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Chair

Mr. Gary Schellenberger

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● (1535)

[*English*]

The Chair (Mr. Gary Schellenberger (Perth—Wellington, CPC)): I'm going to call the meeting to order.

The first part of our meeting is only going to run until 4:25, because we do have to get ready for the video conference we're going to do right after that.

I welcome everyone here to meeting number 29 of the Standing Committee on Veterans Affairs. Pursuant to Standing Order 108(2), we are conducting a study of combat stress and its consequences on the mental health of veterans and their family.

Our first witness is Senator Roméo Dallaire.

Welcome, sir. I'm very pleased you could come to our meeting today. If you would like to open with a few words, you're on.

[*Translation*]

Senator Roméo Dallaire (Québec): Thank you, Mr. Chairman.

To speak of a topic as weighty as operational stress injuries in a brief ten-minute span is not an easy thing, especially for a former general who has now become a fledgling politician.

I'm going to do a quick overview in order to leave the time needed for questions, when the topics of particular interest to you can be broached in greater detail.

I know that prior to this, other committees of the House and of the Senate have studied post-traumatic stess. However, it is a fact that studies require revisiting and updating. And so I congratulate your committee for having undertaken this study of injuries sustained in combat or conflict. These are not diseases, but truly operational injuries, and they should be treated with the same urgency and empathy as physical injuries, that are often easier to detect.

[*English*]

The stigma of having an operational stress injury within a very Darwinian organization like the forces has taken a fair amount of time to make its way into the acceptability, in the culture of the forces, that someone who is injured between the ears—not overtly visible—has the same requirements of urgency and need of care and return opportunities to either full employment or partial employment, or the support from Veterans Affairs, as someone who has any other physical injury. It took us years to simply identify this as an injury. From the minute we mentioned mental health, everyone went running. No one wanted to live with that stigma, which exists still today in the civilian world.

I'll provide a very short history before we can go to questions. Prior to 1997 we had one small clinic at National Defence headquarters that was at about 40% capacity. I was then chief of staff of the assistant deputy minister of personnel and was responsible for all of the medical staff and that clinic, which fell under my authority. It became evident that we were missing the boat in regard to this injury, with an increasing number of family breakups; of early retirements due to pressures from family; of increased substance abuse, including alcohol; and of increased discipline problems, even to the extent of a number of excellent soldiers all of a sudden seeming to turn bad and ending up in front of judges and prosecutors, who couldn't figure out why such circumstances had arisen.

In 1997 I was to present a report to the media that essentially said that although we had a raft of suicides.... Remember, ladies and gentlemen, we really started this new era with the Gulf War, and so we are talking about 1990-91. By 1997 we had troops in Bosnia, Rwanda, and Somalia. So we already had a fair amount of visible casualties, but certainly a lot more non-visible casualties, by 1997, and we had adjusted nothing by that time. However, the report that I was supposed to present said specifically that the 11 suicides over the past were not directly related to operational stress. There were said to be a whole variety of other reasons that all of a sudden simply got exacerbated by the fact that the member of the forces was deployed and was predisposed ultimately to maybe taking their own life.

I refused to recognize that as a reality and started a campaign after becoming assistant deputy minister of personnel of looking, with Veterans Affairs Canada, at the whole arena of operational stress and "PTSD", as we finally had it coined, recognizing the fact that PTSD could be a terminal injury. In so doing, the care, the therapy, the institutions, and the recognition by the chain of command and the forces of this injury had to make a massive leap forward, or we were simply going to continue to lose a lot of very good soldiers, sailors, and air persons not only because they were injured but also because the impacts on the families were simply not sustainable. We were going to lose our shirts with regard to our enormous investments in very qualified people who, after one or two missions, could not continue to serve or who had become administrative discipline problems, ending up in jail, or worse, with some of them killing themselves.

● (1540)

We have been at it for 13 years now, and over that time there have been numerous initiatives at both National Defence and Veterans Affairs. In early 1998 I was able to have a brigadier general transferred to Veterans Affairs as liaison instead of a lieutenant colonel. His name was Pierre Boutet and he'd been the judge advocate general.

For five years he and an assistant deputy minister called Dennis Wallace worked on a massive reform inside Veterans Affairs for the recognition of this injury, but also the recognition that they were in a new era where they were going to pick up casualties, versus the era of anticipating simply losing clientele due to the previous wars.

Larry Murray, an ex-admiral of the forces, became deputy minister of Veterans Affairs after 2000. He continued this significant review that ended in 2004 with the Neary report, which I participated in tabling with him. It recommended that we have not only a new Veterans Charter, but a new way of looking at the casualties and their care.

We've now created clinics. Both Veterans Affairs and National Defence have clinics. We've created joint offices to exchange information, although the computers still don't talk to each other, so there's still a major problem in medical documentation. We have moved into the arena of prevention before deployment.

My son was on a ten-week course for recruits in Saint-Jean. They had a three-hour session with a new-generation veteran who suffered from PTSD, but who was part of the peer support structure. My son said it was the most riveting three hours of the course. The next day four guys quit because they felt it was too much. This whole preparatory exercise has matured, and still needs to be worked on.

There's the in-theatre recognition of casualties, and actually deploying therapists into the field. In 1992, when I commanded my five brigades and had troops in Bosnia, I mentioned that we should have some of that sort of scientific knowledge there to pick up the casualty data. It was said to be unnecessary. We have rectified that.

I think the strength right now is in the coming home and recognition of those who are casualties. The system that is now in place is pretty sophisticated in identifying those who might be at risk. The question, however, is what do we do beyond that recognition? In particular, what are we doing about the reservist who has gone back to Matane, is 500 kilometres from the nearest base, 200 kilometres from the nearest hospital with any real psychiatric capability, and is isolated out there after serving maybe up to 18 months in a high-intensity operation, and maybe more than that due to multiple deployments?

[*Translation*]

The risk arises when the soldier returns home. Preparation in the theatre of operations can always be improved, but the risk arises when the armed forces member returns home. We have to see what can be done to minimize the consequences of this injury for the individual, to convince him to seek therapy and take medication. It is important that he or she receive support from peers. Families must be helped to understand the individual who comes back injured, and care must be taken to prevent substance abuse, and to prevent the individual from committing criminal acts and winding up in jail. And ultimately, the person must be prevented from committing acts that could lead to suicide.

● (1545)

[*English*]

I will give you a short anecdote, if I may, to indicate that if you're studying operational stress injuries and the impact thereof on the forces, it is essential that you study the families also. When I returned from Rwanda, my mother-in-law said that she would never have survived World War II if she'd had to go through what my family went through. My father-in-law commanded a regiment in World War II. The whole nation was at war, so everybody had something to do with it. There was very little information that was let out, and even the technology of that time was quite limited.

In this era, however, the families live the missions with the troops. They are continuously zapping every communications means they have in order to find out if we've been killed, injured, captured, if the mission has gone sour, about any frictions there might be. So when you return from missions, you're not returning to a household that "held the fort", as it historically used to be called, but in fact you're returning to a family that has already gone through significant stresses of seeing what's going on but not necessarily being able to influence it. I must say, though, that the availability of the Internet and those communications have alleviated somewhat the distance between the troops in the field and the families.

So we are now at the stage of looking into the future. Last week I was at a symposium in Montreal, an international symposium on operational stress, that was led by Veterans Affairs and an international body now garnering more and more data and building the capacity in regard to research on this injury, the sources of it, and the means of attenuating it.

I also was two days ago at a forum in Kingston called the Canadian Military and Veteran Health Research Forum—led by Queen's and RMC—that was meeting one criteria that I was most fearful of maybe falling through the cracks. Afghanistan was supposed to end in 2011. We will end the combat element, but we will still have troops in the field and potentially in harm's way, so we will continue to have need of support. But it was feared that as we tone down that mission, we would also start to tone down the needs of the casualties, and Veterans Affairs Canada and DND would not recognize that the girls and boys who have done three or four tours are now going to come down from that adrenalin high. The impacts of those missions are going to start to hit them as they come back to a certain level of normalcy, and that's when operational stress comes in spades. So you're going to have a significant increase of those and their families who have now so far been able to sustain it.

The other thing is that we started with nothing in 1997. I went to the United States veterans affairs clinic in White River Junction, Vermont, to meet the head of that. His name is Dr. Matthew Friedman. I asked him to help us build ours, because they'd had Vietnam and we'd had nothing of real significance except a bit of Congo, a bit of Cyprus, since Korea. There was no depth in our capabilities.

They readily helped us. They gave us a statistic that was interesting, and I'll end with that, before we go to questions. They told us they didn't want us to go through what they had gone through in the Vietnam War. On that black wall in Washington, there are 58,300 names of those who were killed in theatre in Vietnam. However, by 1997, 22 years later, they had on the books, for those they were able to record, just under 102,000 suicides directly related to the Vietnam experience.

So how many real casualties did Vietnam cost them? Was it 58,000, or was it maybe closer to 160,000?

● (1550)

I ask you the same question: how many real casualties have we taken? Is it 152, or maybe 170 or 175? I can tell you about my mission in Rwanda; I had casualties in the field, and two years ago, 14 years after the mission, one of the officers committed suicide.

Ladies and gentlemen, you're into a subject of enormous import to those who are serving and to their families. I would contend it's also of enormous import to the operational sustainability of the Canadian Forces in order to keep the experienced troops healthy and able to sustain such injuries.

Thank you.

The Chair: Thank you.

We'll try to keep our questions to five minutes so that we can get as many questions in as possible.

Ms. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair.

Thank you, Senator. Your testimony is overwhelming, and it's hard to know where to start. Thank you for your courage and your leadership in this area.

I'm going to pick up on what you said about the return being where the risk occurs. We know there's an exit interview in which people must self-identify. But I hear repeatedly that people go home, the families don't recognize them, and there may be alcohol or drugs. They may lose their partner. They're waiting for payment. They lose their house and they end up homeless. That's one scenario.

I'm wondering how we track people as they come out. How do we check in with them to make sure they're getting the support they need? Are we doing enough in terms of medical checks, in terms of counselling? As one man said to me, “I wait a month for my appointment. But it doesn't matter, I've got a shotgun fully loaded.”

How do we do that follow-up to keep them healthy and safe?

Senator Roméo Dallaire: I'll respond with a couple of points.

For those who remain in the forces and go through a process of follow-up at three months and six months—my son came back six months after a tour of duty in Sierra Leone and went through the process—although they may be identified with PTSD at a different level, which is essential to identify early, the availability of care is not necessarily immediately there. So with the follow-up, the care, there's a deficiency, both on civilian street but also with the military, although both DND and VAC have increased the contractual arrangements to get more therapists available.

One of the downsides is that we're not putting enough emphasis on psychologists versus psychiatrists. I like to use the analysis that if a person puts their hand on a burning stove the psychiatrist will give you the pills and so on to attenuate the pain and to try to watch it heal. The psychologist is going to ask why you put your hand there in the first place.

The deficiency is not in giving them that initial stabilizing, and in some cases creating zombies; that stabilizing effect by therapists is more and more available, and it comes out. It is in fact the therapeutic side of bringing them back to a level at which they can sustain a reasonably normal life—i.e., build their prosthesis to live with—because that's what you have to do. So it's professional therapy, medication, and accepting that.

Then the third one is peer support. That is to have someone there between those sessions who's willing not to ask any stupid question but to listen for hours, to let you talk. Rarely is it the family, because they're too close. My family hasn't even read my book. It can be uncles, peers, and so on. In building of the peer support, recently Veterans Affairs opened up their peer support for families, which is interesting, and for children it would be needed.

There are processes in motion for those in the regular force. Those in the units are staying within a cohesive group, like in a regiment. But there are a lot of individual augmentees, who end up all over the forces, who are not necessarily followed up on because nobody else in that unit has gone there. There's not the same concern by the chain of command on the follow-up of the individual, or the leadership won't even understand what the problem is. In so doing, they can fall through the cracks.

However, the greatest deficiency is with the reserves. For the reservist who ends up in all kinds of villages across the country and decides to quit, there is very little follow-up on how they're being taken care of. That's why you're ending up with more soldiers in front of the courts. You'll see a lot of reservists there because they've been nearly abandoned.

That is a great deficiency for the reservists. We are counting more and more on them to be operationally capable, which is a whole world of difference from what we were doing in the seventies and the eighties, when we thought them to be the mobilization base during the Cold War.

● (1555)

The Chair: We have to move on.

Senator Roméo Dallaire: I'll try to shorten my answers.

The Chair: Mr. Vincent, please.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Thank you, Mr. Chairman.

Thank you, Mr. Dallaire, for having accepted the committee's invitation.

I took a few notes during your statement. You talk about acceptance within the culture of the forces, and full employment following post-traumatic stress. But in the field one hears a different take: the culture of the forces still leads people to say that this does not exist. People have told me that they had to wait two or three months before being able to see a psychologist. At a certain point, one person was unable to return to her battalion. She was unable to leave her house for two, three, four or five days. When she returned to the base she was told that if she was unable to do the job, if she was too stressed and didn't like it, she could just leave and she would be demobilized.

This is how these people who experience post-traumatic stress are treated. They can't rejoin the ranks and so they are demobilized. They have trouble accepting this because very often they have been there for years and they have given a lot of their time. One person was telling me that in a theatre of operations, you never leave anyone behind; when you leave it after having experienced certain things there, however, they do leave you behind, and there is no follow-up.

I would like to hear your comments on this.

Senator Roméo Dallaire: You have put your finger on the difference. In a theatre of operations, there is constant follow-up for people. There is a whole structure in place to ensure that they are ready to conduct operations, and they are monitored. In spite of that, there were two suicides on the base, but both were quite particular cases. Basically, the follow-up is continual.

When they go back to their military base, for instance to Valcartier or Petawawa, they resume their normal personal lives. Evenings, weekends and holidays, the follow-up is not as close, even if they are put to work for a month or two, which is one option. This is particularly true for reservists. Rather than just letting them leave, since they have been with the regiment for 18 months, they are kept for a few additional months to see what will happen.

In the regiment that I commanded a year and a half ago, one soldier came back from two tours of duty in Bosnia and three tours of duty in Afghanistan. When he returned he seemed in reasonably good shape. Nine days later, he hung himself. After that everyone tried to figure out why. It is because there was no follow-up.

You talked about isolation. Some men are isolated because they are stressed and at the end of their rope. We need people to carry out operational tasks. The units are small and we have to go and get people elsewhere. The universality of the service does not allow for much leeway. And so they are removed from the structure that is familiar to them. This is being remedied so as to keep them longer within the unit and give them little tasks to do. However, in several other cases things are centralized, and then we lose them. That problem has not been resolved as we speak.

● (1600)

Mr. Robert Vincent: When a person is demobilized in a theatre of operations overseas and is to be sent home, he or she is put on a plane to Canada. Once that person is here, there is no one to meet and support him. These people have experienced major post-traumatic stress but are left to their own devices. They have to find a psychologist to treat them on their own. The forces are not there for them.

Senator Roméo Dallaire: I live in Quebec and I have seen men come back alone from Afghanistan, but they weren't alone. A chaplain or family members were waiting for them as they got off the plane, and the regiment took care of them.

However, it is different for those who are not members of a regiment, for instance.

[*English*]

the individual augmentees.

[*Translation*]

They are plumbers or technicians who come from elsewhere when we need them. Sometimes there are reservists who arrive at the last minute. Those people don't have the same follow-up. We need resources in the reserve units, for instance, so that we can follow these people.

It is not systematic; not everyone is followed in the same way. It depends on the structure they come from. The program has to be developed.

[*English*]

The Chair: Next is Mr. Stoffer, please.

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

Mr. Dallaire, thank you for coming today, and thank you for your recent book on the child soldier. It's going to open up a great debate in this world that we have.

You had mentioned that Dr. Friedman had talked to you about the 102,000 who had passed away as well, and that's an extremely valid point. We know there are certain individuals who have committed suicide after their return from Bosnia or Afghanistan, yet we don't seem to mention them. We mention the 152. I think you make a valid point for them, and I thank you very much for that.

As you know, military life is a culture. Once you get in there and you do it for many years, it gets into your DNA. It's your way of life. You and your family are all part of it. And then, for whatever reason, you are medically released, even though you don't wish to be released, and then you say, “Now what do I do?” Even though they can offer retraining and everything else, you've lost the camaraderie and the spirit. In some cases I've heard someone say, “I've lost being a man. My children don't look up to me anymore.” There's nothing wrong with being a commissionaire, but it's not the same as the military and that kind of thing. So they feel kind of left out. Not that it detracts from them—I don't mean that—but basically, they feel not as worthy.

I just wonder what you can recommend to us to encourage these individuals. What can we do not only to improve their psychological way of living but also to acknowledge the fact that they may no longer be in the military but they still have a role and a purpose?

Senator Roméo Dallaire: In 1971 they had a plan called “Restore”. That was when we massively cut, hugely cut, the forces. We offered people a golden handshake, even people who had been Korean vets, and we let them go, like that.

Within three years, we were getting reports that a lot of them had died. It was not suicide; they had simply died of broken hearts, because they entered a world they didn't understand, and they were abandoned.

One of the areas looked at, and which we were seeing as a deficiency, was that being released from the forces and handing in your ID card and your uniform doesn't mean that the forces are out of you. When you instill loyalty, it stays *ad vitam aeternam*. What you need is a bridge to the next entity, in a sort of paternalistic way, to continue that loyalty you've committed to, particularly if you are a veteran, particularly if you've been in combat, have actually been injured, and have seen people killed. And there was no bridge. They were dropped off the forces, and they had to climb their way back into the veterans system, and then the veterans system took them as they could within the old system.

That process of rehabilitation and reintegration was introduced with the new Veterans Charter, but not many have taken them up on it. One of the interesting reasons is that not many of them have actually been released yet. A lot of them, particularly those from the Afghan war, are still in the forces. When they start to be released after their accommodation period of three years or sometimes four years, we're going to see whether that rehabilitation and reintegration program Veterans Affairs has built to pick them up before they leave—in fact, they're looking at six months beforehand—and help them through that transition to civilian life is going to work.

It's interesting; there was an article today about an interview I did yesterday. With the universality of service, the forces can't keep them, because there are too few to do the job to start with. But you might want to create a sort of subservice, where people who are injured can remain in uniform, maybe under different conditions. They can continue to serve in different jobs, because they have skills and experience, and not necessarily be released out. In so doing, you'd minimize, in fact, that trauma of moving to civilian life. Some don't want to see a uniform anymore and are happy to get out, but others simply want to stay on.

The forces would have to get an extra sort of manpower level, or person-power level, to absorb them, because what will the number be? Post-Afghanistan, there may be 1,500 to 2,000 who are significantly injured, not including all the post-traumatic stress. And we must remember that from 1991, with the Gulf War vets, whom we have treated rottenly, right through to 2006, when we started to bring in the new Veterans Charter, we have taken a lot of casualties. More than 10 were killed and more than 100 were significantly injured, and a couple of thousand were psychologically injured, everywhere from Somalia to Rwanda to Bosnia, and so on. That gang is sort of feeling a bit left out. Yet only with the changes we've seen today, with this coming legislation, are they going to start to be able to benefit from the new Veterans Charter, if that rehabilitation and reintegration starts.

Yes, Veterans Affairs Canada has a program. It's yet to be tested to know if it really works. But maybe DND should be given the option of trying to keep them.

I end that with the following. In 1998, when I was the ADM, I was brought on the carpet, for the forces, in front of our Human Rights Commission. The fourth pillar of it—that is to say, the hiring of disabled people—we were not meeting. The civilian side of DND was doing not too badly, but on the military side, no, because they all had to be universally deployable.

● (1605)

We could actually answer more appropriately the Human Rights Commission the right of employing injured veterans...but within the context that it does not affect the operational effectiveness of the forces—that is to say, those who are committed to deployment.

Mr. Peter Stoffer: Thank you.

The Chair: Mr. Kerr.

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

Senator, good to see you again. I wish we had a lot more time because there are obviously a lot of topics to continue.

I appreciate not only your years of service but also the years of activity in terms of bringing about some of these changes in the last few years and the fact they are continuing. Although there is a lot of work to be done, I think that's important.

What I would like to do is go right to the symposium that we were both at. What strikes me, in the time I'm spending around Veterans Affairs and veterans, is, one, the stigma question that of course stays there; it's a bit of the culture. The other is this growing recognition that as a society we recognize a physically wounded soldier but we don't tend to want to recognize somebody who has a mental problem or a psychological disability, and so on. That's why I was enthused by the conference in the sense that the civilian and the veterans side, if you like, were coming together and recognizing that we collectively have a great responsibility to educate the public, inform the public, and so on.

I was wondering if you would care to comment further on that approach or that partnership.

Senator Roméo Dallaire: The serving member—they can be serving and a veteran also, as you know—although not necessarily overtly conscious of it, is expecting that the social contract of the unlimited liability clause between the individual and the people of this country is forever. It is not a short-term contract, such as an insurance policy. For that person—and the family—having committed to a place where he could have been killed, as some are, or injured for life, the Government of Canada will forever be that backdrop to which they can turn as part of that social responsibility, that social contract.

That is not articulated well yet, and is not felt well. There is this feeling that they are dropping off the radar when they are identified as an injured veteran and then become a veteran.

I remember when I was serving it was honourable to have a physical injury. In fact it was called an “honourable injury”. I remember at happy hour a guy showing me where he had been shot in the buttocks. He never bought a beer for weeks after that. But there were also guys sitting in the corner who always seemed to have a lip on, who were sort of hiding between the paint and the wall. Nobody talked to them, and they talked to no one. They were often mad and difficult to handle. They were those who were affected psychologically. It was nearly considered not an honourable injury: you couldn't hack it.

The Darwinian nature of the forces and the absolute dependency of every member on the other in operations create an incredible intolerance. That intolerance is essential in the field. However, when you come back to garrison and you lick your wounds, there has to be a way of transitioning that into a level of respect.

I would contend that it is culture change, and there is a process going on in the forces. The CDS last year launched a very significant culture change exercise. We are getting less of the intolerance than we used to have. I think one of the greatest advantages we have now is that we have a forces of veterans. It's sort of like the fifties. You have a bunch of veterans and you have non-veterans. Usually the intolerance comes from the non-veterans, even at different ranks. But now we have enough of a volume of veterans at all ranks, including general officers, who are going to attenuate that sort of perspective of you weren't there, you don't know how it was, and that is an injury; that is coming more and more to the fore.

I think it will be interesting to see the leadership of the forces managing the veterans part of the forces with the non-veterans and ensuring that synergy between the two.

● (1610)

The Chair: Our next round is only going to be three minutes. Please try to....

Ms. Zarac.

[*Translation*]

Mrs. Lise Zarac (LaSalle—Émard, Lib.): Thank you.

Thank you, Senator Dallaire, for being here with us today.

You talked about prevention, and we have just talked about synergy between the armed forces and the veterans. That is where there seems to be a disconnect; we have to ensure that there is monitoring of people who are contemplating suicide.

You talked about prevention, that seems effective. Some people have decided not to go that far. Potentially, these people would not have survived.

You talked about a three-hour training. Did I understand you correctly? Is that sufficient?

You mentioned that it is difficult to convince them to seek the therapy they need; I would like to know if the families are also trained in prevention.

Senator Roméo Dallaire: You've managed to insert 15 questions in one. I congratulate you, that is clever.

First of all, what I had recommended in 1998, and this was done, was that the individual seek therapy voluntarily. Without therapy, those who are affected by operational stress will not be able to recover. That is the first principle. If your arm has been ripped apart and you don't go and see a doctor, you will die. It's the same thing with this kind of stress.

So I tried to convince the therapists not to wait in their offices for the people to come to them, but to go to them and try to promote their services. First, the role of the therapists is not explained sufficiently, people don't know what they can do and how they are integrated into the organization, particularly the civilian therapists who are assigned to the Department of Veterans Affairs or even to National Defence, without any experience in the armed forces. They would have to be taken to the field and given some experience so that they get to know the culture.

So, the first step is for the therapists to promote their services.

● (1615)

[*English*]

Woody Allen said it was “in” to have a psychiatrist. Remember his movies? And so it is: it's in to have a psychiatrist. I have been 13 years under therapy, psychiatrists and psychologists, and with medication.

[*Translation*]

The other aspect is how to bring these people around and not let them fall into a state of depression that can lead to suicide.

Suicide can happen in two minutes, any time. An odour, a noise, anything can trigger this catastrophe. In my case, it took four years before I suddenly became completely dysfunctional. I was dismissed from the Canadian armed forces because of this injury. Following that I became suicidal because there was no system aside from therapy and so on. There was no peer follow-up.

[*English*]

The peer support structure for the individuals and the families has to be the most innovative, cost-effective, and progressive—all the superlatives you can find—of the tools we have in prevention. A couple of years ago, the OSISS gang, the peer support gang, said they were preventing a suicide a day; these are just members.

What I have found disappointing, however, until now, was that the 400 involved in operational stress—who do a lot of volunteer work, who spend a lot of time in Tim Hortons with people, listening and so on, very low-budget—are getting a certain recognition, but there are nearly no officers. I've seen a warrant officer go into a jail cell to get a colonel out, and be that colonel's reference, for over a year.

[*Translation*]

In my opinion, operational stress is the element that should be the topic of in-depth study.

[*English*]

Senator Kirby, in his work that he's doing now on mental health across the country, has the founder of the operational stress program working with him, Colonel Stéphane Grenier, and he would be an excellent witness. He created it. I remember I was still serving, and we didn't believe it. The professionals really pooh-poohed it, yet it has proven to be outstanding to the extent that Senator Kirby is now looking at creating this capability within society at large.

The Chair: Thank you.

Mr. Mayes.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Mr. Chair.

Thank you as well to our witness. Senator Dallaire, I know that we have a nation grateful for the way you have served in your role in the Canadian Forces, and we respect that.

One of the issues you identified is that prior to 2006 there was recognition of having to do more than just pension a veteran off and say, "Okay, go take care of yourself. Here's the money." There needed to be a charter to follow the veteran's life and to be that support.

I was here in 2006 with Mr. Stoffer. That was an exciting part of the Veterans Charter, and we're moving through that. I would expect that you support the charter and the initiative. The goals of the charter were to make sure that we followed the veterans and supported them, and PTSD is part of that.

I find this interesting. We had a report last week by the department, which said that the rate of suicide within the general population was the same as it is among Canadian Forces members and veterans. There is going to be a witness after you who is going to say the same thing, that particularly those under the age of 24 did appear at increased risk when compared with civilian males of the same age.

So do you think it's not just the type of theatre we're seeing on the battlefield but also society itself and the value of life and some of the things that bring a hopelessness to those people who are seeing these horrific things happen to their fellow man?

● (1620)

Senator Roméo Dallaire: I won't talk about the charter, because I'm the chair of the veterans subcommittee. We've been studying it for the last eight months, and we hope to continue to study it and get into the nuts and bolts of not only the charter but how it's being applied and interpreted in the regulations. I am also the one who, in 2005, passed it through the Senate, so I'm committed to it.

It is resultant of the studies. The question is how effective it is. Well, we're learning how effective it is, and that's how we'll continue to improve it, of course.

In regard to the state of mind and the impact thereof, what is creating a lot of the injuries is not only the sights and the smells and the sounds. Often you're in the midst of it, you're busy doing things and you're trying to save other people and so on, so there's a kind of a film in front of it. It's when you come home and you're sitting at home having a beer that all of a sudden—boom—it starts to come clear. Or it's at night, or on a bad day like today and stuff like that.

If you don't build that prosthesis of knowing places to avoid.... For instance, I don't go to grocery stores because of the opulence of the fruits and vegetables and the smell and the odours literally paralyze me. I can't move, because it brings me back into the food distribution points and where people were trampled to death and so on. So there's a building of the prosthesis that takes time and must be nurtured by therapy and peer support.

Where we really we see the casualty levels, or that difficulty of living with life around, is in the moral and ethical, and sometimes legal—depending on the mandate—dilemmas of actually.... Contrary to World War II, where the rules of engagement were that you knew what uniform they were wearing—bingo. It was very linear, a very set piece, and so on. Today they are in all directions. Today the other side, the extremists, the terrorists, play by no rules. It could be a 14-year-old pregnant girl who is a suicide bomber, just as it could simply be a 14-year-old pregnant girl who is looking for protection.

It is those dilemmas and how we respond to them that are really burning up the cells. PTSD is a physical effect on the brain; it's not simply psychological.

When it comes to the numbers, I keep hearing all those numbers, that there's no more than on civvy street and so on. But let's think about it. I mean, these people are selected, these people are trained, these people are sort of weeded out, those who will not be able to meet the requirements. They are prepared for the operations. They're under a whole system of control and command and so on. They entered a way of life, a culture that instills pride and all that kind of stuff.

So you have all that positive baggage, and yet we say that our figures are no more than on civvy street? Well, if they're the same as on civvy street, we have one hell of a problem. Surely, even though they see these traumatic experiences, they should have, because of the selectivity of it, less than equal, let alone more.

A year ago I was lecturing at the U.S. Marine Corps where they were having a symposium. The Americans were having massive problems of suicides that all of a sudden appeared because of the stressors of coming back to a normal life that simply was not there any more: I'm not who I was when I left and my family is not who they were when I left.

So bringing that back together is where some of those stressors really create the traumas.

The Chair: Thank you for that.

We have to move on. Perhaps we can keep our question and answer fairly quick.

Mr. Carrier, please.

● (1625)

[*Translation*]

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

Good afternoon Mr. Dallaire.

I had the opportunity of going to Rwanda two years ago, and there I saw bodies lying about, that had been covered in lime to preserve them. I got a glimpse of what you went through in that country.

I rarely have the opportunity of sitting on the House of Commons Standing Committee on Veterans Affairs, but whenever I do I find the discussions very moving. It helps us to better understand the consequences of war. Very often, the Parliament discusses whether or not we should be at war, but here we talk about all of the consequences.

You mentioned that we have data on deaths that occur in combat, but we forget about all of the consequences that follow this combat, such as suicide or mental illness. To my knowledge, that information is not disclosed.

In your opinion, should this be catalogued better with a view to transparency and governmental responsibility, so that we at least have some idea of what happens when one goes to war and comes back from it?

Senator Roméo Dallaire: The same debate takes place in the civilian world: people don't want to talk about suicide because they are afraid that this will generate more suicides. So the reporting of suicides is censored.

Within the armed forces, for several years there was a terrible stigma attached to the individuals from a regiment who had committed suicide. Afterwards a lot of people said that the individual concerned was incapable, that he lacked courage and loyalty, that if he had killed himself, too bad for him, and that his name would not be put on the regiment's monument. For a period of time it was practically said that these people were not really injured and that they had not really died in combat.

This has changed. It is still that way in some places but generally people recognize that those who have committed suicide are still a part of the regiment. Certain regiments put the names of these people on the list and mention that they committed suicide. It is said that they served and that they died from their injuries. They do write that the person "died of his injuries". However, this philosophy is still not the prevailing one.

However, to the population in general, suicides are not recognized as the result of operations. As I said in the beginning, we may have lost 170 or 180 soldiers in this operation. However, that is not new. Neither Canada nor any other country seems to want to include these deaths among those that occurred in the theatre of operations.

Finally, I would like to say that the Department of Veterans Affairs does not really follow the issue of suicides. It does not follow the person's history, it does not try to see whether he received care or not. It does not keep statistics. The department does not seem to want to keep these statistics. I can understand that in the case of older veterans, but for new veterans, I think that this tool has to be promoted in order to allow the department to follow this matter.

[*English*]

The Chair: I'm sorry, that's it.

We could be here all afternoon. I have really enjoyed your answers, sir, to our questions.

If we feel, going forward, that we would like to invite you back for some clarification, I would truly enjoy it.

Senator Roméo Dallaire: I have a final statement, sir.

I don't think there's a more magnificent time to serve than now, because the missions are just. But those in uniform who I've spoken to across the country ask two things of their leaders.

One, when you commit them to a mission, then you give them the tools to win. You leave when you've won or you've handed over or you simply cannot, and then it's recognized as a failure.

But, two, when they come back in body bags or injured, then you treat them and their families with respect and dignity so that they don't have to fight again to live decently as veterans in this country.

Thank you very much.

Voices: Hear, hear!

● (1630)

The Chair: Thank you.

We'll have a short recess before we go to our video conference.

● _____ (Pause) _____ ●

The Chair: I hate to shut off any little side chats, but we have a couple of witnesses waiting for us in Winnipeg.

I would like to welcome our guests. Jitender Sareen is a professor in the departments of psychiatry, community health sciences, and psychology. Shay-Lee Belik is a research assistant in the mood and anxiety disorders research group, department of psychiatry.

Welcome.

Do you folks have a presentation to make first?

● (1635)

Ms. Shay-Lee Belik (Research Assistant, Mood and Anxiety Disorders Research Group, Department of Psychiatry, University of Manitoba): Yes.

The Chair: Okay. Go ahead with it, please.

Ms. Shay-Lee Belik: Thank you.

I'd like to take this opportunity to first thank the committee for inviting us to speak here today. My name, as you've mentioned, is Shay-Lee Belik, and I'm a Ph.D. student in the department of community health sciences and a research associate in the department of psychiatry at the University of Manitoba.

I'm here today with Dr. Jitender Sareen, who's a professor of psychiatry at the University of Manitoba and also a consulting psychiatrist at the Operational Stress Injury Clinic in Winnipeg. I'd also like to acknowledge Dr. Gordon Asmundson at the University of Regina and Dr. Murray Stein at the University of California San Diego, who have closely collaborated with us on this work.

I'd like to thank the Canadian Institutes of Health Research for their funding support for our research. I just wanted to note to your group that we've been conducting research in this area of military mental health since 2004 and have been working on suicide prevention strategies in Manitoba first nations communities since 2005.

My understanding is that I have been invited here today to discuss my knowledge and work in the area of suicide among Canadian soldiers. My initial remarks today are going to be focusing on what we know about suicide in military populations and more specifically in the Canadian Forces. It has been well established that of course suicide is a major public health concern worldwide, and most recently, suicide has also been noted as one of the most common causes of death in military personnel.

Recent U.S. news media have emphasized the toll of military suicides, sometimes referring to what they call a suicide “epidemic”, estimating that suicide accounted for more military deaths than the war in Afghanistan. Although the media reports focus on the high number of suicides, there is much controversy in the research literature as to whether the rates in military populations are in fact higher than rates in the general population. Some studies suggest a lower rate among military personnel, likely due to what has been termed the “healthy soldier effect”, which describes the fact that military personnel generally have better physical and mental health compared to the general population as a natural consequence of the selection procedures for military service.

Other studies have shown opposite findings, demonstrating higher rates of suicide among soldiers than the general population, and some studies have demonstrated no difference in rates. Yet again, if we take into account the healthy soldier effect and the fact that the overall mortality risk is generally lower for military personnel than civilians, findings of no difference in rates between military and non-military samples may actually be taken to represent greater risk for suicide among soldiers. This conclusion would indicate that aspects of the military or post-military experience may be a potent risk factor for death by suicide.

Debate exists in the research literature as to whether or not combat exposure, peacekeeping experiences, and deployment play a role in risk for suicide. Still, the Institute of Medicine has recently concluded, based on data from Vietnam veterans and veterans with war-related traumas, that there is sufficient evidence to support an association between deployment to a war zone and suicide in the early years after deployment. However, suicide risk does not appear to be shared equally among all soldiers. Two studies from the U.K. indicated that the overall rate of suicide in veterans was not greater than that in the general population. However, young males, particularly those under age 24, did appear at increased risk when compared with civilian males of the same age. Younger age has been noted as a common risk factor for suicide across both military and non-military populations. Additional risk factors that are common to both populations include being unmarried, low social support, the diagnosis of a mental disorder including PTSD, a prior suicide attempt, impulsivity, and access to lethal means, especially firearms.

When we think about these common risk factors, it becomes apparent that although the risk is similar, oftentimes these factors are more prevalent among military personnel specifically. For instance, previous work in a Norwegian veterans sample illustrated a preference for veterans to choose firearms and other more lethal suicide methods, and that these methods accounted entirely for the increased rate of suicide noted in this cohort over the general Norwegian population. This preference may stem from soldiers' increased experience with weapons and a possible easier access to such methods compared with the general population. And these differences in the prevalence of risk factors may account for some of the differences noted in rates of suicide, and little work has accounted for this disparity.

● (1640)

Other risk factors that have been noted are specific to military populations, including being an active-duty regular force member rather than a reservist; being hospitalized for a combat wound, or experiencing two or more wounds; short length of service and premature repatriation; lower rank; feelings of shame and guilt related to service; and more recent evidence has suggested an increased risk among soldiers with traumatic brain injury.

Protective factors that have been noted include discussions around military exposures, unit cohesion, comradeship, and military leadership.

It is important to note that the majority of the research to date has focused on U.S. military personnel. One must keep in mind that the U.S. military experience is quite different from military experience in other countries, including Canada. The tempo of deployment, the maximum deployment length and, most importantly, the role of the military and its mission are just some of the ways the U.S. military differs from the role of the Canadian Forces.

Turning now to Canada, media reports have also created alarm with headlines about dramatic increases in suicide rates in the Canadian Forces in the past few years. Recent figures from the *Report of the Canadian Forces Expert Panel on Suicide Prevention* suggest that the suicide rate among active-duty regular force Canadian Forces personnel is quite similar to rates in the Canadian general population. The average rate of suicide between 2002 and 2006 in the Canadian general population of males of all ages was 17.8 per 100,000 population, whereas the average suicide rate for male regular force members during the same time period was 16.9 per 100,000. As well, it appears that Canadian Forces suicide rates have been decreasing as measured in five-year increments since 1995. To date, the suicide rate among Canadian veterans has not been reported.

There have only been four studies that have directly examined suicide in the Canadian Forces. Tien and colleagues recently published a study on the leading causes of death among Canadian Forces members. From 1983 to 2007, 1,889 active-duty Canadian Forces members died, 17% of whose deaths were attributable to suicide. In contrast, combat-related deaths accounted for less than 5% of all deaths. Suicide was noted as the third leading cause of death among Canadian Forces personnel, with motor vehicle crash-related deaths being first on the list.

Interestingly, alcohol-related fatal accidents among military personnel have been found to share many common features with suicide deaths in terms of risk factors, suggesting an overarching self-destructive tendency among a subgroup of military members, whether the result is suicide or a fatal accident, which highlights the risk of death associated with impulsive behaviour.

The second study, by Wong and colleagues, investigated peacekeeping as a risk factor for suicide among veteran Canadian Forces members. In a case-control design, they retrospectively compared 66 military suicides with matched military controls. The results illustrated a greater risk of suicide among soldiers who were unmarried, childless, of lower rank, who had not completed high school, and had French as their first language. They found no increased risk of suicide in peacekeepers and, in fact, the rate among them was half that of the comparable civilian population. However, those in the military who had committed suicide had experienced more psychiatric illness and psychosocial stresses than matched controls had. Psychosocial stressors included relationship problems, pending military release, and conflict over their military job. Importantly, a prior suicide attempt was one of the strongest predictors of suicide completion.

Two other studies were undertaken by our research group and examined suicidal ideation and suicide attempts among active-duty Canadian soldiers. One study focused on the relationship between exposure to traumatic events and suicide attempts, noting that exposure to sexual and other interpersonal traumas, including rape, sexual assault, spousal abuse, and childhood abuse, was associated with an increased likelihood of suicide attempts—yet exposure to combat and peacekeeping did not increase the risk.

Our most recent study compared rates of suicidal ideation and suicide attempts in Canadian Forces members with the Canadian civilian population. The study demonstrated no difference in the rate of suicidal thoughts when the two populations were compared, yet Canadian Forces members were less likely than civilians to have reported a suicide attempt in the past year. Few differences were noted among risk factors for suicidal behaviour between active-duty soldiers and the general population providing evidence of common pathways to suicide.

● (1645)

Recent findings from U.S., Canadian, and U.K. military surveys show that most service personnel do not receive mental health treatment, highlighting the need for outreach. Gatekeeper training is one example of an outreach program, which has been noted as one of the most promising suicide intervention strategies to date. Gatekeeper training, as part of a broad suicide prevention strategy, was shown to reduce suicide rates by 33% in a sample of over 5 million U.S. Air Force personnel.

A recent review of suicide prevention programs for active military and veterans indicated that multi-faceted interventions for active duty military personnel were well supported by consistent evidence. However, there was insufficient evidence of programs in veteran populations.

In line with the air force suicide prevention program, the Canadian Forces has implemented an extensive suicide prevention program around the theme of “Be the Difference”. Part of this training program includes gatekeeper suicide training for all personnel, based on a well-known gatekeeper training program called ASIST, or applied suicide intervention skills training. Evaluations of ASIST have demonstrated the effectiveness of the training to increase knowledge and skills in dealing with suicidal individuals. However, its impact on suicide rates has not been determined.

In the U.S., Veterans Affairs has similarly initiated a comprehensive suicide prevention strategy, which is designed to span the Institute of Medicine's suicide prevention recommended categories: universal interventions, selective interventions, and indicated interventions.

As such, we would recommend that a similar comprehensive suicide prevention strategy be initiated for Canadian veterans. A recent Canadian study, based on a systematic audit of 102 suicides in New Brunswick, indicated a need for better coordination of addiction services with mental health specialists; public awareness to encourage individuals to seek treatment; and training for primary care to better detect mental illness, substance-related problems, and suicidal behaviours.

Along these lines our recommendations would include, first of all, better aftercare for veterans who have attempted suicide, since previous attempts are known to be one of the strongest predictors of suicide death. Second, education and training for the veterans and their service providers in mental health literacy and suicide intervention skills could lead to better recognition of those at risk. Third, greater coordination between and across health services is required to comprehensively address the needs of returning soldiers. Finally, we would recommend increased screening for suicidality and mental disorders among veterans in care settings. One example of a screening program that exists in both Denmark and Norway features questionnaires that are sent to all soldiers six months after being discharged to civilian life in an effort to detect mental disorder development and suicidal risk.

Whether or not the risk of suicide among Canadian Forces veterans is higher than civilians, there is little doubt that suicide prevention programs should be developed with hopes of reducing suicide rates, since any suicide is an unnecessary tragedy. Moreover, suicide may lead to serious trauma and stress for bereaved family, friends, and co-workers, and it may actually induce suicidal thoughts and behaviour in others.

It is essential for steps to be taken to address this important public health concern.

I thank you today for your attention.

The Chair: Great. Thank you very much.

First question, Ms. Zarac.

Mrs. Lise Zarac: Thank you.

Thank you for your recommendations. In the first recommendation you say we should have "better aftercare for veterans who have attempted suicides, since previous attempts are known to be one of the strongest predictors".

Would that also include prevention care for the family? Would there be assistance to the family to be able to help?

Ms. Shay-Lee Belik: Yes, I think it's really important to include the families in talking about suicide aftercare, absolutely.

Mrs. Lise Zarac: I don't see it in the recommendation, but do I read that the aftercare would include families?

Ms. Shay-Lee Belik: It would, yes.

Dr. Jitender Sareen (Professor, Departments of Psychiatry, Psychology and Community Health Sciences, University of Manitoba): The idea would be that among the risk factors—there are a range of them—with suicide attempts, once somebody has either made an overdose or a gesture, a suicide attempt, and landed in emergency, the challenge often is that the risk period right after is quite high. We totally agree that family and outreach in trying to support the person is very, very important. That's the highest risk period.

● (1650)

Mrs. Lise Zarac: Would you say there's more suicide when a soldier has been physically injured? Do you have any studies demonstrating this? Has it been followed?

Dr. Jitender Sareen: The short answer is no, there has been no study to look at that. The long answer is that with post-traumatic stress disorder and depression and alcohol problems, soldiers who are physically injured are more likely to develop post-traumatic stress and depression. Post-traumatic stress and depression are linked with suicide. The soldier often has the reminders of the trauma—they have physical pain and physical injury—which often then leads them to have depression. They might not be able to go back to work with the way they feel.

So we think that likely is an issue, but there is no specific evidence around it that I'm aware of. We can look at it.

Ms. Shay-Lee Belik: There's only evidence that injury may be a risk factor, but not that it's specific to....

Dr. Jitender Sareen: Suicide.

Ms. Shay-Lee Belik: Yes.

Mrs. Lise Zarac: Thank you.

You mentioned also that some studies suggest a lower rate among military personnel is likely due to what has been termed the "healthy soldier effect". I just recently viewed a case in Quebec in which that was the issue. The soldier was healthy—he had a good body—but he ended up losing a leg, and that's the reason he killed himself.

Is this something that you see often? Because you seem to say the opposite in your briefing here.

Ms. Shay-Lee Belik: The only studies that I looked at actually talked about the healthy soldier effect and this way of thinking that it should be a protective role. But I think what you're talking about is the huge impact it has on the person who does feel that they are healthy and fit, and in fact healthier than the general population. The way their life has been up until the point of injury can really have a severe impact. The injury can have a bigger impact on someone like that.

So I guess in that case, in the example you're giving, the healthy soldier effect may not be protective.

Mrs. Lise Zarac: Okay.

Dr. Jitender Sareen: The idea of the healthy soldier effect really is at a general level. When you're looking at a population, soldiers are generally healthier, and so you'd expect a lower rate. But in the case you're describing, the person now has to cope with the loss and the injury and can't seem to figure out how to live with that loss, and how it's going to affect their career and their family. During that time they might become depressed, and if there are any alcohol issues, they might have impulsivity.

Mrs. Lise Zarac: In your assessments, have you ever heard the term "suicide pact", about a pact that has been made in the outfit that if they don't have all of their limbs, they will kill themselves before they come back? Have you heard this?

Ms. Shay-Lee Belik: We've heard of suicide pacts with respect to the aboriginal communities we work with in Manitoba. A lot of youth will get together and decide that everybody will commit suicide at the same time or on a particular date because someone else they knew took their life at that time. I haven't heard about it in a military context, so that's interesting to hear.

Dr. Jitender Sareen: I've never seen any studies on it.

The Chair: Okay. Thank you.

We'll move on now to the next questioner.

Mr. Carrier.

[*Translation*]

Mr. Robert Carrier: Thank you, Mr. Chairman.

Good afternoon, Ms. Belik and Mr. Sareen. You have interpretation services at your disposal, at least I hope so, because I'm going to speak in French.

You compared the studies on suicide rates. We have different sources and so it is difficult to draw conclusions. Do you think that we have access to all the necessary information?

Earlier General Dallaire was mentioning that reservists, for instance, are not tallied and they are offered virtually no follow-up when they come back from the battlefield.

Do you think that we are lacking information and statistics with regard to suicide?

● (1655)

[*English*]

Ms. Shay-Lee Belik: Absolutely. I was reading really carefully through the report by the Canadian Forces on rates of suicide, and I did notice in that report that they talk about how it's very difficult to track the reservist population. They do talk about a couple of different levels of reservists, and they say that they have good stats on a couple of levels, but not on all levels.

So I agree with you that there is data missing at this point. I also think that data on veterans is missing as well.

Dr. Jitender Sareen: The other thing I want to add is that, as Ms. Belik mentioned in her report, motor vehicle accidents are a very common cause of death, and sometimes it's not very clear to the coroner whether the accident was a suicide or an accident. It's a challenging issue. Some work from Europe has shown that the risk factors for accidents in peacekeepers were very similar to the risk factors for suicide in peacekeepers: impulsivity and alcohol abuse in young males.

But you're right that there's a challenge. A lot of what we hear is what's coming from the United States media. As Ms. Belik mentioned, we need to have more information specifically in Canada.

[*Translation*]

Mr. Robert Carrier: You talked a lot about suicide in your comments, and also about mental health, a topic that is in fact the subject of our study generally. Have you had access to data on mental health consequences, adverse consequences that do not necessarily lead to suicide?

[*English*]

Dr. Jitender Sareen: We published a paper in 2007 using the Canadian Forces data set, the same data set, basically showing what Senator Dallaire really talked about in his book, that Canadian soldiers who had been involved in combat or witnessed atrocities like human massacres were at about two to three times the risk of developing not just post-traumatic stress disorder but also major depression, alcohol problems, a self-perceived need for mental health.

Really, that's very consistent with the other studies in the U.S. and the U.K. The important message, still, is that most soldiers are resilient and do not develop any mental health problems, but a small number, probably about 20% to 30% who have been exposed to a high level of combat or a high level of witnessing atrocities like Rwanda, will develop a range of mental health problems—most commonly, depression, post-traumatic stress disorder, alcohol abuse, and panic disorder.

Ms. Shay-Lee Belik: I just want to mention that the study Dr. Sareen has been referring to has been sent to the committee. I think it's undergoing translation currently.

[*Translation*]

Mr. Robert Carrier: I still have time for one more short question.

General Dallaire made a comparison, and said that now families have more information on combat operations. They are given more information, daily, on what is happening in the theatre of operations.

Do you think that the fact that families can follow operations more closely now and know more about what the soldier has gone through will facilitate the soldier's return home?

[*English*]

Dr. Jitender Sareen: I think that's a very difficult question. I guess in the Korean War, the families didn't hear anything, and now it's almost become a challenge. I was at a NATO meeting a few years ago where they were talking about suicide specifically. One of the issues that came up for American soldiers is that sometimes there'd be a loss of a relationship in the family, where, say, the spouse has now left the soldier and has then sent that over by e-mail, and the soldier then becomes of course quite upset and suicidal. The people around the soldier get quite concerned. They were specifically concerned about that level of communication back and forth, for both the soldier and the family.

I think the challenge now is.... I don't know if it's better or worse. I think there's a sense of more connectiveness, that the soldier is not as "away", with Skype and all those kinds of things. But I think there can be negative effects of that on both the soldier and the family.

● (1700)

The Chair: Thank you.

Mr. Stoffer, please.

Mr. Peter Stoffer: First, thank you very much for appearing before us today and thank you for your presentation.

One of the concerns I always have is in comparing military or veteran suicide rates with those in the general population. Years ago I used to live in the Yukon, and we had a couple of suicides in our small town of Watson Lake. At the time there was a conference in Whitehorse that I went up to. I remember talking to some first nation chiefs about the issue, and they said, "We never want to be compared with the general population. We're first nations people. We're aboriginals. Our concerns, our issues, our thoughts, our views, our beliefs are different, and we don't want to be compared with the general population."

I notice here that you mentioned several times the comparison with the general population.

In your brief you say "yet exposure to combat and peacekeeping did not increase the risk". Obviously I can't question your study, but I find it rather hard to believe that people who serve in a combat role or a peacekeeping role are not subjected to this risk. I remember folks who served on the Swissair disaster picking up body parts off the rocks. Some of them had to leave the service because of what they were exposed to.

Now, they may commit suicide many years down the road. As Mr. Dallaire said, one of his soldiers committed suicide 14 years later.

Second, later in your brief you say that gatekeeper training reduced suicide rates by 33%. Does that mean they reduced 33% in that year? Suicide tendencies can last for the rest of your natural life. You can commit suicide in your fifties because of something that happened in your twenties, if I'm not mistaken. So I'd like to know how you quantify these types of statistics.

I say this with great respect. You said you started this in 2004. The Afghan mission really got kicked into high gear around that time. Are you planning to do enhanced studies down the road to follow these veterans and their families, many years down the road, or is this more or less it?

Thank you.

Ms. Shay-Lee Belik: I should start off by saying that the data we used in our studies was collected in 2002, so it was a very different world before Afghanistan in the Canadian military.

I only wanted to clarify that point about the work we have done so far. We don't have access to follow these people. This is an anonymous database that we used, and was collected by Statistics Canada in collaboration with the Canadian Forces. It's only among active-duty soldiers, so that is another limitation to keep in mind. We're only looking at people who are in the military, serving currently, and perhaps these kinds of risk factors will change over time in their lifetime.

The study you are talking about, concerning the relationship with combat and peacekeeping and suicidal ideation and suicide attempts, says nothing about completed suicides and t says nothing about what happens when they are done with their military service.

I agree with you; of course it seems quite reasonable to expect that when people are seeing atrocities of this nature during a combat exposure it will have a possibly negative effect on their mental health afterward. It is limited by the fact that we're looking at it here and now. Anybody who had severe mental health issues at the time of the study would have not been included in that sample because they may have been released from the military. They may have committed suicide already from their experiences. This is simply a representative sample of active-duty people at the time.

Also keep in mind the fact that the combat exposure only asks "Were you in combat?" It doesn't ask specifically or address specifically the experiences they had during that combat mission, so it is possible that some of the people who had more severe experiences and the people who had less severe experiences are being put together, so that might be wiping out a little bit of the effect there. Maybe asking more specific questions around their combat experience might delineate better what kind of outcomes people have based on certain combat-related experiences, rather than only calling it combat in general.

On your second comment—

● (1705)

Dr. Jitender Sareen: Perhaps I may add to that comment.

We were surprised by that finding, as you are. We were expecting combat and peacekeeping to be associated, but as Ms. Belik mentioned, the outcomes there were suicide ideation and suicide attempts. Deaths by suicide were not assessed.

One of the important things that we didn't put in the report was that we don't have data on soldiers after the Afghanistan mission. In 2012, Statistics Canada is going to do a national Canadian mental health survey, and the hope is that they will also re-do the survey that we've been using from 2002, but I'm not sure if that will be done. I would really strongly recommend, as you are suggesting, that there is a need to understand what is happening. The combat missions that have gone on in Afghanistan are very different from those that occurred before with the soldiers that we looked at.

You have to also keep in mind that death by suicide is very different from suicide attempts. That is where some of the discrepancy can happen, too.

Ms. Shay-Lee Belik: Your second point was asking about gatekeeper training and the reduction in risk. Is that correct?

Mr. Peter Stoffer: I was asking about suicide rates being reduced by 33%. Was that 33% in one year? We know that people with suicide tendencies, if they don't exercise...I hate to be simplistic on this, but if they don't exercise an option now, they may do it months or years from now.

Ms. Shay-Lee Belik: Yes, absolutely. That study did track active U.S. Air Force personnel. At the time, did it reduce when they did the training, and then I'm pretty sure they were followed over a five-year period to see if suicide rates went down in that time. That's as far as they went. There wasn't anything to do with after service.

The Chair: Mr. Lobb.

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

My first question is on peer support and the operational service injury support service. Did you come across that in your research? What did you learn about that in your research?

Dr. Jitender Sareen: Around suicide, there isn't any literature around that; I know that's certainly a very important part of the support to the veterans. No one has ever looked at whether an intervention through gatekeeper training, where you train people to be aware of suicide risks, would have an impact on their capacity to help.

I think it makes a lot of sense. Those are the people who are in contact, and they should be aware of mental health problems and specifically suicide risk issues.

Mr. Ben Lobb: In your studies, was any work done examining any of General Dallaire's comments or thoughts on prevention?

Ms. Shay-Lee Belik: I'm sorry, we weren't able to hear anything that General Dallaire said. Your microphone was on mute, so all we could see was the picture.

Mr. Ben Lobb: I don't mean in his statements today, but in his book or any of his speeches or interviews during that time. Did your studies look at any of his work?

Dr. Jitender Sareen: We specifically looked at the impact of peacekeeping on the mental health of soldiers. I'm sorry, but I don't remember what he specifically recommended in his book around suicide prevention.

Mr. Ben Lobb: Certainly he felt that on-base peer support groups were a tremendous help in providing a reduction in suicidal tenancies.

On page 3 of your handout in the last paragraph, it says: Other risk factors that have been noted are factors that are specific to military populations, including being an active duty regular force member rather than a reservist....

I wonder if you can elaborate on that and what that sentence means.

● (1710)

Ms. Shay-Lee Belik: Basically it's saying that the rates are higher in active-duty members than in reservists. I'll come back to a previous comment that we often lack data on reservists, so it's hard to say that's truly the case. But it has been noted in the literature to date that active duty has a higher risk.

Mr. Ben Lobb: Would you support a study or research to track reservists?

Ms. Shay-Lee Belik: Absolutely.

Mr. Ben Lobb: I was at Wainwright last summer when the reservists were performing Maple Defender. I talked to some guys who had performed in three and four tours in Afghanistan and then went back into their communities. I realize that a great many of them are tracked. I'm not sure for how long, but I guess that's a question I have.

In your third recommendation on the last page, it says that "increased attention should be directed towards increasing collaboration". For our analysts and to have a little more detail, I wonder if you can elaborate on that. It is pretty vague. With whom and where would collaboration be increased?

Ms. Shay-Lee Belik: When I was looking at my speaking notes today, I noticed that sentence had been cut short. I was referring to greater coordination among the different kinds of health services available to veterans.

I mentioned a little earlier in the report there is a need for collaboration between alcohol services and mental health services—getting those people talking to each other. Alcohol use disorders can be a large risk factor, especially among this kind of group. Impulsive people are more likely to die by suicide. So we're talking about getting those two groups contacted, connected, and talking about the health of the soldier.

Mr. Ben Lobb: Mr. Chair, how much time do I have left?

The Chair: Very little.

Mr. Ben Lobb: Thanks.

I'm a little surprised that in any of the work or any of the questions you wouldn't have asked either active-duty or veterans if they'd participated in any peer support work with the OSISS program on base. That's about the first question I would ask.

Was that because no data or no reports were available? Why was that omitted?

Dr. Jitender Sareen: Just to be clear, these data were collected by Statistics Canada. We didn't collect the data. Statistics Canada did a mental health survey of all Canadians in 2002. As part of that, the Canadian Forces then commissioned Statistics Canada to do a representative sample. So we weren't involved in the data collection. We were involved in the data analysis.

You've mentioned a very good point, but we weren't involved in that part. I think it is a miss, but it's not something that we were trying to look at.

The Chair: Thank you.

We'll move on to Ms. Duncan.

Ms. Kirsty Duncan: Thank you, Mr. Chair.

Thank you to the witnesses. Thank you for your research and your time and effort today.

I think you've raised two important issues. We know coming home we're going to have a lot of operational stress injuries, whether it's anxiety, depression, PTSD, or traumatic brain injury. You've talked about the lack of tracking. I'm going to speak specifically related to VAC.

If people leave the service, I am looking for very specific recommendations. How do we ensure they are tracked? How do we ensure they have the support they need? We know that data collection is a problem. We've talked about gatekeeping. Should everyone who leaves have an interview with a psychiatrist, a psychologist, a mental health worker?

Should there be a survey? If they are identified as at risk, should they be assigned a case manager—which, we believe, they are being assigned—but specifically a peer support worker? How often should they be checked? Is it often enough to do a survey six months later?

● (1715)

Dr. Jitender Sareen: A post-deployment screening has been developed and is being collected. Mark Zamorski has been doing this.

The challenge is more awareness for the family, as well as for the soldier, and as you were saying, the peer support. As the person leaves the military it is a challenge, and this is the difficulty. How do you get care for people? Raising awareness is probably the most important method. The primary care physician is also a person who can be helpful.

As we mentioned in the report, if the person has made a suicide attempt they probably are at the highest risk. And if they have post-traumatic stress disorder—

The Chair: Ms. Duncan wants to interrupt for a second.

Ms. Kirsty Duncan: Thank you, Mr. Chair.

I've heard from a number of families. They didn't recognize the symptoms. They didn't know that was a risk factor. The family member went into the basement—in three different cases—and they had lost their son.

We have to do more. There has to be more to awareness and education. The child—the young man—lived in the basement for six months.

There is more to this than awareness and education.

Dr. Jitender Sareen: Yes. I mean, this is the real difficulty. One of the challenges, if someone is extremely depressed and a family member is concerned, is whether he should be hospitalized against his will. That becomes an issue in such cases.

The challenge is that not all suicides are preventable. The hundred suicides that were reviewed in New Brunswick, the cases Ms. Belik was talking about, were studied very carefully. That's where the recommendation of coordination of mental health and addictions services came from. Also, they noted that 30 out of the hundred suicides were not preventable, even if anything and everything could have been done. It's important to try to raise awareness among people in contact with the person, and to provide family-member peer support. If a person is depressed and feeling hopeless, and wanting to die, that person is not going to seek services.

You have a comment?

Ms. Kirsty Duncan: Yes, thank you.

Not everybody has a family member. That's really important: then what happens?

Dr. Jitender Sareen: Right. As you're saying, it is a challenging issue, how you track and support these people.

The U.K. study showed that for young soldiers leaving the military, that was the time of highest risk. Probably the first year after is the highest risk of all, but it can happen at any time. So trying to figure out ways to provide outreach and support is essential.

The Chair: Thank you.

Mr. MacKenzie.

Mr. Dave MacKenzie (Oxford, CPC): My thanks to the panellists.

I have a reasonable amount of experience in dealing with suicides. We should not lose sight of the fact that suicides occur in all walks of life, not just in the military. Doctors, lawyers, police officers, factory workers—all commit suicide. I recognize that, and I appreciate your comment that not all suicides are preventable.

My sense...and you didn't hear General Dallaire, but I saw the same thing where I came from. Frequently we ended up with the wrong people, a round peg in a square hole or vice versa. He talked about three-hour sessions in which they sat down with people who had experienced these things. In one group, four young men decided that the military was not for them, or at least that part of it.

If we're looking strictly at the military, and that's what this committee is trying to deal with, how would we avoid putting people who are not psychologically suited to dealing with heavy stress into situations that could cause them to become mentally ill? Based on the studies you have done, do you know a way of heading off the problem before it's a problem?

● (1720)

Dr. Jitender Sareen: This was addressed in a study by Rona in the *British Medical Journal*, using U.K. data. They looked at screening for mental health problems prior to entrance into the military and whether that would predict future problems. If someone had a history of mental illness, depression, or anxiety, would that person have a higher likelihood of post-deployment mental health problems? Their conclusion was no. According to the study, this information didn't help predict who was going to experience problems.

This is the biggest challenge with mental illness in general. As with diabetes or heart disease, there are genetic risks. Childhood adversity, physical abuse, sexual abuse, family difficulties, exposure to alcoholism in childhood—these factors put people at higher risk when they have a traumatic event. At least that is what's thought. But at this point, the short answer is that we don't have a good understanding of who is going to develop mental health problems after severe trauma. This is the huge question. We tried to do a study on it, but we didn't have the necessary support.

Mr. Dave MacKenzie: That deals with post-traumatic stress types of individuals, but we have a lot of suicides, as you well recognize, that have nothing to do with post-traumatic stress disorder. Lots of times it's young people, but it's all age groups.

In this case, what this committee is wrestling with, in dealing with the military, is whether there is any pre-screening for occupational deployment, if you will. We do it in other industries. Some people are better suited to being salespeople and some people are better suited to being whatever.

Are there any kinds of things we can do to help the people in the military prior to being deployed into these situations?

Dr. Jitender Sareen: Do you want to answer?

Ms. Shay-Lee Belik: I was just going to say that I think one of the personality factors that has kind of come up time and time again, no matter which population you're looking at, is impulsiveness as a risk factor for suicide. Across populations, military and non-military, impulsiveness does seem to predict people who are more likely to be suicidal.

Dr. Jitender Sareen: Some of the U.K. folks tried to look at this. At this point, there isn't any evidence that pre-screening.... It makes a lot of sense to do some cognitive therapy or some skills building that helps build resilience prior to deployment. Those kinds of studies are actually very important and necessary, but they haven't been done.

The question of whether training somebody prior to deployment would protect them from getting mental illness is a question that's been asked for a number of years, but no one's actually done a study on that.

What we do know, in general, about what puts people at risk for mental illness and suicide is that suicide is even more difficult to prevent in this kind of way, because suicide is of much lower prevalence than PTSD and depression.

It's very hard to look at that. But people who have gone through a lot of childhood adversity or who have a family history of mental illness and have a genetic loading for it are at the highest risk, generally, of mental illness if there's a stressor in their lives or a relationship loss. But I think it makes it very difficult to screen people out because of that.

● (1725)

The Chair: I have to interject, because we have one more question to come, from Mr. Vincent, and we do have to end in five minutes.

Please, Mr. Vincent, go ahead.

[*Translation*]

Mr. Robert Vincent: Thank you, Mr. Chairman.

Ms. Belik, I read in *Cyberpresse* the article entitled "*War does not lead soldiers to suicide*". It says in this article that you did not find any increased risk of suicide among soldiers who were deployed as combatants or as peacekeepers. We know of course that the peacekeepers did not have a military mission and did not have the right to use their weapons. Nevertheless some of these soldiers went through certain things in these countries, for instance some of them witnessed rapes and could not intervene, and some of them committed suicide a few years later.

Which leads me to talk about our soldiers who are now deployed in Afghanistan. In the same article it says:

> The risk doubles if the soldier witnessed "atrocities", it triples among those who caused accidental deaths, and quadruples among those who killed or injured someone intentionally, for instance by using their weapon in a war zone.

We know that very often soldiers do not have suicidal tendencies when they return from the theatre of operations, but a few years later.

In light of your expertise, I would like to know what recommendations you could make for our veterans. How can we ensure that people who have been in a theatre of operations and witnessed atrocities and all sorts of things, who killed people, can be the object of follow-up, since, as you said, in those particular cases, the risk of suicide can be two, three, or four times greater?

[*English*]

Dr. Jitender Sareen: I think it's very important to understand, as you're saying, that with a higher level of exposure to combat and the witnessing of atrocities, there seems to be a "dose" response relationship. If you had a peacekeeping mission in which the soldier didn't see much combat or didn't observe any atrocities, he or she would not have as much of a risk. So you're absolutely right.

The risk usually can be over time. I think, again, awareness by the soldiers and the family members around them and the post-deployment screenings are trying to get at following people after they come back from Afghanistan. Those are ways people can take the highest-risk people and get them into care.

The Chair: Thank you very much. We really appreciate your time spent with this committee today. Thank you for your candid answers.

I again thank all the members of this committee for their good questions. Thank you.

The meeting is adjourned.

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