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Chair

Mr. Gary Schellenberger

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● (1530)

[*English*]

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

I'd like to welcome everyone this afternoon to meeting number 31 of the Standing Committee on Veterans Affairs. Pursuant to Standing Order 108(2), we are continuing our study of combat stress and its consequences for the mental health of veterans and their families.

For the first hour our witness is Don Richardson, consultant psychiatrist with the Parkwood Operational Stress Injury Clinic.

Welcome, Mr. Richardson. You're on, sir.

Dr. Don Richardson (Consultant Psychiatrist, Parkwood Operational Stress Injury Clinic): Thank you for inviting me.

Usually when I'm asked to present, I'm asked to do a PowerPoint presentation, so I'm assuming that you don't want me to do a long presentation. I'll keep it relatively short, and maybe there will be more time for questions and discussions.

The Chair: That would be good.

Dr. Don Richardson: I did send in advance a couple of published articles that focus on Canadian veterans and military members. I think some of them are being translated. I'll just review some of their highlights and then open it up for questions.

As you're probably aware, Statistics Canada did a survey in 2002, the Canadian community health survey, that had a supplement focusing on currently serving members of the military. Probably the most comprehensive published research on that survey was done by Jitender Sareen in the *Archives of General Psychiatry* in 2007. The prevalence in any past year of a medical mental disorder—this is for any psychiatric condition—was about 15%. For major depression, it was 6.9%; for PTSD, or post-traumatic stress disorder, it was about 2.3%; for alcohol dependence, it was 4.8%.

The other thing that came out of the analysis was that most individuals who met a criterion for a mental disorder diagnosis were not using mental health services. Furthermore, deployment to combat operations and witnessing atrocities were associated with increased prevalence of mental disorders.

Other published studies that have looked specifically at PTSD include one with a sample of Canadian veterans with medical conditions. In that study, the one-month prevalence rate for PTSD was about 10%. In a sample of American military members deployed to Iraq and Afghanistan, the prevalence of PTSD was estimated to be between 11% and 17%. In U.K. members, the rate was 4.8%. As you can see, there's quite a variation.

The other thing for combat-related PTSD specifically and other psychiatric illnesses is that there are high levels of comorbidity. When we ask about comorbidity, it means that if you have one thing, such as PTSD, there are chances of having something else. The most common comorbidities are going to be major depression, and then addictions and chronic pain, and then other physical conditions.

The many studies that were done, though, indicate that even though PTSD often presents with significant impairment, if you are using established guidelines or evidence-based practice, remission rates of anywhere from 30% to 50% can be achieved.

I think I will end there, if that's okay.

● (1535)

The Chair: The first question will be by Ms. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair, and thank you for coming, Dr. Richardson.

What I'm trying to get from you today are really your recommendations. We've heard that in the military, people will be screened for mental health challenges about six months after deployment. I'm wondering if you think that's enough. I'm also wondering if you think there are different ways to screen. For example, in the U.S. they have self-screening, but you can't offer that alone. It has to be with treatment.

My first question is this: how can we better help our forces members to get mental health treatment while they're serving?

Dr. Don Richardson: I think it's been demonstrated that regular periodic screening tends to work better, because in this way, if you're going in for your regular medical checkup and you get screened at that time, and it's not necessarily deployment-specific.... Somebody coming back from deployment, for example, may minimize their symptoms or may not have acknowledged their symptoms at that time, but maybe if the screenings are repeated regularly as part of their general health assessment, then....

Ms. Kirsty Duncan: How often would you recommend screening?

Dr. Don Richardson: I'm not sure how often they would normally be screened. I wouldn't want somebody to be going in too regularly, but I would imagine that they usually go for periodic screening at least once a year.

Ms. Kirsty Duncan: Do you think having self-screening available is a useful tool, as in the United States?

Dr. Don Richardson: If we look at the concept of "no doors are closed", meaning that if you have the opportunity to do self-screening, which is available online for Canadians as well—you can go online and complete all kinds of self-screening instruments—it generally will provide you with information at the end saying that if you scored at a certain level, you should see your primary health care provider.

Ms. Kirsty Duncan: You mentioned there is variation in the statistics. Who has the lowest statistics, and what are they doing?

Dr. Don Richardson: Do you mean the lowest rate of...?

Ms. Kirsty Duncan: Yes.

Dr. Don Richardson: If we look at what has been presented, it really depends on how the survey was done—

Ms. Kirsty Duncan: It depends on how the data were collected. Okay.

Dr. Don Richardson: —and on how the data were collected, so it would be very difficult to come to a conclusion. If one population has a lower rate, it would be very difficult to have a basis for the conclusion that they are doing something different without knowing exactly how the data were collected.

As well, deployments differ in length in each country. For example, U.S. deployments tend to be longer than Canadian ones, so other aspects are also involved there.

Ms. Kirsty Duncan: Can you talk about transitional services? When people come out, how can we make sure they are followed up and have access to suitable screening? How can we make sure they are hooked up and are followed by a case manager?

What would your recommendation be to ensure that people are getting the necessary treatment and follow-up they need? Perhaps you can add some comments on addictions when talking about this aspect.

Dr. Don Richardson: Just so I understand, are you talking about the transition out of the military—

● (1540)

Ms. Kirsty Duncan: Yes.

Dr. Don Richardson: —or transition coming back from deployment?

Ms. Kirsty Duncan: No, I mean their transition out of the military.

Dr. Don Richardson: I think it's a matter of the continuity of care when somebody who is in service leaves and becomes a civilian. For that, there are transitional services available if somebody has already identified themselves as having a problem. Then it's easy for Veterans Affairs, I would assume, to take on that patient client, because the person has already been identified.

Those who release and have not yet acknowledged, or have not yet been identified as having, a psychiatric condition, fall off into primary care by family physicians in Canada, so part of—

Ms. Kirsty Duncan: This is what I'm getting at.

Dr. Don Richardson: One issue with larger organizations such as the Canadian Psychiatric Association and the Canadian Mental Health Association is having them inform primary caregivers, whether physicians and nurses or emergency departments, to actively screen for trauma-related illnesses, including depression, and asking the simple question, "Have you ever served in the military?". That may open the door for an ex-service member to talk about having experienced something that was difficult for them.

Ms. Kirsty Duncan: Do you think Health Canada or CIHR has a role to play here in talking with Veterans Affairs Canada to try to highlight this issue?

Dr. Don Richardson: I think that having more partners and having more people talk about mental health is always beneficial.

Ms. Kirsty Duncan: As someone who treats people with mental health challenges, what would be your three big asks of the government in order to improve services?

Dr. Don Richardson: That's a good question. Nobody has ever asked me for a wish list.

The issue is accessing services and the challenge in terms of how to coordinate health care between primary care and specialists. The majority of people in Canada are receiving mental health services from their family physicians. As specialists, psychiatrists, we're another line behind, so it's partly educating primary care physicians and nurses on the effects of mental health and how to screen. That's one aspect.

The other aspect is providing general education to the public, almost in the same way as an anti-stigma campaign is done. It's letting people know that if they're having difficulties, whether it's depression or PTSD, they can identify that they have a problem, and then it's making them aware that treatment is available.

Ms. Kirsty Duncan: Is there any—

The Chair: We have to move on. Maybe you'll get another chance.

Go ahead, Mr. Vincent, please.

[*Translation*]

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

Good afternoon, Dr. Richardson. How long have you been a consultant with the Canadian Forces?

[*English*]

Dr. Don Richardson: I initially started working with National Defence as a consultant in 1996. In 2000 I moved to southern Ontario, and in 2003 I started working with the Parkwood Operational Stress Injury Clinic, so it would be over 10 years now.

[*Translation*]

Mr. Robert Vincent: In the years you have been practising, have you been called on to treat veterans, or serving members of the Canadian Forces?

[*English*]

Dr. Don Richardson: Have I...?

[*Translation*]

Mr. Robert Vincent: Have you provided medical follow-up to people with symptoms of post-traumatic stress?

[*English*]

Dr. Don Richardson: Yes. My clinical practice right now is all veterans, currently serving members of the Canadian Forces, or eligible RCMP.

[*Translation*]

Mr. Robert Vincent: In your practice, when a veteran or a serving member of the Canadian Forces is diagnosed with post-traumatic stress, has that diagnosis ever been challenged by the Canadian Forces or the Department of Veterans Affairs?

[*English*]

Dr. Don Richardson: It wouldn't necessarily be contested in the way you're asking. The diagnosis we will make is a clinical diagnosis, meaning that if somebody comes in and presents with symptoms that are consistent with PTSD, we make the diagnosis and then pursue the treatment. It may be not necessarily contested, but if they were applying for pension entitlement, whether or not the PTSD they're claiming is related to service, it would go through adjudication, if that's what you mean.

[*Translation*]

Mr. Robert Vincent: Yes, that is what I mean.

I have met veterans, and even serving members of the Canadian Forces, who have told me that, when a diagnosis of post-traumatic stress is objectively made and the paperwork is sent to the Department of National Defence or the Department of Veterans Affairs, the diagnosis is challenged.

So that causes a number of problems. First, the patients cannot get any pension money if the diagnosis is challenged. Second, they may have to wait two or three years to get the matter resolved.

So, during that time, does the veteran or the serving member continue to be seen, or do all the services stop, given that the diagnosis is not recognized?

[*English*]

Dr. Don Richardson: In my experience at Parkwood, you don't have to have pension entitlement under the new Veterans Charter to receive services. They would continue treatment while a pension claim is pending. If they are not being treated at our clinic and they're seeing a psychiatrist in the community, treatment would continue, because it would fall under medicare.

● (1545)

[*Translation*]

Mr. Robert Vincent: Doesn't the fact of knowing that their diagnosis is being challenged cause an even bigger problem for people? When someone in that situation comes to see you, does he not tell you that he has no income because his application is being contested by the Department of National Defence? Does he not tell you that he does not know where to turn and that he does not know what will happen to him? Does that not cause that person additional stress?

[*English*]

Dr. Don Richardson: In my experience, any time somebody is putting in a claim and waiting for a claim would be an added stress for them.

[*Translation*]

Mr. Robert Vincent: From your knowledge of your clinic and of other clinics with which you must surely be in contact, has someone waiting and under additional stress like that ever committed suicide?

[*English*]

Dr. Don Richardson: That I'm not aware of.

[*Translation*]

Mr. Robert Vincent: You said that if you could make recommendations, they would deal with access to services. Is the difficulty of access to psychologists, psychiatrists and other medical personnel not one of the major problems? You have to be able to access the services in order to identify the problem. People can be waiting several months before being able to see someone.

[*English*]

Dr. Don Richardson: What I mean by the challenge of accessing services is that if you're an individual, for example, do you know you have a problem, and do you know where to go if you have that problem? That's one aspect, and it's based on the individual.

Once you have identified that you potentially have a problem, whether it's depression or PTSD, how do you access service? The challenge, in my experience, is that in the military context they provide comprehensive health care, so to access service it's always the same person within their health care system. Once you become a civilian, it's a little bit more complicated, because in general you can't access specialty services without going through primary care. You have to see your family doctor first and then be referred.

As you're probably aware, in Ontario and probably across Canada there are many civilians, including veterans, who don't have a family doctor. It's that process, in terms of accessing care. If you want to see a psychologist, that's not covered by medicare, so to access psychotherapy, you would have to have an entitlement in order to have it paid for. If you're working full time, in another aspect, it would be paid through your private insurance.

● (1550)

[*Translation*]

Mr. Robert Vincent: If I understood your testimony correctly, things get more complicated and more difficult when soldiers are discharged from the Canadian Forces and become veterans. That is when we have to find out whether they are suffering from post-traumatic stress.

We heard that General Dallaire was once found walking around a park naked. That is a major symptom, in my opinion. I gather that a number of people have shown similar symptoms, even four, five, ten or fifteen years later.

The problem is that it is difficult to see a doctor quickly enough, giving the medical situation at the moment. I understand that that is the crux of the problem, and you can understand how people can end up committing suicide.

[*English*]

Dr. Don Richardson: I'm assuming this committee has probably seen people from the military, and it's a different culture. For us as civilians—I speak for myself, as I'm not in the military—our culture is to try to find a family doctor, and then we know how to access services, but if you're coming from a different system and you get released, and you also have depression or problems with concentration, low motivation, finances, or your family, those add another barrier to trying to find out who you can see to access services in a community.

The Chair: Thank you.

[*Translation*]

Mr. Robert Vincent: Thank you.

[*English*]

The Chair: Go ahead, Mr. Stoffer, for five minutes, please.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Sir, thank you very much for coming, and thank you for your service as well.

I've never asked this question, so I thought I might as well try to be as diplomatic as I can with it.

The other day we heard someone say that within 40 minutes you can tell whether or not a person has PTSD or whether they're showing signs of it. Would that be more or less accurate?

Dr. Don Richardson: Do you mean in 40 minutes of a...?

Mr. Peter Stoffer: If I walked into your room as a veteran and told you what my problems were, could you diagnose me within 40 minutes as either having symptoms of, or displaying, PTSD?

Dr. Don Richardson: I think 40 minutes would be quick. However, if you're seeing a clinician you're comfortable with and have a good rapport with and trust as someone working for your benefit and are therefore willing to tell them about traumatic things that most people would be afraid to talk about, yes, the clinician could make that diagnosis within the confines of those 40 minutes, if they asked enough questions.

Mr. Peter Stoffer: Would the reverse would hold as well? I had a conversation the other day with a group of guys over a few beers. They were quite adamant that a fair number of these guys were faking it to get a pension. They're faking PTSD, faking these mental health problems, in order to get a pension. It's the "me too" effect.

In the reverse situation, as a trained psychiatrist, is it possible for you to tell fairly quickly if someone is faking it?

Dr. Don Richardson: Well, I think it would be the same thing. I don't think I'd say we could do it quickly. What we do is that we look not only at what they're saying but also at how they're reacting, even before they come into the waiting room. For example, suppose somebody came in and said they're nervous or vigilant regarding their surroundings and that they are constantly checking. If I saw them in the waiting room and they looked relaxed and were talking to other people, and then they came into the interview and didn't actually look anxious or nervous, then I would bring that up in the interview. I would note that what they were saying might not be consistent with what I was observing and ask how we could better understand it.

Mr. Peter Stoffer: The other point that we heard before is that PTSD can be transferred to the family. If a guy comes back home and he's not the same person he was when he left, it puts tremendous stress on his partner and the children, and thus, in many ways, they suffer from PTSD too.

Do you have an opportunity through your practice to interview and assist family members—spouses and children—or is it just the veterans and RCMP veterans?

Dr. Don Richardson: In part of the evaluation, we traditionally see their spouse or significant other.

● (1555)

Mr. Peter Stoffer: Okay.

Dr. Don Richardson: In the case of some of the younger vets, we're interviewing their parents. At our clinic we are treating the spouses but usually not the children, because that's a specialized service we would refer out. However, we may see the family and assess them.

As for the question of whether or not PTSD can be transferred to somebody else, I probably wouldn't say that the other person has PTSD, but that person might be suffering similar symptoms. For example, a way to explain it would be that if the individual with PTSD jumps or becomes very angry every time he or she hears a loud noise, then the people in that person's environment will quickly learn to expect something if they hear a loud noise, so they become nervous and jumpy regarding their surroundings. It doesn't necessarily mean they have PTSD, because if you remove them from that situation, their level of anxiety may well decrease. Yes, they may be suffering anxiety disorders or depression, but I wouldn't necessarily call it PTSD.

Mr. Peter Stoffer: Thank you very much.

The Chair: Go ahead, Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you, Mr. Chair, and thank you, Mr. Richardson, for attending today.

Parkwood Hospital is not too far away from my hometown. It's about an hour away. Of course, people on this committee are concerned about the issues at hand. We want to make sure, in particular, that people in rural communities such as mine aren't left behind.

You mentioned outreach care when we were discussing this before the meeting started. Once somebody has made contact and is in the system, but is from a rural area, can you explain to the committee how the OSI clinic would work with somebody in, say, Goderich or Exeter or Kincardine, or wherever they may be from?

Dr. Don Richardson: Sure. We try as much as we can to provide services locally. Our clinic and the clinic here in Ottawa and I think those across the whole network are connected by video conferencing. In Ontario it's called the Ontario Telemedicine Network. They are telling us that it's a completely secure line. It's not on the Internet.

I would see individuals who find it difficult to drive to our clinic using the Ontario Telemedicine Network for psychiatric care. The patient would go to their local health centre—most of the hospitals are connected—and then I would go to our office, which has video capability, and we would connect that way. I will be providing psychiatric care in that format.

We also have outreach services. That's what I was mentioning. We have a nurse from our clinic who provides services directly to patients and their families in the Grey Bruce area.

We would try as much as we could in that way. The challenge often is for psychiatric care. We would provide that at our clinic, but we would try to find providers in the community who would see the individual on a weekly basis. If we know of a psychologist in the community who has experience in military-related trauma, we would tend to refer that individual to them. They would do the weekly psychotherapy, and then patients might come to our clinic in person or by video or by phone for the psychiatric care.

Mr. Ben Lobb: For the benefit of the committee as well, Senator Dallaire was in last week and talked about the OSISS peer support network, psychologists, and psychiatrists.

Could you explain for the committee and for this report how that relationship works? How do you interact with the psychologist and with the OSISS peer networks for the benefit of the veteran?

Dr. Don Richardson: At our clinic we have embedded a peer support coordinator. That is an individual who has had PTSD or an operational stress injury and has gone for treatment and has recovered to the degree that he can provide support to other peers and go through the whole program. Any patients who come to our clinic are referred for peer support. We do that automatically. We refer their spouses or their families to the family peer support network.

● (1600)

Mr. Ben Lobb: My understanding is that at the OSI clinics, the idea is that assessment and treatment services are provided under the same roof. That's the goal, anyway. Is that the case at Parkwood? What is the benefit to the veteran of being able to have, at least in the initial phases, a kind of one-stop shopping for their treatment?

Dr. Don Richardson: You may have to clarify what you mean by the assessment and treatment.

Mr. Ben Lobb: It would be that when they would be screened initially, you or whoever would see them. After that, is it a benefit to the veteran to be able to come to the same spot, one that's familiar to them, time and time again?

Dr. Don Richardson: This is what we have heard from veterans. They do like the idea that there is a clinic that is veteran-friendly. It means that the majority of people who are at our clinic are either veterans or currently serving members. The pictures and most of the stuff we have around have a military theme. I think it gives them a sense of belonging. Having clinics like that, I think, is beneficial in helping them feel more relaxed and feel that this is part of where they belong.

When somebody is referred, they are assessed. Then we usually start treatment right away. Once they are seeing somebody, we would be recommending treatment. They may come back to see me in a month's time, but meanwhile they may be receiving psychotherapy locally. Some people prefer to see a therapist at our clinic. That's offered also. Some people don't mind driving.

Mr. Ben Lobb: I have one quick final question. In my area there's a large nuclear power plant. Again, it's not related to Veterans Affairs in any way, but the nuclear power plant has a very difficult time finding nuclear engineers because there aren't any nuclear engineers in Canada, except maybe from McMaster University.

My point is that as a psychiatrist or psychologist, there is no track in your education that is specifically focused at treating a veteran or any of the combat military disorders. Do you think that DND or Veterans Affairs should work with colleges and universities throughout North America to try to develop course tracks that would be embedded into university curricula, or should the training take place right on site, hand in hand?

Dr. Don Richardson: I think that has been talked about. Even at our clinic, we provide training for psychologists. We're in the process of developing curriculum to train residents and give them exposure to military-related trauma. The reason I got involved in treating veterans is that I did my residency at Ottawa and they had a six-month rotation at what was then NDMC.

I think that is a very good point. By giving somebody an exposure to a certain area, you may attract some people who are interested in treating veterans, which is how I got involved with it. I think that's a good point.

The Chair: Thank you.

Ms. Zarac is next, please.

[*Translation*]

Mrs. Lise Zarac (LaSalle—Émard, Lib.): Good afternoon, Dr. Richardson. You said that the biggest problem was access to services. You feel that a soldier has to realize that he has a problem and to know where to go. I would like to pursue that a little more and I would like to know your opinion.

When I think of a soldier, I imagine someone tough and strong. In most war films, after all, soldiers are shown as tough guys who are not afraid of anything. I feel that is how soldiers see themselves. It cannot be easy for them to admit that they have a problem, especially a psychological problem. I would like to hear your comments on that.

Let's talk about access to services. There is always a little shame attached to saying that you have a psychological problem, even in 2010. In the private sector, there is a service called EAP, the employee assistance program. Everything is handled discreetly. You call a number and you get an appointment with a psychologist or someone to help with your needs. It's all done without anyone else knowing. If you work in a company, you won't meet anyone else when you are there. It is done very discreetly. The service is not just available for the employee, but for the employee's family as well.

Is there a service like that in the armed forces? If not, don't you think that one should be started?

● (1605)

[*English*]

Dr. Don Richardson: The first part I think you're touching on is the issue of the stigma of mental illness. The observation, especially in the military culture, which is a macho culture, adds another variable to the difficulty in seeking treatment. Part of the culture of the military is to be strong and to help others. To then admit you have a problem and that somebody has to help you is obviously a very big issue.

I think that is part of the challenge. On the civilian side it is very difficult for people to admit they have depression; for the military, which is predominantly male, it's more difficult. I think you're bringing up a good point there.

With respect to the issue of the employee assistance program, which I think you brought up, most of them have that.

Mrs. Lise Zarac: When you say most of them, who wouldn't have it?

Dr. Don Richardson: Pardon me?

Mrs. Lise Zarac: You said most of them would have it, so who wouldn't have it?

Dr. Don Richardson: A lot of the companies have it, especially people working for the federal government.

Mrs. Lise Zarac: Okay, but I'm talking about the forces. Do they have it in the forces?

Dr. Don Richardson: That's a good question. The veterans have a 1-800 number they can call, and I think it's the same number for—

Mrs. Lise Zarac: What's the service behind that?

Dr. Don Richardson: They will see a therapist. It's for short-term therapy for identifying issues and problems. If it turns out the person will need longer-term treatment, then part of it is to refer them.

Mrs. Lise Zarac: Is it strictly confidential, though?

Dr. Don Richardson: Is it strictly confidential in what way?

Mrs. Lise Zarac: Can he go and get the service without any of his colleagues—other soldiers—knowing?

Dr. Don Richardson: That's a good question. You'd probably need to ask somebody from Veterans Affairs specifically, a person who administers that program. I would assume it's confidential in the sense that there is usually confidentiality when you see a clinician.

Mrs. Lise Zarac: But you don't know exactly. Would you think this would help to identify more cases?

Dr. Don Richardson: I think it may help; however, if they see their family doctor, that would be confidential too. It would be confidential in the same way.

Mrs. Lise Zarac: Would you admit that a family doctor...? We had witnesses come here and say that a family doctor doesn't have the knowledge because he doesn't understand the problem this soldier is going through. We've been told it takes from two years to four years of training to understand and to be able to help a veteran in this situation, so I don't think a regular family doctor would be able to help a veteran. What do you think?

Dr. Don Richardson: I don't know about two to four years. I think it is helpful if you have somebody who is caring and understanding. They may not understand the entire culture of the military, but they are able to screen and know what resources are available. That one person will not necessarily be able to help everybody, but that person would be somebody you're working with who would know what resources are available to you to get treatment.

● (1610)

The Chair: Okay. Thank you for that. We have to move on.

The next questioner is Mr. Mayes, and then we will go over to Mr. André.

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

One of the things we're studying is the occurrence of veterans' suicide. Specifically, I think we know the stress issue is out there, but stress doesn't necessarily lead to suicide. We're trying to determine if there's a higher risk of suicide to Canadian Forces personnel or veterans who have come out of the Canadian Forces. We've had Canadian Forces witnesses who have said they have found no indication that there's a higher risk of suicide for those who have been engaged in combat than for any other veteran who's serving in the forces. I think out of the 10 that they indicated last year, or 2008-2009, there wasn't one that was related to combat.

Stress is a very difficult thing to identify and track. It's difficult to know what the outcomes of stress are going to be. I was just wondering about a statistic out of the U.K. that suggests that if a person is discharged from the forces under the age of 25, there's a higher risk of suffering suicidal tendencies than for those who maybe go longer in their career in the forces. Could you comment? Do you think that statistic is a true tendency?

Dr. Don Richardson: I'd have to review the exact study you're talking about. I probably have heard the same stats from the Canadian Forces, because they presented recently at the symposium in Kingston. The data they have indicate that the rate of suicide in currently serving members has not changed, meaning that it hasn't gone up with recent deployments, in contrast to what has been presented in the U.S., where the rates of post-deployment suicide were higher.

Considering that we're all probably genetically similar, it's hard to read what the statistics or the research is showing. There are significant studies and research demonstrating that people who have depression have higher rates of suicidal ideation, or thoughts of suicide, and have increased risk of suicide, meaning completed suicides or suicide attempts. Then there was a study done in the U.S. indicating that just having PTSD symptoms increases your risk of suicidal ideation, so that for each additional symptom, you have more suicidal thoughts.

The challenge for us is that those who have more severe symptoms of PTSD or depression may have been released and are now civilian veterans. They would not be recorded in the data captured by National Defence, because they're no longer serving. What we don't have in Canada yet are stats specifically on that veteran population, meaning those who are released and are now considered civilians. Having those data, I think, would be very helpful.

Mr. Colin Mayes: How much work has been completed in profiling high-risk individuals in terms of their personal characteristics or tendencies, their family background, their status as either married or divorced, and different issues like that? Has there been a lot of work done on that, and are there any conclusions that can be drawn from those who are potentially at higher risk than others because of their personal profiles?

● (1615)

Dr. Don Richardson: I think there's been sufficient research done on that, and I can probably get you or the committee some comprehensive studies that specifically examine the area of the risk factors for suicide. I'm not aware of specific risk factors for suicide in veterans. They are a distinct group, and I'll probably have to look at that specifically.

The Chair: Okay, we have to move on.

Go ahead, Monsieur André.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good afternoon, Dr. Richardson, I am glad that you are here with us.

I have a very specific question. How long is it between the time a soldier or a veteran contacts you—asks for your specialist help—and the appointment with you? Of course, he has to have a medical referral. On average, how long does he have to wait?

[*English*]

Dr. Don Richardson: For that, you could probably contact our clinic and the network of clinics to get the specific number of weeks, but you're probably looking at waiting six to eight weeks to see a specialist like me, and sometimes longer. Because we work within a team, if somebody is at a higher risk, then the wait list is modified.

[*Translation*]

Mr. Guy André: We know that the longer we wait to provide services to a person suffering from post-traumatic stress, the worse the person gets. That is a concern for us. Sometimes, for example, there can also be problems like drug addiction or relationship breakdown. There are certainly other consequences.

In terms of the assessment, the screening for cases of post-traumatic stress, could you tell the committee what you would recommend so that people in a difficult situation or in distress could get services more quickly?

[*English*]

Dr. Don Richardson: With respect to accessing services, the Government of Ontario came up with a paper. I think it was called "All doors are open" or "No doors are closed". It has something to do with the analogy that wherever you access service, the answer should not be no, but that we will take you on and help direct you to where you need to go to be able to access service. It's like a self-referral, meaning that if you go somewhere, it's up to the organization to do the paperwork in the background. Much in the same way as when you go to emergency, you're able to see somebody, but once you give your health card, somebody in the background determines who's going to be paying.

If a veteran goes to emergency because he or she is in crisis, the emergency departments are not necessarily trained, and they don't think of asking if you're a veteran. If you are a veteran, you may be entitled to other services that other people may not have, and maybe you could then be referred to specific clinics, such as OSI clinics. Can a veteran go into a local OSI clinic, for example, and self-refer, meaning come in, be screened, and then have the intake person do the paperwork in the background, asking if you're a veteran and if you're eligible, and if not, whether they can refer you somewhere else?

Those are all aspects of getting somebody into treatment right away. Another aspect is promoting better shared care, which a lot of the time means seeing a specialist. If the family doctor can take on some of the initial work so that we're working in collaboration, then that frees up more time for specialists.

● (1620)

[*Translation*]

Mr. Guy André: Could…

[*English*]

The Chair: Please make it a very short question, Mr. André.

[*Translation*]

Mr. Guy André: …more training be provided to psychiatrists and psychologists in Quebec and in Canada so that there is a faster response for people experiencing problems with post-traumatic stress.

I was involved in social work for a number of years. I represent the constituency of Berthier—Maskinongé and I am sure that, in the entire Mauricie region, few people are trained to handle former soldiers, veterans dealing with problems like that. I feel that the Department of Veterans Affairs should invest significantly in training a minimum number of people in each of the regions of Quebec and Canada. That could then ensure that a basic response is available. At the moment, no such training exists.

[*English*]

Dr. Don Richardson: I would agree in terms of working with the current national associations. Part of the mandate of the National Centre for Operational Stress Injuries at Ste. Anne's Hospital is to work with the Canadian Psychiatric Association, because they also have a mandate to provide education. We look at how we can partner with them so that when we have an annual meeting with psychiatrists, there are specific symposiums and education sessions about veterans' issues. It's the same thing for psychology.

I've been involved with veterans' files for one of the journals of family medicine, providing continuing medical education through papers that family physicians can read to sensitize them to veterans' issues, and I've been working with the Canadian Network for Mood and Anxiety Treatments. There too I've been providing education to specialists about how to treat PTSD and comorbidity. Educating and sensitizing and getting a network of individuals is key, for sure.

The Chair: Thank you.

I would advise committee members to glance this way every once in a while when it's getting close to the end of five minutes, because we do go overboard sometimes. I don't want to interject, but I might have to do that from now on. I don't like to be taken advantage of.

We'll go to Mr. Kerr.

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

What we are learning the more we go along with this process is that there isn't an easy fix or an easy answer, but it seems that as time goes on, a lot of advancements have been made. Every year there seems to be some improvement, although there is a long way to go.

We've heard the American comparison more than any other. You hear from them a couple of things that are very different. One is about their long history of active combat. Therefore, it's expected that there will be more incidence and higher statistics.

The other thing that's been pointed out strongly on occasion, and it's not a full answer, is that the Americans don't have universal access to medical care. A lot of vets here do have some advantage in getting into a referral process.

I'll stop there for the first question. Do you see that as an advantage in the Canadian system?

Dr. Don Richardson: That's probably an advantage, and it has been discussed among clinicians. If you're a veteran here, you are a citizen of Canada, and you have access to health care. I would assume there are many veterans—although we don't know—who are seeking and accessing treatment but are not identified or having their treatment paid for directly by Veterans Affairs. In the U.S., my understanding is that to be in their health system with the Department of Veterans Affairs, they would have to have a service-related pension entitlement.

● (1625)

Mr. Greg Kerr: Therefore, it's hard to make the comparison as to the end result, because they're different in that regard.

I would like to follow up on something. You mentioned, as others have, the collaborative team approach for recognition during initial training. We've heard from witnesses that it has certainly advanced over where it was a long time ago. In early detection, of course, the military has made huge adjustments in very recent times, and of course it has been done in collaboration with Veterans Affairs.

I'm wondering and concerned about those in the gap period, before we made those advancements, who are perhaps still out there in the public. Are you finding that you're getting referrals from others, or, as you said, are people who have been veterans for a few years—they're still modern vets—entering the clinic themselves? Are people coming in who maybe didn't have the kind of process there is in DND today?

Dr. Don Richardson: I think so. We're getting a significant number of veterans who have been out for more than 10 years. We also get World War II vets, still, and Korean veterans who are seeking treatment for the first time.

In our experience at Parkwood, what has helped is to have a media announcement or some sort of presentation. Then the people are aware that there are services available, especially if they're not at all connected.

People from the peer support program, which you have probably heard about or which has been talked about, are very good ambassadors for our clinic. The ambassadors may know somebody who knows somebody else, and then they are able to tell the veterans that there are services available for them.

The Chair: You have one minute.

Mr. Greg Kerr: Thank you.

On that reference—and we have heard that it's better—there have been a number of symposiums, clinics, and conferences of late, and one of the things that seems to stand out is the stigma issue versus public education.

You talked about the social dynamic within the military. Do you find there's a better understanding in the public and a better reception from the military itself in terms of accepting the fact that mental health is a real problem and has to be dealt with? Do you find the public is more receptive, or is the stigma still a huge problem?

Dr. Don Richardson: Well, I think that for more than 10 years the stigma has been decreasing and I think that the public in general is more supportive. There have been a lot of good public anti-stigma campaigns, so I think it is starting to inch away at it.

I think it's still there. I think it was discussed already that as much as we have it in the public forum, it's still on the individual. If they feel that what they have is a sign of weakness, they may not take the next step and seek treatment.

The Chair: Just before we finish, I know Mr. Stoffer said he had one small question.

I will allow you one small question, sir.

Mr. Peter Stoffer: Thank you, sir.

I know with patient confidentiality you have to be very careful with what leaves the room, but if you notice someone who could be quite violent, either to themselves or their families, what happens in that case? Do you advise any authorities? Do you tell police? What happens in that case in order to protect the interests of the family?

Dr. Don Richardson: I think that in those cases we have an obligation if somebody is acutely suicidal or acutely homicidal. As a psychiatrist, part of my role is that I may have to certify them, meaning I can contact the police and have them assessed and hospitalized against their will.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you very much. I do appreciate your answers and your expertise here today.

We're going to take a short recess so that our next witness can come on.

● _____ (Pause) _____

●

● (1635)

The Chair: We now welcome Linda Lagimonière.

Before we go to your remarks and then our questions, I must mention that we will need to go in camera at about 20 past the hour. We have a short matter of committee business to deal with.

Please make your presentation, Madame.

[*Translation*]

Ms. Linda Lagimonière (As an Individual): Good afternoon. My name is Linda Lagimonière and I am the mother of Private Frédéric Couture. Frédéric had an accident on December 16, 2006. He stepped on a mine. He was then sent home. The army looked after that. I have to say that, when he came back, it was quite the scene. There were soldiers everywhere. They took Frédéric to the Montreal General Hospital, not to Quebec City. That was a first for the army. Frédéric then spent eight months at home. On November 14, 2007, Frédéric committed suicide. He died in my arms. That is very hard, I can tell you.

A little less than a year later, a commission of inquiry was held. That is when I found out that Frédéric had tried to kill himself over there. The army never told us that. We also found out that he had never received any psychological help, except for a 15-minute session with a 20-year-old psychologist who was just starting out in the profession. Physically, Frédéric received the best care possible. Psychologically, he received none.

[*English*]

The Chair: That was your presentation.

[*Translation*]

Ms. Linda Lagimonière: Yes.

[*English*]

The Chair: Okay. Thank you.

Go ahead, Ms. Duncan, please.

Ms. Kirsty Duncan: Thank you, Chair.

Thank you, Madame, so much for coming. I'd like to hear you talk. What would have helped your son, and what would have helped your family? You can give as many recommendations as you want.

● (1640)

[*Translation*]

Ms. Linda Lagimonière: If I had not gone to the inquiry, I would never have found out that my son had tried to kill himself. I would like to have been informed that Frédéric had tried to kill himself before. If I had known, my approach would have been completely different. I would have probably demanded that he be provided with a lot more care than he got. That is one of my main recommendations.

Does that answer your question?

[*English*]

Ms. Kirsty Duncan: Yes.

You heard the previous testimony. Knowing what your family has been through, so this doesn't happen to other families, what support would you like Veterans Affairs to give families?

[*Translation*]

Ms. Linda Lagimonière: Do you mean the families or the soldiers themselves?

[*English*]

Ms. Kirsty Duncan: Both.

[*Translation*]

Ms. Linda Lagimonière: Soldiers receive preparation in order to go over there. I went to Afghanistan two weeks ago. I realized that we are all traumatized to different degrees. My feeling is that the first stage of the trauma soldiers go through happens when they come back. Our families ought to be made aware of that. When soldiers are wounded over there, someone has to look after them immediately, not only physically, but mentally too.

In my son's case, the only care he got was physical. They gave him the best care possible, except psychologically.

[*English*]

Ms. Kirsty Duncan: What mental health care would you have liked him to have?

[*Translation*]

Ms. Linda Lagimonière: First, he was going through two traumas. There was the trauma of going there and the trauma of having lost a limb. There was also the fact that he had to have more operations. If he had been able to see a psychologist right away, I feel that it would have changed things considerably.

[*English*]

Ms. Kirsty Duncan: He was only seen once by a psychologist, for 15 minutes? That was it?

[*Translation*]

Ms. Linda Lagimonière: It happened five months after he came back; it took 15 minutes, at home, at my home. I was there. I couldn't get over it. I did not understand why it was like that. I told myself that surely he needed more help. But Frédéric was a soldier. He did not talk about it because he saw it as weakness. He did not want to show weakness because he was a soldier.

[*English*]

Ms. Kirsty Duncan: Do you think we could do a better job of making it okay for our soldiers to talk? Maybe if people who've been awarded medals speak out, it will help save lives. What do you think we could do differently to make it easier for our soldiers to speak out?

[*Translation*]

Ms. Linda Lagimonière: I think they need to call on someone with whom they went over. There are a lot of soldiers who go over. Take someone from their group whom they trust completely to make the approach.

When they come back from Afghanistan, they spend a week in Cyprus, I think. They could see them when they get to Cyprus; that could be the first time. Then they could also see them three months later, not wait until the soldier goes to see them. That should be the normal procedure, just like the procedure that prepares them to go over.

[*English*]

Ms. Kirsty Duncan: He was being treated by doctors for, I think, eight months for the physical wounds. This was a young man who had to adjust to a terrible physical injury. Did no one among those doctors who were treating him follow up to see how he was doing mentally?

[*Translation*]

Ms. Linda Lagimonière: No, because Frédéric was the first soldier to come back from Afghanistan, in the Montreal region, at least. We did not understand why Frédéric was not transferred straight to Valcartier because that is where he lived. But they took him to Montreal saying that he would be close to his family. But that was no reason, in my opinion. He needed to be surrounded by soldiers because the military was his life. There was no reason to put him back in the civilian world, but that is where he was treated.

● (1645)

[*English*]

Ms. Kirsty Duncan: Would it have been helpful to him, do you think, to have his family nearby? Should we be making it easier for the families to be near the soldiers when they come home?

[*Translation*]

Ms. Linda Lagimonière: Yes, that would be good, but it would also be good to have his buddies by his side, because that was his life.

[*English*]

Ms. Kirsty Duncan: It would be good to have both.

[*Translation*]

Ms. Linda Lagimonière: Yes, yes, that is true.

[*English*]

The Chair: Go ahead, Mr. Vincent.

[*Translation*]

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

Could you explain what happened in Afghanistan? You said that something happened. For the benefit of the people here, could you tell us what happened, starting from the moment he stepped on the mine. What happened then? What are the circumstances of the accident?

Ms. Linda Lagimonière: Frédéric showed me…It was posed on YouTube. I did not know that Frédéric had tried to kill himself, because there was no sound.

Mr. Robert Vincent: Where did he try to kill himself?

Ms. Linda Lagimonière: When he stepped on the mine, a few minutes after stepping on the mine. In the YouTube video, when you hear "no, no, no", it's because Frédéric had taken his weapon, but it jammed and did not fire. Otherwise, he would have killed himself.

Mr. Robert Vincent: There on patrol, right where he was wounded? He first tried to kill himself right on the battlefield, when the mine went off and injured his foot, but his weapon jammed? Do I have that right?

Ms. Linda Lagimonière: Yes, that's it exactly.

Mr. Robert Vincent: How long afterwards did you find that out?

Ms. Linda Lagimonière: A year.

Mr. Robert Vincent: At that time, no one from the Canadian Forces told you that your son had tried to kill himself right on the battlefield?

Ms. Linda Lagimonière: No. When I found out later, I was so mad. I could not believe that the army did not tell us such a vital piece of information. It was completely beyond me.

I feel that, as parents, we have the right to know that our son has tried to kill himself.

Mr. Robert Vincent: Do you think that, if you had been told right away, it would have changed anything? Would you have handled things differently when he came home from Afghanistan, if you had known that he had tried to kill himself?

Ms. Linda Lagimonière: It would have totally changed things. If I had known, I would have asked for a psychologist's help right away. I never saw a psychologist. Even when we went to the hospital, I never saw a psychologist.

Mr. Robert Vincent: As soon as your son came back from Afghanistan, the Canadian Forces never tried to direct him to a psychologist for treatment and to find out if he still had suicidal thoughts?

Ms. Linda Lagimonière: No. In the army, suicide is a taboo subject. I feel they wanted to keep it quiet.

Mr. Robert Vincent: You would never have found it out if the inquiry had not taken place and if, a year later, you had not asked to see the report from the inquiry.

Ms. Linda Lagimonière: No. Actually, I did not even know that an inquiry is held after an accident. I found that out when they called me, and I was very surprised. Being curious by nature, I asked to be part of it. The army was surprised at that. I met a lot of people, and it was during a series of questions that I found out that my son had tried to kill himself.

Mr. Robert Vincent: Do you have a recommendation for this committee to prevent a similar situation from happening again?

Ms. Linda Lagimonière: I would say that a person involved in an accident must see a psychologist immediately. Someone who is wounded is already traumatized. The family must also be told. Even if the soldier is not suicidal, he must share things with his family.

Mr. Robert Vincent: If I understand the crux of your testimony correctly, he got appropriate care for his physical injuries, but, for the psychological ones, the care lasted 15 minutes. Do you feel that the person whom he met with was competent?

● (1650)

Ms. Linda Lagimonière: I am not...

Mr. Robert Vincent: You were there.

Ms. Linda Lagimonière: Yes, but who am I to judge the person? She has the training.

Mr. Robert Vincent: Yes, but in 15 minutes…

Ms. Linda Lagimonière: Personally, I would say not. She was his age. She couldn't understand the military context because she was a civilian.

Mr. Robert Vincent: What was his relationship with the other members of his unit? Was there a pact with other members of the unit, say if someone was not going to come back "in one piece"?

Ms. Linda Lagimonière: I think that people often say that it's easier… I've spoken to other military members. When I went, I spoke to some of them. They say that it is easier to come home in a box—because their problems will be over—than to return to Canada and be a burden to the army.

Mr. Robert Vincent: Do you think making suicide pacts is common practice for Canadian Armed Forces members who do not want to come back if they aren't in one piece?

Ms. Linda Lagimonière: I'm convinced of it. They even say it: they want to come back in one piece, not injured.

Mr. Robert Vincent: Okay.

I feel that this is what the committee needs to look into. First, we need to know what happens when soldiers are on active duty. Do soldiers make suicide pacts in case they don't make it out in one piece? If this is the case, and especially if there is a suicide attempt during deployment, it seems to me that there should be medical follow-up.

What do you think?

Ms. Linda Lagimonière: In my case, in 2006, there wasn't any. When I went there recently, they showed us the field hospital. It is completely different. When Frédéric stepped on the mine, he was taken to a tent. Now, it's an ultra-modern hospital.

[*English*]

The Chair: Go ahead, Mr. Stoffer.

Mr. Peter Stoffer: Thank you, Mr. Chairman. Madame, thank you very much for coming here. I know that the courage you show in going public with what happened with your son is very much appreciated.

When did your son pass away, again? What year was it?

[*Translation*]

Ms. Linda Lagimonière: In 2006.

[*English*]

Mr. Peter Stoffer: Am I correct that you said there was an inquiry after that?

[*Translation*]

Ms. Linda Lagimonière: One year later.

[*English*]

Mr. Peter Stoffer: It was one year later. Okay. How long did that inquiry take?

[*Translation*]

Ms. Linda Lagimonière: It was supposed to take three months, but ended up taking six. It started at the beginning of December and ended in May or June.

[*English*]

Mr. Peter Stoffer: That was June of 2007, correct?

[*Translation*]

Ms. Linda Lagimonière: Yes, in 2007. No, Frédéric died in 2007. It was the next year, in 2008.

[*English*]

Mr. Peter Stoffer: Were you given a copy of the report? Were you allowed to speak to senior levels of the military to discuss the concerns that were expressed in that inquiry?

[*Translation*]

Ms. Linda Lagimonière: I don't understand your question.

[*English*]

Mr. Peter Stoffer: When the inquiry came out, they obviously wrote a report. Were you able to then speak to senior levels of the military to discuss the report?

[*Translation*]

Ms. Linda Lagimonière: No report was given. They simply made a few recommendations and told us that the report was in Ottawa.

[*English*]

Mr. Peter Stoffer: You were never given a copy of the report?

[*Translation*]

Ms. Linda Lagimonière: No.

[*English*]

Mr. Peter Stoffer: Mr. Chairman, I'll pause for a second and recommend to the committee, if it's at all possible, that she get a copy of that report. If there is a documented report of the inquiry, I believe the family should have a copy. It shows that what happened to Sheila Fynes' son in the barracks in Edmonton is not an isolated case.

This is the second time in less than two months that we have heard testimony from a mother of a soldier who committed suicide that they were not told that their son had attempted suicide in the past. I know that happened a few years ago, and we heard testimony from the officers here the other day about what they're doing, but it would be very helpful if we could send Linda's testimony to those two officers and ask them what is being done now to make sure this never happens again.

They made it sound as if this can't happen, and I want to be absolutely sure that Linda's testimony is taken into consideration so that no other family has to go through that again.

I think it would be helpful, Mr. Chairman, one, for her to get a copy of any written report that was done, and two, to be assured, from the testimony of the two officers before, that they get a copy of the blues here, so that they can comment and say, "Yes, these mistakes may have happened, but they will not happen again". That's just so we can be assured of moving forward.

I'll stop right there.

● (1655)

The Chair: Go ahead, Mr. Mayes.

Mr. Colin Mayes: I don't want to disagree with you, Mr. Stoffer, but the issue might be medical confidentiality. It doesn't matter if it's a mother; if you're an adult above the age of 21, that is your information, and it's not shared with your family. Perhaps a policy could be put in place, a recommendation that once a person is deceased, it be sent to the next of kin or benefactor or whatever.

I think that's a little bit of an issue. I don't know that for sure, but I don't think that the department would be arbitrary in not giving that information out, other than the fact that it might be confidential information.

[*Translation*]

Ms. Linda Lagimonière: I would just like to make a comment.

Deployed military members have provided the name of someone. For example, Frédéric gave my name in case something happened to him. But that's where doctor-patient confidentiality enters the picture. But he named me. So, the information shouldn't be so confidential. The armed forces ask for it. It should be much more open.

[*English*]

Mr. Colin Mayes: I agree with that statement.

The Chair: Thank you.

Mr. Mayes, did you...?

Mr. Colin Mayes: I didn't ask to be. No.

The Chair: Okay.

Mr. Storseth is next.

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you, Mr. Chairman.

Ms. Lagimonière, thank you for coming. I know this must be tremendously difficult. Thank you for the sacrifice and the dedication that your family and you have shown to our country.

I come from a riding that has two military bases. We've deployed a lot of men and women all over the world, and much of what you said absolutely hits home. It's important that people like you stand up and support our men and women.

What we are trying to do here—and everybody in this committee is on the same page—is bring witnesses like you or the people who have come before you and put recommendations forward so that we can fix some of the problems that have been created.

Did anybody sit with you after your son came back from deployment and tell you of the warning signs that you should know about? Were you made aware of anything to be looking out for?

[*Translation*]

Ms. Linda Lagimonière: Not at all.

[*English*]

Mr. Brian Storseth: There was nothing.

You said your son had a 15-minute interview when he first came back. That was it? There were no more meetings with mental health professionals?

[*Translation*]

Ms. Linda Lagimonière: He might have at the rehabilitation centre, but we were never told about it. That's the only thing I might wonder about, but still, I think Frédéric would have talked about it. We asked him what kind of people or doctors he saw, but he never mentioned a psychologist.

[*English*]

Mr. Brian Storseth: You also mentioned the lack of mental preparation before your son left on deployment. You said that all soldiers who leave on deployment have a lack of mental preparation for what they'll face when they get over there. What do you think about the need for families to have some sort of education on mental health issues, so that they're aware of what it's going to be like coming home at the end of the deployment? Was there such a thing in place at that time, and do you agree with that?

● (1700)

[*Translation*]

Ms. Linda Lagimonière: No, because where we live, we are a long way from the services in Quebec City. Frédéric was from Quebec City. But one month after he left, I think, we were sent information in the mail. Otherwise, no one from the armed forces ever came to the house to tell us how to act with Frédéric, who was suffering from post-traumatic stress. We were never given any information.

[*English*]

Mr. Brian Storseth: One of the other questions that arose from your testimony was how much he needed to be around his comrades.

One of the things that has come before our committee has to do with dealing with Veterans Affairs or bureaucrats in DND. After the military members come home injured, they often feel frustration with bureaucrats. Do you think it would be beneficial to have more people in the bureaucracy who understood the mentality of the men and women in the Canadian Forces and who would be a bit more understanding of the things they have experienced?

[*Translation*]

Ms. Linda Lagimonière: Yes, absolutely. I find it unfortunate that I had to go on TV to tell our story. But I'm convinced that I'm not the only mother who has gone through this. I would have liked that information, even though my son died.

[*English*]

Mr. Brian Storseth: I agree. I've talked to many mothers who feel the same way you do.

One of the things you mentioned is that our men and women in the Canadian Forces are Type A personalities. They're very bold. There's an attitude, a stigma, attached to coming forward with a mental health injury. It was very much looked down upon over the last 20 years. You mentioned that stigma yourself.

In the research you've done since your son's death, do you feel the education is getting better? Do you feel the military is moving in the right direction when it comes to their new rollout of mental health education?

[*Translation*]

Ms. Linda Lagimonière: I think so, yes. Frédéric's best friend is on his third deployment. He told us that there is some post-traumatic stress. If we were to rate it, it would be the most serious. But he had the opportunity to share those things with us. He understands that, as parents of a soldier, we know what his family might be going through. In fact, he probably wouldn't even tell them, but he knows other parents who have had this experience. As you said, soldiers are tough guys, for sure. They must not show any weakness. I think that they'll all end up cracking if they experience this stress.

[*English*]

Mr. Brian Storseth: Indeed it takes great strength to be able to talk about some of the things they've gone through and to come forward with that.

My last question for you—and I do want to thank you again for coming forward—is of all of the changes you have seen the Department of National Defence or Veterans Affairs make since your son's death, from your perspective as a mother, is there one that sticks out as being the most important?

[*Translation*]

Ms. Linda Lagimonière: Do you mean a change that has been made or one that hasn't?

[*English*]

Mr. Brian Storseth: Either.

[*Translation*]

Ms. Linda Lagimonière: The change that hasn't been made concerns post-traumatic stress. They need more psychologists. No one talks about that. But when they return to Cyprus, the soldiers undergo a decompression process. They have writing to do. I think that's good.

[*English*]

Mr. Brian Storseth: Thank you.

[*Translation*]

Ms. Linda Lagimonière: You're welcome.

● (1705)

[*English*]

The Chair: Go ahead, Madame Zarac.

[*Translation*]

Mrs. Lise Zarac: Good afternoon, Ms. Lagiomonière. Thank you for being here today.

I'd like to go back to the suicide pact that was made. When did you hear about it?

Ms. Linda Lagimonière: It was in one of the letters that Frédéric wrote. He wrote many.

Mrs. Lise Zarac: Who was the letter addressed to?

Ms. Linda Lagimonière: To everyone. At the start of the letter, he had written "To everyone". We were given the letters. People from the military came to the house and we gave it to them. We asked them what should be done about it. It wasn't clear. The end of the letter indicated that there might have been a pact.

Mrs. Lise Zarac: Can you tell us what exactly this pact consisted of?

Ms. Linda Lagimonière: He said that if he didn't come back with all his limbs, he was going to kill himself.

Mrs. Lise Zarac: People in the army saw this letter? They knew about it?

Ms. Linda Lagimonière: Yes. We told them about it right away. We all said that something absolutely had to be done.

Mrs. Lise Zarac: You must have asked them about this. What was their response? Is it something they are aware of, that happens regularly?

Ms. Linda Lagimonière: They said absolutely nothing, except that they were going to look into it.

Mrs. Lise Zarac: You said earlier that you took part in an inquiry following your son's suicide. Do you know if army people tried to contact the soldiers who were in the same group as Frédéric, to find out what the pact consisted of and if other soldiers might be in danger?

Ms. Linda Lagimonière: They told me when the inquiry started that that was the purpose of it.

Mrs. Lise Zarac: That was the purpose of the inquiry.

Ms. Linda Lagimonière: Things changed along the way. At one point, I found out that Frédéric had tried to commit suicide there. At the start, the process was supposed to take three months. In the end, it lasted six, and 54 people appeared.

Mrs. Lise Zarac: Were his fellow soldiers questioned as well?

Ms. Linda Lagimonière: His fellow soldiers, psychologists…

Mrs. Lise Zarac: Do you know if they managed to find out who was part of the pact?

Ms. Linda Lagimonière: They tried, but in the army, no one will talk.

Mrs. Lise Zarac: We've also talked a lot about preparation. Do you know if, in preparing the soldiers before their deployment to Afghanistan, they were told about the possibility that they might come home with one less limb? They need to be aware of this possibility and be pretty strong to come back and accept it. Do you know if this was part of their training?

Ms. Linda Lagimonière: I think so; at least, ever since my son's death.

Mrs. Lise Zarac: I believe you said that you would have acted differently had you been aware of the pact's existence. Does the military provide adequate training to family members?

Ms. Linda Lagimonière: To be honest, we did not get any kind of training. Even since Frédéric's death, no follow up is made, not in the regions, in any case.

Mrs. Lise Zarac: Furthermore, I find it odd that, as a Quebec City resident, he was taken to Montreal General Hospital. He should have been taken to Valcartier.

What reason did they give for doing that? Why did they transfer him to Montreal General Hospital?

Ms. Linda Lagimonière: They told us that Frédéric had asked to be taken there, but you can just imagine what my son was going through. The drugs were affecting him a great deal, he had lost a leg and he was in rough shape. I believe the decision was made by military authorities. We were living in the Eastern Townships, so they likely thought Montreal was closer.

Mrs. Lise Zarac: Did the reason for moving him to Montreal General Hospital ever come up during the course of the inquiry? Did the question as to whether he received the help he needed ever arise? As you stated, Montreal General Hospital does not have any specialists who work specifically with soldiers who have experienced trauma. This type of support is more often provided to soldiers at Valcartier. Was this ever an issue during the inquiry?

Ms. Linda Lagimonière: The inquiry concluded that Frédéric had never received any psychological counselling.

Mrs. Lise Zarac: If you could change anything, Ms. Lagimonière, what recommendations would you make to the military? We do not want to see other mothers come here to testify for the same reasons that you have. In your opinion, what needs to change in order for this to never happen again?

Ms. Linda Lagimonière: I wouldn't use the word “change”, but rather “improve”. As I said earlier, the military trains soldiers for duty. I will say that soldiers are well trained. I saw soldiers boarding the plane who were ready and highly motivated. Maybe their parents need to be prepared and told that if ever something were to happen to their son, daughter or spouse, they should be prepared to be traumatized. Providing help in the larger regions is important, but the smaller regions should not be forgotten either.

● (1710)

[*English*]

The Chair: Thank you.

Mr. Storseth is next, and then Mr. André.

Mr. Brian Storseth: I just want to touch upon a few things, because I find this exceedingly interesting.

You talk about our soldiers before deployment and then after deployment. I've been there in both situations. I've been there when our men and women were being deployed, and you're right that they're very strong. I've also been there many times on the ramps when they've come home. They're still very strong, but there's definitely a change in their eyes and personalities. It's something you are acutely aware of.

In a way I have to say this to the side, but I'm always struck by the ages of these men and women going to Afghanistan and other places in the world to protect the values and freedoms of this country. It's inspiring, but at the same time you also think about yourself when you were that age, and how susceptible they are to different kinds of mental health problems when they endure something like that. It's the same thing we heard from World War II veterans about when they were in combat. I think it is very important.

Mr. Stoffer and Mr. Mayes also had a little discussion that is critically important. It was about personal privacy versus general health care and best practices for our military men and women. I assume you're of the opinion that it would be best for you, as the mother, to know if there's a serious risk to your child when he comes home. I want to get it on the record.

Ms. Linda Lagimonière: *Oui.*

Mr. Brian Storseth: Even that much French I can get.

[*Translation*]

Ms. Linda Lagimonière: It's not that I would want to know about his personal life, but if he were to have an accident, we would want to be informed, to be better able to help him. I'm not interested in knowing who he is sleeping with. At the very least, I would want to know if he needs some psychological help. If so, we would be there for him and could get him the help he needs.

[*English*]

Mr. Brian Storseth: Absolutely.

I want to talk about your son Frédéric's friend. Would you say that he has had better care since he's come home than your son did?

[*Translation*]

Ms. Linda Lagimonière: Yes.

[*English*]

Mr. Brian Storseth: Has it been substantially better? You're indicating yes, so you believe that things are generally going in the right direction, but there are still some things we need to work on.

[*Translation*]

Ms. Linda Lagimonière: Exactly.

[*English*]

Mr. Brian Storseth: Good.

One of the things you talked about—and I understand this because I'm from a rural area—is that you live some distance from the base, the deployment. This would be a different question for somebody who has a wife and children on the base.

Where would you suggest is the best place for a family such as yours to get some kind of group therapy or education before or during your son's deployment? Would you react better to having somebody come to your home or to having a type of group therapy? Would you rather go to the MFRC or somewhere on the base with other military families? I think we both agreed today that there should be something there for families.

[*Translation*]

Ms. Linda Lagimonière: The most important thing, to my mind, would be to visit the base to learn some coping mechanisms and, at the same time, to meet with other parents.

Does that answer your question?

[*English*]

Mr. Brian Storseth: Absolutely. I realize that each case is different, but I would like your opinion on the record when it comes to that.

That's the end of my questions. Once again I want to say thank you very much for your commitment. We on all sides recognize that we need to work on this issue and ensure that it continues to improve for the young men and women who go over there. We need to make sure we're here for them as a government.

Thank you very much.

● (1715)

The Chair: Mr. André, you have five minutes.

[*Translation*]

Mr. Guy André: Thank you, Mr. Chair. Thank you for coming here, Ms. Lagimonière.

The YouTube video shows that after stepping on a landmine and losing part of his leg, he attempted suicide. Did anyone intervene? Did the inquiry find that a doctor or a specialist attempted to intervene—since his life was in danger—to have him hospitalized and removed from the theatre of operations? While he was sent to the hospital to receive treatment for his leg wound, did he receive any psychological counselling after his suicide attempt?

Ms. Linda Lagimonière: None whatsoever.

The question as to whether Frédéric had seen a psychologist came up during the inquiry. He was not seen at any time by a psychologist.

Mr. Guy André: So then, no therapy of any kind was provided.

Ms. Linda Lagimonière: That's the worst part. In my opinion, as soon as a soldier is involved in an accident, counselling should be made available to him.

Mr. Guy André: It is terrible and I am very surprised that this happened.

Had a professional met with your son, anything they discussed would have been covered by a confidentiality agreement. The military or the professional treating your son would not have been able to disclose anything to you, because of confidentiality provisions.

Ms. Linda Lagimonière: I understand that.

Mr. Guy André: But that is not what happened, as you obviously learned. He did not receive any counselling. That surprises me a great deal, because I feel that a person who attempts suicide should at least receive some psychological counselling.

So then, he came home, having lost his leg, but he didn't speak to you about it.

Ms. Linda Lagimonière: No, not at all.

Mr. Guy André: He kept everything to himself.

You said that your son was not in contact very much with the military. Would you have known if the military had had any further contacts with your son? You told us that he met with a psychologist for 15 minutes. But would you have known if he had met with anyone else at some other time?

Ms. Linda Lagimonière: In my opinion, yes.

My son was honest and would have told me if he had met with someone.

I'm such an inquisitive person that when he went to Quebec City, for example, I asked him who he met with while he was there.

If I could say one more thing, when soldiers return home, a case report is usually drafted. That didn't happen in Frédéric's case. Montreal General Hospital only received part of his medical file. It's as if Frédéric fell through the cracks. That is the expression the army uses.

Mr. Guy André: You're saying then that after he came home, he had no contact with any medical personnel.

I assume he was treated by a doctor for his leg wound.

Ms. Linda Lagimonière: Yes.

Mr. Guy André: However, he did not—

Ms. Linda Lagimonière: He did not receive any psychological counselling.

Mr. Guy André: No one called him. As far as you know, no appointment was set up. He wasn't in touch with a psychiatrist. He didn't meet with anyone for 45 minutes for an initial assessment to discuss his experience and possible course of treatment. He had no contact whatsoever with anyone.

Ms. Linda Lagimonière: Absolutely none.

This fact came to light at the inquiry. Some people were surprised to learn that he did not get any counselling.

Mr. Guy André: He went ahead and took his own life.

Ms. Linda Lagimonière: Yes.

Mr. Guy André: Were you offered any counselling after this happened?

What in fact transpired?

Ms. Linda Lagimonière: None at all.

Mr. Guy André: No offer of counselling was forthcoming and neither the military nor Veterans Affairs contacted you to find out what had happened and if there was any need for a follow up. Absolutely nothing happened. You were left completely on your own.

Ms. Linda Lagimonière: Completely on my own.

Mr. Guy André: He returned, and then it was over.

I speak for my colleagues when I say how very sorry I am that things turned out this way.

Ms. Linda Lagimonière: The important thing is to see some changes come about. More changes are needed.

These soldiers sacrifice their lives. They are young, they put their lives on the line and they believe in this mission. They are entitled, in my opinion, to receive the appropriate services when they return from their mission.

[*English*]

The Chair: Thank you.

I really appreciate your being a witness here today. I'm sure that our whole committee has received a lot of good information. Hopefully, down the way, anything that hasn't been looked at can be. Let's hope we can improve this situation.

Thanks for being a witness here today.

Voices: Hear, hear!

● (1720)

[*Translation*]

Ms. Linda Lagimonière: It was my pleasure.

May I just add that if I can help other parents...

I may have lost my son, but I have a mission to fulfill. Thank you all.

[*English*]

The Chair: Thank you.

Voices: Hear, hear!

The Chair: We will now take a short recess, but I'd like to reconvene in the next three minutes, please.

[*Proceedings continue in camera*]

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