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Mr. David Sweet

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● (1530)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): Good afternoon, ladies and gentlemen.

We're continuing our study of services for veterans in Commonwealth and G-8 countries. Today, we have four esteemed witnesses. Let me introduce them to you: Kathy Darte, manager, joint Department of National Defence and Veterans Affairs Canada operational stress injury social support program; Laryssa Underhill, family peer support coordinator, joint Department of National Defence and Veterans Affairs Canada operational stress injury social support program; Major Mariane Le Beau, manager, joint Department of National Defence and Veterans Affairs Canada operational stress injury social support program; Cyndi Muise, peer support coordinator, joint Department of National Defence and Veterans Affairs Canada operational stress injury social support program.

I see that some are from Mississauga, Calgary, and southern Alberta. How many people will actually be presenting opening remarks?

Ms. Kathy Darte (Manager, Operational Stress Injury Social Support Program, Department of Veterans Affairs): There will be two. Then we'll turn it over to the two on our left and right, so there will be four of us who will present opening remarks.

The Chair: But you will be able to contain them to 30 minutes.

Ms. Kathy Darte: Yes, we will.

The Chair: If that is fine with the committee, we will begin. Please go ahead and choose who will start. We are at your behest, and we'll ask our questions in the normal format after.

Ms. Kathy Darte: Good afternoon.

Thank you, Mr. Chairman and committee members, for inviting us to appear before you today. We appreciate the opportunity to talk to you about a Department of National Defence and Veterans Affairs partnership, known as the operational stress injury social support program, better known as the OSISS program.

This program focuses on CF members, veterans, and families who are suffering and struggling with operational stress injury and who know full well the impact that has on them.

How a workplace or organization responds to individuals suffering from mental health conditions and their impacts is paramount in the recovery of the individual who is struggling.

Our vision in the operational stress injury social support program is quite simple. We focus on helping to get people into treatment as early as possible and providing the support they require to continue on that road to recovery. It is a peer support program.

Before we begin the opening remarks, I am going to introduce you to the team. With me is Major Mariane Le Beau. She is the program manager for DND. I am the program manager for Veterans Affairs. Laryssa Underhill is a peer support coordinator working with families and she is a Veterans Affairs employee. Cyndi Muise is a peer support coordinator and a DND employee working with both CF members and veterans with operational stress injury.

I'll not go over our presentation outline but I will go through some slides that will give you a bit of an overview of what our program is all about. There were many drivers to this program. SCONDVA, the Standing Committee on National Defence and Veterans Affairs, was a big one, so we'll go back to the 1999-2000 area. The Croatia Board of Inquiry was another big driver, as well as the DND ombudsman's report of 2001 on operational stress injuries.

This program was the vision of Lieutenant-Colonel Stéphane Grenier, who is still serving in the Canadian Forces. He is himself a victim of post-traumatic stress disorder. He had a vision, and he is the founder of the program and has worked very hard and tirelessly to get this program up and running.

It's a partnership program. It was started at National Defence, and Veterans Affairs became a partner shortly thereafter. It was the subject of a joint ministerial announcement made by both the Minister of National Defence and the Minister of Veterans Affairs in October of 2002.

We used a phased-in approach to implementation. We started by providing peer support for CF members and veterans. We then moved on to do a needs analysis to see what the needs were of families struggling with operational stress injury and the impacts it was having on the families, and we implemented family support in 2005.

In 2006 we moved on to implement bereavement support because we were seeing a great number of families who were losing a loved one as a result of military service.

• (1535)

Major Mariane Le Beau (Manager, Operational Stress Injury Social Support Program, Department of National Defence): Our mission is to establish, develop, and improve social support programs for Canadian Forces members, veterans, and their families. As Ms. Darte has indicated, our focus and the way we do this is as a peer-based program. We define “peer” as an individual who has been through an OSI, in the case of Cyndi, for example, or an individual like Laryssa, who has lived with someone suffering from an OSI, so she can help others like her through the recovery process.

Our mandate is focusing again on developing a national peer support network. As Kathy said, we started with the members and the veterans. We moved on to families. We implemented a model in 2006 for bereavement—so families who lost a serving member, in particular, with the Afghanistan mission—and that has become quite an important aspect of our services. We're also considering developing a peer support program for military members, veterans, and their families who are dealing with a physical injury. We conducted a needs analysis in 2007, and we're starting very slowly to look at that component as well.

Ms. Kathy Darte: In the context of that program, we have a number of value statements, but I'm not going to go through them all. We really focus on working with others and on teamwork, working in collaboration, because we know we're only one part of that big continuum of care.

We focus on confidentiality. This program is a very grassroots program that has been built on confidentiality, and we maintain that throughout our work day to day.

Maj Mariane Le Beau: I would like to spend a little bit of time on the definition of an OSI—an operational stress injury—and what it means. We define it as any persistent psychological difficulty resulting from operational duties performed by a military member. It's used to describe a broad range of problems that result in impairment of functioning. We're not asking people to come to us with a diagnosis; we do not ask for a diagnosis. An OSI can be depression, an anxiety disorder, or PTSD. It is basically a psychological difficulty. We don't discriminate as to what kind of psychological diagnosis that might be. It's any of them.

The most important thing about the operational stress injury definition is that this was defined by our program, and it has been exported. It's starting to be used by other countries as well, such as the U.S., who found that the concept of the psychological injury was very important, as we did, to destigmatize the condition.

So the focus is on injury as opposed to illness.

Ms. Kathy Darte: Why is peer support beneficial? It helps to be able to talk to someone who understands exactly what you are dealing with, what you're struggling with, and what you are going through. They will not judge you because they've been there themselves. We certainly know that seeking treatment sometimes for individuals can be quite a lengthy process before they actually come to understand that they really need to go into treatment in order to get onto the road to recovery. As Major Le Beau has just said, a lot of that revolves around shame and stigma and so on. We also know that the consequences of stigma have major impacts on individuals.

Our program is peer-based; it's a non-clinical approach. We certainly work in collaboration and in teams with health professionals, but we are the non-clinical approach to treatment. All of our staff are all individuals who have an operational stress injury themselves. Those who are working at the field level, who are working with individuals, they themselves have an operational stress injury and have recovered to the point where they can go out and help others. The family members who are working with families know firsthand the impact of living with someone who has an operational stress injury. Everyone in our program who is working in the field has what we call that “lived experience”. They know exactly what someone else is going through.

We also include a volunteer component to our program. Again, the volunteers also have that lived experience.

• (1540)

Maj Mariane Le Beau: In terms of the current situation, we have helped over 4,000 individuals, either CF members, veterans, or families. We have provided service to 120 bereaved members in the bereavement program. These numbers are growing steadily.

I will just remind you that we started with four coordinators. We now have 28 peer support coordinators for military members and veterans and we have 20 for the families. We have 17 trained bereavement peer support volunteers, and we are about to develop full-time positions for the bereavement program as well. As we are every year, it seems, that we come here, we are also in the process of staffing new positions again.

Ms. Kathy Darte: Our peer support workers are what we consider to be well-trained. They come with that essential ingredient: they have worn the uniform at one point in their lives, so they are veterans of the Canadian Forces. They have lived experience. They themselves have had PTSD, depression, or other anxiety disorders—the operational stress injuries. They come to us when they are hired. They're all federal government civil servants. They work for either Defence or Veterans Affairs, and we provide formal peer support training to them. All of that training is done by mental health professionals at Ste. Anne's Hospital.

It's a fairly extensive training program, and they also receive considerable professional development and updates on training as they continue to work on a day-to-day basis.

Maj Mariane Le Beau: If we were to summarize the key messages and some of the strong points of our program, I think involving trained OSISS peer support workers can really help facilitate access to treatment for individuals, because peers build trust. An automatic trust relationship becomes established between someone who is suffering and someone who has been there. That really helps with accessing treatment and rehabilitation, and with the follow-up also—providing support through the rehab, the whole process.

OSISS is non-clinical, as Kathy has mentioned, and the distinction between clinical workers versus non-clinical workers is very important. One service cannot provide all services on its own. Both types of services need to be offered to the members, veterans, or their families. OSISS is basically a partner in care with the clinical side.

Ms. Kathy Darte: We firmly believe that we are a successful program and we continue to be very successful. Just based on what Major Le Beau has said, starting off with four field staff in 2002, working with many veterans and many CF members and many families, and in 2009 having a field staff of 48, probably says that we're very successful. It means that people are coming forward and accessing our programs. The numbers are growing daily.

We feel that the keys to our success have been working in partnership as government departments for a common cause: the health and well-being of CF members, veterans, and families with operational stress injuries.

As we've said, we are the non-clinical side within that continuum of care, but we work very closely with the clinical side because we firmly believe it's a team approach that gets people on the road to wellness. We also involve peers in our program development and policy development, and we think that too is extremely important.

Now we're going to turn it over to a couple of the field workers. I'm going to ask Cyndi Muise to speak first. Cyndi is a peer support coordinator. Then when Cyndi finishes, we'll turn it over to Laryssa Underhill.

● (1545)

Ms. Cyndi Muise (Peer Support Coordinator, Operational Stress Injury Social Support Program - Calgary and Southern Alberta, Department of National Defence): Good afternoon, Mr. Chairman and committee members. Thank you very much for having us here today. I'm Cyndi Muise and I'm a peer support coordinator in Calgary and southern Alberta.

I was born and raised in rural Labrador, in a hamlet called Pinware, with a population of 150. I joined the regular force in October 1990 as a cook, immediately following high school. After training, my first posting was at CFB Chilliwack in British Columbia with 1 Combat Engineer Regiment, or 1 CER. With 1 CER I deployed to Croatia in 1992 and 1993 on Operation Harmony. In 1994 I returned to Bosnia. In 1995 I was posted to CFB Esquimalt on the mighty warships HMCS *Protector*, HMCS *Algonquin*, and HMCS *Huron*, where I did many deployments with them as well. In 2002 I was diagnosed with PTSD as a result of my military service overseas. I was medically released from the CF in 2004 with PTSD, completing 14 years of service.

I started volunteering with this very rewarding, great program in Victoria in 2004. Before I started volunteering, though, I must say, I was a peer. So I started out as a peer with the OSISS program in Esquimalt; then I became a volunteer, and in 2006 I was offered the position in Calgary as a peer support coordinator, because there was only one person in the whole of the province at the time, in Edmonton.

I attend part-time university classes with a future goal of working in public relations. I am married, with one 11-year-old child, and I really love my job.

Thank you.

Ms. Laryssa Underhill (Family Peer Support Coordinator, Operational Stress Injury Social Support Program - Mississauga, Department of Veterans Affairs): Mr. Chair and committee, I'm very grateful to be here today and grateful to you for devoting your time to listening about the OSISS program.

I currently live in Meaford. My area of responsibility goes from Mississauga up to Borden and includes the Owen Sound-Meaford area and up the peninsula.

Today, I was asked to tell you about myself: about my education, my employment, and how I came into the job. But last night I heard Mr. Stoffer say, don't let the facts get in the way of a good story. And, Mr. Sweet, you may or may not agree, given your professional speaking background, but I don't want to start another debate here today.

An hon. member: That was on seals.

Ms. Laryssa Underhill: Yes, that's right.

I think it's imperative that this committee have some insight into the experience of those suffering with operational stress injuries and their families. I can't speak of specifics here within the committee, except for my own case, and my story is not unique.

When I was 19 years old, I married a Canadian Forces soldier, and nine days later he was deployed to Kuwait for seven months. The moment he returned from that tour, I knew he was not the same man I had put on the bus. Of the first 24 months we were married, he was deployed for 18. His symptoms manifested with nightmares, angry outbursts, and avoidance. Thankfully, he did not turn to drugs and alcohol as a means of problem-solving.

We both developed poor skills, and our life became filled with tension and anger. It came to the point where I repressed laughter, which was a real indicator for me that something was wrong. During that 10-year period, as I mentioned, neither one of us knew what the problem was, but we knew that something was significantly wrong. Finally, in the year 2001 he was diagnosed. That was 10 years later.

It seems ludicrous to me that someone would sustain a compound fracture of the femur overseas and not have it diagnosed and treated for 10 years. You can imagine the systemic issues, not just of trying to mend that broken bone, but of consequential effects. There might be blood poisoning and systemic infections. I draw that parallel to operational stress injuries and what developed over the 10 years.

During that time we were posted to Edmonton, where I completed my nursing. Two more tours had followed in the course of the marriage, for a total of four tours.

Once he was diagnosed in 2001, the cavalry came in for him. There were psychologists and psychiatrists, OSISS came on board for him, he had social networks and supports, but there was nothing for me as a family member, so I continued using all the negative skills I had adopted during that time.

We finally came to Meaford, with two boys in tow, where I augmented my nursing doing deployment support with the Military Family Resource Centre, and I began volunteering with the OSISS program. That began a huge turnaround for me. Unfortunately, my marriage ended. I was hired as a coordinator with the OSISS program in May 2008, so I've been with the program for a year. My ex-spouse still serves as a reservist, after retiring from the regular force. He's been promoted and he's deployable, and he volunteers with the OSISS program as well.

I've seen in previous meeting summaries that this committee has asked about the children of those with OSIs, so I'd like to share a story with you.

When I separated from my husband, my youngest son was three years old. At the time I thought that...you know, we hear quite regularly that children are resilient. What does he know at three years old? How much was he really aware of? But about six months ago, three years after he wasn't living in that environment anymore, he spent the weekend with his dad. They went through a Tim Hortons drive-through. Dad got him a chocolate milk, as he usually does, and because he's six, as he usually does he spilled it over the back of the seat. His immediate reaction was to freeze, and he waited for the fallout he was accustomed to. His dad turned around and said, “That's okay, buddy, don't worry about it. We'll get you another chocolate milk, and we'll clean it up when we get home.” My six-year-old's response was, “Dad, are you okay?” because that wasn't what he was accustomed to.

● (1550)

A message I'd like to give to you is that the greatest resource for those suffering from operational stress injuries is not Veterans Affairs. It's not DND, and—I hope I have a job tomorrow—it's not OSISS, either. It's families.

Thank you.

Ms. Kathy Darte: Thank you. That ends our opening remarks.

The Chair: Thank you very much.

To Madam Muise and Madam Underhill, I'm certain that everybody greatly appreciated hearing the personal dimension. You don't have to be concerned about the fashion in which you tell your story here. So thank you for that.

Now we'll go on to questioning from the Liberal Party.

We'll have Madam Sgro, for seven minutes.

Hon. Judy Sgro (York West, Lib.): Thank you very much to all of you, but in particular to Ms. Muise and Ms. Underhill. Thank you very much for coming and spending a few minutes with us.

Most of us on this committee are new, and we're trying to get a better understanding of military life and the challenges our men and women face, especially those who have been abroad and have faced serious military action. Our job is to make sure you're getting the services you require. I think we're all very committed to working those issues through. It's not a partisan issue. It's an issue that I believe we all care very much about. We care about all the men and women who are putting their lives on the line for us.

The family support unit started in 2005, from what I understand. I gather you have reached out and attempted to provide the services to the men and women since then. But what about going back to Ms. Underhill's comments about how long it took for her husband to finally get some help and that it's the family that needs the support, not just the individual. When you're trying to identify individuals who may be suffering from PTSD or various other operational stress injuries, are you looking at them holistically, as a family, right from the beginning, or are you just looking at an individual?

Ms. Laryssa Underhill: You have to look at the member holistically. There's a lot to suggest that in order to provide the best support and services for the military member, you have to incorporate the family, bring them along, educate them about signs and symptoms, and provide positive tools and skills to help the family unit recover. Veterans Affairs does have some programs in place. The area counsellors work and encourage the family members to participate in case management. I think it's imperative, and the families are being drawn in.

● (1555)

Hon. Judy Sgro: How are you communicating with other families out there that are still not aware of the fact that you have these programs to help families as a whole?

Maj Mariane Le Beau: Obviously, the program for family services started in 2005. It's only four years old. We started with only six across the country; now we're at 20. So we're in a better position to focus more on education and not just on providing basic support services—the one on one and the group thing. I think on the DND side it has been very much on the pre-deployment and post-deployment briefings, along with the military family director services. There's been a protocol developed with the military family resource centres and OSISS, on the family side, to work together to better educate and have better outreach.

I'd like to make one comment with respect to the families and all that. You're right. In many ways, it's the families who know first that someone might be suffering from an OSI, even before the member himself may realize that he is suffering. So outreaching to the families and letting them know that the services exist is extremely important.

Hon. Judy Sgro: How can we possibly expect any man or woman to come back from overseas, from Afghanistan or any of the services they're doing, and not be suffering from operational stress injuries? Why don't we automatically assume that everybody is going to need some degree of assistance to resettle? I think we're doing it backwards. We wait for them to be identified. Why wouldn't we assume that anybody who's gone through that experience is coming back greatly affected, to one degree or another?

Maj Mariane Le Beau: I guess we cannot assume that for everybody. We know from the statistics that not everybody will develop operational stress injuries, even following some difficult combat situations. However, I believe there is a greater understanding in the Canadian Forces, and there are more and more steps and tools in place to prevent that.

I would like to mention the third-location decompression. When soldiers come back from Afghanistan they stop at a third location to decompress for five days. A lot of education is provided. Our peer support coordinators are there. Cyndi Muise has been there as a coordinator on the TLD, and I'll bring her in to talk about that.

The post-deployment screenings have been improved. The follow-ups have been improved. That's under the Canadian Forces Health Services and not so much about OSISS—that's not our piece of the pie. As I said, we're one piece in a big puzzle. There have been a lot of improvements in these tools and these ways of screening individuals.

If I may, I'd like to let Cyndi Muise talk about the third-location decompression and her role.

Ms. Cyndi Muise: Thank you, Mariane.

As Mariane said, we are part of the third-location decompression. When I was there, they would come from Afghanistan in groups of 150 at a time. When they first come they don't want to be there; they're angry and they just want to go home. But by the end they're very grateful that they've had a chance to decompress before going home.

Our role is just to be there. When we were there we made quite a few referrals to the on-site psychologist, who was able to set the soldiers up—from Cyprus—with psychological appointments in Canada for them and their families. Before they even come home they have the appointments set up. That's one preventative thing.

We do an OSISS briefing every second day while we're there. They just have fun. When they come in they're tired the first day and they're usually all in bed by seven or eight o'clock at night. The next morning they have a couple of hours of briefing, and they have the CFPSA staff there. They have all sorts of rendezvous and things for them to attend. There's some down time as well.

But they absolutely come to talk to us, and we're quite busy when we're on the third-location decompression. It's quite rewarding to be able to make referrals for them back in Canada and to follow up once we get home.

● (1600)

The Chair: Thank you very much.

Thank you, Madam Sgro.

Monsieur André.

[*Translation*]

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

Thank you for this excellent presentation of the challenges of operational stress. Thank you for the fine testimony from Ms. Muise and Ms. Underhill. Thank you also for the explanations regarding the services.

I have a few questions on the same subject that Ms. Sgro raised previously.

Ms. Underhill, in your testimony, you said that it took you 10 years to realize that your spouse was suffering from operational stress.

With this in mind, do you believe that today—we were discussing 2001, now we are in 2009—your programs have succeeded in giving more information to the families and the close associates of someone who is returning from a war or from a military conflict? Have we succeeded in informing families better so that they can identify or detect a person suffering from operational stress syndrome?

Also, I know that services are often centralized in urban centres, and this always raises a question in my mind. Let us take the case of someone living in a rural environment, for instance, in a very isolated region, someone who has had to cope with operational stress syndrome problems for several years, someone who has returned from an armed conflict. If this person is far from the large centres, for instance Sainte-Anne Hospital near Montreal, how would they go about getting services? Also, are your interventions made with a view to cooperating with existing health and social service networks? Do you train responders on the ground so that they can deliver services in the near vicinity of such persons?

I have a further question. What do you expect from the committee and the government? Are there enough resources available to persons who have to cope with operational stress, for victims of operational stress? Should we have even more resources? Do we need more research on stress prevention—on the stress prevention services offered to these people—and do we need more information for caregivers, peers, etc.?

[*English*]

Ms. Kathy Darte: On whether families are better informed today, we're hoping they are, and I think they are to some degree. When we did the needs analysis in OSISS in 2004, one of the big findings was that families really needed a lot of information. They felt they had very little information and understanding about what an operational stress injury was. They just knew that their husband or wife went off on a deployment and came back a different person. They didn't know it was an operational stress injury or what it was, but it was something that made their husband or wife different.

So they identified to us very loud and clear that they needed a better understanding and more information. We've been working on that, and implementing the family peer support coordination position has helped that considerably.

On urban areas versus rural areas, with the OSISS program the support is provided one on one, face to face, if that's doable. Often that's not doable when families or others are living in remote areas, so a lot of their work is done on the telephone. We try to reach out and use that mode. We also use Telehealth. Some of our peer support coordinators have been involved with Telehealth. Cyndi Muise is one of those.

There will soon be 10 Veterans Affairs operational stress injury clinics across the country, and they provide family services. Our peer support coordinators work with families, in collaboration with the health professionals at the clinics. It's another way of trying to work together in a team effort, because we know there are not enough resources out there to meet the demand. It's improving, but there's still a great demand for services and programs for those suffering. We use whatever manner we can with others to reach out to them.

● (1605)

[*Translation*]

Maj Mariane Le Beau: I would also like to reply in French. Thank you for your question.

With regard to education about the injuries caused by operational stress, the military is a captive audience for us. It is easy for us to require each employee to attend a presentation on the subject before being deployed. But this is not the case with families. We have to convince them to come and meet with us. Even if we could meet with them, be it in a resource centre or in the community, they still remain free to come or not to come. This makes things more complicated when we try to contact them.

In family support centres, we have developed protocols for working together so as to communicate more with them. One of the duties of our coordinators, Ms. Underhill and Ms. Muise, consists in doing a great deal of outreach and in trying to cooperate as much as possible with existing community resources. With regard to families, more specifically, our coordinators must rely on community resources in order to meet many needs. Community services are also useful for the military and for veterans. Thus, things get much more complicated.

You have read our mandates, certainly we must develop support networks, but education is also needed. About a year and a half ago, our sections were separated so that education could get the attention and the resources it needs to develop properly. The Department of National Defence then created what we call the Joint Speakers Bureau. We call it a joint bureau because the health services of the Canadian Forces, both clinical and non-clinical, are in charge of all the training regarding mental health issues. We are preparing a national campaign within the Department of National Defence to discuss mental health issues. There is also a program for families.

Are we anywhere close to saying that the information is available and easily accessible? Not yet, but as Ms. Darte said, we are improving. We have not reached perfection yet.

The Chair: Mr. André.

[*English*]

Mr. Stoffer, for five minutes.

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

And thanks to all of you folks for coming out today. Laryssa and Cyndi, thank you for telling us your stories.

It's funny, in all the years of hearing about the various concerns of men and women of the service and their families, every time we hear you, we always hear something a little new. I thank you both for that.

My first question is for both of you. What do the two of you do for stress relief?

I've spoken to peer coordinators in Halifax and in other areas. They listen to stories all day long. And like anyone else, you're human beings. You naturally say, “Oh, my God.” What do you do for yourselves to relieve the stress? Do you have friends or family you can go to, or do you exercise?

In the old days, an OSISS centre was called the Royal Canadian Legion. We've changed that now to something.... And it has improved. I've noticed improvements in the centre. But you're absolutely right, Madam, there could be a lot more improvements. You saw Pat Stogran's report the other day. It wasn't very pleasant in terms of DVA and other things.

But Ms. Muise and Ms. Underhill, what do you folks do to alleviate the concerns for yourselves?

● (1610)

Ms. Cyndi Muise: Thank you very much.

Part of our program, part of our employment regulation, is that we have 25% of our time as self-care. Self-care is heavily weighted into our program. If we don't take care of ourselves, we're not going to be able to help anybody else, or our families.

Mr. Peter Stoffer: What does that mean, self-care?

Ms. Cyndi Muise: Taking care of ourselves.

During work, I'll go to the gym a couple of hours a day, three times a week. I go to a psychologist once every few weeks, sometimes once a month, or sometimes once a week. It depends on what's going on for me and for work.

I have a very strong family. They have educated themselves about what's going on for me. As you know, most people in the military are men, so it's unusual to have the spouse in the military...to have a female member.

And...just lots of laughing.

Mr. Peter Stoffer: Good for you.

Ms. Cyndi Muise: We connect with people and our peers across the country. We connect quite a bit. We phone each other. Most of us try to make a habit of contacting each other at least once a week. We take turns phoning each other, throughout the country. We also have an MSN-AOL chat thing on our laptops and at our office, so we can always pop in and say hello to somebody, or whatever.

It's very important that we look after ourselves. And we all look out for each other. Laryssa will sometimes say to me, “Hey, take a break.” Everybody else will notice it before we do.

That's what I do.

Mr. Peter Stoffer: Thank you.

Ms. Laryssa Underhill: It is quite individual, but for myself I find it very important to connect with my colleagues. Sometimes just in a very generic sense, I might bring up a difficult case. I work closely with Veterans Affairs area counsellors. They're case managers with Parkwood Operational Stress Injury Clinic. On the professional side I find that very important, because it can be very trying and stressful work. So that's a very important component.

On the personal side, yes, my kids are an important factor, and exercise is as well. We maintain overall health and relieve as much stress as we can in positive ways.

Mr. Peter Stoffer: Thank you for that.

Kathy, I have a question for you. We did a story a while ago on Gary Zwicker that was very public in the Halifax area. One of his biggest concerns, besides the operational stress injury, were his financial concerns, which added even further stress to him and his family. It's great that the OSISS centres are going and that they're going to go from Newfoundland to Victoria and in the centre, but one of the major concerns that men and women of the service have when they get out and they're 3b-released is financial issues, which compound everything else. It puts stress on the family, the children, etc. That's one question: what is the government doing to assist them on that?

The other day I asked Darragh Mogan, I believe that's his name, a question regarding a gentleman who went through OSISS and was okay. He's now fine, but his child is still having difficulties, and DVA—and I checked again today—denied the child access to a psychologist. Mr. Mogan would like to know about that, and I have forwarded that information on to the people in Halifax. But as Laryssa said very clearly, the children and the families...because as we know, PTSD can be transferred unwittingly or whatever, and now this child is left out in the cold and the veteran doesn't know what to do.

Kathy, what should I tell him? The reality is that the DVA has told him twice now, and I plan to raise it obviously with the minister and everybody else, but I was under the assumption that these OSISS centres were there to continue the help as long as it takes. Am I wrong on that? That includes not just the veteran but the family members and especially the children. We've heard all the stories in Petawawa and we know that's improving, but there are still some serious issues out there, especially when it comes to the younger children.

Thank you.

Ms. Kathy Darte: I can't speak about the specific cases that you have referred to, and I don't know those cases, but I will speak generally from what I've heard you say.

Financial issues...yes, we certainly know that this is a factor—not always, mind you—and that in operational stress injuries people have financial issues. If you look back just in the situation that Laryssa has presented, when things go on for 11 years and the family is falling apart, people end up coping in very negative ways and get themselves and their families into very serious situations with serious financial impacts.

Certainly in the new Veterans Charter in Veterans Affairs there is a suite of programs helping individuals get on that road to recovery and wellness, and financial benefits are built into the suites of that program. I don't know if the individual you were referring to is part of that program, has been part of that program, or has tried to access that program, but I just wanted to point out that there are a number of financial benefits around the whole new Veterans Charter suite of programs.

In terms of children, I can't speak to that case, but I guess what I can say is that in Halifax we have two family peer support coordinators, and children are part of that family unit that they're working with. I don't know, but I would strongly encourage those two families, or however many, to access the service of the family peer support coordinator in Halifax—and maybe they already have—because they know the community. One of their goals and objectives when they start to work and continue as they work in the program is to really know the community resources. The resources may not be available within National Defence or within Veterans Affairs, but maybe there is a resource available in the community. Certainly Laryssa has seen this in her community of services that are available for children, which are outside of government departments but are community services. So I would strongly encourage you to have these families connect with OSISS. Because you're quite right, we provide peer support services until services are no longer needed in that family.

● (1615)

The Chair: Thank you, Madam Darte.

Thank you, Mr. Stoffer.

Now Mr. Kerr for seven minutes.

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

Thank you very much for being with us today. Certainly, it's compelling information, and we do learn something more every time, no question about it.

I'm going to get into the substance in a second, but I would like to know a bit more about Lieutenant-Colonel Stéphane Grenier and his vision. What was that about? What did he see and push for that made him stand out and be specifically mentioned here?

Ms. Kathy Darte: Certainly, I can speak to this, because I worked with Stéphane, who was a major at the time he started the program and is now a lieutenant-colonel. When the program started, he was the manager in the DND seat and I was the manager on the Veterans Affairs side, so I can speak to Stéphane's vision, because I know it and him quite well.

He is a person who has post-traumatic stress disorder, and he's made that very public. He has had many deployments, but the major one he refers to in terms of his OSI, his operational stress injury, is related to Rwanda.

Major Grenier at the time was a top-notch soldier, but when he came back he started to show signs that things weren't right. Things were happening, and he started to feel that things were not going well at work, and so on. He did seek help through the medical system, but that didn't seem to work for him.

The person who reached out to him and started him on his road to recovery was a peer, a fellow soldier in uniform, who called him aside one day and said, “Stéphane, there's something desperately wrong here; you're not the same person. You're a top-notch soldier and things are going”—as they say—“down the tubes, and you need to get help.” He said he would support him getting on the road to recovery. And that's what got Lieutenant-Colonel Grenier on that road to recovery; it was a fellow soldier, a peer, who reached out. That individual didn't wait for Stéphane to come to him, but he reached out to the major.

Major Grenier reflected on that, once he was in treatment, and he really felt it was what has been missing. He felt there had been something missing in the way the system had been set up to treat individuals with mental health conditions. He discussed his vision, his concept, with the senior leadership in his department and was asked by them to put together a proposal. When the proposal was written, it was fully accepted by the senior leadership in National Defence, and he became the program manager to get that program on the road. That was in the spring of 2001.

The vision was that of the peer, the person who reached out and pulled him aside and said, “We have to look at this and address it”, which helped him to reframe the way he was thinking at that particular time.

That's what OSISS does. That's what Cyndi does, that's what all of her colleagues do, and that's what Laryssa does.

● (1620)

Mr. Greg Kerr: Okay. Thank you very much.

So at the beginning it started very much as peer support, and it was really non-clinical, but help, support, and contact, and I think you all said there was trust. So it started in that context in the beginning. Thank you.

I have a general question about the 10 years you referred to, Laryssa, but I don't know which one of you should answer. I know things still happen, but would that 10-year wait likely happen again, or is the intervention so different today that it couldn't be repeated?

Maj Mariane Le Beau: If I may, when OSISS started—and Kathy was there at the beginning—the average time for someone to ask for help, or the average delay, was seven years. That's the average time. Obviously, some of the times were longer and some shorter.

We do not have recent statistics on those delays, but we do know anecdotally that people are reaching out a lot earlier than they used to.

Would it still be possible? Yes, it probably is. It's still possible for someone to go on and continue with their career, depending on their symptoms, without being detected. It's not an impossible thing, no.

Mr. Greg Kerr: But there's a greater net today than there used to be.

Ms. Kathy Darte: Absolutely.

Mr. Greg Kerr: When we had the senior staff in here the other day, there was a comment made about post-traumatic stress versus the other psychological problems. There's still a real stigma attached to the entry or the catchment.

Has that changed at all? It's one thing to accept post-traumatic stress disorder, but to say you actually have clinical problems or are depressed or you have dependencies and so on.... Do you see any change taking place in that or ways to bridge that gap, or is the stigma still, in your minds, a very serious problem?

Maj Mariane Le Beau: Could you answer that, Cyndi?

Ms. Cyndi Muise: I think the stigma is individualized. I really believe, just from the work experience we're doing now, that the soldiers are coming forward sooner. I know for me, like Laryssa's husband, it was eight years before I was diagnosed with PTSD. I think the soldiers now are more educated. As Mariane said, they get their briefings before they go overseas, they get briefings there, and they do third-location decompression before they come home. There's post-screening, there's follow-up screening, there are all sorts of things.

I can't speak specifically about numbers or statistics or anything like that, but just from my experience, the younger guys are coming in—in droves, if I may say—and I'm still reaching out to the veterans of the 1990s as well. They take longer to come in. These Afghanistan vets, the younger vets, are coming to me sooner.

Maj Mariane Le Beau: I would also add to this regarding the stigma. I believe the last time I appeared before this committee I was asked what was the biggest challenge I saw, and my answer was the stigma. There's still quite a bit of it. Today, it's not going to be the same answer. It's not going to be that, because I think there's been a lot of effort put into developing processes and programs to try to beat it.

Will we ever beat it completely? Again, I have to say no. We are a microcosm of Canadian society, and stigma exists in Canadian society. It will continue to exist in the Canadian Forces. I would invite the committee to ask as witnesses the joint speakers bureau, which I talked about. They are developing a national campaign on education to fight the stigma. This may be of interest to you, sir.

The Chair: Thank you, Major, and thank you, Mr. Kerr.

Mr. Greg Kerr: Thank you for that, because I would like to follow through. I'm glad to hear we're making some progress in that area.

The Chair: Now to Madam Foote for seven minutes.

Ms. Judy Foote (Random—Burin—St. George's, Lib.): Thank you.

Like my colleagues, I want to thank you so much for being here.

As I listened to Cyndi and Laryssa talk about their experiences, it just reconfirms for me the thinking.... Every time I hear of a soldier, male or female, and watch what is happening, it just boggles my mind as to how you deal with it. You have the experience of war and then you come back and deal with those experiences. My heart goes out to each and every soldier who goes to fight. I listened to Laryssa's story, and I feel for you, and for Cyndi. The fact that it would take so long—so long—to find help, the help you needed to move on with your lives....

I'm really interested in the whole idea of peer counselling. It's one thing, I guess, to have the experience and to turn to those who have gone through it, but I'm just wondering, what's the extent of the training that peer counsellors have? I'm reading some of the things it says here, like a focus on boundaries and self-care, conflict resolution, crisis intervention, suicide, and helping networks. Does every peer counsellor receive the same amount of training, or does it vary depending on the experience of the peer counsellor?

● (1625)

Ms. Kathy Darte: No. All peer counsellors—peer support workers, as we call them, or peer support coordinators—receive the same amount of training. When they initially start as workers in the program, they get two weeks of fairly intensive training. The training—

Ms. Judy Foote: How long?

Ms. Kathy Darte: Two weeks, and it's consecutive.

It focuses on peer support, providing safe peer support and what that's all about. It also focuses on services that are provided by organizations, such as my own, Veterans Affairs. They have presentations from many folks in Veterans Affairs about the services we provide. They have presentations from National Defence on the services that National Defence provides, and also from the community.

Over the course of the two weeks, they learn about the main resources they need to work in collaboration and cooperation with and to reach out to, because they will have people and families coming to them with specific issues and concerns and they need to know who they can refer them to, or how to assist them in getting to those referrals. So the training is fairly extensive.

The volunteers in the program—Cyndi referenced volunteers a while back—also receive training. The training they receive is, again, peer support training. And that training is provided by mental health professionals from the National Centre for Operational Stress Injuries at Ste. Anne's.

We put a lot of focus in this program on training, on updates, on refreshers, and on professional development. We meet in conference a couple of times a year, and we put an emphasis on training. It's training they have identified the need for themselves, from the work they're doing in their own local communities.

Yes, they are well trained. It's not only a one-shot training when you start to work in the program.

Ms. Judy Foote: Are these positions that they apply for, or do you reach out and look for those who have experience? Or are the positions advertised and they apply for them?

Maj Mariane Le Beau: They're both, actually.

Ms. Judy Foote: Obviously, from some of our soldiers who return, there's anger. There's an anger component there.

I listened to Laryssa's story. Is there any component of that training that deals with, for example, a peer counsellor encountering someone who's really angry and how to deal with that?

Ms. Kathy Darte: That's very much part of the peer support training they receive—crisis intervention, conflict resolution, and how to develop healthy working relationships. That's part of what they receive.

We know from experience that a lot of people, when they initially come forward to access services...it has been a long time for them. They've been struggling and trying to cope on their own and they are very angry. They feel as though organizations, communities, even families, have let them down. That's how they feel. So yes, they do come to us with a lot of anger.

The people they come to, the coordinators, need to know how to deal with that anger and not to take it upon themselves. They try to get the individuals to understand where they are. Because they were there themselves at one time, they can re-frame it for them and try to get that out of the way so they can get on the road to recovery.

I want to focus on the stigma there too. This program is about reducing stigma.

You've heard today from both Cyndi and Laryssa. They give their personal stories; their stories are public. When individuals see where Laryssa and Cyndi have been and where they are today, they become beacons of hope for others. For those who are angry and struggling with operational stress injury, they become examples they can aspire to—they're now working for the Government of Canada and have good jobs. So they become that kind of beacon of hope that says, "I was once where you are today, and look where I am now. But I didn't simply jump from this to this."

The road to recovery can be long sometimes, and sometimes it's not very easy. But we—

● (1630)

Ms. Judy Foote: It's unfortunate that it took eight years for Cyndi and ten years for Laryssa. Why is that? Why would it take so long? Were there services not available or did you not know about them?

The Chair: That will have to be the last question.

You can go ahead and answer that.

Ms. Cyndi Muise: For me, I know the reason it took so long was the stigma at the time, and there was no OSISS. If it weren't for OSISS, I wouldn't be here. I can't speak for everybody else, but for me, I would not be here.

OSISS is really a driving force. It's not unlike any aid group or a cancer group where everybody is there because we've all experienced similar things. We don't focus on the injury as much as the symptoms. We focus on what's going on for us. We don't care where you were or what you did. We can all relate to the PTSD or the OSI.

The Chair: Thank you, Madam.

Now we'll go to Mr. Lobb for five minutes.

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

Again, thanks to all of you for attending today. It's been a pleasure to hear about your experiences and your knowledge of the topic.

I would like to say to Ms. Underhill that I'm not too far from Meaford. I'll be attending a fundraiser on the twenty-second of this month in Meaford for our troops, and there is a reception in Owen Sound at the armoury on the thirtieth. I'll be at that as well, so we'll probably cross paths a couple of times in the near future.

Our study, really, is to examine some of the benefits our veterans receive and to compare them to those of other countries within the G-8. What I really want to know from your perspective is whether you compare this particular service that you provide to our veterans to what other countries provide. Where do we stack up when we take a look at that?

Maj Mariane Le Beau: The members of the OSISS program have done a number of international presentations. We actually did a NATO presentation in 2006. I was a member of a working group on operational stress with Land Staff Headquarters before I became involved in OSISS.

Kathy and I have received numerous requests for information from colleagues across the world. Some U.K. individuals on the veterans affairs side have contacted us. We have always been extremely willing to share any information, including our training manual, our documentation, and our policies, with anyone. With the U.S., we've done that quite a bit. We've done it with the U.K.

Two years ago, in June, I did attend an international conference and I managed to connect with two other countries, Sweden and the Netherlands, which have a peer support program of some sort. We've been exchanging information. Actually, we've managed to get a full symposium in June on the different models of peer support across different countries. So yes, we are sharing.

The OSISS program was built without a blueprint. There was no blueprint of what this could look like. There was the AA model, which did not necessarily fit the needs of the Canadian Forces, so Kathy, Stéphane, and the members of the management team at the time really worked from scratch to develop the model we have.

● (1635)

Mr. Ben Lobb: I can appreciate what you're saying. In another committee we're studying poverty in Canada, and we're recognizing that mental health is a huge component of that issue, and it's quite likely 30 years behind the times. So I know that the work you are doing is really groundbreaking in some respects.

Another thing I want to talk about is the decompression component, particularly with our new veterans when they've done a tour in Afghanistan. One of my very good friends has just finished a second tour in Afghanistan. He texted me a short while ago and said how much he enjoyed his decompression in Cyprus.

I just wonder if you can tell the committee about that and about how that compares to other G-8 nations.

Maj Mariane Le Beau: I must say that I'm not able to compare the decompression model to what other G-8 countries have. I'm sorry.

Mr. Ben Lobb: Perhaps you could just give us some of the ideas or the theory behind decompression.

Maj Mariane Le Beau: As far as I know, there is not a lot of research that was ever conducted on the decompression model. Way back in 2002, which I think was the very first time this model was used with individuals coming back from Afghanistan, it was done in Guam at the time. There was one study being quoted, which looked at the difference between U.K. soldiers coming back either by plane or by boat. Those coming back by boat—it took longer—seemed to show better adaptation, I would say. I will not cite any mental health statistics at this point.

There has been very little research. It was mostly a leadership initiative, and it's also logic. If you are in combat and you pack your bag and 24 hours later you're back in your front room with the children running around you, it can be very quick in terms of travel. It is good common sense to have a time to rest—rest is a big one—and to recover.

Mr. Ben Lobb: I know this is probably not going to be a quick answer. Given the fact that we really are breaking ground worldwide here with what we're doing, where do you see the next five years for OSISS? Where do you see the program heading?

Ms. Kathy Darte: We talked a little bit about this earlier. As we well know, there are many significant physical injuries as a result of Afghanistan. We're looking to this: can we use our peer support model to assist them? A couple of years back we probably didn't think we would be looking in that direction, but we are.

We're also looking to focus on exporting our model, certainly, and not only outside our country but within our own country. I think—and certainly Major Le Beau agrees with me—our communities that are struggling with mental health issues can benefit from our model of peer support.

We were very proud to be part of a recommendation in the report on mental health and addictions in Canada, which was done by Michael Kirby and a Senate committee a few years ago. We became a best-practice recommendation. It was recommended at that time that the federal government look at paid peer support workers, because there aren't a lot of paid peer support workers in communities. There's a lot of peer support and there are a lot of peer support programs, but they're run on volunteers. This is a program where the government has paid peer support workers.

There is some movement and discussion in that area, where other government departments as well as others outside of government departments can look at our model. Also, we are continuing not to work in isolation. We will work with others, so that everybody in the continuum of care works together for the overall benefit of our members, veterans, and families.

[*Translation*]

The Chair: Thank you.

Thank you, Mr. Lobb.

Mr. Carrier, you have five minutes.

Mr. Robert Carrier (Alfred-Pellan, BQ): Thank you, Mr. Chair.

Good afternoon, ladies. I am sitting on the Standing Committee on Veterans Affairs for the first time in my life. I am replacing someone and I am glad to be part of such an important debate. I thank you for coming, and above all, I congratulate you for the work that you are doing, I am convinced that it is of crucial importance. I hope that you realize the importance of your work.

Earlier, I had questions about training, that were partially answered. I believe that all coordinators and peers get training, but I am convinced that the problems you are facing can go beyond the level of experience or knowledge that you have acquired. I see that you have a multi-disciplinary team. Does this team meet the needs?

Our common objective is to improve the condition of people suffering from operational stress. In general, are there enough resources? Do you have enough funding or could you do better with more support?

● (1640)

Maj Mariane Le Beau: Thank you for the question, Mr. Cormier.

I will begin by answering the question about resources, because it was already put twice and it has not been answered yet.

The resources for the Social Support Program have increased on a yearly basis ever since the program began. Our budget has never been cut. One of our greatest challenges is to meet the demand, and as we are victims of our own success, we do not always succeed in doing that. We need time to grow. In 2002, we had a total workforce of four persons, and now we have more than 40. Our growth calls for more development of supervision, of delivery of training and support to caregivers. We also have to develop a larger management structure.

In a certain sense, I anticipate that we will continue growing for some time. Even if the forces could withdraw from Afghanistan in 2011, we are not expecting any decrease in demand. To the contrary, we are expecting that many returning soldiers who have ignored their symptoms during a period of time will need us.

Mr. Robert Carrier: You say that you are victims of your own success. If you are succeeding, it is because you are realizing that the demand is great. We cannot really be satisfied with this kind of success. There are still many needs to be met. Finally, you say that you need more money to meet the needs of all the soldiers coming back from combat.

Maj Mariane Le Beau: Yes. Let me connect this to what was said earlier. We are one element in a continuum of services. For us, for Cyndi and Laryssa, it is important that we can refer people to mental health professionals who can provide services. In Canada, there is a shortage of mental health professionals in various sectors. We have the same problem.

Mr. Robert Carrier: Does all the experience that you are acquiring on the ground allow you to identify the qualities that are required to become a soldier and the various weaknesses that we all have within us and that we suffer from in combat situations? Does it help you to make a better selection so as to prevent returning soldiers from suffering from post-operational stress symptoms?

Maj Mariane Le Beau: You are talking about recruiting.

Mr. Robert Carrier: I said selection, but I was thinking of recruitment.

Maj Mariane Le Beau: When members of the Canadian armed forces are recruited, there is no psychological assessment. There are psychological evaluations of cognitive skills and other skills, but there is no screening with regard to mental health.

Mr. Robert Carrier: This seems to me like a great oversight, because post-operational stress is the worst thing that can ever happen to a soldier. The death of a soldier is a serious thing, and it is recognized as such, but those who suffer from post-operational stress will suffer from it for another 10 or 20 years, perhaps for the rest of their lives.

You should be able to provide the information that you gather on the ground, so as to identify weaknesses in the people whom you recruit.

● (1645)

Maj Mariane Le Beau: I am a military personnel selection officer by trade. Thus, I am somewhat familiar with the selection process.

Any selection tool implemented at recruitment must allow us to anticipate certain things with a certain degree of certainty. It is not necessarily easy to determine who will develop operational stress injury. To my knowledge, there is no tool that would allow us to do that.

I know that the people in the Canadian armed forces have wondered whether we should develop recruiting tools. It is true that there are none at this time. Nevertheless, we do checkups before deployment. The soldier must meet a social worker before being deployed and make sure that his medical tests are completed. He must also meet the physical requirements. This stage involves another, micro-selection process.

The Chair: Thank you, Mr. Carrier.

[*English*]

Now we're on to Madam O'Neill-Gordon, for five minutes.

Mrs. Tilly O'Neill-Gordon (Miramichi, CPC): First I want to thank you all for being here this afternoon and sharing your story with us. I congratulate you on the fine work you do. I can certainly see why other countries are reaching out for your information.

I was wondering if you could elaborate a little bit as to what started this, if you had any one action or experience that really caused the formation of OSISS. How long has it been in existence?

Ms. Kathy Darte: I will respond to that question.

It was a vision of Lieutenant-Colonel Stéphane Grenier, a soldier who has post-traumatic stress disorder. In 2001 he presented his vision to senior management in National Defence. He was told that it sounded like a really good concept and was asked to go put pen to paper and come back and they'd see where to go from there. That's what happened. He put pen to paper. He did a lot of research.

Speaking of other countries, when Stéphane was designing the program he did look to other countries and other models, and unfortunately he didn't find anything. There was no template that you could pull and start from. It had to start at the grassroots, because he didn't find anything else out there. So he did that, and it was accepted by his senior leadership in the spring of 2001.

That's when it started. It started with four people who were hired later on that fall, and they started to work in the winter of 2002. We've grown considerably.

What was your second question?

Mrs. Tilly O'Neill-Gordon: I just wondered if there was one crisis or something that caused it to start. Mind you, I missed the first part, so once I hear the name, I can put it all together. I think you probably touched on that earlier, before I came in.

My other question was that you mentioned how long it takes, that it's sometimes around seven years before a guy or a gal may reach out for help. Is there any limit to the time they have after they've been home? If it's many years later, will they still be able to reach out and get this help?

● (1650)

Ms. Kathy Darte: Yes, of course. There's no time limit.

Mrs. Tilly O'Neill-Gordon: I too have experienced children missing their parent while away, and the children receiving the support that they needed from the schools and overcoming this. But later on, you may see that that child may resort to the same actions.

I'm wondering, if it's now junior high and you received this case in primary school, can they also go back and start again? Is there help to offer them the second time around?

Ms. Kathy Darte: Yes.

Mrs. Tilly O'Neill-Gordon: There's no end, for any of the family?

Ms. Kathy Darte: No. When someone comes forward for help, there's really no time limit on that. It's needs-based; if someone needs something. You look at the needs and try to find the resources, whether they're in our own departments or whether we have to look to the community, because the community may have their resources.

Mrs. Tilly O'Neill-Gordon: So even if he has overcome the first setback, it could still come up again later on in junior high or high school, and that service would still be there.

Ms. Kathy Darte: Yes, it's still there.

Maj Mariane Le Beau: If I may just clarify something, when we said it's seven years before people seek out help, we meant it used to be that. We're talking about early 2002. We're not talking about today.

Mrs. Tilly O'Neill-Gordon: Yes, I understand that.

Ms. Kathy Darte: There are certainly a lot more services today in 2009 than there were in 2002.

Mrs. Tilly O'Neill-Gordon: Oh, yes, and we're happy to see that there are more services available and that people are taking advantage of them.

Ms. Kathy Darte: Exactly.

The Chair: Thank you, Madam O'Neill-Gordon.

Mr. McColeman, you have a little bump of 50 seconds of Madam O'Neill-Gordon's time.

Mr. Phil McColeman (Brant, CPC): Thank you, Mr. Chair.

I too want to express my appreciation for your being here, and frankly, for the courage of the individuals who have experienced it to tell us their story. It's very significant and it's a model that I admire.

I spent quite a bit of my life working with mentally challenged individuals, and certainly mental illness that comes into a person's life at a certain point is similar to when individuals deal with those challenges throughout their lives. I really commend you on the model of using peer counselling and peer intervention.

We have a very expansive country, and I'm just wondering, as individuals come back and they reconnect with their families, is geography at all a problem in reaching some of these individuals and providing services?

Maj Mariane Le Beau: Yes. I guess you saw my head shake. Yes, it is always a problem.

We have peer support coordinators in 20 sites across Canada, so obviously, given the size of Canada, you know, 20 is only 20. As Kathy mentioned earlier, we are exploring the idea of using the Telehealth model for telepeer support for distant locations—that would be a video. They're reaching out a lot by phone, and I would say we also have a big part of our budget in travelling, so that Cyndi can visit those locations that are more distant so that she can do outreach to individuals. Peer support coordinators don't stay in their offices and have people come to them; that's not their work. Their office is often a Tim Hortons where they meet individuals.

Laryssa, I think you were saying yesterday, about one of the offices, that you never have families there.

So the peer support workers are out there. They're travelling a lot and they're going out to meet people.

Mr. Phil McColeman: Very good.

Before, if you didn't exist, it would really be placed on the shoulders of the medical community, probably, to handle these issues. I'm wondering, have you had any kinds of reviews of or comments on this model by the medical community that said it is effective, that it works? Is that something you have either undertaken to do on your own as a service provider and/or has just been offered voluntarily by outside agencies? In particular, I'm thinking of the medical community.

Ms. Kathy Darte: We have a psychiatrist. When we talked earlier about having a multi-disciplinary team to support management, we've had a psychiatrist who is a consultant with Veterans Affairs, who has always been attached to the OSISS program from the very beginning. There is a psychiatrist who is from the medical community, who fully supports this kind of model.

Also, there are the operational trauma and stress support centres, which are the National Defence medical clinics for operational stress injuries, and in Veterans Affairs we have the operational stress injury clinics, so in total we have eight in place in Veterans Affairs, and we'll soon have two more, for a total of ten. Defence has five, and they have medical professionals working in those clinics. All of the clinics across the country, pretty much, all know about OSISS. In fact, some of the OSISS peer support coordinators are actually working full-time from the clinic, so they are working in collaboration with these medical professionals.

Referrals will come both ways, and Cyndi can speak to this because she's a case in point of someone who works with a clinic. Cyndi will refer individuals who come to her to the clinic. They have to go through the Veterans Affairs district office, but then to the clinic, and vice versa; the medical professionals in the clinic know of Cyndi and the kind of work she does, and they know about how that can support their work and they will refer individuals to her.

So, yes, the medical community in National Defence and Veterans Affairs are aware of OSISS, and also in the medical community as a whole there are many medical people who are aware of OSISS and encourage their patients or clients, if you will, to seek the services of OSISS or make them aware of the services of OSISS.

● (1655)

Mr. Phil McColeman: I'm thinking along the lines...as you've grown and as you've been able to serve more individuals, are you seeing any kinds of trends? Where I'm heading here with this question is this. Are there any trends in age groups? Are there any trends in certain types of experiences they've had in their military lives? Are you seeing any of that, or is this one of those situations, like in a lot of mental illnesses, that it can hit anybody at any point in time?

Having said that, I'm thinking specifically of the aboriginal community, and I'm thinking specifically of people who have served and are part of that community. I'm not trying to put this in any way in a racial manner—that's not where I'm heading here. I have the largest aboriginal community in my riding. I'm just wondering whether those people get served as well, and how you reach out to that community along those lines as well.

So there are two questions. Are there any trends at all on ages or anything like that, and secondly, are you successfully getting to the aboriginal Canadians who have served?

Maj Mariane Le Beau: I guess I could say we don't have any data to show the trends. We don't know. So it would have to be studied further.

Ms. Kathy Darte: I'll ask Cyndi to answer the aboriginal question, but I just want to make another point on trends.

We're seeing in the OSISS program—and we didn't see this probably three years ago, but we're certainly seeing it over the last two—more traditional veterans accessing the services of this program. When I say traditional veterans, I mean our older veterans. The program was set up for CF members and CF veterans, which we traditionally think of as being the younger population. In fact, one of our peer support coordinators in southern Ontario has peer support groups for the elderly veteran. Again, that is all based on awareness too; it's awareness in that community and that area, because they have the elderly veterans coming to the clinics and they're seeing they can benefit from the services of peer support.

Over to Cyndi.

Ms. Cyndi Muise: Thank you.

Another thing we've done in Alberta...I have several aboriginal peers. Due to confidentiality, I wasn't able to say who was who, so we found a way to connect them. There are five of the aboriginal veterans who just hang out. That's a big part of our job too, connecting people. Sometimes we'll sit with a person, and then the next person will come in and you'll realize that was the guy's boss who was just here. So it's dynamic in that way, and we're able to connect them in that way.

We also have coordinators who are involved with aboriginal communities.

Mr. Phil McColeman: That's excellent. Thank you.

The Chair: Thank you, Mr. McColeman and Madam Muise.

We'll now go to Mr. Stoffer, for five minutes.

Mr. Peter Stoffer: I noticed on the continuation of OSISS that it always deals with DND and Veterans Affairs. Maybe this question should be directed to the government, but Kathy, has there been any discussion with the RCMP in order to bring them in as the third part of this? As you know, RCMP veterans apply for DVA benefits—or veterans benefits, I should say. Is there any talk about including them as a third branch of OSISS?

● (1700)

Ms. Kathy Darte: We in OSISS do not turn anybody away. If someone needs services or needs any kind of help and comes to us, we don't say because they're RCMP or they're this or they're that, they have to go in that direction. We don't turn them away.

We can say that in our program we have a number of RCMP members, both serving and retired, as well as family, who we're providing service to.

On the second part of your question, yes, we've had discussions with the RCMP. They are certainly well aware of our program. We have just formed a new mental health advisory committee, again a partnership committee. Some of you may recall the OSISS advisory committee, which was chaired by Colonel Don Ethell. That has amalgamated into a mental health advisory committee including Veterans Affairs, National Defence, and the RCMP. The membership of that committee involves mental health professionals from the three departments, and OSISS also has membership on that particular committee. So yes, they are aware of our program, and they are trying to learn about our program and see how it can benefit their members.

Mr. Peter Stoffer: Thank you.

You also said that if OSISS isn't able to supply a particular need of some sort, there are other things within the community, generally provincial or municipal concerns. But one of the concerns, of course, is who would then pay for that. If OSISS wasn't able to have a particular child psychologist or someone of that nature, and then, say, the province had one and the person went there to get their treatment, they would have to pay for that. Would OSISS end up paying for that, or would they themselves have to pay for that if they go outside OSISS to get help?

Again, I go back to the financial problems they have. If they go to OSISS—

Maj Mariane Le Beau: OSISS does not provide professional treatments. We only offer peer support. So you might be referring to the OSI clinic maybe—the operational stress injury clinic.

Ms. Kathy Darte: If they were referred to an operational stress injury clinic of Veterans Affairs and were eligible to access the services of that clinic, then Veterans Affairs would be paying for that particular service.

I want to point out that for veterans, there is the Veterans Affairs Canada Assistance Service, which is there for family members of veterans. The "family" could be the spouse, children, or others within that family unit. That is counselling—and not only psychological counselling; there is financial counselling available through this service. When accessing that particular service, they are entitled to a certain number of sessions; it's a starting point.

If they do access that particular service as a family member of a veteran, it's paid for by Veterans Affairs. These counsellors are in their local communities and are well aware of what other services may be available in that community to which they could refer them.

Mr. Peter Stoffer: Kathy, what happens in a case where a peer support coordinator like Laryssa or Cyndi...? Of course, everything is confidential, but if they suspect that Buddy is going to go back home and do some serious damage to his family, through domestic violence or whatever, obviously Laryssa and Cyndi would be concerned about that. What is the procedure in that regard? I know it happens; we know there is domestic abuse, just as among civilians, and that it happens all the time. What is the procedure in that case? If I came to Laryssa or Cyndi and said, "Man, that operation in Afghanistan really brought me down", etc., and you suspected that I might go home and take it out on the people I love the most, what's the procedure then?

Ms. Cyndi Muise: Like everybody else in any community, we follow our duty to report. We have to report, if we suspect harm to self or others, if there's child abuse, or if we're subpoenaed.

● (1705)

Mr. Peter Stoffer: Who do you report that to?

Ms. Cyndi Muise: We report it to the local authorities. In my area I'd call the Calgary Police Service, and then they would contact Family Services. But yes, we have to follow under that duty to report.

Ms. Kathy Darte: Let me add that this is made known to the person as well, if they've shared that kind of information with them. They may not—

Mr. Peter Stoffer: What if they didn't, though?

Ms. Kathy Darte: If they didn't and the peer support individual has a suspicion, again it's their duty to report. If you suspect child abuse, there is a duty to report under legislation.

Mr. Peter Stoffer: Thank you very much.

The Chair: Thank you, Mr. Stoffer and Madam Darte.

I want to make a quick assessment. We have some committee business at the end.

Madam Crombie has some questions.

Mr. Clarke, do you have any questions you want to ask?

Okay. We'll need to make these two rounds pretty tight.

Madam Crombie, you'll have five minutes, and then we'll go to Mr. Clarke.

Mrs. Bonnie Crombie (Mississauga—Streetsville, Lib.): Thank you for the opportunity to be here today, and thank you to Scott for allowing me to ask his questions.

I'm just fascinated. I came in at the tail end, so I'll try to make it brief.

How well do the two departments work together?

Maj Mariane Le Beau: Since 2002?

Ms. Kathy Darte: Yes, 2002.

Mrs. Bonnie Crombie: And how well do you work together, coordinating?

Maj Mariane Le Beau: We've worked together, actually, since 2001—

Ms. Kathy Darte: And very well, I think. Hopefully, today you've heard us as almost one voice. It's as if Major Le Beau speaks and I speak; we're like one person with two voices.

Mrs. Bonnie Crombie: Mr. Stoffer asked about RCMP officers being brought into the OSISS program. What about regular police officers?

Maj Mariane Le Beau: Some are accessing our services. As Ms. Darte said, we don't turn anybody away.

Clearly, there are differences. If Cyndi is trying to offer peer support to a military member or a veteran, we have a lot more resources we can refer them to, which is not necessarily the same for a police officer or an RCMP officer. They need to be reconnected to the services they have in their organization.

Mrs. Bonnie Crombie: Are families brought into the OSISS program as well? Do parents—not just spouses and children—receive counselling as well? And to what degree, and how long does it last?

Ms. Laryssa Underhill: I work with a number of parents within my area, and that's reflective of the coordinators across the nation. They are entitled to access services as long as they're required, just as the other people who are accessing the program are. The nature of what they're seeking support for is individual. Some of them might want to understand possible signs and symptoms, or how they can support their loved one and help them through the recovery process.

I want to reiterate what Kathy said, that the program doesn't turn anyone away. Essentially, whether it's a best buddy or a grandmother or a parent or a sibling, we'll provide support to them, however they may require it.

Mrs. Bonnie Crombie: Is it primarily wives and mothers?

Ms. Laryssa Underhill: Both sets of parents are quite supportive; I have some husbands I'm supporting, and the children indirectly through the parents—we provide support and resources to the parents to assist their children.

Mrs. Bonnie Crombie: Of course.

Ms. Foote brought up the peer counsellors. How long does a peer counsellor last in a position? I would imagine there's quite a bit of stress involved with just being a counsellor.

Maj Mariane Le Beau: We don't call them counsellors. We avoid the term, because it has a clinical overtone, and they don't do counselling; they do peer support.

We have some peer support coordinators—we have two of them—who have been with us since the beginning. They were some of the first hired.

Mrs. Bonnie Crombie: What's the turnover rate?

Maj Mariane Le Beau: I don't have a rate. One reason we've been doing so much staffing is that we are growing, more than because of turnover. But there are some people who have come and gone, there's no doubt.

Mrs. Bonnie Crombie: I was also very interested in the decompression location in Cyprus. Could you tell us a little more about it? And are peer coordinators involved there as well?

Ms. Cyndi Muise: Yes. I had the opportunity to go to Cyprus two summers ago. They split our tasking. It's an eight-week tasking, and from OSISS we were split, so that there were four of us who took half the time, because if we stayed there the whole time, it would be too much.

We go there, and it's really good. The guys come back from Afghanistan and they turn in all their stuff. They relax and do educational briefings for five days and then go home. During that time, they're told about all the services they can access, for them and their families, once they get home.

It's a great, great program.

● (1710)

Mrs. Bonnie Crombie: Does the peer support start right there in Cyprus?

Ms. Cyndi Muise: Absolutely, the peer support starts right there. OSISS is part of five briefings that are given over the course of five days. When I was there—and this is my own experience only—OSISS's was the briefing most attended by the soldiers, who have a choice of briefings. Our briefing was the one attended by the most people.

Mrs. Bonnie Crombie: Why is Cyprus the location?

Maj Mariane Le Beau: It's a logistical decision.

Mrs. Bonnie Crombie: It's because it's on the way back?

With respect to post-traumatic stress disorder, are there other similar conditions? And is it recognized as a mental illness?

Ms. Kathy Darte: It's recognized as a mental health disorder, yes. It's in the *Diagnostic and Statistical Manual of Mental Disorders*, which is used for diagnostic purposes.

The Chair: I'm sorry, we have to keep this tight. That will be the end of these questions.

Thank you, Mrs. Crombie.

We now have Mr. Clarke, for five tight minutes.

Mr. Rob Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

I'd like to thank the witnesses.

I come from an RCMP background, and I thank my colleague for bringing up the RCMP background. I spent eighteen years in the RCMP. My fellow RCMP officers and I have had to deal with the situation and circumstances of traumatic situations and have had to go home on a regular basis without having any outlet to decompress, or basically an outlet to talk.

I wasn't aware that the RCMP had access to this specific OSISS program. I was a detachment commander, and I see some benefit, from your appearing before this committee today, in your going out and preaching more about the successes of this program. What I see, coming from my background, as you do from yours, is the place of intervention models. There's a role that a detachment commander has to play, if we see a situation in which a member needs to seek counseling or needs to be spoken to in order to seek proper medical help.

From the peers and subordinates, what follow-up and tools are in place to measure the success of your program? Also, do the clients have access to self-evaluation?

I'm also curious about the peer supporters. I realize how post-traumatic stress can trigger emotions from the peer supporters when speaking with the clients. What mechanisms are there for the peer supporters as well?

Ms. Kathy Darte: Are there tools in place to measure success? No, we don't actually have a tool that's measuring the success of the program. But what we're seeing, certainly, is that many of the individuals we're working with are being referred to the new Veterans Charter rehabilitation program and are going through medical rehab. They're already in psychosocial rehab when they're accessing OSISS. Then they're moving on to vocational rehab. We're seeing people getting their lives back in order and getting back to work and getting good jobs. That in itself is a success, and we've had many thank yous from people saying thank you for getting them on that road to wellness.

On self-reports, yes, we have lots of evidence of that. We are continuously told, and I think you heard Cyndi herself say it today, that if it weren't for OSISS, they wouldn't be here today. Many, many people who access OSISS would say the very same thing Cyndi was saying.

What's in place? One of the things we didn't mention today is that all the peer support coordinators have access to a clinical psychologist at Ste. Anne's Hospital, the national centre. He is the one who is responsible for self-care, which we talked about earlier. He is only a phone call away. He's located in Montreal, but all of these individuals can pick up the phone and call him at any time to discuss their own situation as it relates to self-care and how the work is having an impact on them. They do group teleconferences during which they discuss the impact of this kind of work on their own health and well-being.

We put very strong emphasis on self-care in this program, because we need to keep our workers healthy. They are exposed to this, you're right. They're exposed to this day in and day out, and they also have their own health challenges they're trying to protect, because they are recovered or are on that road to recovery themselves, and we do not in any way want to impact that.

● (1715)

The Chair: Thank you very much. I just have two brief questions I'd like to have answered as well before we say goodbye.

On behalf of the committee, thank you very much for your testimony. It's very enlightening.

Some hon. members: Hear, hear!

The Chair: Major Le Beau, you answered a question earlier regarding the lack of psychological testing upon recruitment. When we were doing the study on PTSD in the last Parliament, it was my understanding that there is a psychological examination prior to deployment. Is there not?

The vast majority of CF personnel would not see deployment, would they?

Maj Mariane Le Beau: What's the question you're asking me? What's the percentage of CF members who are deployed?

The Chair: Yes, the vast majority of CF members would not see deployment to a theatre of conflict. Is that correct?

Maj Mariane Le Beau: I cannot answer that question with any level of confidence, to tell you the truth. I don't know what the percentage is. Sorry.

The Chair: Okay. Let's just go back to the original one, then. If someone is going to be deployed into a theatre of conflict, they have to go through a battery of tests. Is that correct?

Maj Mariane Le Beau: Well, they go through what we call the dagging process, which is a funny word, but there is a meeting with a social worker. There is a medical to make sure the person meets the medical criteria and the psychological criteria.

I don't want people to walk away thinking there's a battery of tests being administered prior to deployment. That's not what I'm saying. They will fill out surveys and they will have a one-on-one meeting, yes.

The Chair: Okay. So there's some level of assessment of how they would respond in a stressful situation.

Maj Mariane Le Beau: Yes, there is, absolutely.

The Chair: You're making the point that there might be some need for improvement in the development of the sophistication of that.

Maj Mariane Le Beau: Sir, I think you're making that point.

Voices: Oh, oh!

The Chair: I felt the inference in your answer, but point taken.

Do you think there could be some development, then, in your opinion, in the sophistication of those tests?

Maj Mariane Le Beau: You know, my background is in psychology. I have a master's degree in psychology. My background is selection, so tests are something I've worked with. We would need to look at the benefits of having a psychological tool that would help us distinguish who will develop a mental health problem, and that's not simple. We think it's simple, but it's not a simple process. It's very complex.

I would love to see mental health screening at recruitment if it would ensure that some people don't develop mental health issues later on because of their work. I think that would be a great gain, because a lot of people who are suffering now would not be suffering. But what would that percentage be? Will the tool be effective? Sir, that really needs to be researched carefully.

The Chair: It's my understanding that the Americans are doing some research on that right now.

Maj Mariane Le Beau: Yes, they are.

The Chair: There were a couple of questions during the general questioning of the committee on measurement, and there's very little data. Are you ramping up? I understand there was a question about tools for success, and that might be difficult. But are you ramping up the data collection process now so that down the road you'll be able to have some data to report on about clientele and the outcomes?

Maj Mariane Le Beau: Yes, we are. We're also engaging in the process of strategic planning to look at performance measurement. The database has been an issue, and I had a meeting on it yesterday. We're hoping it will be back online again. So we are looking at that, and it's something we understand we need to do.

● (1720)

The Chair: Very good.

You heard the applause before. Again, thank you very much for your testimony and the good work you're doing. We appreciate it.

Some hon. members: Hear, hear!

The Chair: Members of the committee, we'll give the witnesses a couple of minutes to leave. Then we'll be going in camera for committee business.

[*Proceedings continue in camera*]

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