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Chair

Mr. James Bezan

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● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone.

We are continuing with our study on the care of our ill and injured members of the Canadian armed forces.

Joining us today, appearing as an individual, is Lieutenant-Colonel Stéphane Grenier, who is retired. He served in the Canadian military since 1983. He has served in several missions abroad, most notably in Rwanda and Kandahar, and has also been deployed to Cambodia, Kuwait, the Arabian Gulf, Lebanon, and Haiti, just to name a few.

He was faced with his own undiagnosed PTSD and related depression upon return from Rwanda and took a personal interest in the way the Canadian armed forces was dealing with mental health issues. In 2001, Lieutenant-Colonel Grenier coined the term "operational stress injury", and conceived, developed, implemented, and managed a government-based national peer support program for the Canadian military, namely the operational stress injury social support, OSISS, program.

In 2009 he spearheaded the development of the corporate mental health awareness campaign that was launched nationally by the Canadian Forces Chief of the Defence Staff. He had that campaign endorsed by the Mental Health Commission of Canada, with whom he works today on a volunteer basis. As well, that campaign was endorsed by the Canadian Mental Health Association and the Canadian Alliance on Mental Illness and Mental Health, using his example of corporate leadership in reducing the stigma that is often associated with mental health illnesses.

Lieutenant-Colonel Grenier was awarded the Meritorious Service Cross by the Governor General of Canada for taking the concept of peer support and driving it from the grassroots up to a formal federal government program.

He has been retired for the past year, but is still playing a leading role with the Mental Health Commission, as I mentioned earlier, on its workforce advisory committee.

Lieutenant-Colonel Grenier, welcome to committee. We look forward to your opening comments. If you could keep them to 10 minutes, that would be great.

Mr. Stéphane Grenier (As an Individual): Thank you very much.

Ladies and gentlemen, *merci beaucoup de m'inviter ici*.

As some of you may know, this is the first time I have come here as a civilian. I've been here three or four times in the past decade, always in uniform, however.

I have chosen to share with you some thoughts on the last couple of years of my military service and what I observed was happening. Of course, it's very important to me that everyone on the committee know that I am retired, and more important, that I was seconded to the Mental Health Commission of Canada for the last two years of my military career, which means that I may be outdated by a couple of years.

However, my goal today is not to get into the specifics of issues, but perhaps discuss more strategically some of the long-standing concerns that I had while I was in the military that I maintained in my role as operational stress injury special adviser for General Semianiw, in his tenure as Chief Military Personnel. To this date I still have concerns about several issues, and these issues are the ones I feel I can share with you today.

Very broadly, and I will stick to five or six minutes, I simply want to whet everyone's appetite on some issues that the committee may wish to explore further as you continue your work.

First, I would like to mention to you that one strategic concern I've always had is the care and support of military families. I start with that because I'm very passionate about making the point that, when we speak about families of military personnel and veterans suffering from stress injuries, we should stop mentioning families last because families are the pillar of our military force, to a great extent. They are the ones who literally stitch us back together when we come back from deployments and have a really hard time integrating.

While soldiers keep going back to their regiments and units and battalions, and in plain English, suck it up every day—and it is a good thing that soldiers are attempting to be resilient—it's mostly at home that things fall apart.

I wish to mention to you that many of my colleagues and I have attempted many, many times to raise the issue of the military reality with military members repeatedly moving around Canada. We know that our health care system in Canada is stretched in some provinces more than others. For a family member who is dealing with a very complex mental health condition in the family, the impact of the mental health condition on the family is very well documented. Therefore, what is the responsibility of the federal government and the Department of National Defence to take care of families in their own right?

My suggestion to the committee is perhaps that may be worthwhile looking into. Is it appropriate to simply assume that the health care system inside a new community where a family has been moved will be able to rapidly absorb and seamlessly continue the mental health care of the spouses and perhaps children? That is one point I thought I would share with you.

Switching gears now, going into some policy matters perhaps, there is a concept that I feel has not been explored sufficiently. Even in my tenure in the military, I failed to make the point in a way that would galvanize senior leadership's interest in exploring new ways of retaining military personnel with operational stress injuries.

In around 2003-04, we developed a concept of remustering, or allowing soldiers to be retained in the military through an occupational transfer but on a provisional basis. We know that in the military, after several years of career, soldiers can change classifications or change trades. There comes a point in a soldier's career, and I'm talking mainly of the combat arms, when a soldier has been on a few too many deployments, clinicians have expressed to me their concern that the soldier is no longer capable of being around cordite, explosives, and things like that, but the person would likely thrive if he or she were offered the opportunity to continue to serve in the military and carry on with his or her military career, but in another occupation.

● (1540)

The issue that the military confronts is that, sadly, if the soldier who wishes to transfer from one occupation to the next has a medical limitation of any kind, that makes him or her unsuitable for service in his or her current occupation. In other words, as an example, the infantry medical classification is fairly high. In order for that soldier to be able to remuster to a position that has a lesser medical category, a category that is easier to achieve, that soldier cannot remuster because the soldier must be healthy or deemed healthy in his current trade.

It's a weird logic that the system has been built that way. Nevertheless, it is built that way, and what I saw during my tenure were dozens, if not hundreds, of soldiers who were literally medically released who might have been able to continue in the military, which would essentially allow the military to maintain that corporate expertise or experience that had been garnered and gathered over the first part of that soldier's career.

I worked on that provisional occupational transfer policy for years and never got that off the ground, really. I failed at it myself, and I wish that soldiers in the future would or could benefit from that.

Clinicians have shared with me that being medically released sometimes is a good thing. Of course, not everyone would fit in that category. For many, facing a medical release is not always happy times, of course, and having that opportunity to serve in another capacity is something we should seriously consider.

Let me speak a bit about physical injuries and operational stress injuries. As the opening remarks indicated, I did coin the term “stress injury” years ago.

When the heavy fighting started in Afghanistan in the mid-2000s, as you're aware, we started repatriating a lot of physical casualties. From that moment on, there was a school of thought that we needed to create support programs for these physically injured soldiers. I attempted to ensure that we would not create two streams. An injured soldier is an injured soldier. It doesn't matter if it's an injury of the brain or an injury of the leg or the foot. If you lose a foot, you lose a foot; if you lose your marbles, you lose your marbles.

Unfortunately, what I've noticed since I've been retired is that there are two streams. While the military continues to attempt to combat the stigma around stress injuries and mental health and post-traumatic stress disorder, I believe it is a strategic mistake to create two separate programs. As long as we continue to separate the injured, we are continuing to emphasize or indirectly support and really endorse the fact that there are legitimate injuries and there are injuries of the mind that could be imagined, and so on and so forth.

I'm not suggesting that somebody who has post-traumatic stress disorder could support an amputee. However, from a structural perspective, I believe it's a strategic mistake to have separated these programs as opposed to integrating them into one. It's one thing to say that an injured soldier is an injured soldier, but the military needs to behave like they truly believe that.

Moving on, I am simply making the point that when I started the peer support program 12 or 13 years ago, I was a major back then. I remember a full colonel telling me here in Ottawa, “Stéphane, you're too late. We don't need this any more because the tough Bosnia days are over.” I looked at the colonel and said, “I'm not a historian, but history has demonstrated that after periods of reconstitution and strategic pauses, the military is re-engaged in yet another conflict. So now that we are in strategic pause, it is time to build these programs.” Despite his opinion, the leadership made a decision. We launched these non-clinical programs, which are still alive today. I am just hoping that through all these cuts we're not going to make that mistake and start shaving the ice cube and end up as we were after Rwanda, when I came back, where we had literally nothing to support the soldiers.

Despite the cuts, and I can understand the austerity measures in the government and at National Defence, I'm hoping that some of these programs will be protected.

● (1545)

I have a few thoughts on my own transition out of the military. I was not pleasantly surprised to go through the military release process. I must say that I wish I were here today to tell you that we have come a long way because my military release was a very seamless, smooth process. I share this with you not to complain, making the point that if it happened to a colonel, who was the OSI special adviser, who the surgeon general knew and who Veterans Affairs Canada knew, imagine the corporal from Valcartier or Petawawa who is being medically released today, who doesn't know anybody. If these things happened to me, such as medication coverage stopped, my doctors' bills, which I receive at home and I'm sorting those out now.... This is not a complaint. I'm making the point. There are nice people at DND and Veterans Affairs who are fixing the matter. However, I was very surprised to see that because I've been in so many meetings and boardrooms where, you know, people would look at each other and say, “We've come such a long way.”

Well, I remember supporting soldiers who were literally going postal who were very angry at the system in 2001-02, thinking, “What am I going to do to afford these medications; my psychiatrist is too expensive, I can't pay him and I'm getting the bills ” Well, in 2013 I have my own medication bill and my own doctors' bills. It will get sorted out; however, it's very disappointing for me to see that we have not come a long way.

I have a couple of last, quick remarks. I encourage this committee to find the clinicians who have left medical practice at National Defence. I, out of respect, will not share the names of those clinicians, but I encourage you to do so, and invite them here so that you may ask them why they left the medical practice for the military. They will probably tell you stories of inefficiencies in the medical system in the military and the fact that they cannot live with themselves making more money, seeing fewer patients every day. I, out of integrity, am here to encourage you to have a look at that issue and potentially find clinicians who have left the practice.

I also encourage you to look at the in-patient treatment issues. Despite clinicians and treatment facilities that will tell you that everything is fine, you will rapidly notice, if you delve into the issue, that the criteria are so strict and stringent, that you're either too sick or too healthy to be in those programs.

I will stop here and am open for questions.

The Chair: Thank you very much for your opening comments.

[*Translation*]

Ms. Moore, you have seven minutes.

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you very much, Mr. Chair.

I would like to talk about the Operational Stress Injury Social Support Program, which is provided by peers. Could you give me an overview of how that program works?

Considering that this is a peer support group, is any supervision provided by professionals?

Mr. Stéphane Grenier: The program has been in place for 13 years. It used to be supervised by professionals more than it is today. In the program's first six years, we had a multidisciplinary team—made up of mental health nurses, social workers, psychologists and even a psychiatrist—on my advisory committee.

Unfortunately, over the past few years, there has been an erosion in that multidisciplinary approach, and I now see a tendency to bureaucratize that program. I'll give you an example.

This peer support program is basically provided by people who have suffered from mental health issues themselves. By the way, as a civilian, I now institute that approach in large companies to help employees with mental health issues. That's seen as a service that will contribute to companies' ability to deal with their employees' mental health problems.

Naturally, employees really need to be taken care of in a peer support program. That applies to any company. However, when you manage a peer support program, you certainly have to monitor the situation and really take care of your employees.

Over the past two years, I have noticed a bureaucratization of this approach and a laissez-faire attitude toward a few of the self care policies that were important to me. Those policies ensured that people would have quick access to a psychologist when they are going through the wringer because their case is very difficult to handle. So that monitoring has declined over the years. I am always worried when I hear that a program refers peer support volunteers to traditional programs for assisting federal government employees.

I think the program should do more.

● (1550)

Ms. Christine Moore: How is the family involved in this program? Is that a separate program? For instance, do spouses provide peer support to other military spouses?

Mr. Stéphane Grenier: Yes.

I don't know what the numbers are today, but when I left the Department of National Defence, there were about 20 coordinators in charge of family support, and most of them were wives. There was no segregation—in other words, they were not all women—but unfortunately, or fortunately, I think most of them were. There were 23 veterans.

So there is one program for veterans and military members, and another program for families. Families that provide support to other families have a lot of relevant experience.

Ms. Christine Moore: Are any services provided to children—perhaps not to three- of four-year-olds, but maybe to teenagers—to help them deal with injured parents? Is there a component dedicated to teenagers or children who are able to grasp that dynamic?

Mr. Stéphane Grenier: To my knowledge, there is no such program. I was unable to develop something like that, and I don't think my successors have done it either. That's very complex. There have been some small initiatives where peers, on a family level, established connections with social workers and psychologists locally. Those were small local initiatives. However, nothing has ever been established in terms of strategy.

Ms. Christine Moore: Okay.

How do you deal with people who come to seek peer support, but who have never consulted a health care professional and have consequently not received a diagnosis out of concern that it would appear in their medical records and cause problems, especially in terms of their career or insurance coverage? The seriousness of their injury is not really known.

Mr. Stéphane Grenier: You just described about 70% to 75% of the cases involving individuals who use the peer support program. That's sort of a typical case. It's exactly as you described it.

I have been working with the commission as a civilian for three years. It's really important to understand that a peer support program does not replace clinical care—as you probably implied with your question. It complements it. There is a complementarity between the two systems when things are going well.

Thirteen years ago, when I established this organization, many doctors were convinced that it wouldn't work, that these people were sick, that they would exceed their limitations, and so on. Fortunately, no such problems have arisen. Peer helpers generally work closely together. The situation in some parts of Canada may be worse than in others, but I think that, generally speaking, peer helpers are the light at the end of the tunnel that gives people hope. Peers give them enough confidence to seek help. Their situation will certainly get worse if they do not seek help. We cannot guarantee that their doctor will help them recover fully. However, it's certain that, if they continue to experience symptoms of that nature, they will slip up and get fired.

Basically, peer helpers encourage people to seek help, but without making any promises.

[*English*]

We don't know what the outcome is going to be.

[*Translation*]

In any case, that's what I saw when I was part of the program and what I still see when I work with them as a civilian.

● (1555)

Ms. Christine Moore: Do the peer helpers who participate in the program undergo a psychological assessment—either on an annual basis, or more or less frequently—to ensure that the task entrusted to them does not become too difficult to handle? Is an assessment carried out to ensure that peer helpers' mental health does not deteriorate because they help others and have to deal with their suffering?

Mr. Stéphane Grenier: I would like to provide a bit of background.

Over the program's first three years, we assessed the mental health of our employees on a voluntary basis to determine whether it was deteriorating, improving or remaining stable. We noted no deterioration, despite some minor snags here and there. However, we really emphasized self care.

That self care comprised seven levels when it came to program policies. One of those key levels was regular access to a psychologist. A sort of update was done three times a year, when people could really talk to a psychologist. That was not clinical care, but it was related to what they were doing to protect their mental health. There is a whole theory about that. That's what I was saying earlier. That aspect has been abandoned, and that worries me because it was one of the program's strategic pillars.

To answer your question, I am not sure whether this is still the case, but we used to do medical screening. However, that was not a psychological assessment. It was essentially normal screening similar to what's done when someone with a health problem is hired. That employee is asked to consult their doctor and show them their job description. The doctor can look at the job description, understand their patient, make connections, say whether it's appropriate and whether they think problems may arise. It's somewhat similar to any other medical condition where an employee could be at risk in a different work environment.

The Chair: Thank you very much.

[*English*]

Mr. Alexander, it's your turn.

[*Translation*]

Mr. Chris Alexander (Ajax—Pickering, CPC): Thank you, Mr. Chair.

I want to thank Mr. Grenier for joining us today. Your testimony is very important to us because, given your very diverse professional experience, your thoughts on this issue will carry a lot of weight with us.

I congratulate you on the role you are playing in helping us gain a more accurate understanding of post-traumatic stress disorder injuries. I also want to congratulate you on your tour of duty in Afghanistan—where we ran into each other—and on having the courage to talk about Rwanda and the harrowing experience involved in that operation. That's now a bit further behind us, but it's still very relevant when we think about Africa and the international situation. That was a nightmare we do not want to recur.

I would like to move on to a few very direct questions. They are also related to our conversations with other witnesses. Your expertise could be very useful to us.

A great deal has been said about tenacity, resistance and the prevention of mental health issues. Experts and doctors sometimes debate over that. In your experience, how much of a role did that play for people who were being prepared for deployment to Afghanistan or Rwanda? Is it really possible to toughen our soldiers and make them more resistant to sometimes traumatizing experiences they will go through, and to prevent mental health issues through sound training?

Mr. Stéphane Grenier: The question is very complex. I am not a scientist or an epidemiologist. So I am speaking from experience, but there is also some supporting evidence out there. Today, neuroscience is starting to provide fairly rigorous evidence that change is possible.

It has been known for some time that there is some plasticity to the brain. I think the true meaning of your question is the following: What can be done to change things? Exposing a whole battalion or unit to unimaginable situations will certainly have a major impact. What can be done to prepare people better?

About seven or eight years ago, I created another program, which is now called the Joint Speakers Bureau. That is a program for educating military members that has taken on a very positive role over the past few years. The program's name is Road to Mental Readiness—that was the “pre-deployment” version of the Joint Speakers Bureau. For the committee, the beauty of this program lies in the fact that the instruction is not provided by doctors. It's given by soldiers, by veterans who have credibility with their audience. That's a first step in the right direction.

To achieve total prevention, we would have to move forward and completely change the military culture. According to doctors like Matthieu Ricard—who is doing studies with Tibet Buddhists—many philosophical changes need to be made in order to exercise the brain. In light of all my current knowledge, I unfortunately don't think a 19-year-old man is either ready or mature enough to accept that philosophical shift. Making a young 20-year-old man who wants to serve his country think differently is a monumental task. However, we know that it's possible.

What kind of contributions will research in neuroplasticity make over the coming decades? That remains to be seen. However, the answer to your question is yes. Figuring out how to achieve that goal is a separate issue.

● (1600)

Mr. Chris Alexander: However, I don't think everyone will volunteer to become a Buddhist monk—

Mr. Stéphane Grenier: That's certainly true.

Mr. Chris Alexander: —or would be willing to go through that preparation, but some of them will do that or something similar.

I will ask two questions at the same time.

You have noted some shortcomings in our system. We have already talked about the issue of leadership. Nothing can work in this area without leadership.

Have you had an opportunity to compare Canada with its allies when it comes to mental health and the quality of our programs? We are trying to make that comparison in our study, but your comments on the issue would be very useful.

You also talked about two types of injuries—the so-called normal injuries and mental injuries—and the need to treat them equally. We agree with you. However, our mental health system is still much bigger than the military system when it comes to hospitals that are dedicated to those types of illnesses.

Have you seen any noteworthy precedents in the civil system or in other military systems where the two kinds of injuries are treated equally? Are there any we may want to try to imitate?

Mr. Stéphane Grenier: Regarding your first question, I think that, if you have not yet invited Dr. Marc Zamorski, you should ask him to appear before your committee. He could provide you with a very comprehensive answer to the question of how Canada stacks up against its allies. I want to point out very candidly that he shared with me in 2009 certain studies indicating that, compared with the United States, England, New Zealand and Australia, Canada was a leader in "destigmatization".

Dr. Zamorski congratulated me and pointed out that we have invested a great deal of effort in the peer support program. He did not give the program I launched all the credit for Canada's position among other countries, but he said that it has certainly had an impact. He also mentioned the fact that the Canadian culture was not comparable to the culture of other countries. So this is a complex issue, but I suggest that you invite him because, as an epidemiologist, he is very open. He could provide you with much more information on this topic.

Based on my experience and on what I have noticed by working primarily with Americans, I think that we are indeed ahead of the pack. As for the term "operational stress injury", I developed it somewhat strategically by moving away from the notion of combat. When the United States began to use that term—which was first adopted by the U.S. Marine Corps—they reverted to the use of the word "combat". They talk about "combat stress injury".

I think that is a tactical error because it gives the impression that people need to participate in combat to experience the consequences of an overseas deployment. In short, I think this is both a step forward and a step backward.

To answer your second question regarding the two types of injuries, my answer would be no. Unfortunately, I have not seen any programs that are as rigorous as the Canadian one in terms of non-clinical care. Some countries have made a lot of progress on a clinical level. The idea, especially in the United States, is to deal with physical injuries through a psychological approach from the outset. Here, in Canada, I think we are a little bit behind in terms of that. Unfortunately, other countries don't have any significant non-clinical programs. So I have not seen any examples we could follow.

● (1605)

[*English*]

The Chair: Merci.

Just for everyone's information, Dr. Mark Zamorski is on our potential witness list, so hopefully we will invite him.

Mr. McKay, you have the last one, for seven minutes.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair.

Thank you, Colonel Grenier.

You came out of Rwanda with undiagnosed PTSD. How did that affect your career?

Mr. Stéphane Grenier: I would say that in the end, it affected my career trajectory, but I can honestly say that for me, but I am an exception, it did not negatively impact my career in the sense that I was not promoted or I didn't get the good posting. I did not notice any of that.

What happened, however, is all the unwritten stuff. When people become aware that you have a mental problem, there is a very silent movement of the culture. Different associate deputy ministers would react to me very differently. I was actually, for all intents and purposes, relieved of my duties in 2006 because I was probably seen as somebody with bad judgment and things like that, and the fact that the person who relieved me knew that I had an operational stress injury probably compounded that. We'll never know.

Hon. John McKay: That was 10 years after the fact.

Mr. Stéphane Grenier: Yes.

I was in a role where I was managing the operational stress injury social support program. I was an internal advocate for policy change. As I said earlier, this occupational transfer policy was very important to retain our people in the company. Of course, depending on who is the ADM, some will be happy with this kind of thinking and some won't, and those who aren't will probably, unbeknownst to themselves, be impacted by the notion that "Well, no wonder Grenier is such an avid advocate, he's half crazy." Essentially the stigma works in very interesting and—

Hon. John McKay: Very subtle ways, yes.

Mr. Stéphane Grenier: Very subtle.

Hon. John McKay: You said that Canada is doing better with its stigma than anybody else is, and yet in your personal case, I guess because of your rank, the stigmatization was quite subtle in its own way.

Mr. Stéphane Grenier: It was very subtle. That's right, and I'm a lucky one.

Hon. John McKay: I guess it's an unfair question to ask, but I'll ask it anyway. Do you think the military treatment of your kind of diagnosis is different from what it would be outside the military?

Mr. Stéphane Grenier: I will say that I believe it's better in the military than it would be outside the military, and that's a good thing, because we have an institutional obligation and a moral obligation to develop expertise at that level. That is why, when I was advocating for more clinics and more treatment programs, for in-patient programs, some people were saying, "Well, you don't understand, Grenier, what we need to do is just refer them to the civilian health care system." I thought that no, that's abdication, that we need to create that expertise.

On cancer, as an example, I can completely understand that the military surgeon general should probably not develop a robust capacity to deal with cancer, because there are outstanding civilian capacities across Canada. However, for this form of injury, which is literally caused by service, if we don't develop that expertise, then who will?

Therefore, I think we're there. I don't know, but I'm pretty sure that our military psychiatry is up there, and that's a good thing.

● (1610)

Hon. John McKay: Yes. Actually, that leads me to a question. I didn't understand your comment. You said we should call in people who have left military practice for the military, and I didn't quite understand—

Mr. Stéphane Grenier: Medical.

Hon. John McKay: Left medical practice for the military? Do you mean that they leave their practice behind and go into the military? Is that what you're saying?

Mr. Stéphane Grenier: No. I'll rephrase that. Civilian doctors will get hired across Canada into medical clinics to augment the uniformed presence there. In psychiatry, you'll have psychiatrists who work in a military clinic and see military patients. They maintain an affiliation with the large hospital in their city or a clinical practice in their civilian life, and they develop an expertise and work within our medical system.

The people I was referring to and who would be interesting to invite to this committee are those who chose to leave. There are many who chose to leave because they were having a hard time, perhaps, in dealing with the fact that they were being paid more to see fewer patients, and they felt it was wrong, that it was simply wrong.

Hon. John McKay: They were being paid more in the military to see fewer patients—

Mr. Stéphane Grenier: That's right.

Hon. John McKay: —than they would have been in a civilian life?

Mr. Stéphane Grenier: That's correct, so quoting the inefficiencies, perhaps, of the military system, and how it is developed and built, and how efficient it could perhaps be.... Now, I'm not saying that we should encourage the surgeon general to create a factory of treating soldiers, but when psychiatrists have openly shared with me the notion that they just couldn't put their hand on their heart and feel good about making all that money to see three patients in a day and to spend half the day twiddling their thumbs when the lineup, the waiting list, was six months long....

Hon. John McKay: Okay.

Now, I will turn to another thing you said that I thought was interesting. Actually, there were a number of interesting things, but I only have seven minutes and I'm down to about five, or two, or whatever I'm down to now.

You didn't seem to be happy with the process of your being released. You're a lieutenant-colonel. You're well known, and you have good contacts. Whatever shortfalls there are, you can probably succeed in rearranging, so that the treatment isn't as onerous as it would be for an enlisted corporal. Could you expand on that thought? That's a pretty serious issue.

Mr. Stéphane Grenier: The only motivation that I've always had in doing what I managed to do in the last 12 years of my career was the motivation to think that if it's bad for me, imagine what it's like for the privates and corporals. That was my motivation for everything I ever tried to do or achieve, and yet again, when I was released 13 years after starting to work on all these systemic problems, the very issues that were present 12 years ago, such as the lack of transition services between DND advising Veterans Affairs that Grenier is taking these pills and please make sure that the coverage is right and I went to the pharmacy and all of a sudden I had to pay out of my pocket. That is not the issue. I had the $180 to get my pills, and I didn't go without. But what if you are somebody with a low income who doesn't have a job and who has to find $180? What happens to these soldiers or veterans? Well, they go without, and when you stop medication, that's not a good thing.

An issue that existed 12 years ago, which I along with so many others thought was over, unbeknownst to me, it happened to me. Again, the question is, if it happened to Grenier, it must be happening to someone else.

The Chair: Mr. McKay, your time has expired.

Mr. Strahl, we're going to the five-minute round with you. The committee needs to keep the comments as concise as possible in the five-minute rounds so people have a chance to get in their questions.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Mr. Chair, and thank you, Colonel Grenier, for your passion for an issue that obviously we continue to have some issues with.

Maybe we'll get to finish up with Mr. McKay's questions. To use a football analogy, it sounds as if the hand-off was fumbled between DND and Veterans Affairs. Maybe you can describe to me how the system is supposed to work. You said transitional services, so is there an organization or individuals who are theoretically supposed to do this? Where was the failure in the system? Was it in the process, or was it a matter of falling through the cracks?

As a committee that's hopefully going to make some recommendations, I'm trying to figure out what needs to change so people like you and people in much lower ranks than yours don't experience this problem.

● (1615)

Mr. Stéphane Grenier: I've been known not to invent stuff when I don't know. I'm not sure. But what the committee should be aware of, and this is an issue for the committee to look into because my information may be outdated, is that National Defence and Veterans Affairs Canada may still have two inventories of approved medication for psychiatric conditions. Part of what probably happened to me is that DND and Veterans Affairs still haven't agreed as to if this medication is covered at DND and Veterans Affairs. I believe it was approved at DND and it wasn't approved at Veterans Affairs. One has to ask, why is that? If it's good for Grenier when he's in uniform, why is it all of a sudden bad for Grenier?

In the world of psychiatry, that is probably a very small example of the dissonance in the whole mental health system, not only in the military and Veterans Affairs, but across Canada. If this were a committee that looked at mental health in general, you would discover this throughout. Not that DND doesn't need to get its act together, but the entire process is very systemic.

Mr. Mark Strahl: I think there are two departments that—

Mr. Stéphane Grenier: —need to talk.

Mr. Mark Strahl: —yes, need to talk, or if they had some seamless transition, it would be those two.

You also talked about remustering problems, recognizing of course that the military needs everyone to deploy, that a certain standard has to be met. Using the example of someone in the infantry who can no longer be around explosives, how could you see them being remustered in a way that would still allow them to meet that basic requirement? They meet the physical standards and meet all the other standards that we require of people who are in the military, but they couldn't deploy into active combat. Can you explain what you were talking about?

Mr. Stéphane Grenier: I'm not sure if the committee is familiar with employment limitations. When medical practitioners provide the leadership and the decision-makers for people's careers with information to help guide that decision-making process, no diagnosis is necessarily shared. No medical information is shared, but employment limitations are shared with the chain of command. The employment limitations normally are very clear, non-medical articulation of what the individual can and cannot do in the military. Of course, medical doctors write these things, and of course these doctors are people who are familiar with the medical company, the organization.

One case comes to mind. Several years ago we were reviewing the file of an armoured master corporal in Petawawa. The head of casualty support management and I are with the unit that releases military members, that has the authority to say, “We need to release the person, or do we have the authority to retain him? Yes, we do, but we're not sure what to do with the person.” The employment limitation in this master corporal's file was, as I recall, word for word, “can no longer serve in the armour core”. That was it. That was the employment limitation written in black and white by a medical doctor who is in uniform. To me, it clearly opens up the potential for suitability testing for another trade. Despite these very clear limitations, the occupational transfer was denied and the person was kicked out of the military.

For a case that is as clear as that, and they are not all like that, mind you, but when they are clear, these are the soldiers who should be given an opportunity.

The Chair: You were right on the money at five minutes.

[*Translation*]

Mr. Larose, go ahead.

● (1620)

Mr. Jean-François Larose (Repentigny, NDP): Thank you, Mr. Chair.

I want to thank our witness for joining us today.

Mr. Grenier, I applaud you for all the energy you have invested in this matter. What you had to say has been very insightful. I could actually ask you 40 questions, but we will stay within the 5-minute period allotted to me.

When I was in the reserve, some of my instructors had been to Bosnia. They were amazing instructors. Those sergeants were living with physical and mental injuries. I realized that during training. I saw some of them cry. I understood that this was a culture—and I see that the situation has not changed much—where everything was hidden. People would not talk about their difficulties and had to hold on to that pain. Not much was offered in terms of support. So some progress has been made, and that's a good thing.

A couple of minutes ago, you talked about incentives. I thought that was interesting. Can talking about your need for support be a problem? You talked about two issues. First, the physical aspect and the mental aspect are kept separate. Second, if someone reports their injuries and undergoes an assessment, they are likely to lose their job. Have I understood that correctly?

We have only five minutes, and I know that my other question could require more answers. What could be done to improve things in the area of incentives, given this specific culture?

Mr. Stéphane Grenier: As you have surely noticed, I don't mince words. When I am not happy, I say so. However, the Canadian Forces have made some improvements in this area. Once again, Dr. Zamorski could show you how much things have changed over the past few years.

When I left to join the Mental Health Commission of Canada, most military members—if not 80% of them—who were showing early signs of mental health issues six months after returning from Kandahar were already receiving clinical care. That was not the case during the Bosnian conflict. Generally, people would wait between seven and eight years to seek help.

In the 1990s, people would wait seven or eight years. They were hurt, things were not going well in their lives, and they were falling apart. That waiting period has been reduced to less than six months today. That is a pretty significant difference, but it does not mean that there are no problems. A lot has been done in this area, and that is a good thing. You seem to be a bit surprised.

Mr. Jean-François Larose: No, but I am glad to hear it.

Mr. Stéphane Grenier: However, this is not for everyone.

Mr. Jean-François Larose: As you said, there is a problem when it comes to incentives.

Mr. Stéphane Grenier: Yes, but the culture has changed considerably.

If we had more time, I could tell you some stories. I encourage the committee to watch a video. I can give you its title later. A 30-minute video was made about the military culture and operational stress injuries. The video shows uniformed soldiers talking a lot. I think the video depicts an everyday reality. Military members are hiding that reality much less than they used to.

The video also shows an infantry sergeant in Afghanistan, and his story is amazing. He was not given a script to read. He simply talked about what happened in Afghanistan. He talked about the experience very openly. Soldiers had told him they were becoming worried because he was starting to make bad decisions. That was after a fight with the Taliban. The culture has to have changed for soldiers and corporals to say to a commanding section sergeant that they were worried because he was starting to make some strange decisions. That would not have happened when I was younger.

Mr. Jean-François Larose: Exactly.

You talked about how important families are. That is a very important element. Where do family needs fit in in this sponsorship program? What kind of an experience do families go through? Have you noted any changes?

Mr. Stéphane Grenier: I can't really comment on the improvement. Once again, I do not have a family perspective. However, through my work, I realized at some point that there was so much isolation and guilt involved. Families don't know what is going on or what is happening to the family unit. Many wives feel guilty. They wonder whether they are to blame for the problem and feel that their husband no longer loves them. Since all those dynamics do not stem from a specific incident on a given date that resulted in an obvious physical injury—such as the loss of a leg—they erode the family unit.

Military wives are very often isolated; they feel guilty and ashamed. Once they acknowledge the problem, they need to be given support. That's why I am wondering if anything could be done to improve services for families. Currently, spouses cannot seek help from on-base clinics. They have to wait in the mental health system's queue. The government needs to determine whether those families have deserved to be given priority. That's the first question.

The second question is knowing what kind of mental health care families receive on the civilian side. I don't think that the civilian health care system was designed to deal with those kinds of dynamics or that it's strong enough for that task.

In a perfect world, those families would be provided with services on base and not in the civilian world.

● (1625)

Mr. Jean-François Larose: Thank you.

The Chair: Thank you.

[*English*]

Mr. Norlock, it's your turn.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Chair.

Through you to the witness, thank you for attending today.

I have a whole whack of questions I'd like to ask, but I have only five minutes.

I'm very interested in something. When a member is injured, physically or mentally—I'll say injured and let's forget about what kind of injury, because it's all the same—are you telling me there is no unit in the Canadian armed forces that says that officer Joe Blow has received this kind of injury, so what job is he qualified for—forget about what he is not qualified for—if he can no longer serve in that particular unit. Is there no unit that makes that kind of determination? Is it left up to the commanding officer or someone in the unit?

Mr. Stéphane Grenier: No, sir. There is a unit here in Ottawa in the headquarters that will slice, essentially. It will look at somebody's file. It will determine yes or no, the person can remuster or the person cannot. There is an office. However, the process to allow injured members to be retained in the military after an injury occurs, in my estimation, is wrongly calibrated. It is calibrated for an antiquated peacetime vision of occupational transfer. I won't apologize for saying what I'm about to say, but I'm very sorry to have the opinion that when a soldier has given 17 years of loyal service and has been on seven deployments, we should give that person another chance if they feel as though they want to serve and their employment limitations say that they still could deploy and that their limitations are that limited that they would allow the soldier to transition to a softer trade.

I'm not saying, sir, that every military person who is injured should be retained. The military exists to fight wars, but there is room for change.

Mr. Rick Norlock: I'm interested in the processes. Would the people who work with this person day in and day out—his commanding officer, the guy next to him.... I come from a paramilitary background. Is there not some kind of chain of command that says, “This is my guy. Here's what is wrong. I know him and have worked with him for *x* number of years. This is his record previous to coming under my command. He is no longer able to work in my unit; however, I think he is capable of doing this, that or the other thing”?

The commander knows what other parts of the military apparatus could handle that. Are you saying that doesn't exist, or that insufficient attention is paid to this at a higher level?

Mr. Stéphane Grenier: The unit that makes the decision here in Ottawa does so based on a bunch of reports. The commanding officer normally has his or her piece to say, and that will be factored in. I think the processes are there. The system has enough wrenches and screwdrivers to make this work. There is, however, a bit of an antiquated paradigm driving the decision-making process. I've seen the decision-making process occur, and I would not change the process. I would change the filters through which people read the files. As I said earlier, when you read a file that says the person can no longer serve in the armoured corps, it's very clear to me, and I interpret this as, what else can this military person do? However, for some reason, the people in those spots interpret the file in a very different way.

The system exists. The commanding officer has his or her say, “yes” or “yes to all”, but unfortunately there's a piece of culture missing.

● (1630)

Mr. Rick Norlock: Is the filter the person?

Mr. Stéphane Grenier: In most cases it is.

Mr. Rick Norlock: Or is the filter the system, or an attitude? People are promoted because they fit the profile that management wants. The senior military is management. It's like any company. They promote the people they think have the attitude that best meets their needs, so what you want to change is people's attitudes.

In the report we're going to write, what kind of recommendation could we make to solve that? As a member of Parliament whose riding has a very large military base, Trenton, members come to see me when they run into problems, and I'm surprised that we have as much success as we do in the system.

What specific recommendation could we make that would help change the filter?

Mr. Stéphane Grenier: I think the million-dollar question is, who audits that process? Nobody audits that process. I'm sorry, but if you are a psychologically injured soldier and you're asked to put a redress of grievances or to go to court, you will not have the energy or the wherewithal to do that. Because there is no audit process, I think the time will come, perhaps through your efforts, when National Defence is asked to demonstrate that every single injured soldier who was released could not be employed elsewhere in the military without affecting the operational effectiveness. That's the catch-all.

If you're pushing paper at the base orderly room in Trenton, how operational do you need to be? I understand universality of service, but if you dig into that principle, you will find that the navy, the air force, and the army don't test universality of service the same. If I am an infantry soldier, to demonstrate my universality of service, I go through a lot more physical exertion than if I'm in Trenton.

All that said—

The Chair: Time has expired.

[*Translation*]

Mr. Brahmi, go ahead.

Mr. Tarik Brahmi (Saint-Jean, NDP): Mr. Grenier, thank you for agreeing to appear before us today.

I would like to have a quick look at the history of the peer support program you created and at what prompted you to create the program.

I understand that this program has more in common with a psychotherapeutic approach than with a medicated one. Was that one of the factors that prompted you to create the program? We know that some people do not respond to pharmacological approaches in the treatment of mental health injuries.

Mr. Stéphane Grenier: I would say no. Just to correct the record, I would clarify that the peer-support program is not an approach based on psychotherapy or one that conflicts with a drug-based approach.

Last week, I was speaking with people who were looking to launch a peer support program for doctors in a particular province. They already have a similar program but not for mental health specifically. It's a peer support program because it's doctors helping other doctors. And they want to take that program further by adding a mental health component, given that many doctors suffer from those issues.

I think doctors understand the difference. If a doctor in a province has a mental health issue and turns to the physician's assistance program, when that person asks the doctor who is supposed to be helping them how he or she overcame the problem, the helper cannot answer the question. The doctor acting as the peer helper has never been in that situation. At the end of the day, peer support answers that question and gives the individual hope for a way forward, be it with the help of psychotherapy, drugs or other means.

That lack of hope is often the reason someone suffering from a mental health illness in our society today doesn't seek out help. They think those who provide assistance are just quacks and that the treatment doesn't work. But there's nothing like asking the question and hearing an honest and genuine answer that comes from the heart. There's nothing like hearing someone explain how they overcame their problem, knowing they will be there for you and realizing you'll get through it together.

So peer support is that ongoing assistance.

● (1635)

Mr. Tarik Brahmi: Very well.

You mentioned a problem that could arise. There can be different perceptions of what constitutes an operational stress injury versus what constitutes more of a combat stress injury.

That brings to mind a constituent of mine who suffers from such an illness. Since she was on a ship, she was not exposed to combat directly. Her injury stems more from operational stress than the stress of being deployed. She did not have first-hand experience with an explosive device exploding, for example.

What more could peers bring to the table, through your program, in those two different cases?

Mr. Stéphane Grenier: I would start by saying that, under the peer support paradigm, no diagnosis is required. The traditional medical model requires a diagnosis and a list of symptoms. Each specific intervention addresses a specific symptom. Conversely, peer support looks at the human being with the initial understanding that a specific incident need not have occurred, a bomb need not have gone off, for example, to recognize that the person has a problem. From the outset, it is understood that the person's problem can be the result of trauma, wear and tear or operational fatigue. It can be related to grief or the moral conflicts that arise when serving the institution.

By broadening our understanding of what contributes to an individual's collapse and psychological illness, we remove judgment. We look at the individual's circumstances with a broader understanding, instead of simply noting traumas. There is a sort of generalized acceptance. In short, our peer helpers are chosen because they understand those dynamics. They don't pass judgment. We look for open-mindedness. There is no doubt that if we were to limit our peer helpers to those who had been in combat, who had a very narrow view of things and who were inclined to pass judgment, the program would not be the same. At least, I would not be choosing those people. Regardless, there are selection criteria. An effort is made to choose someone who is truly open-minded and who understands that whole spectrum of causes.

[*English*]

Mr. Tarik Brahmi: Thank you.

The Chair: Mr. Chisu.

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much, Colonel, for appearing in front of our committee.

You mentioned that your PTSD and depression, after returning from your deployment in Rwanda, went undiagnosed.

I know for sure, and I went through these things, that there are pre-deployment checkups and post-deployment checkups for Canadian armed forces members to try to curtail the development of combat-sustained injuries, including mental injuries. On top of this, when you are promoted from one rank to another, at least in the regular force, you need to go through a medical checkup, at least at the officer level, and when you leave, you have another medical checkup.

How are these different? I understand, and I personally experienced it, that when you are deployed, the pre-deployment checkup is very thorough and very well done. Post-deployment is less so. When it comes to a release from deployment checkup there is none or it's quite non-existent.

I just retired in 2009. Is there any difference in this one, or do you observe the same things I observed?

Mr. Stéphane Grenier: In my case, remember that the undiagnosed issue is post-Rwanda. In Rwanda there was no pre-deployment screening. There was no post-deployment screening in those days, in 1994.

Mr. Corneliu Chisu: It was there for Bosnia, I think.

Mr. Stéphane Grenier: In some cases, but it wasn't systemic.

In any case, the issue for me is when I became suicidal in 1995, about six months after my return, I showed up at the hospital, went through tests and all that, and was basically given a few sleeping pills and sent back home. This was in 1995. About a year later, a diagnosis appeared in my medical documents. At first I was undiagnosed and I lived like that for a year. Eventually I was diagnosed, but what the bio doesn't say is that nobody called me to say, "We just found out what's wrong with you", so I was untreated for many years. But that was back then and it's important not to think that what happened to Grenier in 1994, 1995, and 1996 is still happening; no, I think it's very different now, but this is why....

When I went to get help, no diagnosis was given, and when a diagnosis was given, nobody bothered to tell me. That wasn't very helpful back then, which is why I became so passionate about stopping this system that was letting the walking wounded, like me, just wander off and try to fix themselves.

● (1640)

Mr. Corneliu Chisu: That's how it is now. You have a pre-deployment—

Mr. Stéphane Grenier: Yes, now there's a pre-deployment, a post-deployment—

Mr. Corneliu Chisu: There are differences between these checkups. I noticed that when you are in post-deployment, it is very superficial, and I served in the regular force.

Mr. Stéphane Grenier: It's screening.

Mr. Corneliu Chisu: When you are leaving, it is non-existent.

Mr. Stéphane Grenier: Yes, you fill out questionnaires—

Mr. Corneliu Chisu: They're just asking you to tell them if you have high blood pressure, to pay attention to that one, and so on. Should that not be a little bit more serious?

Mr. Stéphane Grenier: I don't know. You see, if I were a medical practitioner, I could comment on that, but I'm not an occupational doctor, so I would reserve judgment.

My issue, though, is if a soldier is diagnosed with a condition that is caused by the military that Veterans Affairs should pick up, that transition should be very seamless. I could have cancer right now, but the military doesn't know. Maybe they didn't do a thorough checkup. If I have cancer, and I die of cancer later on, it won't be the military's fault. In a sense, for those injuries and conditions that the military is aware of, well, those should be properly transitioned. Whether the release transition medical process is thorough enough, I couldn't comment. Honestly, it's not my area of expertise.

Mr. Corneliu Chisu: Okay.

I have another question.

The most traumatic day in the life of a soldier is when he's forced to retire or is retiring from the armed forces. How would you comment on this?

Mr. Stéphane Grenier: I think the military culture is a very demanding one. I don't think it is worse. It's not an issue of degree, whether it is worse or better. It's very demanding and it's unique. The whole transition, I believe, from the military mindset and the military way of doing things to the rest of society and how society operates, and how they reintegrate into the other ways of functioning is a big change for a healthy person. Therefore, for a person injured in the mind, who is literally ejected and rejected from the system, I believe it is very damaging. I think the system has improved that process; however, there are many people who go through that process who should not go through that process. They should be retained in the military. They could continue to serve. That's the sad thing.

The Chair: Thank you.

Mr. Allen, it's your turn.

Mr. Malcolm Allen (Welland, NDP): Thank you, Chair.

Thank you, Lieutenant-Colonel Grenier, for your testimony.

I'm going to posit the civilian side of this. I actually have experience around the civilian side, coming out of a trade union movement, where I represented workers. I don't want to suggest by any stretch of the imagination that the occupations are similar, or the cultures, or the sense of duty of what has to happen or not. Clearly, the military has a different sense of what it needs as preparedness versus a worker in a work environment, but the work environment, at least in the province of Ontario, has what's called the duty to accommodate. This simply means that if you're injured, regardless of the injury, physical or mental, an employer has the duty to accommodate within certain parameters. It's not at all costs, clearly. Sometimes a worker is not able to return to any work that the employer has.

Help me if I went down the wrong path with this. What I heard from you earlier, and I'll use your example of someone who's in the armoured corps, was that the duty to accommodate, if I can use that term in the military sense, is you must be able to do the piece that you're in rather than something else. You must be fit for the armoured corps, period, or sorry.

If the military took the position within the confines of the things it needs to do—and I'll grant it's a limited field versus perhaps that of civilian employers, in that their field might be wider in some but not all cases, but it seems the military one might be a narrower place—is there not a sense that folks sign up voluntarily? They're looking for careers. They're looking to put in their time, whatever that is, 25 or 30 years. These are not folks who want to serve one term and go. These are folks who've opted to continue. Is there not a duty to accommodate them somehow, give them opportunities? Should we not have a system that checks the boxes off along the way: can this person from the armoured corps go to this position; if not that one why not this one; and if not that one, why not this one; and then sorry, there are no more other places and the person will have to be transitioned out. The debate about the transition services is a different piece.

In your sense, sir, is that something perhaps this committee needs to think about in recommendations when it comes to folks who have limitations, whatever those limitations happen to be, because of an injury?

● (1645)

Mr. Stéphane Grenier: The committee should be aware that there is a duty to accommodate process in the military. Do I agree with the process? The answer is no. Do I trust the process? No. I simply don't agree with the way it is being applied.

Every year every trade in the military provides a certain percentage of vacancies for every trade and at every rank level. As an example, there could be three billets for infantry warrant officers in the entire infantry corps for accommodation purposes. That means the military has embraced the duty to accommodate process and will actually select people to fill those billets on an accommodation provision.

As you are probably aware, it's until there's undue hardship on the organization, which is why it limits the number of billets per rank, per trade. It's understandable that if an entire trade were to be plagued with injured members and it couldn't deploy, then they would not be serving you.

Where I have an issue with the duty to accommodate process is that it's on a first-come, first-served basis, which makes no sense to me. If you are up for an accommodation at your rank in your trade on January 2 and the list was published on January 1, you are automatically pigeonholed in that billet and you block a billet. It might have changed, but as far as I know there is not yet a process by which we also recognize length of service, merit, and other factors. In other words—I hate to be crude—what if an incompetent.... We do have incompetent sergeants or captains.

To me, there is an issue there. There are limitations to the process, and I understand that, but I find that it could be upped a little bit. Duty to accommodate does exist in the CF. It is being applied. I think it could be improved a little bit and it should not be on a first-come, first-served basis.

The Chair: Thank you.

Time has expired.

Mr. Opitz.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Mr. Chair.

Turning to our witness, thank you very much for being here, Colonel. I do appreciate it sincerely.

I hear you on duty to accommodate. I think that bears a little bit more examination on how it's being applied because things do change when we leave, too, and I think we need to do some due diligence to find out. Because the military isn't always the first to tell you that it's changed something, I think it bears some looking into.

I want to talk about families right now. You said at the beginning of your comments that families are the last to know, or the last involved, in some cases. In some of my experiences where I've been personally involved in this, I've made sure that families were part and parcel first and right there every step of the way.

Can you describe why you think families tend to fall to the bottom of this list, in your view?

Mr. Stéphane Grenier: Quite clearly the military is not allowed to treat families, and therefore in theory they don't. However, in my past role in the military as stress injury adviser to the chief military personnel, I visited bases and came across some very innovative social workers who would see families unbeknownst to the system. If the base surgeon would ask questions, the social worker would say, "Well, I was seeing the military member and the family"—that's legal—"but the military member had gone to the washroom". It's a very innovative way to deliver health care to families, and that shouldn't be. I think it's putting our health care professionals in a very.... They know that they need to provide treatment to the family, and they have to do it *au noir*, and I think that's just not called for, but by law, National Defence cannot deliver health care services to families.

That is why I think you will see literature in the military that indicates "for our members and their families". Veterans Affairs will publish things indicating "for veterans and their families". Families are always an afterthought. Of course something needs to come first or second, but strategically and philosophically, families have been forgotten.

I strongly believe, and there is literature to prove that I'm correct, that if you can finally deliver health care to the entire family system, it will pay back, because if the family system is allowed to implode, your military person will continue to implode and leave the military. If you manage to intervene at the family level, the benefits to the military member will come back in droves to the federal government.

It's simply a different approach, and there is a precedent. In Germany, military wives could go on the base and seek health care from the military. There were exceptions in history. I think it's time to look at those exceptions again to see if we can't change things.

● (1650)

Mr. Ted Opitz: Point taken.

I'd like to shift a little bit to outside organizations and get your opinion on how effective they may be in working with soldiers who may have OSIs, and just transitioning, not necessarily remustering or anything like this. You're familiar with True Patriot Love, Canada Company, and the Canadian Institute for Military and Veteran Health Research, and folks like that. What is your opinion of their effectiveness in how they treat soldiers who have OSIs and general injuries as well?

Mr. Stéphane Grenier: I hate to say this, but I'm not familiar enough with their success and their programs to comment, but what I do find is that there is a continued need for organizations like this. The Wounded Warriors foundation was very effective in some areas. I believe it's a great complementary system. When our federal bureaucrats cannot fix a problem because the soldier's falling through a gap, then these programs can probably pick up where legislation drops the ball.

I'm not saying it's deliberate, but I have seen the efficacy of such programs. I think they're instrumental, generally speaking, in making sure there's a safety net around our federal programs, so, bravo to them, but I can't comment any further.

Mr. Ted Opitz: Are you familiar with the Treble Victor Group?

Mr. Stéphane Grenier: No.

Mr. Ted Opitz: Then we won't go there.

The Chair: Mr. Leung, your turn.

● (1655)

Mr. Chungsen Leung (Willowdale, CPC): Thank you, Mr. Chair.

I have not had the privilege of serving with people in uniform, but I did serve as a military adviser in UNCTAD. My area was in the provision of emergency water, emergency power, and shelter. I must admit that having been in areas of non-combat, I also feel the effects of how the operational stress injuries could happen because it does happen to those of us who are not in uniform. Because we serve with a broad contingent of people in these UN missions, is there a difference between an actual engagement in the combat situation versus in the non-combat situation? Sometimes these different types of operational stress injuries will manifest themselves much later in life.

I'll share my personal experience. I was asked to do some water purification work and I came across a mass grave. I must say that was something that still affects me today. From time to time I often ask myself whether I should seek some psychiatric care, even though I feel very strongly that I can handle the psychological impact of that and I'm still functional, but again, a lot of these things can manifest much later in life.

Perhaps you could share with us how we should look at the combat situations versus the non-combat and peacetime situations where we are put in a situation of operational stress.

Mr. Stéphane Grenier: I think what your question alludes to is the core of the definition of the four causes of operational stress injury, the four causes that we developed in cooperation with the U. S. Marine Corps in the 2007-08 era.

Very clearly one is trauma. I believe it's very fair for me to say that if you are in a combat situation, you are experiencing high-intensity trauma. That's the trauma perspective, or the trauma lens, that allows, unfortunately, some people to develop mental health conditions from traumatic events.

The three other causes of operational stress injury are those causes that are under-endorsed, misunderstood, and often ignored. This goes back to an earlier question. These are the three other causes which, by the way, remain to this date, despite years of fighting in Afghanistan, I believe, the top causes of why soldiers decompensate. They are fatigue, the cumulative wear and tear on the soul.... I'm not talking about being tired and wanting to sleep. I'm talking about the fatigue of really having a hard time continuing to do what you're doing because there have been too many mass graves.

There's grief. Grief is that sense of loss. When you look at grief as a cause of stress injury, you don't need to know your friend or you don't need to know the person who died. It's a sense of loss. It's a corporate sense of loss. Mr. Alexander was in Afghanistan. There were a lot of ramp ceremonies, weren't there? The entire contingent grieves. I lost only two soldiers on my tour of duty. I knew them very well. I grieved at a different level. But every time a coffin came back to Canada, there was institutional grieving, and there's a cost to that.

Finally, there's the moral conflict. Moral conflict is probably the most important cause of stress injuries, and I think it's what you're alluding to. You went overseas thinking you would do *x*, *y*, and *z*, and all of a sudden you're confronted with situations that don't quite fit. You're not too sure what to make of all of this. It causes moral conflict, questioning, and it opens a Pandora's box.

Whether you need treatment, sir, I couldn't say, but the fact that you're talking is a good thing, and it just shows your humanity. For that, I applaud you.

Mr. Chungsen Leung: I've always been very open about my experiences, but I am just thinking of it from an institutional point of view. What this committee needs to bring to the attention of Parliament is whether our role, our international role as peacekeepers in the future, because we're not always in a combat situation, should be included in this entire framework of support services for operational stress.

Mr. Stéphane Grenier: Absolutely, which is why I said now that we're not in a combat role, we cannot let these programs erode, because we will be one day. Peacekeeping erodes people as much as combat does. I'm convinced of it. I hope that one day Parliament will calculate the human cost of all these operations, not fuel, boots, tanks, and planes, but the human cost.

The Chair: Thank you. The time has expired.

Before I skip to the third round, I want to get in a couple of questions myself.

I'm listening to your testimony, Colonel, and you're talking about the delivery and some of the gaps between different levels, for example, between Veterans Affairs and National Defence, and provincial services versus the quality available within the Canadian Forces.

I don't know if you're familiar with the ombudsman's report to the minister, “Fortitude Under Fatigue”. The sixth recommendation is that the CF's strategic leadership consider the viability of a more modern application of the principle of universality of service.

Is that what you've been trying to get at in your testimony today, that we need better universality?

● (1700)

Mr. Stéphane Grenier: Well, I will be very candid, Mr. Bezan, and say that I think there is no such thing as universality of service. I'll be very candid again. I'm not in uniform anymore, but I think it is a figment of the Canadian Forces' imagination to think that every soldier, sailor, airman, airwoman is put up against the same standard in order to validate their physical and mental ability to serve their country. I know for a fact that if you are a corporal at 2 RCR in Petawawa, in order to demonstrate your ability to serve against universality of service standards, it is significantly different from if you are, let's say, an air frame tech serving in Trenton, which is why this paradigm of ours has to change. If you are an infantryman and can no longer demonstrate universality of service in Petawawa, where the standards are much higher than in Trenton, let's stop kidding ourselves. Give that person a chance. Let the person go to Trenton, and I bet you that person will meet the universality of service. It is the biggest misnomer, in my estimation, that we have to wrap our minds around, and the ombudsman is completely correct.

The Chair: Would a recommendation of how we go about achieving that be changes in the philosophy within the leadership?

Mr. Stéphane Grenier: I would have to think about that. I did not come prepared to answer the question of how, but I do know that it does start at the leadership level. I do understand that hopefully there will one day be a chief of military personnel or a chief of the defence staff who will accept that this universality of service thing is a figment of their imagination. It's a bit like an alcoholic finally realizing that they have a drinking problem.

Some of our leaders unfortunately have not realized that it's a joke, quite frankly. Until that happens, nothing is going to change.

The Chair: I applaud you for all the work you've done in reducing the stigma and putting together the organizations to provide the support to our members of the Canadian armed forces.

One of the witnesses we had here last week was from the True Patriot Love Foundation. Bronwen Evans actually made the comment that the women who serve us in the Canadian armed forces are least likely to come forward and say that they are suffering from PTSD or they have some other OSI.

In your experience in the work you've done in and outside the Canadian armed forces, do you see that as well, that women aren't stepping up to say they have a problem and they need help?

Mr. Stéphane Grenier: I don't have decades of experience in my civilian work now, but I have to say that every meeting I go to, every corporation I work with, the majority of people who are stepping up are in fact women. So if True Patriot Love is reporting that women aren't coming forth in the military, I would say that is not consistent with what I've experienced. I find that I work with a lot more women out there who wish to engage in these programs than I do men. However, I don't know what that's attributed to.

I have to say that—

The Chair: To quote her, she actually said that women are concerned that they are going to be perceived as not being able to cut it.

Mr. Stéphane Grenier: I don't know what it's like to be a woman in the military; I have no idea, but I can imagine that in order to make your place in a man's world, you're going to have to work perhaps as hard or harder. Therefore, when you've achieved that, the demise could be that much more rapid if you expose these potential vulnerabilities or perceived vulnerabilities. I can imagine that it is most likely true; however, in my experience in the military, I did see a lot of women come forward. Actually I had outstanding peer supporters who were women who were doing an outstanding job.

I think the women who engage in our program were representative of the demographics of the military, but I'm not saying this to dispute your former testimony.

The Chair: Thank you.

We're going to go to our third and final round so that everybody has another chance to ask some questions.

Madame Moore.

● (1705)

[*Translation*]

Ms. Christine Moore: Thank you, Mr. Chair.

I'd like to come back to the peer support issue.

As far as programs go, it's clear that people have a very hard time overcoming the stigma and admitting they have a mental health problem that is affecting their life. Alcohol or substance abuse problems are prevalent. In terms of alcoholism, Alcoholics Anonymous is one example of a peer support program that works well.

The situation is different when it comes to drugs, however. Unlike in the civilian world, where drug use doesn't have a stigma, in the armed forces, it does. So on top of the initial stigma of having a mental illness, people face a secondary problem. If someone talks about their drug use, they risk ending their military career.

How can we handle drug or substance addiction by members of the armed forces more effectively? Could peers play a role in that regard? I would appreciate hearing your view on that problem.

Mr. Stéphane Grenier: You're no doubt ware that DND introduced blind testing policies to screen for those who could be taking drugs. As parliamentarians who study these matters, you also know, however, that soldiers are resourceful people. Our soldiers are extremely resourceful.

Something unexpected and unintentional happened. Under a policy that was put in place, testing was done to check whether anyone had used drugs on the weekend, for example. And soldiers in some places began replacing cannabis with harder drugs such as cocaine. Why, you ask? Because cocaine is eliminated from the body in 24 or 48 hours, whereas cannabis stays in the blood stream or urine for months.

From a strategic perspective, then, it's important to first consider the unintended consequences that our drug testing policies could have. When a soldier uses drugs or alcohol to cope with a mental illness, that addiction is what we call the presenting problem, but it's not the underlying problem. Unless we're talking about a criminal thug who slipped through the cracks at the recruitment centre, generally speaking, substance abuse is a way to cope with the illness.

What is imperative is to treat the illness, ensure it is recognized. Through a strategic lens, I believe we need to maintain our peer support programs to encourage people to seek help as early as possible. It's extremely important that we not let austerity measures in difficult years chip away at mental health programs for Canadian Forces members. The worst thing the government could do would be to allow the army to cut what is sometimes perceived as fat. We've finally got some good programs. It would be a sin if the army lost them.

To answer your question, I would say that, first of all, the current screening system could be having devastating consequences on some individuals because they are so resourceful. Second, I would say that we really need to continue focusing on mental health. That is my view.

Ms. Christine Moore: As things stand now, do members of the Canadian Forces talk about their drug use or do they keep quiet about it until they are caught? Do people ever seek out help before they are found out?

Mr. Stéphane Grenier: Again, this is my opinion and I can't prove it. But my intuition tells me that among younger members, say those with less than 10 years of service, 4 or 5 years in, for example, a certain culture has developed in some units. It is seen as cool. Certainly, like anywhere else, people don't shout it from the rooftops, but it is known within their group, and they party hard on the weekend.

As I said, members of the military try to get around the screening policies. Cannabis is cheaper but riskier when it comes to testing. Cocaine is more expensive but less risky in terms of testing. The drug problems today are a bit more complex than they were when people stuck to cannabis.

● (1710)

Ms. Christine Moore: Basically, then, people get help only when they're caught and backed into a corner, in other words, if they are forced to do something.

Very well. Thank you.

Do you know the percentage of program participants who are active members, meaning, those still serving in the Canadian Forces, versus the percentage of veterans who are in the program?

Mr. Stéphane Grenier: Unfortunately, I don't have any numbers with me. I've been away from the program for three years now. But those numbers are easy to get. There shouldn't be any trouble obtaining that information.

Ms. Christine Moore: Were many women available as peer helpers?

Mr. Stéphane Grenier: You mean women acting as peer helpers?

Ms. Christine Moore: Yes.

Can a female member ask to speak with another female, or is she simply assigned someone without the option of specifying the helper's gender? In terms of post-traumatic stress syndrome, say, a woman may have an easier time talking to another woman.

Was that a possibility?

Mr. Stéphane Grenier: You bring up an important consideration when it comes to the peer helper. When I put programs in place in private industry or large companies, we do the same thing. There isn't an official way to access peer support. In other words, the person who needs help seeks out a person of their choosing. If you look at the OSISS website, you will see a map of Canada with all the names of those who are available. If you're in Petawawa and you'd like to speak with Janet in Winnipeg, you can call long distance. The cost of the call is covered by taxpayers, but that's okay. People are talking.

That's a fundamental difference from the medical system, which is very much planned and extremely dogmatic. The medical system relies on reference material and prescriptions. The peer support system conflicts with that philosophy. It's a complementary system. Philosophically, it's a huge departure, but it's not a problem. The peer support system doesn't work like that.

My answer is affirmative. The individual chooses the person she feels comfortable with.

[*English*]

The Chair: Merci. We're well over our time.

Mr. McKay.

Hon. John McKay: Your testimony has been a fascinating two hours. I appreciate the effort you've made to be here.

I have a couple of issues.

The observation you made about soft drugs and hard drugs is one I've heard about. Soldiers are very clever about getting around whatever tests they need to get around.

I want to go back to the beginning, in terms of when you decided the military needed to run peer support programs. My observation, from testimony here, is that the walk and the talk don't actually match up all the time. Soldiers say, “We really need this kind of therapy”, and the brass are saying, “We don't have any empirical evidence that this actually works”, and there are arguments to be made on both sides.

I'd be interested in your experience with respect to the genesis of the proposal for the peer support program and what your observations were with respect to getting it off the ground, as well as what resistance, if any, you received, and how you measure success.

Mr. Stéphane Grenier: Regarding resistance, at the time there was a very entrenched clinical paradigm, which incidentally I think the military is slowly gravitating back towards, unbeknownst to itself, perhaps. They're letting the clinical world re-influence everything, which, I think, is part of the problem. The impetus for this was really to give a very active, proactive engaged role of leadership.

I travel the country now, providing keynote—

Hon. John McKay: Engaged role of leadership by whom do you mean?

Mr. Stéphane Grenier: I mean by the leadership itself to recognize that the mental health of its members is not a clinical matter.

When somebody is ill, it's definitely a clinical issue. Somebody needs proper treatment, etc. But the mental health of any employee in Canada is not a doctor's responsibility; it is a leadership responsibility. Corporate CEOs and vice-presidents have the mental health of the employees in this country in their hands. What they choose to do with it is up to them.

Until we started this peer support revolution, I would contend that we had a very dogmatic clinical paradigm, which was the only paradigm through which the military looked at mental health. Therefore, the minute people exhibited behavioural signs that were not acceptable, they were told to go see the shrink. That to me is the fundamental problem.

The minute people start decompensating, it doesn't mean they need a diagnosis and they need to take pills. They might need to have a chat. They might need their boss to put an arm around them and say, “Let's talk.” Whatever happened to human interaction in the workplace? The only human interaction we have nowadays is, “Did you get my e-mail?”

Essentially we have dehumanized workplaces in the military and probably everywhere else in Canada. This whole movement for peer support strategically, as I now do my work with civilian industry, was to literally re-humanize workplaces, one after the next. That was the impetus.

The barrier was the clinical paradigm of thinking that an injured soldier.... God forbid an injured soldier would be able to wear his pants, show up at work on time, and support somebody else without getting further injured. And I think, 13 years later, they're all still doing this job—well, not all of them. Some left the program, and that's a good thing. But do you know what? Nobody committed suicide, and things have been fine.

Measurement is another issue. I'll share with the committee that since I retired from the military, I created a non-profit organization in this country, mandated through Industry Canada, to validate and measure the efficacy of peer support in this country. I'm a volunteer board member. If DND wants to measure, they can contribute to this non-profit organization and we'll be happy to measure. So the measurement matrixes are there.

● (1715)

Hon. John McKay: My impression with General Natynczyk is that he was very supportive of mental health issues.

Mr. Stéphane Grenier: Yes.

Hon. John McKay: It really was a marker, if you will, of his career. Yet you're saying that in this era of retrenchment and cutbacks, you're afraid that these programs will just go south, or they'll be, if not wound up, certainly circumscribed.

Do you have a specific list of programs that you're concerned about, or is this a general feeling on your part?

Mr. Stéphane Grenier: I think history has demonstrated that when the budgets are tightened...and perhaps rightly so. You know what? We all have our opinions. But having been through the mental health gauntlet myself, and having come close to killing myself, I know how important it is to not allow the erosion of programs for our men and women in uniform.

Therefore, this is my opinion: history has proven from time...or it has as long as we've recorded this, and my prediction is that in the next five years, with austerity measures, there will be a slow erosion of these programs. I don't think you will see a lot of slicing of programs systemically, but the erosion will slowly occur.

My thinking is that unfortunately, some of the non-clinical programs will erode. I've seen already the first sign of this. It may be a symptom. The joint speakers bureau, a non-clinical mental health education approach that's under director casualty support management, which is the leadership end of things, has now been transferred over to the surgeon general.

That's strategic mistake number one. When the surgeon general needs more money to buy scalpels, what is he going to cut? He's going to cut the perceived fat. Why? Because now you have a doctor making decisions on what is important to the doctor.

I believe that non-clinical mental health programs may end up—I'm not saying they will, but they may end up—as a casualty of these cuts.

● (1720)

Hon. John McKay: Scalpels: no pun intended.

Mr. Stéphane Grenier: No, of course not.

Hon. John McKay: Okay.

Thank you.

The Chair: The final round of questions goes to Mr. Alexander.

[*Translation*]

Mr. Chris Alexander: Thank you, Mr. Chair.

We find this conversation extremely thought-provoking. We very much appreciate all aspects of your input. You put your finger on a crucial consideration in this very extensive phenomenon of injuries related to post-traumatic stress syndrome and those that are not combat-related. They include grief, fatigue and moral conflict. Those are different dimensions of mental anguish that people experience during civilian and military missions, when they are close to the conflict or around the loss of life.

From my own experience, as well as your comments, I gather that the incidence of injuries varies. It depends on the nature of the mission, the nature of the operation and the geographic region. Even the outcome of the operation, how the mission turns out, is a factor. It also depends on what happened afterwards. Was the mission deemed a success or not? Is that a relevant factor?

Mr. Stéphane Grenier: Absolutely, I would say so. You've no doubt heard stories about some soldiers who wanted to go back to Afghanistan to die there, to finish the job or to avenge fallen comrades on some level. Without question, the ambiguity around our success in Afghanistan will remain a moral dilemma. With the benefit of a few years, those who may still be grieving the loss of comrades who died in battle, or what have you, will ask themselves the fundamental question: What did they accomplish in Afghanistan? Certainly, the outcome of the mission there has yet to be determined. It may take another 10 years.

But the fact remains, that fundamental question must be asked for all missions, not just the one in Afghanistan. Unfortunately, General Hillier placed so much weight on Afghanistan that nothing else mattered. All of that attention was well-intentioned, but I would say it caused many soldiers returning from other missions to feel as though they didn't matter.

That damage to someone's morale in an institution is the strategic equivalent of one parent paying more attention to one child over the other. All of this importance was placed on Afghanistan for all those years. To my mind, that showed a lack of mature leadership to some extent.

Mr. Chris Alexander: We all know that choices have to be made when it comes to investments, political intentions, financial resources and so on, as far as the challenge of mental health care goes. I am going to give you four options. The first option is to invest in professional medical treatment and shore up that dimension. We're trying to do that, but there are still deficiencies, as you know. The second option is to invest in leadership and, in particular, to raise the quality of leadership during that post-combat period. The third option is to invest in peer support programs, which you are quite familiar with. The fourth and final option is to invest in prevention programs and to strengthen members' resiliency before the fact.

Of course, investment is needed in all of those areas, but where do you think the priority lies?

Mr. Stéphane Grenier: As far as treatment goes, we're there. It's good. From my experience, it's fine.

As far as peer support goes, the program exists and is working well. Don't change it. Don't let it disappear. No more investment is needed on that front.

As for leadership, I believe leadership education programs already exist.

If I could make one recommendation, it would be to invest in prevention. Prevention of what? The next strategic turning point, North America-wide, Canada-wide and Canadian Forces-wide, is suicide prevention.

We haven't even begun to understand suicide, despite the epidemiological studies that have been done. I had a rope around my neck, Mr. Alexander. I was three minutes away from hanging myself. My email to the police was written. All the arrangements were made. With the benefit of hindsight and with that experience in mind, I can say that we don't understand suicide when I look at prevention efforts today.

● (1725)

[*English*]

I didn't fit the model of suicide when I had the rope around my neck.

[*Translation*]

So I would say, invest in suicide prevention.

The Chair: Thank you.

Mr. Chris Alexander: I would just like to wrap up with one other thing, Mr. Chair. When I was a student, I worked in Montreal with communities that were dealing with the challenge of people wanting to take their own lives. I still watch the situation closely today. Mr. Grenier, you are very brave for speaking up, for continuing to speak up and for doing the work you do. Thank you.

[*English*]

The Chair: We thank you, Colonel, for coming to committee, for your frankness, your honesty, and for providing your expertise. I also thank you for your general concern and empathy for your fellow soldiers, for people who have served, and your leadership in establishing the peer support groups, and having the joint task force in place to help all those who need assistance.

I have family members who battle depression and I know how severe it can be and how it influences the rest of the family as well. I want to thank you for your commitment and your continued role in OSI and other mental health issues.

With that, the meeting is adjourned.