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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 welcome everyone here today. This is the 33rd meeting of the Standing Committee on Veterans Affairs. Pursuant to Standing Order 108(2), we are studying combat stress and its consequences on the mental health of veterans and their families.

I welcome our witnesses. From the Royal Canadian Legion we have Brad White, dominion secretary, and Andrea Siew, service officer. From the Royal Canadian Mounted Police we have Murray Brown, staff relations representative, occupational health and safety.

Mr. White, you're first on the docket. I will ask you to make your presentation, followed by Mr. Brown. Then we can ask questions around the table.

Mr. Brad White (Dominion Secretary, Dominion Command, Royal Canadian Legion): Thank you, Mr. Chairman and honourable members of the committee, for your welcome.

I'd like to introduce Andrea Siew, who is with me today. Andrea is one of our service officers in the dominion command service bureau. She is a 28-year member of the Canadian Forces and a recently retired commodore. She has joined us to help with our advocacy for veterans.

On behalf of our dominion president, Patricia Varga, it's an honour to be here again today to discuss the issue of what we call "combat stress", or operational stress. For those members of the Canadian Forces who have served on operational combat missions around the world, the experience of those deployments may never end. The experience will also affect their families both during and after their deployment periods.

We've looked at a number of factors that will affect how members of the Canadian Forces will react to combat stress. You have that in the presentation before you.

We look at pre-existing vulnerabilities, which include things like age, family background, and their emotional state.

We also look at the training and the organizational environment, which includes such things as how many reservists are in the deployment. A large percentage of reservists are going out on deployments on the operational side now. You can imagine that any casualties that happen in a given deployment will certainly affect the whole psyche and structure not only of that command element but also of those people on that deployment.

Of course there is the nature of the stressors linked to deployment. They include the duration of the deployment—sometimes when Canadian Forces members deploy, they're deployed longer than what they anticipated at the beginning—the number of additional deployments, how many deployments a person goes through during his very short span, and the complexity and the exposure of those deployments. Some deployments are easy. Some deployments are not so easy.

As well, there's the multiplication effect of pre-existing comorbidity problems, such as chronic pain, depression, and things like alcohol and drugs.

Trauma directly affects how individuals define themselves. Some individuals react to trauma more than others do, for various reasons. Those more at risk are sometimes individuals with multiple and/or fragmented personalities. They may have difficulties adapting. They may have changing perceptions of not only themselves but also the world around them.

Trauma will affect soldiers differently based on gender. Female soldiers exposed to trauma will have less PTSD and fewer alcohol abuse problems, but they will most likely suffer from greater levels of depression and eating disorders. It is also likely that their trauma will be associated with increased exposure to sexual stressors, which will require a completely different type of intervention to deal with.

Traumatic effects can be minimized depending on the duration of the exposure and on the environment, such as the workload, the goals and values of the organization, the support of leaders, and group cohesion. Group cohesion is important. Exposure to stressors in early childhood will also reduce resiliency later in life. The more a person is exposed to them, the less likely it is that he is going to suffer in later years.

During deployment, exposure to warfare can be seen in different ways, based on the perceived threat and concerns about relationships that may already be fragile, especially if the deployment is of a long duration—12 months or more—and if one is subjected to multiple deployments.

Research done in the United Kingdom indicates that one should never deploy for longer than 12 months in a three-year period. I hazard to say that some of the deployments today are for a shorter timeframe than that. If you cross that threshold, the rate of PTSD doubles.

Try to take that relationship back to those who went to World War I and World War II. They were gone for four years. They never came home during the four years.

Research in mental health has established a direct link to trauma exposure, operational stress injuries, and suicidal behaviours. Those impacted see themselves as different, but not necessarily in a negative way. They do, however, see their world in negative terms. They develop a we-them relationship with civilians and sometimes with other organizations within the Canadian Forces itself, and often express hostility and contempt toward those outside agencies.

● (1535)

While they live deliberately to the full, they have to deal with a diminished self and they exhibit emotional fragility. Unfortunately, this emotional fragility draws a toll on spouses and children, who actually live the mission through our modern IT connectivity these days. For example, how many times have you heard that six NATO soldiers were killed in Afghanistan? Imagine the impact that has on the families sitting back in Canada, knowing that their people are deployed and not having any idea of what's happening. The world of media brings it closer into the home today.

Families not only live the mission through IT connectivity, but they're also directly affected by the impact of returning injured family members. The bottom line is that they're all casualties. The Canadian Forces and Veterans Affairs must take responsibility for not only the soldiers but also their families. The current status quo is no longer a choice.

It should also be recognized that there are numerous barriers to improved mental health. Some may have no interest in treatment. Some will abandon treatment after too short an intervention period. Young males may be more inclined to refuse the treatment or the intervention. Young males with major problems are often those who leave the Canadian Forces early. They are often alone—marriages have broken down—and they spiral downwards into alcohol, drugs, and homelessness. They go all the way to the bottom. They have not built up the necessary resiliency to actually deal with their conditions. For those silent sufferers, barriers to mental health must be eliminated. The leadership must continue to provide support at all levels. That's starting to change these days. It's starting to happen.

Practitioners need to establish trust. All barriers to access must be eliminated. Treatment must focus on resiliency rather than pathology. What I mean is treat the individual; don't give him a bunch of drugs. Drugs may be a necessary aspect of it, but don't just give him drugs.

Unfortunately, in the CF there is no model that provides prescriptive guidelines for intervention by either Canadian Forces or Veterans Affairs mental health practitioners. This is the norm in the United Kingdom and the United States. In Canada, Canadian Forces and Veterans Affairs mental health practitioners at both the operational stress injury and the operational trauma stress support clinics rely on informative guidelines provided by the Canadian Psychiatric Association.

Additionally, access to a single point of service for Canadian Forces members and their families remains an unattainable objective. A more cohesive approach must be found to deal with the fact that access to mental health services is dependent on the CF member coming forward, self-identifying, and asking for that treatment.

A critical issue is services for family members who are also victims of interpersonal violence. Assistance to families of reservists who come back and are back in their home environment must be improved to break down the sense of isolation. Imagine: they've been trained and deployed, they have group cohesion, they come back, they go through the decompression period, they go back to their home units, and they're isolated.

Programs that can meet the needs of children must be developed, keeping in mind that the needs of children when they're five years old will be different from their needs when they are teenagers.

Though progress has been made, from our perspective significant challenges remain. The OSI and the OTSSC clinics are not always in the right locations. More importantly, there's a profound lack of academic research in Canada on the life course of mental health issues related to Canadian Forces members. We have to rely on information that comes from the United States and elsewhere.

Even though we see the recently announced Canadian Forces cancer and mortality study as a step in the right direction, there needs to be greater coordination between the Canadian Forces and Veterans Affairs on what is needed in analyzing all life-course issues related to the mental health of Canadian Forces members, veterans, and their families.

● (1540)

I'll step back in time. In its day the Legion played a valuable role, and it still plays a very valuable role today. Back when PTSD was not a common community thing you could identify, members came back from World War I, World War II, and Korea and went to the Legion halls where they self-medicated. They closed circle with their friends and buddies they trusted. That's where they got their treatment for PTSD, or what was called “shell shock” back in those days.

We continue to be engaged in various programs, including transition programs for the homeless, such as the Cockrell House in Victoria—a very effective program—and the B.C.-Yukon transition program for those with mental health issues. This has been in place since 1998, in cooperation with both UBC and the University of Victoria. It's a very effective program for treating individuals with PTSD.

The recent Leave the Streets Behind program, which is in partnership with Veterans Affairs and centred out of Toronto, Ontario, is a model that is working well. We're starting to transport that model to our other provincial commands across the country so they can start looking at homeless programs for veterans in their communities.

There's also the Alberta-Northwest Territories command program with Outward Bound. You may have seen some of that on the CBC report *Connect with Mark Kelley.* They did a report on the Outward Bound program for people with PTSD. The Legion funds members to go on that program. It doesn't cost them a thing.

In Alberta, and particularly in Edmonton, we are supporting the Alberta military family resource centre child program for children of parents who have experienced trauma. So far we've funded eight serials of that program in Edmonton.

While it is said that we sleep to forget, one must not forget the impact of operational stress on Canadian Forces members, veterans, and families. The Government of Canada must provide support to those who served and to their families, who are now alienated through no fault of their own. The status quo is no longer a choice. If we do not become more proactive rather than reactive, we will regress.

At the bottom of the page you will see the various organizations we have consulted. The Royal Canadian Legion makes presentations such as this, and we shop it around to various organizations. The Army, Navy, and Air Force Veterans in Canada, the Canadian Naval Air Group, the National Aboriginal Veterans Association, the Royal Canadian Naval Association, the Air Force Association of Canada, the Royal Canadian Mounted Police Veterans Association, and the Company of Master Mariners all support our presentation here today.

Thank you for the time to make our presentation.

● (1545)

The Chair: Thank you, Mr. White.

Next is Mr. Brown.

S/Sgt Murray Brown (Staff Relations Representative, Occupational Health & Safety, Royal Canadian Mounted Police): It's a good day for colours, eh?

Mr. Chairman, with your patience, I would like to take this moment to acknowledge the presence of my own constituency's member of Parliament, Mr. Stoffer. I don't have to go back to our area and say that I saw him working; most of us take Peter for the good job he does.

I'd also like to acknowledge an old family friend through politics, Mr. Kerr, from Yarmouth, and also Dr. Duncan, whom I've met a couple of times. I had the pleasure of meeting Dr. Duncan at a Legion about two weeks ago during a town hall discussion.

With that, good afternoon, Mr. Chairman, committee members, and guests. I am particularly honoured to be here today on behalf of my organization, although as yet I don't speak for the commissioner. I want to acknowledge that I'm here with the presence of the Legion. I couldn't think of better company I could associate with during this presentation.

I am a senior staff sergeant with 37 years of service in the Royal Canadian Mounted Police. My duties have taken me throughout much of our country, but my primary provincial postings have been in Nova Scotia and Prince Edward Island. My service to Canadians started where most members begin their careers: in front-line, uniformed policing in the communities throughout our nation.

These duties transitioned in later years to include drug enforcement, undercover operations and covert duties, drug awareness roles in two provinces to meet the federal government mandate on the national drug strategy, and criminal intelligence within the world of organized crime, with a dedicated specialty in outlaw biker gangs.

During this service, I have also been a volunteer member for more than 10 years with a tactical weapons team in an emergency response capability. I acted in two primary roles: one as a marksman or a sniper, and the second as an assaulter, the person who is usually one of the first or second guys in the door, depending on what door we're going in. These collective duties have left some life-impacting experiences and injuries with me.

My current duties as a staff relations representative involve the well-being and safety of our members. I have had numerous responsibilities within this program, which is a non-unionized system of labour. I've been continuously elected by the members of Nova Scotia and Prince Edward Island for more than 16 years. Along with my SRR partner, I represent over 900 members in the province of Nova Scotia.

I also represent thousands of members nationally from coast to coast to coast, and I'm involved in that role through the national occupational health and safety projects. This is a role I've held for many years, and I plan to follow it into retirement as an advocate for those members and their spouses and families who continue to give but do not receive.

In the time that I am privileged to have in your presence today, I've been asked to speak about the issue of suicide among our members and about the impact on mental health and related issues I have encountered with both serving and retired members.

I am not as yet a member of the RCMP Veterans Association and therefore do not speak for them officially. However, I have been advised that our interests and theirs are very similar. I am a member of the RCMP, and in our family there are few secrets, as collectively those still in service and those out of service continue to try to help each other.

Without having prior knowledge of this appearance, earlier this week I sent out over 30 letters to some of you and to many others. In fact, this opportunity, which came out of the blue for me, is going to give us as an organization two chances to refresh your memory on a number of issues.

I come to you today to tell you that I work for an organization that knows very little about occupational stress injuries and has done less than is necessary in that area. Our veterans have been served by Veterans Affairs Canada since 1947-1948, which is about 64 years, but this organization knows little about the serving and retired members of my organization.

The RCMP and VAC should both be ashamed. We are the distant cousins of our sisters and brothers in the Canadian armed forces. That said, our collective belief in each other is very strong. We serve jointly in various capacities, both domestically and internationally. We support their cry for justice, as they do ours.

The lack of VAC understanding was so evident that several years ago we jointly created two positions to enhance education and operational efficiencies within Veterans Affairs Canada. An experienced RCMP inspector was assigned to be embedded with Veterans Affairs, and they, in turn, assigned a senior person with us. Both of those men were excellent selections.

● (1550)

It's sad to say that today that program is essentially dead. Our position of experience and operational exposure for those who work in Veterans Affairs has been replaced by a civilian member. I want you to know that this comment is not to slight our civilian members—they are as dedicated as any other employee—but the fact is that civilian members do not have the operational experiences that are necessary to convince VAC of the real world in which we serve. We failed to maintain that connection, and VAC has not replaced their representative.

Currently there are some veterans' programs that the RCMP cannot access, and I have to ask why. I've asked about this previously in rooms similar to this one. Two of these are the veterans independence program and chronic care and the transition interviews, which is the most recent. Multiple parties, including politicians, veterans' organizations, my friends to my right, and other community groups across Canada, have supported the implementation of these programs, but cannot justify the lack of our success. Around 1988, when Veterans Affairs transitioned from the old Veterans Treatment Regulations, the RCMP got benefits, albeit minimal, within the VIP program. Then VAC rewrote the regulations in 1988. They created the Veterans Health Care Regulations, and despite being one of VAC's clients, even back in 1988 the Mounties were not included in that rewrite or those regulations. How can that happen?

We—I and many others—have been to both Houses. We've been to the Senate and the House of Commons. We have spoken to many members of each over the years and have obtained letters of overwhelming support, but still there has been no action. Previous Ministers of Public Safety and other politicians in and out of power supported the RCMP in getting this coverage. However, there has been nothing to date, and there appears to be nothing on the horizon.

The reason I say that is that I wrote the Commissioner of the RCMP about two to three weeks ago and asked him if he would give me an update from his perspective. He told me he was leaving the country and would call me when he got back. Well, he's back, but I haven't received a phone call, so I assume there's nothing on the horizon. Perhaps you can now see a bit of our poor-cousin frustration.

Our friends in the Canadian Forces are currently at war, and the cost for Canadians is high. We bleed with them, as we have recently suffered our own international casualties, but these were not our first. Our members and their families are primarily deployed at home in Canada in the various communities where we live, serve, and volunteer. Our combat zone is at home, and our tolls of injured, ill, and dying accumulate silently. Two of our most recent casualties were the result of a motor vehicle accident in the west, and a young man went missing in a river in northern Canada. We searched for his body for about three weeks and were fortunate enough to recover him and bring him home.

Programs and services that you need to know about are not limited only to those two that I'm telling you about. In your packages, I've given you some space to jot in some comments about these if you choose to do so. There are about 17. I'll go through them quickly, as I know the time is precious.

First is identity. VAC needs to know more about who we are, what we do, and the nature of our service delivery. It's a sad statement of affairs that they're not even going to replace the embedded member. He was beneficial and worked with our senior management here in Ottawa to help the two-way understanding of each other.

As well, we need acknowledgment about what we are, our service deliveries, and the nature of the duties we cover. The pressures are difficult on an undercover operator or a person working on child sexual assault cases or computer sexual assault crimes. It's not like being in a trade and carrying out some external service to equipment or whatever. I don't mean to correlate that in a cheapening way to the military, because they are as technical as we are.

There are service shortfalls from Veterans Affairs. Every time I go into a VAC office across Canada, I always go to their pamphlet rack. They have one publication there that is uniquely for the RCMP. You have it in front of you. The RCMP worked with them to create that pamphlet in 2004 or 2006. This is an exact duplicate, with the exception of the content, of the Canadian armed forces blue pamphlet. Theirs is blue and their images reflect the Canadian military.

There has been one printing of this since. Now, we have over 40,000 serving and retired members of the Mounted Police. There was one post-printing of this, and they printed, I believe, 10,000 copies. They haven't even printed enough of these pamphlets for them to go individually to each of our members.

● (1555)

I'm going to refer to another one, because it's one that the members receive if they're successful in a pension claim. I only have the English version; I'm sure the French version would come in the French packages. It is to explain the outcome of the person's claim. It's not educational material in the context of picking it up.

I've been in VAC offices from coast to coast. I always leave a note or a complaint that there's no material relevant to the RCMP in their news racks. We got the force to start sending them some *Gazette* magazines and some other RCMP material, and now there are finally some posters representing the force in their offices.

When I was stationed in P.E.I., I went to some of their hearings. There was no RCMP plaque in the hearing rooms. All the regiments' plaques were around the room, but there was no recognition for the RCMP. Now, I'm not blaming anybody for that; it's just that, are we in, or are we not? I wrote the commanding officer of L Division at the time, and that could now be covered off. I've since been relocated from P.E.I.

The materials need to be expanded. I've been to a multitude of presentations; they do a thousand overheads or whatever, but you never see the colour red. In Moncton, not long ago, I said, “You have nothing in your presentation that is relevant to the RCMP. I don't even see the colour red”. The guy said, “Well, we'll put something red in there”. I've got to tell you, being in the room as the only Mountie with a number of people from Blue Cross and others, I wasn't very impressed.

This unknown person came up to me with a BlackBerry. He leaned over and showed me the Veterans Affairs website on the BlackBerry, and it had a banner that went across the top with the Mounted Police and a horse on it. I said to him, “Thank you very much, sir, but the reason you're able to show me that is that I'm talking about this now”. When you're not even acknowledged in an audience at a conference.... I told the guy I didn't care what they put in there, as long as it was red. That's the battle we're fighting. It hasn't changed a whole lot, but it has changed a bit.

In relation to the VIP, I'm not going to talk much more about that, other than to say that I don't know if it's ever made it to a minister's letter of priority. There must be already 30 volumes of memorandums to cabinet over the years on VIP and chronic care. Somebody beat me with the outcome of those discussions because, really, you have to ask yourself.... If there are 25 or 30 memorandums to cabinet on a program that everybody else in the country has, there's something missing. Maybe this is just being lost in the central parliamentary agencies. I don't know, but we're going to find out.

Transition interviews are a core VAC program. We were never entitled to those until we found out they were a core VAC program. When we did, we launched a pilot project in F Division in Saskatchewan. Saskatchewan was chosen because Veterans Affairs had resource pressures in many of the other provinces because of deployments to Afghanistan, so we chose Regina and Saskatchewan as our pilot. The pilot was carried off really well. It was reported on well, and so on. Then we said, “Where are we going from here?”, so we went to Atlantic Canada, primarily because I was on the board that was making those decisions. We went to Atlantic Canada; the program is now running there, but really with no emphasis. I just received a retirement package and I notice there's a letter in there, but the program is essentially frozen. It is shut down.

There are negotiations going on between Ottawa RCMP and Veterans Affairs in P.E.I. in relation to resources and who's going to pay for this program and so on. While that is being fought out, we've got members all across Canada from coast to coast who are leaving our organization without knowing what their entitlements are and without knowing how to transition into the private sector.

● (1600)

I am excluded, as a Canadian, from the Canada Health Act. I don't feel bad about that. The problem is that the employer, the commissioner, is now responsible for my health care. I'm with a very special crowd in the exclusion from the Canada Health Act: all of Canada's federal inmates and all new immigrants to Canada. That's who is there. When I don't get my benefits from the commissioner, then my health care is shut down.

Those are some of the issues we deal with when we have to negotiate with the commissioner on programs or changes.

When we look at transition interviews, now VAC is coming to the RCMP to be paid. I'm not concerned about who pays. I'm concerned about the service delivery. British Columbia and Alberta are both crying for this program, but we cannot provide it. It is not being rolled out anywhere in Canada, except for in the five provinces I've indicated to you. I could give you a number of recommendations from Veterans Affairs themselves that date back to January 20, 2003, on the requirements and needs of the transition interviews. Here we are, stopped, with only five provinces.

I mentioned the liaison positions. I'm going to give you a recommendation, hopefully before I get cut off here, and I'm not going to say anything more about them than I have already.

Another thing is that members are afraid to self-identify. That might surprise you about people who carry guns. What would we have to be afraid of? There are a number of reasons members withdraw from the force. Since the force has converted its health care program to an occupational health model from a clinically based model that allowed us to go to our doctors and be given health care, the whole timeframe and the rules have changed. Some of the things you will hear from members—and I believe Dr. Duncan may have heard some of this—include statements like the following:

“It would harm my career or future job promotion if I disclose PTSD, depression, or a number of other mental illnesses.” This is in 2010 in the Mounted Police, when most of us have university degrees.

“Members of my unit might think less of me and have less confidence in me.”

“Unit leadership might treat me differently.”

The leaders blame the member for the problem: “Now we're down one body.”

Members are seen to be weak, so there's the “suck it up” concept. I know you've heard that before.

“It would be too embarrassing for my family.” You know, one thing about my organization is that we've never given much thought to our families until the last couple of years.

I would hope this won't be reflected in the minutes. I would ask that you don't. I've been in treatment for post-traumatic stress and depression for over three years. I know what this is about, and I know when I see it, and I've talked to lots of people who suffer from it, but if you ask the RCMP to give you the numbers, they can't do it. They don't have them.

“I do not trust the RCMP. I do not trust RCMP health services. I will get better on my own.” Well, I tried that route, and I crashed on the road. I don't mean that I physically crashed; I just knew that I was in trouble on the road. I was close enough to a family doctor to pay a visit, and it has been better since.

These are only some of the reasons that you have to understand that this is not like walking into an IBM building and saying, “I'm not feeling good today”. Not only that, men and women don't go off sick. The reason they don't is that they're working in two-, three-, and four-person units. If they're gone, the unit's down another body, and there's no replacement. We're the only organization in Canada that doesn't believe its female members should reproduce, because we have no allowance in any formula to replace those people when they're off duty. Who fills the hole? It's made up by the people left behind.

So that's the fear of self-identifying.

Then there's the Privacy Act. I don't have to tell you people anything about VAC and the Privacy Act. I'll spare you that pain, and I don't mean to indicate that there have been pure violations. I won't know until my privacy application comes back.

When you look at the RCMP right now, if I were to make a claim, Veterans Affairs is sharing that success—if you want to call it that—with the health services units of the RCMP all across Canada. If I get an acknowledgement of a disability, they write a letter to the health services people. The health services people go into the record room, pull out my medical file, and confirm what my conditions are compared to the medical profile. Then they either change my medical profile or leave it alone. I'm going to talk about that in a minute.

● (1605)

Where's the privacy here? I realize it's about money—everything is about money—but why isn't that letter sent to the corporate side of the House for the financial accountability when it comes time to deal with the votes? Tell me why two organizations are sharing that information.

The Chair: Mr. Brown, if you could wind up, then maybe some of what you're saying could be put into questions and you could have some time to answer then.

S/Sgt Murray Brown: I thank you very much. I went farther than I thought I would be able to, so I appreciate that.

The Chair: Okay.

S/Sgt Murray Brown: There are a couple of other things. I have nine recommendations, and you have those in front of you.

I recommend that VIP and chronic care become an immediate priority of government and that relevant legislation be created and/or amended to enable members with disabilities to receive in-home services that are deemed necessary; that direction be provided to Veterans Affairs Canada and the RCMP senior management for the immediate implementation of the transition interview program; that the committee exercise whatever power it has in having the RCMP and VAC reinstitute those two liaison positions between the two organizations; that communication and education materials properly reflect the RCMP as a true VAC client; that the RCMP put in place forthwith a comprehensive program to deal with the growth of occupational stress injuries; that the RCMP senior management be instructed to separate the necessary costs of health care from the general budget and that this budget allocation be fenced so that the money given to the force in the operational budget for health is protected.

That's so they can't come running for it, scamming off 5% here and 5% there to meet government cutbacks or whatever. That money must be protected.

As well, I believe the health services delivery resource level in both the RCMP and VAC is insufficient. I'll certainly speak for my own organization. There has been a review of existing policies within VAC that restricts retired members of the RCMP and makes it impossible for them to access a Veterans Affairs hospital bed and/or a bed in a facility of a private nature that they control. Why is that, when we served overseas? We are getting hurt on the job in the same way that everybody else is.

I'll give my last recommendation, and then I'll get out of your life: the VAC ombudsman's position needs to be reviewed. We believe that the mandate needs to be widened to give a bit more flexibility for that person to also speak on behalf of the Royal Canadian Mounted Police.

I thank you for your patience and your extra time.

The Chair: Thank you.

The first question will be from Ms. Zarac, please.

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

Mr. Brown, when you started you said we were changing colour. I think we did more than that. We went into a different world completely, from the Legion, which seems to know the problem and has statistics, to an organization that does not know exactly where it stands. You brought us to a completely different world.

Mr. White, you mentioned you had made a gender-based analysis because there are different problems. Do you have the statistics on that?

Mr. Brad White: Thank you for the opportunity, and I would like to say thank you to Murray. I have a vested interest in what the RCMP says because I have two sons in the RCMP. I like to see what their progress is going to be and how they deal with these issues in terms of my military experience.

The “Report of the Canadian Forces Expert Panel on Suicide Prevention”, which came out in February 2010, is where we're getting a lot of our information and a lot of the stats on those issues. They mention that suicide in the military does have special significance. They talk about males versus females and what they found there.

This is a very initial study, and this is where we're taking our stats from.

● (1610)

Mrs. Lise Zarac: I'm happy that you're talking about it. You also mentioned perception, and I think that if we can identify how the different genders react to stress, we can maybe pinpoint exactly the treatments that need to be given to people.

Mr. Brad White: If you'll permit me, I'll let Andrea speak to that. She has actually organized a bit of a focus group.

Ms. Andrea Siew (Service Officer, Royal Canadian Legion): One of the areas that's recognized is the lack of research, particularly on mental health issues. There is no national research institute to prioritize and follow the research and define the programs that are needed. A key gap is gender and the impact of operational deployment on women in the Canadian Forces. There's been very little research done on that.

We have attended two recent research seminars sponsored by academic institutions, both international and national, and they've raised gender differences in some of the research. It's very limited. One of the papers, which was done by Ryerson, indicates that for women on deployed operations, there's a 2.2% increased risk of development of PTSD as opposed to men, but that's based on information from back in 2002. We've now had women deployed in Afghanistan and in other operational deployments for over 10 years, and there's no research in that area.

It's important to do this type of research to ensure that the unique needs of women are being met. Are the pre- and post-deployment screening processes adapted to meet the gender requirements? Are there adequate resources available to them when they come home?

Mrs. Lise Zarac: If you had to make a budget, would you allocate more funds to research or to a data collection system?

Mr. Brad White: That's a good question. We don't do any research in Canada. We have to rely on research done offshore through other militaries and other governments. I would like to see research conducted. These are our people. We need to define what their needs are, and we haven't done that yet. We can transfer research done in other countries, but we need a database of our own people if we really want to scope our programs.

Mrs. Lise Zarac: Would that be a recommendation you would add to Mr. Brown's?

Mr. Brad White: I think it would be, but we can't forget the treatment side of it. We have the problem here and now, so these have to be two paths that we have to go down together. They have to be parallel paths to make sure we have the research that supports the programs.

Mrs. Lise Zarac: One of the big problems seems to be the disconnect between everybody. I like your recommendation, Mr. Brown, on having the RCMP in VAC. I would add the Legion and everybody concerned with veterans. They should all be put together with the government to find out what needs to be done. I think there's a disconnect, and that's what we're hearing. When a soldier leaves the forces, we lose him and he doesn't get the care. If he comes and asks for care, he's sent to a regular doctor, a family doctor.

Mr. Brad White: In both organizations, one of my primary concerns is the transition from being an active member of the Canadian Forces to the other side, the dark side.

What is the dark side? For a lot of members of the Canadian Forces, it's civilian life. That's a traumatic event for people. If they're also suffering from mental health issues, that compounds the stressors that they have to go through.

We need to make sure that there's a smooth transition from active service, whether with the military or with the RCMP, to being a client of VAC. I'm not sure I like the term “client”, but that's what they call it. This is a critical period in an individual's life and in the lives of people he's close to. He's going to take that stress and those stressors and he's going to put it onto his family, so the whole group is in a critical transition period.

● (1615)

Mrs. Lise Zarac: You mentioned isolation, and you mentioned how the Legion helped in the Second World War. It was like self-medication.

What can we do to bring these people back to the Legion? Did you consider what the Legion can do?

Mr. Brad White: I'm not sure that I want to stand up here and say that you have to bring them back to the Legion. What I want to say is that you need to use the resources. Veterans Affairs needs to use the resources.

We already do. We run a program called the long-term care surveyor program. We are on contract to Veterans Affairs. We have people across the country who go into long-term care facilities and check on the individuals in the facilities. They write reports, and the reports are submitted back to Veterans Affairs. It's a very effective program. It's extremely effective. We've resolved a lot of issues.

What we need to do is build on that program, maybe, and use it as an outreach tool. The Legion, I would say—more so than any other organization of our kind across the country—has a huge infrastructure that goes east, west, north, south, and everywhere. Build on that infrastructure—we're going to suggest this to Veterans Affairs—and use us as an outreach mechanism.

Those people who are reservists and those people who are injured go back to their home communities. Allow us to use the training we have in the long-term care surveyor program. In this day of privacy—and, as Murray says, privacy is a prime consideration when you do this—our long-term care surveyors are cleared to have access to the information they need to visit the people. We've overcome that hurdle.

Use that similar type of program and transition it to an outreach program. Talk to the people in the reserves and to those who are injured who are maybe having difficulty. We're there. We can do it. It's a very easy transition to do. We're there to help.

The Chair: Thank you.

We'll go to Mr. André.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good afternoon, Mr. White and Mr. Brown.

People with PTSD are most definitely faced with a lack of resources and services. I feel that we first have to address the screening issue. We're talking about resources and time that the RCMP and the Canadian Forces should invest in screening people with post-traumatic stress or related problems and in actually providing services. If it turns out that those people don't have any problems, a follow-up should always be done on individuals who have experienced traumatic situations that could later lead to post-traumatic stress.

Correct me if I'm wrong, but I get the impression that, if the Department of Veterans Affairs recognizes that a person has PTSD, it questions the whole thing and it raises doubts because there is a cost associated with it. When these people talk to mental health workers and officials, they must fight to prove that they actually have this particular problem. So not only do they have to break a taboo, but they also have to fight against the system within which the problem is not recognized because of the future costs.

I am going to tell you about a situation I'm familiar with and draw a parallel to our discussion. When someone with a mental health problem goes to see a psychologist or a worker at a CLSC, they are seen within 48 hours, in most cases, and they at least get an answer. It goes without saying that this is not the case with Veterans Affairs Canada or with the RCMP. But the difference is that it is not up to the organizations providing the services to establish whether these people are entitled to a disability benefit.

On a number of occasions in this committee, individuals told us how mental health problems and PTSD led them towards suicide. Some people say there is no link. I personally believe there is a link. These people never got any services. There are grey areas. Could you talk about those grey areas and could you comment on what I just said?

● (1620)

Mr. Brad White: I'm sorry, I will continue in English. This way, I will be able to express myself better.

[*English*]

You hit a couple of real issues. In connection with self-identification, it's easy for an individual who's not in the army or not in the RCMP to walk into his local clinic or up to his local doctor and say he's having an issue, but you're dealing with a culture. You're dealing with a military culture, an RCMP culture, and you're dealing with young people who are predominantly male. I have two of them, a 24-year-old and a 25-year-old. Do you think they're going to tell me they're having a problem on the job? I can sense that they might be having a problem on the job, but do you think they're going to identify to me that they are? It's a cultural thing, a mentality.

[*Translation*]

Mr. Guy André: Of course.

[*English*]

Mr. Brad White: Today we're dealing with PTSD in a way we've never dealt with it before. It's being accepted. The leadership is starting to deal with PTSD, and they've never dealt with it before. We're at the really beginning stages of making an impact.

I'll go to one of the other comments that you made. Are the resources there? Are the systems there? No, they're not. We're good at dealing with physical injury, because we know how to do it—we can see it, we can touch it, we can fix it—but when you're dealing with a psychological injury, you don't see it, you can't feel it, and how do you touch it? You have to rely on the individual to self-identify, and if he or she won't self-identify, then you have a real problem of getting through to the individual.

I always relate to a story of the young guy from the Eastern Townships who went through an IED. I'm not sure if he was a reservist or in the regular forces, but he went back home on convalescence. If I recall correctly, the individual on the battlefield basically tried to take his life at that point, and his comrades stopped him. He went back home. How many attempts did he make until, finally, he was successful? There should have been a lot of red flags up there, shouldn't there, to deal with that individual? We didn't deal with it. He went home. Was he isolated? Yes. We missed one. We really did.

There are a whole bunch of issues there, but it's cultural. It's a new thing. Do we have the resources right now? No, we don't have the resources to treat everything. This is the start of trying to get those resources, because you need to have things identified and you need to understand what the requirements are. That's why we need more research to identify those requirements. Then maybe we can start moving on into good programs.

I'm talking too long.

The Chair: Mr. Brown, do you have something to say?

S/Sgt Murray Brown: I have only a couple of quick comments. Primarily I want to refer you to something that each of you was provided with in the House. If you're doing a review on post-traumatic stress, this book should be on your file somewhere.

This publication is true. It's not driven by management. What you see in here are some members who have laid out their personal lives for the reader, with the goal of trying to help our people.

Brad's touched on an interesting point, the point about the cultural makeup. I come from an organization that is traditionally very quiet, very within itself, and hard to get close to, and the cruelty is as real today. I don't mean that in a bad way, but it's a job that has a lot of sadness attached to it, even though you feel good about the quality of your work.

When I first knew I was in trouble and was in treatment, the first person I chose to speak to was my brother, in a vehicle. We were coming back from another part of the province. I realized very early in that discussion that this was not the place I was going to disclose. He's a retired member of the Mounted Police.

I can give you thousands of those examples. We don't understand. There's no education. There's no research. There's no proactivity. We're talking about something here that we're now in the infancy of, although we've been aware of it for years. We've called it burnout and all those other terms, but we are starting this as a forest fire. We're cutting a track and working back.

In a way we're at a disadvantage compared to the military, because the military have their own infrastructure within medicine. We used to have that, and the doctors knew what the members were exposed to, but now that we've transitioned from a clinical model to an occupational model, the last thing a member of the Mounted Police is going to do today is go to an RCMP doctor. It ain't going to happen. If you do, they'll go to your personnel file and start to make notes that are going to be reflected in profiles, which are limitations and restrictions that will prohibit your lateral and vertical movement. You can kiss the Mounted Police goodbye when it comes to disclosure. However, that doesn't mean they should neglect what's going on or not deal with it at the front end.

● (1625)

The Chair: Thank you.

Mr. Stoffer is next. You have five minutes, please.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman, and thanks to all three of you for being with us today.

One thing that Murray didn't tell us is that he'll be retiring at the end of this year. Murray, on behalf of all of us, thank you for your great service to everyone you've helped throughout the country and also for my education with the RCMP. That was really informative. When this magazine first came up, you showed us the story of Paul Smith. It was really disturbing.

You're right, Brad. We missed more than one. We've missed a few out there.

I remember very well the Legion I used to go to, which was Branch 5 in Richmond, B.C. Every Friday and Saturday they had the meat draws. The World War I and the World War II guys would let it out right there, and they'd be good for a week until they came back and got their fill of camaraderie once again. The Legion played an incredible role in mitigating an awful lot of pain and suffering. Even though you may not have done it on an organizational basis, you gave them comfort by having facilities across the country where they could go and feel safe.

My colleague Ms. Duncan does this once in a while, so I'd like to try it as well. If you could do three things right now that would improve the lives of the people you represent, what would they be?

Murray, you mentioned transition care. I find it rather disturbing that it's not already there. I'm sure it's something this committee will seriously look at in that regard, but if each of you could have three things right now that this committee could recommend in our report, what would they be?

S/Sgt Murray Brown: I could probably make it longer, but I'll go with interest. I don't mean to be cruel, but sometimes those in power don't want to know, so the second is knowledge. The third is process.

Mr. Peter Stoffer: Okay, thank you.

Ms. Andrea Siew: I would say access to timely, high-quality care for both reservists and regular force members, regardless of where they live in Canada. It needs to be not just reactive but proactive care, care that reaches out to wherever they're located. It has to be standardized across the country.

Mr. Brad White: I think you very much want to have buy-in and longevity. Now we're getting veterans from World War II who are starting to say they realize they've got a problem. A program is not short-term; it has to go over the lifespans of the people we're dealing with. You can't give people resources just on an annual basis and tell them to spend their resources on an annual basis. You can't tell them they're done in five years.

We're going to be dealing with this now. How many people have we deployed through Afghanistan in the last 10 years? We're going to be dealing with these issues over their lifespans. I'm talking now from a CF point of view, but I know that from an RCMP point of view those stresses are happening every day, every minute, in Canadian communities everywhere in Canada. They have to deal with these issues. Murray's had 37 years. Think about those 37 years and think about how we're going to deal with those individuals for the rest of their lives. You can't have a short-term program.

● (1630)

Mr. Peter Stoffer: In conclusion, I want to thank you for the fact that you've shared this with your other veterans organizations across the country. Brad, we've said this privately before, but the cooperation and the integration of discussion with other veterans groups—and maybe the RCMP as well—to better enhance the dialogue would only improve the situation for everyone. Thanks to the Legion for doing that.

Mr. Brad White: I appreciate that. Thank you.

The Chair: Go ahead, Mr. Kerr.

Mr. Greg Kerr (West Nova, CPC): Thank you for being here. It's good to see you.

I'm going to concentrate more on Murray's stuff because I'd like to go in a couple of directions. I want to thank Brad and Andrea. I want to point out that dialogue is great and I think what we're saying as we face these problems is that we know progress is being made. We've heard that from so many sources. We have a long trip to go, but it's true in many cases.

One is that the awareness is out there now. There are more conversations and discussions about stigma. All those types of things are far more public than they were five or 10 years ago. I get the sense that the cooperation you're talking about is critical. I think we have to go down that path. I think we're recognizing some movement. I think you agree in general that at least that we're collectively making some progress.

Mr. Brad White: I think we are. I think we're starting on that road. I think it's a very valuable road. We as an organization are certainly trying to reach out to all the veterans' communities and greet different groups—Murray's group, and Tim Hoban, and the RCMP Veterans Association. We hold an annual meeting with everybody to bring them in. There we talk about these issues and about where we want to be.

Also, there's consultation. We call it the consultation group. Consultation with government and with Veterans Affairs and this committee—with all of you—is essential so that we can explain to you where we are and you can drill us on where you think we should be, or however that's supposed to work. This is essential consultation that we have to continue. We can't cut this off. We have to be in there.

Veterans Affairs is reorganizing their consultative process at this stage in the game, and they're going to have a larger organization or group to do the consultation through. It's not just the new Veterans Charter advisory group; they're going to take the GAC and the new Veterans Charter advisory group and mishmash all this together. We're waiting to see how all of this is going to turn out.

Mr. Greg Kerr: Great. We'll have lots more to talk about on that, I'm sure.

The reason I wanted to give Murray the bulk of the time is that a lot of what you're raising—and we have talked about this—is the culture. A lot of your problems are within the organization itself. I understand you have these things with Veterans Affairs, as we've talked about. I'd like you to talk more about that, because I think it's an education for most of us here to realize that it will be a whole new culture for the RCMP itself to bridge that gap or to jump over that gap and engage.

The services are there, but it was never set up to be exactly as the military connection would be with Veterans Affairs. That's what you've been talking about now for some time.

Could you explain what it is that the RCMP has to do to help get across that chasm?

S/Sgt Murray Brown: I appreciate that. I think, really, that one can't happen without the assistance of the other. I'll tie that directly to VIP and chronic care. If those two are not chugging in the same direction, we're going to be stalled for many more years. You know my view on that.

In my organization we may portray an image that it's very regimental and so on, but at my level it isn't. There are many at the top who feel that it still is, but we're slowly slagging away at that.

In my organization we are severely understaffed in health care. In the health services delivery areas, we have not had a chief psychologist in the Mounted Police on a permanent basis for probably three or four years. The job is still vacant. In fact, they're using the salary dollars to pay for two projects going on within the unit. Here we are, keeping the chief psychologist position vacant while we're funding two sidebar exercises.

I'm telling you that there are a lot of members out there who need to be identified. I come from an organization of approximately 20,000 to 22,000 police officers, and we have just 14 staff psychologists. The position of the chief staff psychologist, who should be getting everybody on program—on base, on whatever—is not even filled.

The force jumped as a result of the Brown task force and the change management team, as they normally do. They react to some of these things, because there's always short-term interest, so they bring something forth.

One of the products they jumped up with was a mental health program, which is referred to as...it will come to me. Anyway, we have a staff sergeant in B.C. who is a psychologist as well. He's coordinating a program on decompression. The idea of these decompressions is to get out ahead of the disability or the illness or the injury and try to train people in how to handle it. They're doing classes of, let's say, 21 to 24 people. They did three in B.C. They were going to do two in Newfoundland for the Atlantic region in the month of December, and they have one scheduled each month from now to March.

Now, I've already told you that we have 22,000 members. We're going to have a lot of casualties before they roll around and have any noticeable effect with that program.

I want you to know that it's my information that the other 14 staff psychologists are rarely consulted on this. This was something senior management ran with because it came out of the change management group, and they thought it was a good idea. That's how that baby is coming down the pipes.

There are a number of risks with this program. I'm not one to speak about that. I'm not a psychologist.

When I was preparing for this and the force was here and spoke, there were three terms I found interesting. One was the RCMP's traumatic and resilience program for post-traumatic stress. One was the mental health wellness program, because they all transition into each other. Then there was the workplace wellness program. Now we have a new baby on the network, which is called.... Well, it's another wellness program. I'll just leave it at that.

Over the period since somebody's been trying to be accountable for this, they've rolled out a new health care model we're telling the world about. The commissioner has signed a two-page principles of wellness document. I challenge you to tell me what it means. There are some nice phrases there, but what we need is some results. We need some outcomes. We need some people helped. We have to re-establish trust internally in the force.

There are a lot of frustrations that are unfairly put on Veterans Affairs. Some of those are because the force has not maintained our medical files in a very good way. People like me thought our employer was keeping our medical records, not unlike in the military. When the time came that I needed them, there was nothing there except a record that they paid a bill one day at Walmart for medications or whatever. Now we have to catch up and put together materials to support our duty-related injuries. That's not often easy.

Remember that we had no involvement with Veterans Affairs until after October 2001 or 2002. After that, a serving member of the forces and the Mounted Police could collect a disability pension for pain and suffering while serving. Prior to that time, even though we had been with them since 1948, we weren't really taught about them, or we didn't know what they did, because they had nothing to do with us until we went to pension. That changed a bit in 2002, but there has never been a good education component, and the transition interview is critical to filling that gap.

● (1635)

The other thing is the continual taking back of money through the vacancies that are run in the health services program. That has to stop. Do you know how they allocate the health care money for the Mounted Police? They give it to them based on how much they spent the year before. That tells you how we funded health care for the Mounted Police during the last number of years. I'd like to see that money protected. It needs to be there for health care. God, we can't even collect data. Do you know that the only way my force can tell you any reasonable numbers on post-traumatic stress or a couple of other disabilities, including depressive disorders, anxiety and depression, and anxiety disorders? Those are the top four in our organization, and they result in....

I just read a psychologist's comment to me the other day. It said 60% to 75% of our sick members are suffering from occupational stress injuries. VAC will support that, in a way, because if you look at the VAC numbers for our 8,000 claims, the largest percentage of those are for post-traumatic stress.

I call the Mounties and ask what we have for numbers. The only way they can verify any numbers is to call Veterans Affairs and ask them what they are making payments on, and that's no good, because the only numbers Veterans Affairs has are those that are successful. It's not about who is in the system, who is getting in the system, who has failed, or who is appealing the system. We can collect statistics on how long somebody has been going through the same stop sign, yet we can't give anything back. That goes for suicide as well.

I implore you to look at that. I'm going to suggest that our suicide numbers are down, but I can sit here and give you four or five. Most of our people kill themselves with their own tools. Paul Smith is but one of the most recent casualities. Paul's casualty was a self-inflicted gunshot wound. His wife is now in possession of a pension because Paul was killed as a result of his duty-related injury. Now, you unwrap that one.

This is the way it goes all the time.

There are a number of inherent issues with Veterans Affairs. One is that we don't get the feeling that they know us. The position on the liaison is critical. In all fairness, the guy wasn't treated very well in Ottawa. They might as well have stuck him a building and let him roam around until he did his week and then went back home, but our guy embedded in Charlottetown was treated like a king. He went to all the meetings. He was part of the process.

There needs to be a maturity in this area within the upper crust of my organization. I'm not speaking out of school here. I've told them all pretty much the same thing during the year. This is not the first time I have spoken to and or about my employer in relation to this issue. What's going on here needs to be fixed.

● (1640)

The Chair: Thank you.

We went a little over time there, but I wanted you to get it out, so that's good.

Ms. Duncan is next.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair. Thank you all for coming and thank you for your service to our country. Mr. Brown, congratulations on your soon-to-be retirement.

S/Sgt Murray Brown: Thank you.

Ms. Kirsty Duncan: I want to pick up on what you said that this can't be short term. I recently met with some veterans and some psychiatrists, who told me that one gentleman had his first mental health crisis at the age of 87. There are many veterans, whether from RCMP or from the forces, who take their OSIs to the grave. Psychiatrists reported that they treated two veterans who had lived in a basement in the dark for 17 years. They really brought it home that they never met someone who didn't want to be a contributing member of society.

You mentioned proactive care. That is extremely important for prevention, and I would you like to give the committee the most specific recommendations you can. How do you do proactive care?

Ms. Andrea Siew: The first part starts in the education process prior to deployment, and it has to be accepted in the military culture. It cannot be career-ending. In that way people will come forward and get treatment, because it's that early intervention that's absolutely key to preventing their living a life of isolation. It translates into the family: you live in complete silence at work, you don't report it, and when you go home, your family bears the brunt of the aggressiveness and the isolation you feel.

There needs to be that early intervention and that education. There are programs in place. There has been lots of progress with the Canadian Forces—

● (1645)

Ms. Kirsty Duncan: Do we track that with research to see whether it's working or not?

Ms. Andrea Siew: Well, that's my point. What monitoring do we do to ensure that the successes are there? What are the challenges, and what needs to be changed? The Canadian Forces launched the Be the Difference campaign in 2009, and there has been no performance measurement done on that particular campaign. They've introduced education programs at all the leadership schools and at recruit training. How is that being monitored? There is no data collection on operational stress injury.

Ms. Kirsty Duncan: When you compare what's on our VAC website versus what's in the United States, many more things are being done in the United States, ranging from people who have won service medals and have had the courage to come forward, screaming that we're not doing.... Would Canadians benefit from any of this?

Ms. Andrea Siew: Well, I think we need to look at what we're doing in Canada. Certainly on the Canadian Forces side they've done an awful lot in terms of health care professionals and putting the programs in place while members are still serving.

Our model is different from the American model. I think there may be a risk in following the American model instead of focusing on the unique Canadian circumstances. When you look at the care of the family in Canada, where there is that constant jurisdictional issue and where we have a moral obligation.... Yes, there is a jurisdictional issue, but that needs to be overcome, and the program needs to be holistic for the member and the family.

Ms. Kirsty Duncan: Thanks.

I'm going to switch to treatment. We've heard from veterans that you have to have walked in their boots or have served in a foxhole for three days. In terms of treatment, how do you feel about treatment in groups? I know the Legion has supported a wonderful veterans transition program in B.C., a co-ed program for the partners and for children.

Can you comment on what we need to be doing to support families, and could we have a comment from the RCMP as well? I'd like you both to answer.

Mr. Brad White: On your comparison to the Americans, it's economy of scale, and we're dealing with two different health care systems.

If you want to take the military and the RCMP out of the Canada Health Act so that, as soon as they join the Canadian Forces or the RCMP, they are covered by that organization until the date they're not on this earth, that would be great, but that's the American system. If you join the American armed forces, you're covered from that time until your grave. That's how they do it.

I'll mention two other issues. I believe that if you create a climate of change and a mentality of change and acceptance, an individual won't feel the stigma. To get that, you have to have buy-in from the leadership.

I'm going to go back to your other question about treatment. The programs that we're sponsoring right now have been very effective and very welcome. The one in Edmonton, in particular, with the MFRC, the military family resource centre, has gone through eight serials of it. The results with the kids—and we're talking about kids from young to late teens—have been very effective in getting them to deal with the issues of PTSD, to recognize PTSD, to recognize why mommy or daddy comes in and is really screaming at them for no reason. PTSD does that to people. The switch goes. These programs have been very effective.

Ms. Kirsty Duncan: Is it being replicated?

Mr. Brad White: No. At this stage it's not being replicated.

The Chair: We have to wind up. Thank you.

Mr. Vincent is next.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Mr. Chair, I would simply like to make a request.

[*English*]

The Chair: I'm going to go to you and then I'll go to Mr. McColeman. I'm sorry, Mr. McColeman; I missed the list here.

Go ahead, Monsieur Vincent.

[*Translation*]

Mr. Robert Vincent: Mr. Chair, before you start timing me, I would like to make a request.

I identified Major Michel Sartori as a witness. I'm not sure that he'll want to testify, because he is still in the Canadian Forces. If the committee receives a negative answer, I would like us to be able to issue a subpoena for him to testify just because Mr. Sartori's testimony plays a major role.

In fact, the Canadian Forces said that only seven soldiers committed suicide in 2006 and nine in 2007. Major Sartori is a soldier who did his PhD thesis on suicide among soldiers. The difference between the numbers provided by the two sides is very significant. In 2006, they said seven suicides, whereas he identified 20. In 2007, they said nine suicides, whereas he found 36.

It is important that Major Sartori be able to speak to his PhD thesis before the committee. That could shed some light on suicide among the Canadian Forces for us.

● (1650)

[*English*]

The Chair: Keep going. You're on your five minutes. Are you presenting a motion?

[*Translation*]

Mr. Robert Vincent: If you want me to introduce a motion, that's fine with me, but I would like to ask you one thing. If Major Sartori declines our invitation, I would like us to be able to send him a subpoena to testify.

If you want me to make a motion, I will do it. I can move a motion and we can proceed with the vote. I would rather proceed with a motion.

[*English*]

The Chair: If it's a motion, then you'll have to put notice of motion. I'll have to bring it up in 48 hours.

[*Translation*]

Mr. Robert Vincent: No.

[*English*]

The Chair: Are you just adding another witness? Can we take that under advisement to see if we can get...?

Hon. Judy Sgro (York West, Lib.): I understood that he was asking to put on the list another particular individual as a witness. I don't know that we need a motion if it's just a request for additional witnesses.

[*Translation*]

Mr. Robert Vincent: That's not what I asked. You were talking and you did not hear my request.

I've already asked this man to come to testify. The problem is that he is in the Canadian Forces and they do not allow him to talk about suicide. It is forbidden, as Ms. Lagimonière told us. So it is problematic for this gentleman to appear before the committee.

If the clerk calls him to come testify and he says “no”, I would like us to be able to send him a subpoena to testify so that he can come.

[*English*]

The Chair: It's my understanding that the gentleman is on the witness list and that the clerk is working on bringing the witness. Until he doesn't come—

Mr. Colin Mayes (Okanagan—Shuswap, CPC): I have a point of order, Mr. Chair.

We're right in the middle of a question to the witnesses and we're going off looking at adding witnesses to a list. I have no problem with that, but I think that should be dealt with by the Chair and the clerk after the meeting. We're in the middle of questioning the witnesses. They're here for a limited time. Let's get on with the order of business today.

[*Translation*]

Mr. Robert Vincent: I am not opposed to that, but we will have to discuss it at the end of the meeting. I wouldn't want people to rush out and avoid the debate. I want to make sure that we are going to do it and we won't run away from it.

I said I had something to ask you, and I have done so. This comment should not be counted in my time. I made this request so that we could have the debate.

[*English*]

The Chair: We do have witnesses here. This person is on a witness list. When we have a negative from this person that he won't come, then we will deal with it. I will deal with the clerk on it, and that's how it'll be. We do have witnesses here, and I don't think it's right that we take that witnesses' time away. We will deal with it as we go forward.

Your five minutes is up, sir.

● (1655)

[*Translation*]

Mr. Robert Vincent: Are we going to talk about it at the end of the meeting? We have not finished. I can understand that...

[*English*]

The Chair: We're good. This meeting is for our witnesses. We've already lost five minutes for hearing our witnesses.

Go ahead, Mr. McColeman.

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

Thank you as well to the witnesses for being here and sharing with us—

The Chair: There is a point of order.

[*Translation*]

Mrs. Lise Zarac: Mr. Vincent clearly said that he was not using his time and that he was introducing a motion. I think he should have that time back.

[*English*]

Mr. Greg Kerr: No.

[*Translation*]

Mrs. Lise Zarac: Yes, he said so in the beginning.

[*English*]

Mr. Greg Kerr: No. Absolutely not. We cannot play that game—

Mme Lise Zarac: Yes, he asked four times.

Mr. Greg Kerr: That's irresponsible.

The Chair: We have witnesses here. I'm not getting into...

This is getting out of order. I want to treat our witnesses with some respect. They're here today. We're dealing with them today.

I'm going on with the list. I'm going to Mr. McColeman. Mr. Vincent has used his five minutes. I said that the time was going on.

Mr. McColeman, please go ahead.

Hon. Judy Sgro: Mr. Chairman, is it possible to have five minutes before the conclusion of our meeting? At that point we could possibly discuss what Mr. Vincent wants to discuss. We also have another issue to raise.

The Chair: We've already lost over five minutes with our witnesses here, and now Mr. André wants to take a little more time.

[*Translation*]

Mr. Guy André: Mr. Chair, Mr. Vincent did specify, before taking the floor, that he was introducing a motion, which should not interfere with his floor time. You let him speak under those terms.

I would like to remind those before me that, towards the end of the last meeting when Mr. Lacoste was here, we had a bit of a situation that prevented me from asking a question. That happened at the last meeting, this past Tuesday.

I believe Mr. Vincent should have the floor.

[*English*]

The Chair: I will explain what happened at the last meeting. It's the same thing as has happened right now. People were on the list, and there was a motion brought forward that was dealt with. That's why you never had your opportunity to speak. In fact, the last person to speak to it, instead of having five minutes, had three minutes. Right now we've cut even more time down. I'm going to deal—

[*Translation*]

Mr. Robert Vincent: So they have a right to introduce a motion and we don't, is that it?

[*English*]

The Chair: —with our witnesses and I'm going to ask Mr. McColeman to please ask his question.

Mr. Phil McColeman: Thank you, Mr. Chair.

I'd like to use my time to clarify your comments, Staff Sergeant Brown. We have a copy of your remarks here, and I appreciate your both providing those.

I think it was off the notes that you said something to the effect—I didn't get a chance to jot it down—that when a member retired, there was some kind of health gap, and they no longer had a certain coverage. I think it was in some of the examples you were giving.

Maybe the way to clarify, if you would, is to tell us about what happens when you or any individual retires from the RCMP. It doesn't matter who it is. What are the steps? What falls into place for health care for that member upon retirement?

S/Sgt Murray Brown: The member will receive a package dealing with his discharge. In that package there will be a number of provisions or options for the member, both under insurance and under health care. In a normal discharge, if the member is in possession of any Veterans Affairs disability pension, he or she would take that with them. What most members do is to elect to enter into the public service health care program as a supplement program to provincial health care. That's what most of us do. In my province it's MSI, so I'll make an application for an MSI card within three months of my departure. That will allow me to enrol into provincial health care at home.

● (1700)

Mr. Phil McColeman: You fall under the provincial health care. I think that's standard for most police services across Canada. I'm talking about municipal and regional police services, with which I have a lot of familiarity. You fall into the provincial health care program, but there's an additional optional program that you can put in place—

S/Sgt Murray Brown: Yes.

Mr. Phil McColeman: —through your RCMP insurance plans or connections. Again, I want to make sure. Are there any significant gaps in that for the member in terms of not being able to access services? If they're in need of health care services—in this case we're studying mental health care services—are there gaps in the system that other people have that the RCMP member would not?

S/Sgt Murray Brown: VIP and chronic care would be two examples of those gaps. They're not medical, but they're clearly two examples. Members may be in need of in-home assistance as they get older and leave the force, but there is no in-home care for any member of the Mounted Police as it currently stands. We are the only agency in government that has no such program.

Mr. Phil McColeman: Okay.

S/Sgt Murray Brown: From a medical point of view, the gaps would be that if you had ongoing dental or medical care not completed prior to your departure, you have three months after departure to have that looked after. If you don't, then the force, as a serving force, doesn't cover any other things for you in your next life. It comes either from Veterans Affairs, from provincial health care, or from the public service health care program.

Mr. Phil McColeman: There are three kinds of envelopes of health care available to you, then, as a retired member of the RCMP, and depending on the type of health needs you have, you could be covered by one of those three envelopes.

S/Sgt Murray Brown: That's correct.

Mr. Phil McColeman: Now, because we are studying PTSD—

The Chair: You have to wind up. You're at five minutes.

Mr. Phil McColeman: Perhaps I could come back to it, then.

The Chair: Okay.

Mr. Lobb is next.

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

The first question is for Mr. Brown. For the purposes of our research here, RCMP members have access to OSI clinics. Is that correct?

S/Sgt Murray Brown: The clarity is not pure on that. Do we have RCMP members in OSI clinics? Yes, we do. The protocol has been an issue of discussion. I was also fortunate to be a member of the national mental health advisory committee. We have some members who are there and are very happy with it, and we have others who wish to stay in the private sector.

Mr. Ben Lobb: Okay.

It says here in the magazine you provided that in 2006 there was a joint MOU signed with VAC, DND, and RCMP that would provide a network for that.

S/Sgt Murray Brown: There is, and you can enter that program. In fact, I believe there is work going on now to try to enhance it and simplify it and so on.

Mr. Ben Lobb: That's good to hear.

General Dallaire was here two weeks ago today, I believe, and commented on the importance and the significance of the OSISS networks. It's my understanding that the RCMP have access to these OSISS networks as well. Is it your experience that these are working well for the RCMP? Can you tell us a little about that?

S/Sgt Murray Brown: I'm familiar with some members who are using those facilities and the peer support program as well. Those who go there seem happy. They seem satisfied with it. Again, others have opted not to go that way. It's a personal thing, rather than mandatory.

Mr. Ben Lobb: Concerning the members' employee assistance program, both companies I've worked for in my career had employee assistance programs. They're always evolving, always changing, always trying to best suit the needs of the employees and staff. I understand that yours is under review right now. Could you tell us a little bit about what you'd like to see come out of the review?

S/Sgt Murray Brown: We have what's called the MEAP, a member/employee assistance program, which is fundamentally the same as what you experienced. That program has been around for a while, and we see it as a core program. It works as well as the confidentiality that it proposes to have. If one or two people violate that confidentiality, then you have to remove the MEAP person or the program will collapse. There's no room for error.

The MEAP is currently under review. Tragically, when they got into it and hired a consultant, they ran out of money and had to shut down the review. The review is back on now, in a haphazard way, and we are monitoring it very closely, because the MEAP, to us and our membership, is a core program. It is a program that is very much peer dependent. That doesn't mean there aren't people who are non-police officers you wouldn't go to; you go to people you have confidence in, but we believe there is an effort to have the members who are referral agents in that program replaced with public servants or civilians or whatever.

● (1705)

Mr. Ben Lobb: My time is probably running short here, so I wanted to get to another point.

Mr. White commented that there was a need to medicate, but that probably the most important point was to see a psychologist and to get the mental aspects dealt with. You mentioned that there are 14 psychologists directly employed by the RCMP. Obviously there would be a significant number of psychologists also employed through Veterans Affairs who would work through the OSISS clinics and who would also potentially service RCMP officers.

There's a difference between service to the Canadian Forces and service to the RCMP. There are parallels, but obviously there are differences too. Moving forward, would you like to see the ability to service RCMP needs within the OSI clinics, or do you feel it's already there?

S/Sgt Murray Brown: I believe there's capacity there, and we are there. I personally am one who would prefer to stay in the private sector. I'm confident in the resources that I have access to, and many are.

I'm a referral agent and have been in the Mounted Police for a number of years. I have made many referrals, even though I'm not a doctor. I don't make medical referrals, but referrals based on situations, or we'll go through the MEAP coordinator, and he or she will make referrals and then advise health services that we've referred a member for specialized treatment.

The Chair: Thank you.

Mr. Mayes is next.

Mr. Colin Mayes: Thank you, Mr. Chair.

Thank you to the witnesses for being here.

I'd like to direct my first question to Staff Sergeant Brown. As a former mayor, I had a very close relationship with all the staff sergeants in my community. I was reading about some of the symptoms of stress in this magazine. I recognize those in the corporate world, and I can tell you what that stress is from: fatigue, overwork, being under-resourced. I'm talking a bit about preventatives, rather than about treating a patient.

How much work is really being done to address that? Quite often the RCMP is understaffed. The duty watch is very challenging. Members get burned out. It affects their family, and then you have the stress problem, but if you get to the root of the problem, it's the fact that they're working too much.

Could you please answer that question?

S/Sgt Murray Brown: Your observations are exactly on the money. The difficulty is that if you were to look at the stats from Veterans Affairs, the point where you would see most of our people finally stepping up and saying they need some help is when they are beyond the age of 50. I'm going to suggest to you that many of them are burying that and getting to the point where they're at pensionable service.

This is one big difference between us and the Canadian armed forces, and it's important. Many of the forces members are getting out at the age of 33 or 34. They need to work. They need a second career. I think our mean departure age is a little over 54; most of our people are leaving with a mature pension, but they could be put out on medical as well. It depends. There are a number of strategies.

Another solution to your observation is that we have to do a better job on leadership and middle-management training. There's very little of that in my organization, and what is present in two particular courses is relatively new. I'm not asking for every member of the Mounted Police to be made a specialist in identifying post-traumatic stress or depression, because I think during our lives we've acquired a lay skill set to do that anyway.

In relation to the private sector, when you look at the number of 14 psychologists, you have to bear in mind that those are the program people. Those are the people who are setting up the policies and guidelines that allow you to function within the private sector.

● (1710)

Mr. Colin Mayes: I actually appreciated the fact that you said you're different, because you really are different from the Canadian Forces—

S/Sgt Murray Brown: Yes, we are.

Mr. Colin Mayes: —and you're in totally different circumstances.

The other issue—and I'd like to have this answered by either Mr. White or Ms. Siew—is that when you're on active duty in the Canadian Forces, there's a challenge because it's around you all the time, whether you're on base and stationed in Canada or whether you're overseas and stationed at some outpost.

Is there any effort to break people away, to identify the....? This is not part of the discussion here, but I'm trying to stop the patients coming, stop the stress, and I think that's important.

With the people you're dealing with and with the feedback you're getting, are you finding that it's not necessarily the combat duty, but the fact that you just can't get out of that box?

Mr. Brad White: I'm not saying it's not necessarily combat duty, but it's called operational tempo.

Mr. Colin Mayes: Okay.

Mr. Brad White: When you are continually deployed, you come home and have a certain period of downtime. That downtime is usually required to decompress. Following decompression, you then have your taskings that you've got to look after. Then you have your career courses you have to look after. By the time you get through the first tasking and never get to your career course, you're put back on alert again to go back onto deployment because it's a matter of resources, because when you make these types of commitments as a government, you have to say that these are the resources that you're going to provide. We don't have infinite resources out there, so when a guy is deployed with 1PPCLI on one commitment and comes back, maybe he's posted over to 2PPCLI, and within six months he's tasked to go back. It's a matter of judging what your resources are.

You asked if there's a way to get out of it. I lived all of my life on military bases. That was them, up on the hill; that was us. We lived in PMQs. We lived in our environment and we lived in our culture. We self-supported each other because that's how we survived. Spouses couldn't work in the local towns because they knew that they'd be gone in two or three years.

You built that community and you protected yourself in that community. That's what you did.

Where do today's individuals go for relief? They go to the Internet. The world is at their fingertips now. I liken it to what I experienced back in the 1970s when I was in Germany. There was a lot of what you might call power drinking and stuff going on. I went back in the 1980s, and do you know what the young guys were doing? They weren't going to the messes and they weren't going to the bars. They were going to the museums. They were going to see the sights. There was a whole cultural change of focus on where the individual wanted to be. That's happened already.

S/Sgt Murray Brown: Is there more time?

The Chair: Please be very short, sir.

S/Sgt Murray Brown: I think that question is so important that I'd like to make this acknowledgement to you as well. When you look at the Mounted Police, most of our people live in the community they police. When they come home from work, either off shift or on shift, the door-knocks go from there until the start of the next shift.

The other thing is that in our communities you can't hide. Everybody knows where the Mounties live—all the Mounties. Even in Canada, we live in compounds in some communities, not because of the nature of the community but because that's the way the government buys the land. If there's some swampland on sale somewhere that doesn't run too much water, we buy the whole lot.

Mr. Colin Mayes: Our government has hired more RCMP and troops for those reasons.

● (1715)

The Chair: Does anyone else have any questions that they'd like to ask the witnesses? We have one small matter that Ms. Sgro wants to bring forward.

Mr. Stoffer, you may have one question, please.

Mr. Peter Stoffer: Following on Mr. Mayes' comments about overwork and stress, you made reference to a female officer getting pregnant, then leaving and not being replaced. That's part of your stress right there.

S/Sgt Murray Brown: Yes.

Mr. Peter Stoffer: I wonder if you could just elaborate a bit more. If you had additional officers who could come in and follow up so that the other folks weren't doing double duty.... Could you elaborate a bit more on that?

S/Sgt Murray Brown: Yes. You know, to an extent I was kidding with you, but I've made that reference so much that it usually gets a little laugh.

The truth of it is that for our female members there's still a lot of ostracization over the fact that they're going to be away for a fixed period of time to have a child. Now we also do male-hunting when the wife comes back to work and the male wants to take paternity leave. You know what happens now? It's both. We say, “Well, in my day, I never took that stuff”, but these are benefits that they're entitled to, and I'm glad they can enjoy them. The trouble is that in a detachment in Sherbrooke, Nova Scotia, with four people, if you have your female member down—probably the only female in Sherbrooke—then she's gone for a minimum of a year, if there's no splitting of leave. We have no replacement for that.

For a number of years—probably 15 years now—we've been working on resourcing formulas, and there were none in the police industry. We created a resourcing formula so that we could go to the contracting partner, ask them to tell us what kind of service they wanted, and pump that into a resourcing formula. We can factor in things like family leave, compassionate leave, training time, or court time. If the town says they also want someone on bicycle patrol, we can factor that in and tell them that for the duties they want in their contract, we will need *x* number of members. However, that formula is not being executed in that fashion, so those are difficulties.

Peter, regarding the two members who just recently got washed off the rocks in Peggy's Cove while trying to save that young fellow, both of those members haven't returned to work yet. One of them was thrown pretty hard against the rocks there in the Atlantic Ocean. Those two men went to save that guy who got washed off the rocks, and one of them was hurt fairly badly. As Brad said—and I thank him for it—this is what happens every day in theatre.

Mr. Peter Stoffer: The only reason I say that, Mr. Chairman, is that if a woman in the military in the 1950s became pregnant and was not married, she was dishonourably discharged; if she was married, she'd be medically discharged. We have come a long way in that regard.

Thank you.

S/Sgt Murray Brown: We have, yes.

The Chair: Thank you.

I thank our witnesses very much for their testimony here today.

Some hon. members: Hear, hear!

The Chair: We're going to take a two-minute break and then we'll go in camera.

S/Sgt Murray Brown: Mr. Chair, just before I leave, I want to thank you very much for your patience.

The Chair: Thank you.

[*Proceedings continue in camera*]

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