departments—namely, the chief of military personnel, Major-General Walt Semianiw, and the assistant deputy minister of veterans services, Brian Ferguson.

OSISS itself came into being within DND in the spring of 2001 in response to input from SCONDVA, the Croatia board of inquiry, and the DND Canadian Forces ombudsman's office. Shortly thereafter, recognizing the shared responsibility for the welfare of CF members and veterans and their families, a partnership was formed with Veterans Affairs Canada.

OSISS was clearly the result of the vision and drive of one officer—similar to Major Le Beau—by the name of Lieutenant-Colonel Stéphane Grenier, the founder. He has recently returned from a tour in Afghanistan, and is now the OSI special adviser to the chief of military personnel. He and General Couture, then ADM of human resources in DND, and ADM Brian Ferguson are the ones who kicked this off. But as I say, Stéphane Grenier is the founder, and he is dedicated toward this OSISS program.

His VAC partner in that early work, Ms. Kathy Darte, is here today. She continues her great work alongside Mariane Le Beau from DND.

The mission of OSISS is twofold: to develop social support programs for members, veterans, and their families who have been affected by operational stress; and to provide the education and training that will eventually change the culture toward psychological injuries in the CF.

The key to effective peer support—the heart of the OSISS program—is the initial selection of the right kinds of people. For example, I direct your attention to slide three, and to the peer support coordinators who are here today. Shawn Hearn is the peer support coordinator in Newfoundland and Labrador. Cyndi Greene, although she's a Newfoundlander, is the peer support coordinator in Calgary and southern Alberta.

Both of the aforementioned, like all of the peer support coordinators serving military members and veterans, have suffered from an OSI. They are now at a point in their recovery where they can help others like them, which is the basic ingredient of peer support.

● (1540)

Aside from the basic two-week training program they all receive, the OSISS program runs a far-reaching continuous education phase, including self-care for peer support coordinators and the family of peer support coordinators. In the end, it all comes down to developing trust with the members and the veterans and the families who come forward, allowing them to proceed at their own pace and providing a support shoulder to lean on. As Shawn has indicated to many of his peers throughout the years, it is a beacon of hope.

It is essential that the peer support workers understand the role they play: encourage to seek treatment, acknowledge the problem or problems, facilitate referral to a professional resource, and assist with access. The danger for the peer support coordinator is burnout, compassionate stress, trauma, depression, and physical illness. What is absolutely amazing and an attestation to the quality of the people involved, selected by the co-managers left and right, is that the level of care provided by both departments in this program is such that there have been very few problems with the peer support coordinators in the years this program has been running.

There are several new initiatives to talk about in OSISS, which you are welcome to pursue in a question period. They include the bereavement peer support initiative, which delivers support to the immediate families of those who have lost a loved one in military service, again to be delivered by those who have been through a similar event. Though not technically part of the OSISS mandate, it's being done anyhow under the leadership of the managers left and right.

There has been considerable international interest in the success of this program. Ms. Kathy Darte and Major Le Beau can talk to some of these approaches at more length during the Q and A.

The third-location decompression operations in Cyprus provide members rotating out of Afghanistan an opportunity to spend a few days transitioning from the theatre of war to their living rooms and bedrooms, all part of a significantly enhanced redeployment program. Shawn Hearn and Cyndi Greene, the two PSCs we have with us, have both spent time with the troops in Cyprus and can speak on that during the question period.

We have learned that there are several key determinants to success in a program like this. The first and most important is the need to involve peers such as Greene and Hearn right from the beginning in the program development and policy. An excellent interdepartmental partnership is essential, as is the use of a multidisciplinary management team. This OSISS program is a sterling example of excellent cooperation between DND and Veterans Affairs Canada.

The emphasis on self-care and realistic boundaries has been another key area. As I mentioned at the beginning, it is essential to recruit and screen the right people, and this is perhaps the area in which this program has excelled, at least in my opinion. To provide relief for that key group of peer support personnel, it is vital to recruit, train, and retain a network of volunteers. I am sure Cyndi and Shawn will want to talk about volunteers; while they're here, their volunteers are covering the bases with the peers they have on file.

In terms of challenges, there are certainly some out there. For example, there are a number of systemic barriers in place. Some clinicians are still suspicious of those who are not mental health professionals meddling in their business. On the other hand, others who have experienced the value of working with peer support coordinators literally sing their praises.

Just the physical size of the territory covered by this very small group of peer and family peer support coordinators is amazing. We recognize that many soldiers are off in the rural areas where they just literally cannot be reached. Especially for reservists who may live far away from a major base, getting to where we have a peer support coordinator or getting the PSC to the soldier can be a very real challenge. Our two PSCs today can address that challenge in a few moments.

● (1545)

Growing that volunteer network I referred to earlier is another challenge the PSCs face each day. Once the investment has been made to find and train these folks, retaining them becomes another challenge. The peer support groups that are such an important part of this program also take a lot of effort, time, and coordination. Because many peers are reluctant to use on-base facilities, even finding a place to meet can be problematic.

The last challenge on this list is certainly not the least. Let there be no doubt that the culture of the Canadian Forces in dealing with mental health issues has been changing, albeit slowly. However, there's still a long haul ahead. Education and training are key to culture change, and as is often the case, the longer-term investments are frequently overtaken by the shorter-term demands. To even sustain the gains made in the last few years, great effort is required. This is and will remain a significant challenge.

Before I finish I would like Shawn Hearn and Cyndi Greene to give you a two-minute briefing on their activities.

Shawn.

Mr. Shawn Hearn (Peer Support Coordinator, Newfoundland and Labrador, Department of National Defence): Good day, ladies and gentlemen. My name is Shawn Hearn and I'm the peer support coordinator for the province of Newfoundland and Labrador. I was born in 1972 in St. John's, Newfoundland, and was raised in a very small community, a place called Colinet on the east coast. I now live in Mount Pearl. I'm the youngest of 12 kids. I have five brothers and six sisters. My mom and dad are saints, because they raised all of us. I have a grade 12 education.

I joined the Canadian armed forces in 1990 as a member of the regular force, the Princess Patricia's Canadian Light Infantry. I also served with the Canadian Airborne Regiment. I was medically released from the Forces as a member of the 3rd battalion, Princess Patricia's Canadian Light Infantry para company.

In 1994 I was deployed to Bosnia and worked as a battle group sniper. I was diagnosed with post-traumatic stress in 2000 and medically released from the Canadian armed forces under a 3(b) in June 2000.

My road to recovery has been quite interesting. I've had several hospital admissions along the way, and I started therapy in 2000, which I'm still in today. With the help of a local psychologist and psychiatrist, I began some peer support on the ground at a local level. I was contacted in 2002 by the OSISS founder, Lieutenant-Colonel Stéphane Grenier. I began to work half-time at the OSISS program in 2002 and 2003 on the advice of my therapist to not jump back into the workforce.

In 2003 I became a full-time employee with the OSISS program. I'm still with OSISS today as the coordinator for Newfoundland. I'm married and I have a baby girl who turned three on February 21.

Thank you.

Ms. Cyndi Greene (Peer Support Coordinator, Calgary and Alberta South, Department of National Defence): Hi, ladies and gentlemen. My name is Cyndi Greene. I too am from Newfoundland and Labrador. I was born and raised in a small town of 150 people called Pinware on the southern shore.

I joined the regular force in 1989, immediately after high school. I was a cook for 15 years. In my first six years I served with 1 Combat Engineer Regiment out of Chilliwack as one of the very first females integrated into the field units. With them I did two tours of duty. In 1992-93 I deployed with 1 Combat Engineer Regiment to Croatia, and then I went back to Bosnia with them in 1994. In 1995 I was posted to the mighty warships out in Esquimalt, and we did many things with them as well.

Like Shawn, I was diagnosed with post-traumatic stress disorder as a result of my service in 2000. I was medically released in 2004. I started working with the OSISS program as a volunteer in Victoria, British Columbia, and eventually moved to Calgary to take the job of peer support coordinator for southern Alberta. I am based out of Calgary, but I work the whole area of southern Alberta.

I have been with OSISS since February 2006, and like Shawn my road to recovery was quite lengthy. There were administrative issues with work before I finally figured out what was going on. I spent three months in a treatment centre for prescription medication addiction, and from there I saw a psychiatrist and a psychologist. It's still ongoing, although it's not as frequent as it used to be.

I am married to Brad. We have a daughter named Rebecca, who is ten, almost thirty.

I am in contact with roughly 197 ex-military and a few still serving in southern Alberta.

Thank you.

● (1550)

Col Donald S. Ethell: Ladies and gentlemen, thank you for your attention.

With that, I would like to invite your questions, Mr. Chairman.

The Chair: Thank you all very much. And, Colonel, thank you for your years of dedication to Canada and to Canadians. We appreciate your efforts, all of you.

We will have a seven-minute round, starting with Mr. Coderre.

Hon. Denis Coderre (Bourassa, Lib.): *Merci, monsieur le président.*

I'm pretty sure, Colonel, it's not over and you still have a lot of years to give for Canada. Kudos for your job.

Major, ladies and gentlemen, I think we probably have the most important witnesses today, because if we want to know what's going on, through the troops' minds, and the way we treat our soldiers and those who are released, it is important to know what's going on in the field.

My concern right now is that we witnessed issues like Agent Orange, Operation Plumbbob, and now we've heard about the *Chicoutimi*. What's your comment on those soldiers who feel left alone?

First of all, as you noticed, there is a matter of culture in the Canadian Forces regarding mental illness. At the same time, it sometimes falls through the cracks. There is so much red tape inside the department itself. What would you say about that?

If we have some recommendations to make—and I know that you're not dedicated to a clinical approach—if we are thinking about how we should treat our soldiers, who truly suffer and feel alone sometimes and have to wait years and years sometimes even before having an answer, what's your comment on that?

Col Donald S. Ethell: I'll answer that and then I'll ask the two co-managers to provide some input.

Thank you for the remark about service. I've spent a lot of time out of this country and in some contentious areas. To be quite frank, I'm an OSI sufferer myself.

Out in the field, a commander in the field—and I'm not speaking for DND, but I'm speaking as an individual now—has a reasonable amount of autonomy in regard to decision-making, including an example like the *Chicoutimi* or incidents where a terrible event happens. The commanders on the ground are the ones who have to make the initial decisions. Sometimes—I don't like to use the term "resources" because that may mean money to you—the people and the facilities aren't available to take the appropriate action right then. Then these things will come back to haunt them, such as the Gulf War syndrome, the depleted uranium, the smoke and whatever in the submarine that probably nobody could have controlled, and so forth, and now they're suffering.

Having said that, if you look at what's happened with the new government with regard to settlement of various things that have been pending for years, be they in Suffield or Gagetown, these things do take time. Even the medical community.... Once again, I'm not speaking for DND, but having talked to a number of doctors, there are some who call it the rabbit nest. They know there's something wrong, but they just can't identify it. They'll do what they can for the individual.

Mariane.

Major Mariane Le Beau (Manager, Operational Stress Injury Social Support, Department of National Defence): There are many aspects to your question, Mr. Coderre.

I want to speak to the issue of falling through the cracks. It will always be a challenge, inasmuch as you do not control one's life completely, and neither should we as a military institution. I would like to hear some of the comments that Cyndi and Shawn may have with regard to that. But it is an issue we have struggled with and will continue to struggle with in terms of how we can do better outreach. How can we be known? How can we make sure that those people who need help know that we are here and that we can outreach to them, so that they will trust and come forward and ask for help? That's at the OSISS level.

At the most systemic level of the Canadian Forces, and I will say under DCSA, the director of casualty support and administration, in the last year there has been a lot of discussion and steps have been taken to try to counter that—people falling through the cracks—with the creation of the detachments, which I believe you've heard of here, and with some of the plans also to expand these kinds of services across the country. The Canadian Forces are very conscious of trying to outreach to all of their regular and reserve members. They're working really hard to do that.

Sir, will there ever be a perfect net? I don't think that will ever happen, but outreach is something we are constantly working on.

● (1555)

Hon. Denis Coderre: But one of my concerns is that sometimes it sounds like divide and conquer. I'll explain.

There is some lack of transparency or there is a perception of a problem with all the red tape. It's not just based on the clinical approach; it's just to take care of their own situation.

You spoke about Bosnia. There were some problems. There were some of our fellow troops who experienced PTSD, and there was also the issue of uranium. You had Operation Plumbbob in Nevada in 1957; they're still waiting for an answer, and they don't have it.

It's the same thing now regarding the *Chicoutimi*. After three and a half years, now they're going to check the content of the smoke.

All I'm trying to understand—for the benefit of our future recommendations—is that we spoke about a systemic approach. What should be the best approach to make sure that those people.... At one point, they feel so lonely, and kudos to your organization, because it's all about the follow-up.

But at the same time, if we want to settle those issues, we need to find checks and balances in the process under due diligence that will permit those individuals to see the light at the end of the tunnel. It's more than just a clinical issue. It's clear that they even have problems getting information on their own files.

And they speak to you all the time. What are they telling you about that, Major, Colonel, Cyndi, Kathy?

Ms. Kathy Darte (Manager, Operational Stress Injury Social Support, Veterans Affairs Canada): Our program is about that. It's about peer support.

And yes, I think if you directed the question to both Cyndi and Shawn, they would both say "Yes, we fell through the cracks. We were very lonely. We were isolated. We did not know what to do and there was no one to help us."

Peer support is helping break that isolation, helping break that loneliness. It is helping veterans and CF members to get through the red tape, the bureaucratic process.

Oftentimes the peer support will go to visit veterans in various locations. They'll go to their homes, and they'll even see a stack of mail, like this, that the veteran or the member has not been able to open or maybe opened it and was not even able to read, based on the condition or the injury they were struggling with.

What the peer support coordinators are all about is helping to bring those individuals out of their basements—we often say—and back into the world they once were in. They work with them and they work with the health care providers. They work with my department, Veterans Affairs, and they work with DND to help deal with the various issues you have raised.

The Chair: Thank you. We'll hopefully have time to get back to some of that.

Mr. Bouchard, for seven minutes. Go ahead.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chair.

Thank you for appearing before the committee.

In my region, a 26-year-old soldier died in Afghanistan. I attended this young man's funeral. His spouse is expecting a baby. I saw the parents, the grandparents and the whole family, and everyone was deeply affected by this sad event. Could you explain in detail what kind of support you provide? What support is given by the Department National Defence or the military to the soldier's spouse, parents and loved ones?

● (1600)

Maj Mariane Le Beau: I will describe the support provided by the Operational Stress Injury Social Support Program. In September 2006, we formed the first group of volunteers who would offer social support to people—such as spouses, parents and siblings—who had lost a loved one in Afghanistan. The key component of our program is social support, which I can explain. I cannot, however, give you the details about what a designated officer can do or the benefits provided by Veterans Affairs Canada.

The OSISS program began in 2006 with nine volunteers. Last October, we offered a second training session and we now have a total of 17 volunteers. They will provide support across Canada, especially by phone. After all, the family of someone serving in Edmonton may very well live in New Brunswick. And part of the family may live in western Canada.

Approximately 10 days ago, we created a discussion group with volunteers to take stock of the program and discuss what direction it should take. On the basis of the comments and the vision expressed by the participants, we have decided to request a budget to create permanent positions so that we can continue to provide and develop this support service. It is aimed at people who have lost a loved one, who may be a member of the Canadian Forces or a veteran. We feel that there is a real need for this in the long term.

Mr. Robert Bouchard: If I understand correctly, you are talking about phone calls to the spouse or parents. Could you tell us how long that support is offered? Is it for one, two or three months?

Maj Mariane Le Beau: It can vary a great deal. Since this is a new program, it is hard to talk about trends. Up to this point, we have provided support to 77 people. In some cases, it may be a spouse, but it may also be parents and siblings. This support can be provided immediately. It is arranged through the designated officer. Some people call 48 hours after the death has occurred and ask for support, whereas other people wait for six months before doing so. Some people want to be called once a week, whereas other people may end the process but come back a month or two later. I cannot really tell you what is typical, since the program has really not been around very long. And we are learning as we go along.

[*English*]

Col Donald S. Ethell: If I may, sir, it also is by osmosis. One of my other lives in Calgary is organizing an annual ceremony for all the fallen, except Korea, since the Second World War: 188 names are engraved on the Wall of Honour, including the 79 plus the diplomat from Afghanistan, plus the 31 from Egypt, etc. All the surviving relatives, as we call them, are on the invitation list. It has grown in the last four or five years. The informal and formal receptions are very emotional ceremonies. They are there or they hear of one and then come out.

A separate park in Garrison Green is mission-specific to the Buffalo 9. The Syrians shot down that aircraft. We had 38 relatives who finally came out of the woodwork, if I could use that term, and finally got together for some closure. They had never been honoured. In this case they were all there. It was very emotional, and that's part of it. Professionals will support me that it is part of the healing process.

When I say “osmosis”, the word passes around from the Goddards to the Kellers to the Dallaires to the Walshes to the Isfelds: he's passed on. When they get together there is a great dialogue and the odd coffee and beer drunk at the receptions. That's part of the process, when I say it's osmosis. It is a healing process. They know all about her bereavement program, and they're jumping on board. Unfortunately, there is sometimes not enough money to go around.

● (1605)

[*Translation*]

Mr. Robert Bouchard: Is it common practice to reintegrate soldiers who have suffered from post-traumatic stress syndrome? When that happens, are they in reasonably good health? I am talking about what I call rehabilitation. How do their peers react? Are they open to the idea of working with soldiers who have been affected in some way and who need rehabilitation?

[*English*]

Col Donald S. Ethell: I'm going to ask Shawn and Cyndi to answer that, but in fact rehabilitation is a very important thing. Reintegration—that's a DND concern. Stéphane Grenier, the founder of this program, although he's a sufferer, was found capable of going back to Afghanistan, and he did. Whether he's going to go again remains to be seen. Whether others go is a judgment call by those in DND.

Shawn, do you want to comment on that?

Mr. Shawn Hearn: Sure.

Sir, in working with a number of peers, of course, as the colonel said—I'm not going to get into the aspects of reintegration—I am working with some peers in the province who have successfully reintegrated back into the military. Right now I have an individual who is actually currently back in Afghanistan. At the end of the day, for some of these individuals, it's a long road to recovery. I guess there's a make-or-break point for some of these individuals. They realize that they can either go back in uniform or they can carry on.

I guess a big role we play, as peer support coordinators on the ground, is helping with their rehabilitation. A lot of these individuals, when they come to us, often feel very isolated and alone. Part of our job is to just break it down. One comment that was made to me this past summer in Cyprus, when I was there for the reintegration back to Canada, was that OSISS works because it's coming from a soldier's perspective, from a veteran's perspective, and there aren't people there in white coats talking to them—and no disrespect to the folks in white coats. I think that's why OSISS works: we've been there, we've walked in their shoes, and we understand what's going on.

A lot of times, with peer support, we can speak to these individuals, as I said, as soldiers. We can break things down. Sometimes we can take off the OSISS coordinator's hat and put back on the infantry soldier's hat and say to the guy, “Listen, your doctors have a treatment plan in place for you, so suck it up and listen to these guys. That's why they're paid the big bucks. They have the knowledge and education to get you going in the right direction.”

That's a big role we play. I'm not sure if Cyndi would like to add something.

The Chair: We'll have to give you a chance later, Cyndi, to do that. We have to move on.

This is a very poor format to get a full-blown debate going, but maybe Ms. Black will help get that organized.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thanks, Mr. Chair.

Thank you all for coming.

We're all aware of the good work OSISS has been doing. We travelled as a committee to Edmonton and spoke to some of the people there and have followed it. So congratulations to all of you for the courage that Cyndi and Shawn show in doing the work they're doing. I know that it's invaluable.

I agree with the whole premise of the peer-to-peer notion, because in the area of the country I'm from there's a first nation saying: “You never understand a person until you walk a mile in their moccasins”. This is one very graphic example of that, I think.

I'm wondering if the number of people accessing OSISS has increased with the Afghanistan deployment. I assume that it has, but I don't know that we've heard any specific numbers. And has the mission presented any particular challenges in this area?

The next question is one I'd like either of you to answer. My colleague Denis Coderre mentioned the *Chicoutimi*. I'm wondering about the other services. We're hearing now about the army, but I'm wondering about the services for naval personnel, in that instance, or the air services, and how they access the programs as well.

Col Donald S. Ethell: Before I get the numbers lady here to talk, you mentioned the numbers coming out of Afghanistan. One of the phenomena, and that's my word, coming out of Afghanistan, even from the clinical staff, is that individuals are coming home from Afghanistan and may present a problem, and it has been a trigger for people from other instances—Kosovo, the Balkans, even going back further, maybe to Somalia, and so forth—who say, “Gee, I have a problem”. In fact, it's wider-ranging.

One of the strengths of having the closing of the ranks in DND and VAC is that some of these veterans from the Korean War and a couple from the Second World War are saying that they think they have those problems too. I don't know what the numbers are that are banging on the doors of the district offices. It's risen dramatically in regard to.... They're not worried about the payoff or the money. The money's nice, but fixing it.... They want it to be fixed, okay? That's where the strength is.

As for numbers, I emphasize to you.... In Afghanistan, we've lost a lot of troops, and there are a tremendous number of wounded. Remember, we're not just dealing with the families of the fallen. Put yourself in the scenario where there's a vehicle blown up, such as with the young trooper from the Strathconas. What about the other people who were “not hurt” in that vehicle? Horse feathers! They were hurt! It may not come to pass for the four to six months that Brigadier-General Jaeger has indicated—and that's a good guideline, in our opinion—but it may be four or five years. Who do they talk to first? It's Cyndi or Shawn or McArdle. Sometimes at Tim Hortons they've heard about them and they want to know how to seek them out.

● (1610)

Maj Mariane Le Beau: I think there are definitely two sets of numbers, and I will refer to Kathy afterwards.

As Mr. Ethell is indicating, from the very beginning of the Afghanistan campaign we saw a phenomenon, anecdotal but nevertheless it seemed to come out, that a lot of the peers from the 1990s who had access or services and had ceased to use them were coming back, because they were getting re-triggered. So there's that re-triggering that occurred.

As Mr. Ethell was saying, also from past conflicts, people are feeling re-triggered because it is on the news, because it is out there. So there's that.

There's the fact also is that some of the people coming back from Afghanistan now may come up with some OSI issues but may have been carrying an injury from previous deployments, and there's no way we can tell that either.

There are definitely some soldiers who will develop an OSI who have only been deployed in Afghanistan, especially the younger soldiers. Some of them may have up to two or three deployments already.

I do have some numbers of how many people have had deployments in Afghanistan who are accessing our services, but I guess I want to put that in with all these caveats, because there's no way for us to really tell.

Right now we have approximately 235 peers who have been deployed in Afghanistan, out of more than 3,000 peers. On the family side, we have almost 100 families who are accessing our services, whose partners have been deployed in Afghanistan.

I'm going to pass it on to Kathy.

Ms. Kathy Darte: I guess what I would add to that is that I think it's a good thing. I look at it in a positive light that we're seeing 235 soldiers coming out of Afghanistan.

Going back to the first question of people falling through cracks and having a considerable delay from the time of the injury to the time they sought out treatment or at least got themselves into treatment, when we started OSISS we were seeing periods of injury to getting into treatment of five to seven to nine years.

Afghanistan is a recent deployment. So if people are coming to us now from Afghanistan deployment, it says that they are getting into treatment and seeking out treatment much earlier. That's the positive side of that.

Ms. Dawn Black: I had a question around what we've been told about the military culture making it more difficult for people to come forward when they start to experience this. We've been assured that that is lessening as time goes by, but that it is still part of the problem with people coming forward.

I'm wondering, from Cyndi or Shawn's perspective, if there are differences according to rank in coming forward. I wonder myself if officers who are in leadership positions find it more difficult or less difficult to come forward. I'm also wondering about differences between regular forces and reservists and how the follow-up is done with reservists in particular.

The third part of my question is whether there are specific challenges for women. Maybe Major Le Beau and Cyndi would respond to that. I'm wondering about how women come forward. Is it different from their male colleagues in the Canadian Forces?

● (1615)

Col Donald S. Ethell: Cyndi, you're much younger than I am, and hopefully you remember all three questions.

Ms. Cyndi Greene: You knew there were three. I will try to remember.

I guess on one part of your question about the coming back to work and if that's making it harder, in my area the majority of the people I deal with are already out of the military. They're coming forward now, and I think a lot of it is as a result of word of mouth, as everybody has said here. The guys go out and they see results and they're getting help, and then their friends notice a change in them and they ask, "What's going on with you?", and they say, "Well, you've got to give this person a call."

I work with people in Thunder Bay, and I live out of Calgary just because I've had friends of those people.... I work out of the Veterans Affairs office. I can tell you one thing: in the office I work in, Veterans Affairs are really, really looking after their people. Every single time a soldier or a former soldier phones that 1-866 number, and they want to make an application or just ask questions about post-traumatic stress disorder or OSIs in general, they are automatically referred to the OSISS personnel at my site. I think that is part of the reason why I'm so busy.

I know the reservists on the base in Calgary. That's 41 Brigade, which I work with in Alberta. They just took on a new initiative, and I'm thinking it's called Operation Home Grizzly, but I'm not 100% sure. That's going to be a committee, and they're going to have one unit representative per reserve unit. So they'll be the liaison officer. And we'll be part of the committee to make sure these people don't fall through the cracks. That committee will be made up of Canadian Forces health services, the unit representatives, Veterans Affairs Canada, padres, operational stress injury clinics, family resource centre, and of course OSISS.

So the efforts are there, being done. From a Veterans Affairs perspective, I can tell you that I was 100% confident there's nobody falling through the cracks who are coming through.

The Chair: Thanks, Cyndi.

I apologize; time moves fast here. I appreciate your being thorough.

Mr. Hawn is next.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

Thank you all for being here. It's really appreciated.

Did I hear correctly? Are there 17 PSCs, 17 peer support coordinators?

Col Donald S. Ethell: It's on your—

Maj Mariane Le Beau: There are 21 coordinators for military members and families.

Mr. Laurie Hawn: How many peers can one peer support coordinator comfortably handle? I know that varies widely.

Cyndi, I think you said you're handling 197. Is that correct?

Ms. Cyndi Greene: That's correct, yes; it's 197.

Mr. Laurie Hawn: It sounds like a lot. How much time does that take every day?

Ms. Cyndi Greene: It does take a lot of time and a lot of effort. I do have one very good trained volunteer. Our volunteers, of course, also have suffered OSIs and are at a point in their recovery at which they're able to help out on a limited basis.

It's a huge client base, but there's really nothing we can do. Word on the street, if you will, is that we are there and we are available for the work we're doing, and there's the fact that it's 100% confidential. Sometimes I might spend a week working with one peer on certain issues, and sometimes I just call up the guys once every couple of months just to see how they're doing.

Mr. Laurie Hawn: You're dealing with 197 clients; they're unloading their troubles on you, and you're downloading their troubles onto yourself. What do you do to cope with your own...?

Ms. Cyndi Greene: Part of our job as peer support coordinators, sir, is we are mandated to see psychologists. Every year we have to get a medical screening from our psychologist, saying that we are still able to do this. As well, we have self-care calls once a month with a psychologist at St. Anne's. He phones us individually—or as a group, sometimes—in each region, and we talk about what's going on. There are tons of support available, plus our managers; as well, our own peer support coordinators—we ourselves—talk a lot.

Mr. Laurie Hawn: We talked about burnout as the biggest problem of peer support coordinators. How many have we burned out to this point, or have we burned out any?

Mr. Shawn Hearn: I'd just like to add to what Cyndi is saying. I'd like to break her job into two percentages: 75% of her job, I think, is peer support; the most important and first percentage, for me, is 25% on self-care. In order for me, Cyndi, and other folks in our program to be able to help others, we have to learn to take care of ourselves.

In the beginning, it's not easy; there's a lot of playing checkers, but you learn to get it right and get your kings in one end. At the end of the day, we do self-care teleconferences with the veterans hospital in Montreal, Ste. Anne's Hospital, referred to in the presentation given by Colonel Ethell, as well as teleconferences with each other. We do regional teleconferences to talk about lessons learned and things like that.

The biggest thing, I think, is talk among peers. It's been harped on by our management team to take care of ourselves.

● (1620)

Mr. Laurie Hawn: Colonel, would you comment?

Col Donald S. Ethell: I think Kathy has some figures for you here. Of the 197, how many would be active? They're not all active, as I indicated; some of them would go for a couple of months.

Ms. Cyndi Greene: Currently I have 89 active cases that I'm working on. However, at any moment.... I could go home tomorrow and ten of those inactive may be active now, and I may have eight e-mails and four voice mails and more referrals from within the office. That number changes quite regularly.

Mr. Laurie Hawn: The Cyprus program has been playing a role in that for close to a couple of years now; can somebody comment on the successes and the challenges that are there?

Maj Mariane Le Beau: I'll start, but both Cyndi and Shawn have been on the ground; I have not. I can only talk to you from some of the lessons learned.

When we were invited to participate in a TLD, a third location decompression, we were extremely happy to be working with the mental health team. As it progresses from decompression to decompression, it has provided us with many opportunities. One of them is definitely for the peers, and I'll let Shawn and Cyndi talk to that.

The kind of contact it affords the soldiers to the peer support coordinator is absolutely outstanding, and also for the mental health teams, because they're not always the same, obviously; they rotate. It's the same thing with our peer support coordinators; we try to identify those in the area to go to the decompression so that they will be providing education briefings to soldiers they may eventually provide peer support to. I think it has a lot to do with getting OSISS to be known more widely among the soldiers, indeed.

Cyndi and Shawn, would you like to add something to that?

Mr. Shawn Hearn: Sir, I think the third-location decompression in Cyprus has been a great thing. When I came back, I ended up slipping through the cracks because I was very unaware of what resources were out there for me.

When I was in Cyprus it was quite encouraging to see soldiers of all ranks coming up to talk to us after our briefings. Our briefings mainly focused on the OSISS program, peer support, but also redeployment from the veteran's perspective—going back home and talking to them a little bit about what it was like for me when I came back home, what the road to recovery was like for me.

I will say that we still have a ways to go, but I can say it's been quite encouraging for me to see young men and women who I've seen in Cyprus approach me now in St. John's, saying “Hey, I remember you when I was in Cyprus, and I remember you talking about the OSISS program.”

In part of our presentation in Cyprus there was a slide about possible reactions when you come home, and the key there—if you looked at the presentation that Colonel Ethell handed out—the definition is “any persistent psychological difficulty”. A lot of men and women, when they come back, are going to have normal reactions to having served in a place like Afghanistan, which is a very abnormal place, but the key, of course.... And that's the thing that I hit home in my presentations: “Listen, I'm not here to implant in anybody's head that they have an operational stress injury, and I'm not qualified to tell anyone that they have an operational stress injury; however, if you come home and any of these issues are persistent, then the bells might go off and you might need to get help.”

This is where Cyndi and I get a lot of contact, because our program is 100% confidential, and they know that, so they come to see us. A lot of our job is spent encouraging these individuals to get in touch with either the CF health services or Veterans Affairs Canada.

Ms. Cyndi Greene: Also, in Cyprus there are five briefings that the troops have to attend. There's one mandatory—battle mind—that everybody has to do, and then on the second day there are four, out of which they have to choose two. The briefings were battle mind, as I said; healthy relationships; leadership after the action; coping with stress and anger; and OSISS. The OSISS was by far the most attended briefing in my three and a half weeks, and I believe when Shawn was there as well. As Shawn referred to earlier, the comments were that they were quite happy that they were talking to ex-military people who had been on tours. We've been through the wringer, so to speak, and they look at us as mentors or as somebody they can look to, when they get home, for some help.

● (1625)

The Chair: Thank you.

Sorry, the clock seems to be going extra fast today—it's our interesting witnesses.

We start into our second round, and it's only five minutes now, so it's going to be tougher to keep on the schedule. We have official opposition, government, the Bloc; official opposition, government; official opposition, government. That's how it goes for the next seven spots. So we'll start with official opposition.

Go ahead.

Mr. Anthony Rota (Nipissing—Timiskaming, Lib.): Thank you, Mr. Chair.

My questions go mainly to Shawn and Cyndi. I'm glad to hear you're both from small towns, because I think that's something many of us can relate to when we look at military personnel who leave and go home. They're not around a base. I notice where you're set up. You're in major centres, and that's great, because there are a lot of people in major centres. But for the individual who goes home and is in a small town in rural Alberta, Newfoundland, Ontario, what outreach programs are there? How do you set up? What's the process for someone sitting in northern Ontario or northern Quebec who's feeling uncomfortable? They've heard of OSISS, they've been to the briefing, but now they're out of the military atmosphere. How would they go about getting someone to talk to, getting a group together? Who goes in to see them? How does that work?

Mr. Shawn Hearn: I can really speak to this, sir, being from Newfoundland. We have a lot of rural and outlying areas. Currently I work in St. John's, in the Veterans Affairs district office. However, I'm responsible for the other bases in Newfoundland, Gander and Goose Bay.

I think one of the keys to the OSISS program has been our volunteer component. Currently I have seven volunteers across the island of Newfoundland and Labrador. I have one in Goose Bay. I have one in Corner Brook on the west coast. I have one in central Newfoundland. As well, I have four in the greater Avalon.

The phone for us is a very big tool. Plus we're in a different age, with the Internet, and a lot of our peers spend a lot of time on the Internet.

Just to give you an idea of what I do, I'm in touch with roughly 168 peers in the province of Newfoundland and Labrador. A lot of these individuals who come back do go to outlying areas. One of our biggest challenges has been to access proper mental health professionals outside the immediate areas of Gander, Goose Bay, and Corner Brook, and of course any of the other outlying areas.

The big thing we do—and a lot of the time, this makes the difference—is break the isolation and give these individuals someone to talk to. I like to think that God gave us one mouth and two ears for a reason sometimes. A lot of what I do is just listen.

A lot of times what we hear is very confidential, and at times it's very extreme. We're just somebody on the other end of the phone saying, “I understand, I know where you've been, I know what you've done, but at the end of the day, there is light at the end of the tunnel.”

As the colonel said earlier, we're just acting as that beacon of hope. A lot of times they look to us for that source of hope. They look to us when things are not going well.

When it's a stormy night and the guy out in Rocky Harbour or in Pumphandle Junction is having a rough go, he can pick up the phone and give me a jingle. I have a toll-free number in my office. He can pick up his phone and call me free of charge.

At the end of the day, when they're having a rough time—they're “in the bunker”, as they call it—or they've been in their basement for three days and their wife says “You need to talk to somebody”, they can pick up the phone and give us a jingle. It makes a big difference for them. It takes the load, the rucksack, off their backs.

The volunteers who go out are key, but again, the key word here is “volunteer”. I can't phone a volunteer and them they have to do this or that. But the volunteers are chosen quite carefully, because they are people who want to pay it forward and give something back to the system. The folks who are chosen as volunteers have had a medical screening as well, so they're at a good point in their recovery where they can offer that shoulder or be the bosom buddy for somebody.

Mr. Anthony Rota: What process do they go through when they're coming up to that, when you're choosing your volunteers? And what training do they get? I mean, they're going through some rough times themselves. At what point does it come to “Okay, I'm past the point where I need the support”?

To a certain extent, it's therapeutic just being able to talk to somebody else who's coming up and who wants to be where you are. So it's kind of therapeutic that way. But at what point do you decide, or does a volunteer decide, they're well enough to talk to other people? And at what point do you decide it's safe to put the two together?

I mean, you're talking about very ambiguous areas. It's kind of hard to decide.

Mr. Shawn Hearn: At the end of the day, they're all soldiers, so right from the beginning they want to help.

We know the peers. I spend time with them and talk to them. I see them face to face. In Newfoundland I have the luxury of having a lot of these individuals come to major centres, so we bring these individuals along.

That's not to forget, though, that all these individuals are in touch with therapists. If I go to an individual and ask them to become a volunteer with the OSISS program, or if, vice versa, they ask if they can become a volunteer with the OSISS program, we have the individual get a medical screening form signed by his or her psychologist saying that there are no negative implications in their being employed as an OSISS volunteer or with the OSISS program.

Not only that, but we know these individuals pretty well. We know where they're to in their recovery. We know what's going on with them and if they do have the potential to go out and meet one on one with peers, to run groups, or to speak to peers. Only certain individuals are cut out to do this.

At the end of the day, the most important thing is self-care. We try not to do any harm here.

● (1630)

The Chair: Thank you very much.

Over to Ms. Gallant, and then back to the Bloc.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman, and through you to the witnesses.

First of all, congratulations on the growth and success of your efforts with OSISS overall. I'm sorry there's a need for it, but I remember when you were a very small organization, just a handful of people.

I also understand that the U.S. military is using OSISS as a model for their issues with PTSD. I'm also pleased to learn that the founder, Colonel Grenier, whom I believe is depicted on this brochure, is back with OSISS and playing an important role, I understand.

In some of the cases, does OSISS, in addition to helping the veterans, serve as a bridge? I understand you're peer support, but does it serve as the bridge between serving volunteers reaching out for help and actually getting the psychiatric treatment they need?

That's to whoever would like to answer it.

Ms. Kathy Darte: Yes, they do serve. That's a big part of what they do, being that bridge. A lot of individuals, as we discussed earlier here today, have fallen through the cracks, are in basements. They're very isolated. When they connect with people like Cyndi and Shawn, Cyndi and Shawn act as where they can be if they can get themselves into treatment.

Oftentimes they're very skeptical of treatment. They're not comfortable with coming forward for treatment, or maybe they've already been in treatment and they didn't find that it worked for them. So Cyndi and Shawn work with them, try to build that trust if that trust had been broken previously in the system, and walk with them through the treatment process.

For example, many times they may need to see a mental health professional very frequently, but we know there is a shortage of mental health professionals, so they may not be able to see them every day. But if they see people like Shawn and Cyndi on a daily basis, or a phone call to ask how it's going today, they can discuss with them how it is going and they give them the encouragement to stick with the treatment plan that the individual mental health professional has set up for them. So they help them stay within treatment by walking with them and encouraging them that they can be like the Cyndis and the Shawns if they go through that process.

Some journeys are long and some are short, but OSISS is a big part of getting individuals into the health care system, because they're not going to recover unless they do get into that clinical side of the services that they desperately need.

Col Donald S. Ethell: In your area, Ms. Gallant, Petawawa, the former base commander, Dave Rundle, who you know quite well, was a permanent member of our advisory council for a couple of years before he moved on. He's an outstanding individual and had a significant number of initiatives on his own, at the peril of his career a couple of times, I think, but he made it work.

On the point that's been made by the Surgeon General in regard to numbers of clinical staff that are not available in your area—because we go back to this business of rural, having to come to Ottawa to see the professionals—the good news is that these folks have recognized that. I'm not putting words in their mouths, but the numbers of PSCs are going up, and I understand there'll be a system for further assistance in the Petawawa area.

Mrs. Cheryl Gallant: You've jumped to my third question, which was that I was pleased to see in the former Conservative budget the extra funding that was going to OSISS, five centres, but very disappointed to see that it was not going to an isolated area like Petawawa. As you mentioned, Colonel Rundle was very concerned about putting these soldiers who were in the throes of an OSI onto a bus for several hours, coming here for the day, and then back again.

● (1635)

Col Donald S. Ethell: I couldn't agree more, and with the stigma of getting on that bus.... Where's the bus going? Guess what? And we understand that. But that was obviously not the decision of our two co-managers. It was disappointing, and I know Dave is disappointed in it. We're disappointed in it.

Mrs. Cheryl Gallant: We're going to continue to push for that.

Col Donald S. Ethell: Sure. We look at the past, at the present, and where we're going in the future.

Mrs. Cheryl Gallant: With respect to medical releases, we're heard testimony at both ends of the spectrum. The brass tell us, absolutely not; somebody who goes for treatment for PTSD is not going to be medically released automatically. Then we hear from people on the ground who say they go to see the psychiatrist and are told they're likely to be medically released. That word gets around, and in and of itself it is an obstacle for people to seek the help.

In your experience in dealing with the serving soldiers—our goal is to keep them working, because that's what they want—are they being automatically medically released or on the path to it, or are they getting the help they need to continue to be effective currently serving soldiers?

The Chair: I apologize, but we need a short response, if you can.

Maj Mariane Le Beau: Unfortunately, there's probably not a black and white or yes or no answer on this one, Mrs. Gallant.

I'm not in the management of releases, but based on the peers, there are Shawn and Cyndi, and across Canada. Clearly having an OSI is not an automatic release. More and more, we have heard of protocols and people who have suffered from an OSI and are being treated, recover, and are redeployed.

However, there are definitely people suffering from an OSI who will be released because of their condition, the severity and the resistance to treatment.

So I would say there are probably all kinds of scenarios there, but not black and white.

The Chair: Thank you.

Mr. Bachand, for five minutes.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you, Mr. Chairman.

Thank you for being here.

Something that caught my attention in your presentation was that you said that your idea was greeted favourably by senior management at National Defence and Veterans Affairs Canada. It makes me think of how the principal of my school used to react. When I came up with an activity program, he told me that it was a great idea and that, in addition, it would not cost much. That is what I want to discuss with you. I gathered from your presentation that the program has coordinators, who are paid, I imagine, but it mainly uses volunteers. So what you are running is almost a charity. It is made up of people who want to help their peers.

Here is my concern. Are those in charge of National Defence and Veterans Affairs Canada investing money in this, or are they like my school principal? Are they simply encouraging you to continue to set up good programs because it does not cost very much and it works well. I think that what you are doing is good, but I am very interested in knowing whether you are being given the resources to really do the job properly. This is especially true since I see that you are not doing clinical work, but rather you are networking and trying to help peers who are also victims.

Would you recommend that the Standing Committee on Defence insist that the minister come up with more substantial funding in order to really help people? The approach that you are taking is different from clinical therapy. I see some people smiling. I think that I am on the right track. I have the impression that you would be onside with our requesting more funding.

[*English*]

Col Donald S. Ethell: As a non-departmental representative, I'll give you my personal point of view, and these two will skate around the question, or give you a candid opinion.

If you look at where this program started from, with four people, it took senior management, as you say, General Couture and Mr. Ferguson, to get onboard and make it work. But the money wasn't there. They eventually got the money. And lately, as you know, with the new funding for Veterans Affairs, you have the five new OSI clinics. These are very successful and not as bureaucratic as the OTSSCs; you can get through them a little more quickly, which is just a question of the methods of operations between the two departments.

I notice that the Surgeon General, God bless her, is going to bring in 450 more clinical staff. I don't know where she's going to find them, but this will be great. What we would like to see is, how many of those are going to be PSCs, and how many more are going to be FPSCs? I might add that Cyndi is only one of two female peer support coordinators. The FPSCs are all females, so they are a little unique. But it's not a matter of gender, but of who can do the job.

So it would be nice if some of that DND funding—and we have VAC funding of $9.5 million from the last budget....

Is there a shortage? To answer your question, yes, there is, sir. I'm sure they would like to have many more people.

● (1640)

[*Translation*]

Mr. Claude Bachand: I will continue with you, Colonel Ethell. You head up the advisory committee. The document states very specifically that the committee has no executive powers. So you have to be content to make recommendations. That is why I think that it would be important for you to have the support of parliamentarians. Senior management at Veterans Affairs Canada and National Defence must be telling you that this is great, that they are very pleased with your efforts, that you are doing an extraordinary job, but that they are unfortunately short of funding this year.

Would it not be possible, for example, to amend the National Defence Act to give your organization real recognition in legislation? Then you would have access to much more stable funding.

[*English*]

Col Donald S. Ethell: That's way out of my purview, but I must admit that I'm on the advisory committee, and we just had a meeting three weeks ago. In the minutes, or the recommendations in the minutes, will be additional PSCs and FPSCs.

As I said, we don't have any executive authority, but we do have influence that gets passed to the senior management and through the two career managers to the respective chains of command.

To be quite frank, it may sound a little self-serving, but the advisory committee has made a number of significant inroads in the thinking and in the improvement in regard to OSI. The only reason that committee exists is because of the OSISS program.

Maj Mariane Le Beau: About budgets, I would like to answer with some numbers and I'll answer in English.

As Mr. Ethell said, it started with four peer support coordinators. We're talking about a budget of $500,000 in 2002 and 2003. It slowly went up to $1.2 million, and in 2005-06 we had about $1.5 million budget. For the year 2006-07 we went up to $2.6 million, an increase of 25% of the previous year. On the DND side I have made representation for another increase of about $800,000 for the next fiscal year. We have had no confirmation at this point for the budget year of 2008-09. These additional budgets are for new positions for PSC and FPSC but also for the bereavement peer support program. We want to create positions in that area as well.

So the budget of OSISS has increased every year throughout its existence. Particularly for the year 2007-08 there's been a substantial increase, and that's just on the DND side. We have to keep in mind that this is a DND-VAC program, and I will let Kathy talk about the financing of the VAC.

The Chair: We'll have to get back to that. We're just a little over time. Hopefully we could get those. If we don't get back to you, I'd like to have the numbers submitted anyway.

We have Mr. McGuire and then Mr. Lunney.

Hon. Joe McGuire (Egmont, Lib.): Thank you, Mr. Chair.

We're told that 79 have been killed so far in Afghanistan and 270 to 280 wounded. How many are mentally wounded? How many have had to be permanently discharged or discharged on a temporary basis from Afghan operations at this point?

Maj Mariane Le Beau: Sir, we do not have such information at the OSISS program, I'm sorry. We do not have the capacity to answer that.

Hon. Joe McGuire: How many people do you treat or are involved in your organization?

● (1645)

Maj Mariane Le Beau: As I said, so far we have 235 peers who have been deployed to Afghanistan and 92 families that are accessing our services that have had a partner involved in Afghanistan. But in terms of those statistics, even in terms of impact, sir, we will probably not know for years what really is the psychological impact on soldiers. So that is a very difficult one to answer.

Hon. Joe McGuire: I was just wondering if there were any current numbers, but you don't have those anyway.

Maj Mariane Le Beau: I would expect it would be the CF health services that would keep numbers of the diagnosis and how many members, such as the 2002 statistics that were gathered. They would have to conduct a similar study to have numbers to answer your question, sir.

Hon. Joe McGuire: Do you deal a lot with the families of those who are killed? Or is it mainly those who survive?

Maj Mariane Le Beau: As I said earlier, I talked about the bereavement peer support program of OSISS that was created September 2006. We have served 77 peers who have lost a loved one, either a spouse, parents, or siblings. That's how much we've been involved so far.

Hon. Joe McGuire: That's most of them.

Kathy, what about somebody who is charged? I know the accidental discharge of a rifle killed a fellow soldier. Was that family involved? I can just imagine the mental anguish those people are going through waiting for their son to be dealt with in the military justice system. Are those people being reached out to or are they reaching out to you?

Ms. Kathy Darte: I can't speak to individual situations, Mr. McGuire, but what we do through our program is make people aware by reaching out, just through awareness, that we have a part of the OSISS program that is for families who have lost a loved one, whether it be to sudden combat trauma or.... Also we lose military members and we lose veterans from a terminal illness, which again is very traumatic to a family. So of the 77 that we have seen, they're not all due to direct combat trauma in deployment like Afghanistan.

So I think through awareness of our program...and the awareness is not only with OSISS, but with my department, Veterans Affairs. With DND knowing that OSISS has a bereavement component, they will make individuals that they are in contact with aware of this particular component we have and refer them to us or suggest to the individuals that they may want to connect up with OSISS. The same is true from the Veterans Affairs side. They are aware that we do reach out to families. So the individuals may be in contact not with OSISS initially, but with Veterans Affairs. And Veterans Affairs will say that it may be good for them to connect with the OSISS program.

Col Donald S. Ethell: If I may, Mr. McGuire, we know of whom you speak. In fact, I know the parents very well; they come to Calgary for the annual ceremony, and part of the healing process for them was to talk to fellow parents and widows and so forth. They're very sympathetic to the other family.

That having been said, it goes back to the peers here. If that individual or that family were to come forth to one of the PSCs or FPSCs, they wouldn't turn anybody away, even though it's not in their mandate. Do they talk to RCMP people who have problems? You're darn right. You can ask them. They don't turn anybody away. If somebody comes in, even though it may not be officially sanctioned by either of the departments, they will sit down and have a coffee and suggest that they seek some counselling.

Hon. Joe McGuire: I know General Hillier dropped into Cyprus at least once. I was wondering if that would have a pretty positive effect on people who were whole or wounded and going through that decompression process. Are you using commanders as part of your process too? Are their ex-commanders visiting these people to follow up when they're up there?

Col Donald S. Ethell: General Hillier is one of the very strong supporters of the Eykelenboom Boomer's Legacy, which is run by Maureen Eykelenboom in memory of the medic who was killed. As a matter of fact, I'm one of the directors.

General Hillier's personal involvement in fundraisers is significant. The military family fund—he's one of the shining lights, to the extent that he'll.... In fact he's attending another function in Calgary on June 14. He loves Calgary because there's lots of money there for the fundraisers and so forth. He is very dynamic, very charismatic.

I don't think there's a soldier in the service who doesn't look to him as an outstanding example of leadership. His personal presence along with General Leslie and the others—the air force chief of staff and so forth—in showing the flag at their units is what commanders are paid for. It's to get out there and talk to the people, and not only to talk to the operational units and visit unexpectedly in some cases, but to go to these fundraisers. I've seen him relate with the four families out of Calgary who lost family. The reception will take them aside, and they'll have a tête-à-tête.

Does that answer your question?

● (1650)

The Chair: Thank you.

Go ahead, Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Mr. Chair.

Again I'd like to welcome you all here.

I'd just like to say first off, though, Colonel Ethell, that I think it's gone without being noted that you're the most decorated peacekeeper in Canadian history.

Col Donald S. Ethell: Well, thank you, sir. I've done 14 tours; that's why my OSI didn't get identified until last year.

Mr. James Lunney: I'd like to say that we really appreciate your involvement at this stage in your career in providing OSISS with your leadership and your experience for our soldiers.

One of the things about jumping late into the conversation here, as some of us are doing, is that a lot of questions have been asked already.

I'd like to make an observation, if I may. First, in my riding on the west coast we have an organization called NIDMAR. It's the National Institute of Disability Management and Research. I don't know if you've heard of it, but we're talking about workplace injuries in that context. They have developed a program, and British Columbia is actually establishing Pacific Coast University—the province just dedicated it—for managing workplace injuries. The type of HR management they're promoting involves getting involved early with workplace injuries and making sure they're followed up so that they get the treatment they need at the beginning and that they get the follow-up. If they're not possible to rehabilitate, they find room for them in the workplace somehow.

The credentials are being accepted worldwide. It's a bit of a Canadian success story, although we still have major challenges.

What I wanted to say is that what I hear here is the military seems to be actually following along on that pathway in making sure you're doing the right thing by getting involved early. I want to applaud what I hear happening with the peer support, and the fact that we have volunteers involved to a certain extent with bereavement in families. Boy, when we're short of mental health workers, there's nobody actually better as a first point of contact than people who have actually been on the ground and understand the pressures people have been under.

I think you're doing something tremendous, and maybe there is some international support that you might find beneficial for training your two HR leaders here, really, and then a bunch of volunteers and support people around you. There is some great stuff happening in that realm, and it sounds as though you're on the right track.

Col Donald S. Ethell: If I may, the two co-managers here have conducted many briefings in the United States, everything from Miami to Las Vegas. They didn't go there because of the gambling. They went there because there was a conference there, and in the Netherlands and so forth. That's where we're having the next AC meeting.

The other thing is Colonel Stéphane Grenier is back in the saddle as the OSI adviser to the chief of military personnel, and, as such, he's involved along with the director of mental health from Veterans Affairs in Senator Kirby's commission and on a couple of their committees there.

They're also expanding into the civilian world—and Mariane can talk more knowledgeably than I—with initiatives in Regina at the university there. We had an excellent presentation by four students from the University of Toronto—the engineering faculty, believe it or not—who wanted to set up a peer-oriented program. Boy, our country is in good shape if all our kids are as switched on as these four were. It was literally outstanding.

That's the spread of the OSISS program.

Who can we have talk about OSISS? These two? Okay, for the organizational element or Colonel Grenier.

Mr. James Lunney: That's great.

I want to jump in and ask a question that hasn't been asked. My colleagues will all know this, as I've been asking it of some of our senior medical personnel who have been here on behalf of DND, and that is about some of the options on treatment. I've talked about it from the top level and some of the medical personnel treating soldiers, but you're dealing with people for our front-line peer support groups. You're meeting people right at the grassroots level. With the treatment options you're saying are offered, a lot of soldiers don't want to go on the drugs. I'm aware of some soldiers who have very good success with the non-drug approach, with the approved approach of the EMDR. I wonder what your experience is with people who may have had that option presented to them. Can you comment on any experiences you've had with the non-drug treatment and EMDR?

● (1655)

Mr. Shawn Hearn: I don't think that it's fair for me to comment on that, because my role is strictly peer support. As I mentioned earlier, I'm not a psychologist, social worker, or anyone from a mental health background. I don't offer any advice to my peers about medications or any types of therapies or anything like that. However, part of our role is if the therapist or mental health professional recommends, then we encourage treatment and compliance with those plans.

The Chair: Thank you.

I'm sorry, you're out of time, but you did get your vitamin question in.

Over to Mr. Coderre, and then back to the government.

Hon. Denis Coderre: I don't have any questions on vitamins, but I'd like to talk about confidentiality.

[*Translation*]

We are able to identify one of the problems. The reason that I am asking you this question is that you are sort of champions for this kind of support. People come to you and you understand. The culture has to change.

One of the problems we need to deal with is that some soldiers, according to experts, are afraid to speak out because they are afraid that information from their file will get out. It is also a bit of a macho thing. If they return to a combat role, they may feel shame, regardless of their attitude.

How do you view the need for confidentiality? Are you certain that files are now treated with complete confidentiality? If you put yourself in the shoes of a soldier or a veteran in that kind of situation —and not with respect to what happens at National Defence—do you believe that things have improved? What do you do to assure people that they can speak freely and that even when things move to the next stage, they will not have to worry?

[*English*]

Maj Mariane Le Beau: On the OSISS side, in terms of confidentiality, I am totally confident in saying that it's fully confidential. It is actually probably *une pierre d'angle* of our program. It's such a necessity that the soldiers know that when they talk to Shawn or when they talk to Cyndi, there are no files kept. We don't keep files on people.

Kathy and I are unaware of the names of our peers.

[*Translation*]

Hon. Denis Coderre: I am really trying to understand what goes through the soldiers' minds.

Do you often hear that they worry about possible breaches in confidentiality? They do not want to confide in anyone other than you, because you are close to them and you have experienced the same kind of situations. But there have to be steps taken with their file. Do you often hear that they do not want to get help because they are afraid that the information will be revealed?

[*English*]

Mr. Shawn Hearn: Sir, one of our biggest assets is that we listen to these individuals without judgment. Yes, there is a lot of fear on the soldiers' part—fear of being branded or labelled by peers, or being shunned or ostracized by peers. A lot of times in the CF world, these symptoms are seen as a sign of weakness, although it is getting better. We still have a ways to go.

The number one reason I see for soldiers being afraid to go for help is not so much that they're afraid of the system, but rather it is the fear of jeopardizing their career—"I'm not going to get that next tour. I'm not going to get that next promotion. I may not be promoted."

Part of our job is that when they come to us.... Again, I can speak to these individuals as a soldier. I can put things into a more balanced perspective. I can affirm and reframe actually what's going on with them.

I'm currently seeing 16 vets of Afghanistan right now in Newfoundland. Some are still serving. These individuals come to me. A lot of times, as I said earlier, what I hear is very confidential and extreme. They're really unsure about what's happening with them.

A part of my job is to encourage these individuals to either go through the CF health system, where the proper professionals are in place.... Again, if a soldier comes to me and says he has something going on, I don't say "You've got PTSD" or "You have an OSI", because I'm not qualified to do that. But I do encourage them to seek treatment.

● (1700)

Hon. Denis Coderre: I guess my question, Shawn, is are you assured that if you send them to DND, and they go through due diligence and through the process, you can tell them with certainty to go ahead, there's no problem, and they're going to be treated great, not only at the clinical level but also at the bureaucratic level? The problem is that they are afraid to talk mostly because of their jobs. They might have a medical release or whatever, and they see that as a downer. Do you trust the system? That's basically the question.

Col Donald S. Ethell: If I may, sir, you have to trust the system. That's why you have the mental health professionals there, and the doctors and so forth. The medical documents are confidential.

However, having said that, the bureaucracy is such that if an individual has a problem and needs to receive treatment or needs to be released, then that's the way it's going to go. There's a hesitancy by the soldier to come forward. The danger, as these people have experienced, I'm sure, personally, having faced a number of suicidal events, is that if that individual doesn't go forward, it may trigger something else and it may do damage to him or her.

You could almost say it's a Catch-22 situation. You have to go and seek some help from somebody, because if you don't, you may have additional problems. As Shawn and Cyndi have emphasized a number of times, they're not professional clinicians but they can steer people toward them. And they know the signs.

The Chair: Thank you.

To end this round, Mr. Blaney.

[*Translation*]

Mr. Steven Blaney (Lévis—Bellechasse, CPC): Thank you, Mr. Chairman.

I want to welcome you to the committee. I have missed a few meetings lately, but I have the impression that this was an important meeting to attend. I want to congratulate you on this program that I would call a mentoring program. I am an engineer. We have our own kind of mentoring program for engineers. Some information can be shared among peers that cannot be provided in any other way. That is the key aspect of your program.

There has been talk about funding. I think that your program is an investment because you are able to help people who have much more serious health and psychological problems. We are basically talking about broken lives. You can give these people hope and help them get back on their feet. That is extremely encouraging. What you are doing goes to the heart of our work, and so it is interesting to listen to you.

You are helping us understand and demystify post-traumatic stress syndrome. I have a few short questions for you on that.

Do you also help people who have psychological problems? You said that there are 21 coordinators for peers, who are soldiers and veterans, and 20 for families. You mentioned that there were 3,000 clients and 77 families. I find the number of military peers very high compared with the number of families.

Do you have francophone coordinators? If so, how many? Does the number depend on demand? It is important for people to be able to speak French if that is their mother tongue. I see that you have coordinators who speak Newfoundland, which is the third national language, but do you have coordinators who speak French?

If there is time, I will ask a more personal question.

Maj Mariane Le Beau: In Montreal, Saint-Jean and Valcartier, our coordinators have to be francophone. This service is offered in French in Quebec. I hope that that answers your questions on that issue.

The matter of the ratio is important. The peer support program for soldiers and veterans really began in 2001-2002. But the services for families started only in 2005. Until last summer, we had only six coordinators for all of Canada, and then another position was added in Ontario. Last year as well, the Department of National Defence gave us six extra positions, and Veterans Affairs added eight more. Not all of the family support coordinator positions have been staffed to this point. That will be completed between now and next summer. The number of families who receive services depends on availability. Since not all the positions have been staffed, the ratio seems unequal.

I hope that I have answered your question.

● (1705)

Mr. Steven Blaney: It seems to me that there are not many coordinators for the 3,000 soldiers. Are there only 21 coordinators?

Maj Mariane Le Beau: Yes, there are 21. According to the statistics compiled over the years, 3,000 soldiers and veterans have been provided services by the Operational Stress Injury Social Support program. Some of them are no longer using the service.

Mr. Steven Blaney: If 25,000 members of the military have been to Afghanistan and 10% to 15% of them will suffer from post-traumatic stress syndrome, then that means that there will be another contingent. You have a potential pool of 2,000 to 3,000 new military personnel. Therefore there has to be a significant increase in military personnel.

Maj Mariane Le Beau: Yes, as I mentioned earlier, we have already made a budget request for the next fiscal year, that is for the 1st of April to the 31st of March. I have also made a request for more coordinators.

Mr. Steven Blaney: There is also of the issue of psychological assistance. Have you...

Maj Mariane Le Beau: I am not sure I understood your question.

Mr. Steven Blaney: Apparently there are psychological issues and there is post-traumatic stress syndrome.

Maj Mariane Le Beau: Those are called operational stress injuries. That does not only include post-traumatic stress syndrome, which is a diagnosis. The term “operational stress injuries” is not a diagnosis but rather a term that includes all the other psychological disturbances that you are referring to. Those may be anxiety of depression. In fact, depression is probably the most common psychological impairment that has been observed in surveys and investigations.

[*English*]

The Chair: Go ahead, sir.

Col Donald S. Ethell: If I may, I'll just clarify a point.

Remember, the figures you're hearing are for those who are approaching the PSCs and so forth. There are quite a number of people who will walk in, particularly in the district offices and so forth, who will not have seen a PSC. The number in the veterans community is around 10,000, but they didn't all go through PSCs.

Numbers can be warped to tell you what you want them to tell you.

The Chair: Thank you very much.

We're on the last round. We have ten minutes before the bell rings, so let's proceed as quickly as we possibly can—official opposition, government, and then Bloc.

[*Translation*]

Hon. Denis Coderre: I know that this question has often been asked and the experts have provided us with an answer, but do you see an increase in operational impairments due to a change in mission? A mission is a mission and one may witness terrifying things, as in Rwanda, for example. Do you think that the fact that you are involved in a combat mission in Afghanistan will change how you feel following your experiences in the past within other missions?

[*English*]

Col Donald S. Ethell: No. I'm going to answer that to start with.

As one of your members indicated, with all due respect to the combat role, sometimes on the other missions you are not able to return fire. You have to stand there and take it, including suffering casualties, as they did in many missions, such as the Turkish invasion, when the Canadians fought the Turks for control of the airfield, the Beirut situation in southern Lebanon, when you're at the mercy of air attacks, and so forth. Sometimes it's more awkward—you have to use that term—than a purely combat role.

I don't know what the figures or percentages are now, but Afghanistan has brought OSI, PTSD, addiction, and so forth out of the closet because there's so much focus on Afghanistan, and rightly so. We have people in Darfur. We have others who are serving in some very contentious areas, and they're going through some of the traumas.

It has convinced people, as I indicated, right back, including a couple from World War II who have walked through the door at Veterans Affairs. So the numbers have gone up dramatically, and they're going to go higher. As Major Le Beau has indicated, these kids coming back from Afghanistan, those passengers I was telling you about in the LAV where the driver was killed and so forth, that may not come back to haunt them for four or five years. So it's a growth industry. I hate to use that term, but it is.

● (1710)

[*Translation*]

Hon. Denis Coderre: The experts have told us, and it makes sense, that the more one participates in missions, the higher one's risk of suffering from a syndrome, whether that be extreme anxiety or post-traumatic stress.

For example, in Afghanistan there are non- commissioned officers and combat soldiers. Some non- commissioned officers have been to Afghanistan six, seven or eight times. Perhaps I did not understand what you were saying. Can you tell me what the difference is between the high brass, the upper ranks, and the other soldiers?

In your-follow up, have you noted a difference between those in positions of command and the others?

[*English*]

Col Donald S. Ethell: I'm going to ask Shawn to comment on that and then Major Le Beau, but I can assure you as a long-time infanteer and so forth.... You look at the actions that have happened in Afghanistan and elsewhere. The regimental sergeant major was killed. His two warrant officers were killed. There have been a number of officers, including majors and so forth, who have been decorated by Her Excellency, as have there been a number of corporals and privates.

We've always been taught to lead from the front. So you're going to take probably fewer casualties in the command structure than you are at the level of corporals and privates, because if it wasn't for the corporals and privates you wouldn't be in the command structure. They're the whole guts of the unit.

Shawn.

Mr. Shawn Hearn: Sir, my take on it is that I really don't think that PTSD makes any distinctions—and this is strictly from my point of view—on who it's going to hit. They say it can happen to some of the finest. I'm dealing with people of a lot of different ranks, and I haven't seen it being limited to just the non-commissioned members.

One other thing I did see from my time in Cyprus in speaking to some of the chain of command and some of the senior leadership who were at one time my bosses or my commanders: there was a big worry for them on how their troops were doing when they came back. But again, I haven't seen it being limited to just privates and corporals. It makes no distinctions, I think.

The Chair: Thank you very much.

Mr. Blaney.

Mr. Steven Blaney: Thank you.

I have one last question. Maybe this can go to Ms. Greene and Mr. Hearne.

In the case where someone is no longer deployable, do you think the process is appropriate for the military? Because this is a tough decision that you have to go through. Do you think that the process in which the military forces decide that you are no longer deployable because of a psychological issue is appropriate? Is it reversible? Could you comment on this?

Ms. Cyndi Greene: The decision on whether someone is deployable or not is a medical decision, obviously. Is it reversible? Yes, it is.

Some people have been diagnosed with different conditions on temporary categories and they get treated and get better and they can be redeployed. So yes, it is, and we've known of many OSI sufferers who have been treated, gotten better, and have continued on with their military career.

Maj Mariane Le Beau: The decision as to whether someone is deployable or not is a medical decision, obviously.

Now, is it reversible? Yes, it is. Some people have been diagnosed with different conditions on temporary categories, and they get treated and get better. They can be redeployed. So yes, it is reversible. We've known of many OSI sufferers who've been treated, gotten better, and have continued with their military careers.

Mr. Steven Blaney: If I may just conclude, you say that as coordinator you have two ears and one mouth. I think that as politicians we are often seen as having two mouths and one ear.

The Chair: That is a dangerous feature to have.

Go ahead.

Mrs. Cheryl Gallant: I have one quick question.

When I looked through one of these folders from you previously, I thought there was a CD, a little movie. Is that something you could provide to the members of this committee?

● (1715)

Maj Mariane Le Beau: Yes, absolutely.

The Chair: We still have some time.

Mr. Laurie Hawn: I have a last question to wrap up. Colonel Ethell, given your incredible experience and expertise, where are we today, where do you see we've been, and where do you see we're going in a macro sense?

Col Donald S. Ethell: As I indicated to Mr. Coderre and the committee, this is a growth industry. As I also indicated earlier—not that it's within my purview—I think more money should be devoted to the increased number of PSCs and FPSCs, the regional coordinators, and so forth.

You've made the point about rural areas. Personally, I don't think we need PSCs all over the Northwest Territories or anything like that. That's a waste of resources, particularly in this day and age, the electronic age, when people can talk on videophones and so forth.

This business is not going to go away. Thank God the OSISS program was started, and thank goodness the peer support coordinators and the volunteers and so forth are out there so that somebody can call them up and meet them at Tim Hortons.

Before we finish, Mr. Chairman, it's not my right, but Mrs. Black asked a question about women. I was hoping that Mariane Le Beau could answer that question.

Maj Mariane Le Beau: Would you mind framing that question again, just to make sure I answer correctly?

Ms. Dawn Black: The question I asked was around people self-reporting and whether there were particular, special challenges for women. I asked about reservists, and women in particular.

Maj Mariane Le Beau: To my knowledge, I know of no particular challenges that preclude women from self-reporting. Cyndi...?

Ms. Cyndi Greene: I have several women peers on my peer load. Of course I'm female myself. It just goes to show that as we discussed earlier, OSI knows no trade, no rank, no gender, no race.

Ms. Dawn Black: I understand that, but is it more difficult, or do you think it's easier for women to self-identify?

Ms. Cyndi Greene: From my perspective, I didn't have a difficult time coming forward once I figured out what was going on with me. I have quite a number of women I work with on a daily basis.

Ms. Dawn Black: So it might be easier for them.

The Chair: Thank you very much, all of you, for being here.

As you can tell, the bells are ringing, and Mr. Bachand is on crutches, so he has to get a head start on the rest of us.

Before we conclude, we didn't get an opportunity to get a financial update from VAC. Could you supply that?

As well, if there's anything you—any of you—think this committee could use to help formulate its recommendations, even in the form of a couple of recommendations, please supply it to us.

I want to thank you very much for your service to your country and for being here today. Thank you.

The meeting is adjourned.

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