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# Standing Committee on National Defence

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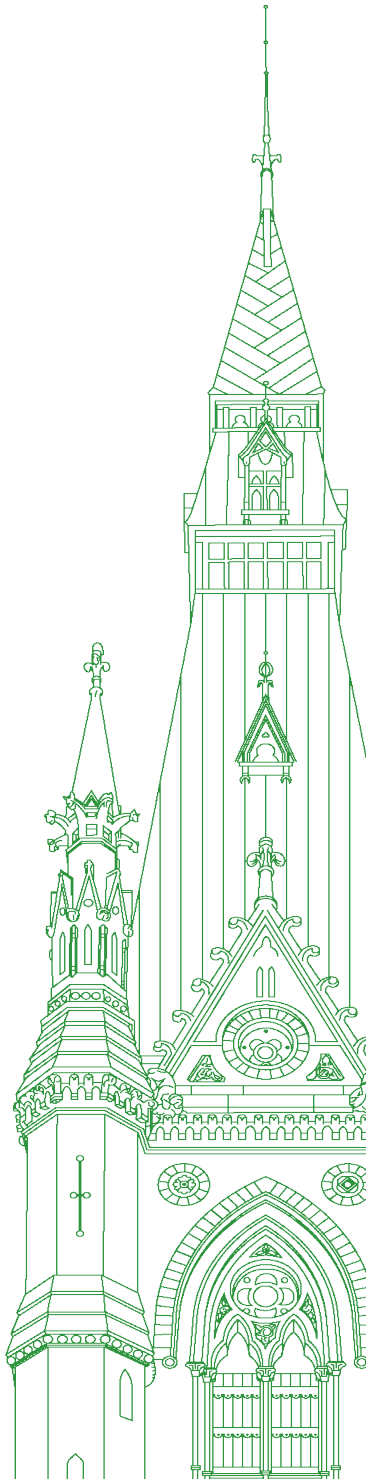

Chair: Mrs. Karen McCrimmon

# Standing Committee on National Defence

**Monday, November 30, 2020**

● (1110)

[*English*]

**The Chair (Mrs. Karen McCrimmon (Kanata—Carleton, Lib.)):** Ladies and gentlemen, I'm calling this meeting to order.

[*Translation*]

Good morning, everyone.

[*English*]

Today's meeting is meeting number eight of the House of Commons Standing Committee on National Defence. We're in a hybrid format, as agreed by the House order of September 23, 2020, so the proceedings will be made available on the House of Commons website.

Our meeting today will be twofold. Our first panel for the first hour will be composed of Ms. Sheila Fynes, who is the parent of veteran Corporal Stuart Langridge, who died by suicide in 2008.

Also, we have Ms. Jackie Carlé, the executive director of the Esquimalt Military Family Resource Centre. Good morning, Ms. Carlé. I know it's early in B.C., and we thank you for joining us today.

After a short pause around noon, we will engage with the second panel.

I want to start by thanking Mrs. Fynes for her testimony and for joining us here today. Thank you for having the courage to join us here today. I know it's not easy, but it's really important that parliamentarians actually hear from people like you, and that we listen, even though it might be difficult to do so. We have to try.

The programs we put in place, the policies we put in place, are designed so that we can make people's lives a little easier, maybe a little bit brighter. We do that by talking to the people with lived experience and experts, and bringing all that information together.

As a veteran as well, I acknowledge your son's service to this country and let you know that we're deeply sorry for your loss. I must say that your courage... I mean, it's inspirational to all of us that you still keep going, as painful and as frustrating as I can just imagine, and I can only imagine, it must be. It's hard and difficult, but I wanted to thank you. I wanted to acknowledge what you're doing. It's important. What you have to say to us today is so very important for us to hear, because this is all about people.

With that, thank you for joining us today, and I thank you in advance, and I will now ask you to take the floor, Mrs. Fynes.

**Mr. James Bezan (Selkirk—Interlake—Eastman, CPC):** Just a quick point of order, Madam Chair, for whatever reason, my English channel doesn't work. The floor channel does.

**The Chair:** Okay, yes. Right now the translation from French to English is not working, so maybe you can put it on "floor" for now.

**Mr. James Bezan:** That's what I'll have to do. Okay.

**The Chair:** We're working on something in the background about the translation to English. We've got about 12 minutes of grace time before our first French-speaking intervention. If we don't get it fixed in 12 minutes, then we will stop. All right?

**Mr. James Bezan:** Okay.

**The Chair:** In this first 12 minutes, I believe that most of the conversation will be in English, so "Floor" would be acceptable. I'm sorry. I should have probably said that first, before my intervention.

All right, then. Thank you very much.

We'll go over to you, Ms. Fynes.

**Ms. Sheila Fynes (As an Individual):** Thank you, and thank you for your kind words.

Good morning, Madam Chair and committee members, and hello again to those members I have met before.

My name is Sheila Fynes, and I will begin by thanking you for this opportunity to speak to possible revisions to the National Defence Act, specifically regarding section 98(c). The specific elements of that offence that are of concern are:

> 98. Every person who:
>
> (c) wilfully injures himself...with intent thereby to render himself...unfit for service...
>
> is guilty of an offence and on conviction, if he commits the offence on active service or when under orders for active service...is liable to imprisonment for life or to less punishment and, in any other case, is liable to imprisonment for a term not exceeding five years or to less punishment.

That's a lot of words.

Notwithstanding the need to support good order—

● (1115)

[*Translation*]

**Mr. Alexis Brunelle-Duceppe (Lac-Saint-Jean, BQ):** Ms. Fynes, I am really sorry to interrupt you.

I have a point of order, Madam Chair.

We no longer hear the French interpretation. I'd really like to hear Ms. Fynes' testimony in French.

**The Clerk of the Committee (Mr. Michel Marcotte):** We'll do a quick test. It won't take very long.

[*English*]

**Ms. Sheila Fynes:** May I continue?

**The Chair:** One minute, please.

[*Translation*]

I'm told that things are working now.

**Mr. Alexis Brunelle-Duceppe:** Indeed, it is working.

Thank you.

**The Chair:** Ms. Fynes, you may continue.

[*English*]

**Ms. Sheila Fynes:** I believe that, even if never used, this subsection provides an unintended negative consequence simply by remaining in force.

In 2007, while completing the last phase of training towards his next promotion, Stuart admitted in a questionnaire that he suffered from chest pains. That triggered a return to his unit, where he was placed under military medical care. We did not know at that time that chest pain is symptomatic of post-traumatic stress disorder. In the year following, until his death, Stuart was dispensed multiple prescriptions, but went progressively downhill and suffered nightmares and night terrors. He also began to self-medicate, primarily with alcohol, supplemented by marijuana, the latter now being an accepted and provided treatment.

As his condition deteriorated, Stuart began what became a series of suicide attempts and accompanying emergency hospitalizations. He became more and more isolated from his military comrades and began to see himself not as a good soldier but rather, as he put it, “one of those losers”.

In desperation, towards the end, he took himself to a local civilian psychiatric hospital for help and was admitted. At the end of the standard 30-day mental health certificate, he wanted to continue in treatment but was surprised when he was ordered back to base instead. A few days later he was placed on what were later described as restrictions, but they in fact closely resembled defaulter's discipline. He was subjected to a curfew, as well as an extended work day. He had to report all his movements on a form at the regiment and report in every two hours. He was required to sleep with the door open in the defaulter's room behind the duty desk at the regiment. He was completely shamed and humiliated.

Reportedly, a decision had also been made that he would not be allowed to attend a treatment program at a cost of about $50,000, and Stuart became even more dysphoric. He gained access to a room at the barracks, purportedly to do laundry, where he instead hanged himself.

Fifteen months after his death, we were informed that Stuart had left a note apologizing to his family that he could not take the pain anymore. The application of quasi discipline to a mental health problem was a spectacular failure that cost our family a son, a brother and a grandson. It also cost the military a dedicated, extremely well trained and experienced soldier.

Indicative of the prevailing attitude at that time was a bizarre suggestion at the board of inquiry that followed: Officers opined that Stuart could not have acquired post-traumatic stress disorder from his deployment as a recce soldier and his patrols in the mountains of Afghanistan.

Thankfully, much has been learned since then, and post-traumatic stress disorder or, more generically, operational stress injury, is now accepted as a bona fide injury. In that paradigm shift, effectuated by a new generation of leadership in the forces, extensive new suicide prevention strategies have been implemented and more treatments are becoming available. Victims are no longer written off as just discipline problems. The institution now encourages a more contemporary warrior ethos, which recognizes that soldiers, however exceptional, are humans and not machines. Even thinly disguised discipline is misplaced abuse of the subordinate and is no longer a default alternative to medical treatment.

Currently, the military justice system has come under general scrutiny, and a review headed by former Supreme Court Justice Morris Fish has been undertaken. Hopefully it will address the broader issues of impartiality and fairness within the system.

Contrasting section 98(c) to civilian criminal justice in Canada, I would point out that a possible sentence of life imprisonment equates self-harm in the military to the most serious offences, such as murder or treason. I believe that the concept of punishing for self-harm is a relic of the World War I era. Back then, some soldiers weighed the lesser evil of self-harm against that of charging on foot through no man's land against waiting machine guns. Canadian soldiers were punished and some even executed for perceived cowardice. Of note, all those executed have since been pardoned on humanitarian grounds.

● (1120)

Now, in the age of a professional, volunteer military, trench warfare-era punishment for self-harm has lost any true relevance.

In recent times, our military has suffered a slow-drip epidemic of soldiers being lost to suicide. Today, any soldier inflicting self-harm is more likely to be suffering from an operational stress injury than trying to avoid combat. Suicide attempts resulting in self-harm should summon immediate help, not punishment.

By contrast again, in Canada the criminal offence of attempted suicide was repealed almost five decades ago. Such incidents are now managed under mental health provisions rather than by criminalizing and punishing victims.

I worry that the lingering stigmatization of operational stress injuries faced by members of our military inadvertently dissuades them from seeking help. That reality is oppositional to the hope that early medical interventions can offer better outcomes.

Members of the military intuitively understand the difference between “talk the talk” and “walk the walk”. It is not enough to tell them to put their hands up and ask for help when they see that they may be punished instead. In this instance, continued reliance on arbitrary discipline undercuts efforts to support members who may be struggling. To a soldier attempting to end their pain by taking their own life, the possibility of future discipline holds no deterrent.

Because section 98(c) prescribes punishment for self-harm, it frames it as a discipline problem. Because discipline is administered for misconduct or failure, it invokes shame and thereby actually reinforces the stigma around mental injuries. Members of Canada's military have earned our respect and support, not disdain or punishment.

Our sincere hope is that some good will come from Stuart's death and that positive changes regarding treatment of victims of OSI will form a part of his legacy.

The provisions of section 98(c), when applied to those with mental injuries, are a travesty and opposite to how wounded Canadian patriots should be treated. It is inconceivable to me, and hopefully to you, that threats of Code of Service Discipline and possible life imprisonment will in any way help address the high numbers of suicides in the forces.

In a volunteer military with professional leadership, punishments under section 98(c) of the National Defence Act have become inappropriate and may, in a deleterious way, undermine good order and discipline. I would respectfully suggest that there is no appreciable downside to removal of that section.

Proper administration of the forces should rely not simply on threats but on effective leadership. Our injured troops are not to be treated as disposable military assets, and if repeal of section 98(c) saves even one life, you will have had a profound impact.

Thank you for your efforts to effect positive change and to look after the best interests of each and every one of our service women and men.

Thank you.

**The Chair:** Thank you very much, Ms. Fynes.

I'm going to ask Ms. Carlé, please, for your opening statement.

**Ms. Jackie Carlé (Executive Director, Esquimalt Military Family Resource Centre):** Good morning, and thank you so much for having me here.

I'm touched by your testimony, and this is a story that we hear, so thank you very much for sharing it. It's moving, and it really does speak to our response to operational injuries and also the moral injury that your family experienced. That's something that we deal with fairly frequently in our military family program.

● (1125)

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Madam Chair, on a point of order.

I think we have a problem having to do with interpretation. The interpreter tells us that the person is not speaking into the microphone.

[*English*]

**The Chair:** Ms. Carlé, could you hold the microphone as close as you can? Thank you. We'll try it again.

**Ms. Jackie Carlé:** Is that better?

**The Chair:** Yes, and if you speak slowly and a little louder than normal, that will surely help the interpreters.

Thank you.

**Ms. Jackie Carlé:** Thank you so much.

Good morning. Thank you for having me here today. I'm in beautiful Victoria, British Columbia.

I am the executive director of the Esquimalt Military Family Resource Centre, and I've worked in military family services programs for 23 years.

I'll give you a bit of background about military family resource centres.

A lot of people don't realize that we are not-for-profit societies. There are 32 such centres across Canada, and we are all specialists and subject matter experts in the military family lifestyle. We receive some funding from the Canadian Forces morale and welfare organization, and we also receive funding from the local base for what we call site-specific services. I'm telling you that is because later on I will talk to you a little about some of our mental health services that are supported by CFB Esquimalt.

We have the ability as not-for-profits to fundraise, to apply for grants and to charge user fees for things such as day care to meet our budget requirements.

Military family lifestyle is unique and involves frequent and unpredictable geographic relocations. It involves the endurance on the home front of military members who head away for long missions and deployments and their exposure to risk. As we are also learning this morning, it's about families dealing with operational stress injuries.

In terms of that and in terms of our mental health services towards families, we offer a variety of programs and services. I'll briefly go over those for you.

We offer counselling. During the pandemic, we have moved to a virtual platform for our counselling services, but I'm sure you can understand that when we have cases of interpersonal violence in the home, we have created opportunities for people to meet with our counsellors in person, following all the appropriate COVID protocols. That's very important, because in some households it's impossible for a family member to receive counselling support when the military member or other family member is around. This has also proven to be something for the youth we support, who are often more comfortable going for a coffee or a walk. Again, this has been somewhat of a challenge during the pandemic, but we have been able to create appropriate protocols so that we can work with those folks.

Part of the work that we also do is preventive. That would be facilitating groups and workshops that relate to things such as parenting, maintaining wellness and relationship issues.

We're just about to launch into return-and-reunion workshops. We have a ship returning after six months away, with 220 members on board. We'll be working with their families to help to integrate that military member back into the household and to talk about things such as operational stress injuries and how they can support their families as they return back into their homes and into their communities.

We're also very fortunate to be able to offer specialized services, and this refers to my previous comment that we receive funding from our base commander. These would be services such as therapeutic play for children and youth, as well as navigation services. I'm sure you can imagine how it feels for families who have a child who is on a wait-list for exceptional needs when they finally get to the top and then have to relocate again. We're doing some work on harmonizing those wait-lists across provinces. Our staff also help people navigate the local services so they can integrate quickly and get the help they need for themselves and for their families.

We have a strong partnership with base mental health services, and this is very important, because families are complex. When we see them, we're not just seeing the family members; we're seeing the military member as well, and providing wraparound service. It's very important for us, with the appropriate confidentiality agreements in place, to have a close working relationship with base mental health as well as close working relationships with partners in the community, so that we can make meaningful referrals for families who are experiencing issues that are a little beyond our scope.

● (1130)

The Canadian Armed Forces has a construct called a transition centre. This is for members who are ill and injured. We have a counsellor who is co-located there. The purpose is to support families who are dealing with an injury, including an operational injury. Sometimes it can be an illness.

What they do in this unit is work with the military members. We work with the families, with the ultimate goal that the member might be transitioning out of the Canadian Armed Forces due to an illness or injury or might be needing some specialized care in order to get back to duty. We engage very heavily in this centre with military members, as well as with families, to create what we hope is a healthy transition.

What happens then is that the member gets passed along to our veteran family program coordinator, who works with families of veterans to assist with that very difficult transition, especially when it's a transition that was unpredictable due to a member's illness or injury.

I want to speak to you for a few minutes about some of the things that concern families when it comes to accessing mental health care for their military member.

One of the things we have certainly experienced is that at CFB Esquimalt, and I think at many bases across the country, there is a lack of mental health care after hours. During the day, if a military member is having any health issues, including mental health issues, they go through the clinic system, although there are some barriers to that for those members. Our big concern is when the office is closed down and it's after hours. Then organizations like ours, the chaplain team and the military police become the go-to resources under those circumstances. It almost seems inevitable that once a military member goes home, in the evening or over the weekend is when they or their family will reach out for help and support.

As I mentioned, I've been in this program for about 23 years. Previously, there was always a mental health professional from the base on call and ready for those after-hours emergencies. We have, in Ottawa, as part of military family services, a family information line that includes virtual counselling. The problem is that there is a lack of understanding of the local communities and how to support somebody over the telephone when there is a crisis under way.

I would have to say kudos to our chaplain teams, who are the ones taking those after-hours calls. I hope at some point that the committee gets the opportunity to speak with a member from the chaplain team to begin to understand the unique pressures that they experience in terms of caring for families and military members.

The other issue that has concerned us in the past is that our military police force are not, in British Columbia, able to transport someone under the Mental Health Act. They're deemed not to have the proper credentials that the city or municipal police might have. What we've experienced, for example, is that a member might come through our doors with thoughts, for example, of suicidality. The military police are limited in terms of negotiating with that person, getting them into their vehicle and getting them to appropriate care, whether that's at the base hospital or at our local hospital in the psychiatric unit.

It's heavy negotiation for somebody who is already in an extreme situation. Oftentimes we find we have to divert ourselves to the municipal police or ambulance which, of course, adds to the trauma. Our goal is to be providing trauma-informed care, and we find this does undermine that.

We often get some assistance from the chaplain team and chain of command for those things, but I think that relates to the previous testimony that we just heard: that it can be a very bureaucratic and a traumatizing experience for a military member who is undergoing mental health issues.

● (1135)

Thank you.

**The Chair:** Thank you very much, Ms. Carlé. I appreciate that.

We're just going to stop here for a minute. They are going to try to reset the interpretation system here to see if we can get it back to operating. We'll give them five to 10 seconds, and then we'll hand the floor to Mr. Benzen to start the round of questions.

**Mr. Bob Benzen (Calgary Heritage, CPC):** Mrs. Fynes, your opening remarks were very amazing. I thank you for them. It's touching, and I thank you for what you've done in terms of advocating for your son and for all the military members.

I'm interested in the journey that you've gone through in getting the information to learn what's happened to your son. As a parent, I know that I would want to know everything and that I would want to know every detail. I would want to know as soon as possible. I'm sure that all the other parents and families feel the same way. Can you talk a little bit about how the information...? Did you receive it easily? Was it difficult? Do you have all the information so far? What would you change in terms of getting all this information that you need?

**Ms. Sheila Fynes:** We've had a very difficult journey, and it's been a very long one. We were initially notified of our son's death by phone. It was actually a telephone message that was left. We returned a call to the base and were told that Stuart had died. Later on that evening, a padre and an officer came to our home and spoke to us.

Our first reaction was that we'd told them this would happen. We knew Stuart was in trouble. We knew he needed help. We knew he wasn't getting the appropriate help. We knew that when he left the hospital the base didn't have a plan for him. It turned out that he was living in his car in the parking lot at the base. Eventually, he ended up at the duty room and had a further hospitalization. There were a lot of things that happened in succession. When we were notified, the first words out of my mouth were, “I told them this would happen.”

I think that because we wanted to know why this could have happened when everyone was aware of how much trouble he was in, we asked questions. The more questions we asked, the more the military closed in. I think, to be honest, they recognized that they'd messed up. They had a soldier who was dead and really didn't need to be. The more they closed up, the more questions we asked.

We went through a very painful funeral. We weren't given his suicide note for 15 months. We'd asked if he'd left one, and they said no. They designated someone else as his next of kin, and when we looked at the paperwork, it turned out that the person was definitely not his next of kin. It was a series of events that just kept piling on and piling on. Of course that made us angry, and in a way it almost helped put the grieving process on the shelf because by then we were asking, “What's going on here?”

We ended up having a board of inquiry that didn't really answer our questions and was definitely designed to have an outcome that protected the military. From there, eventually, as some of you may know, it ended up being a military police complaints commission inquiry that went on for some time and cost the military a tremendous amount of money. We became very vocal advocates.

There's nothing we can do to bring Stuart back. We recognize that, but we came to know a lot of serving members and people who had been released who were really at risk and were going through comparable situations. We would get phone calls. We became this very informal family whom they knew they could call. We still get calls from soldiers, sometimes in the middle of the night. Sometimes they've had a few drinks or whatever. We will always make time for them because our job is never to have another Stuart again.

We also have a secondary purpose, in that military people are really smart. When someone is seen to be struggling, they start walking this walk of shame, and they're disenfranchised and all the rest of it. They're not stupid. They know that if they put their hand up, this is not going to go well for them. Eventually they'll be released. They'll lose everything in life that's important to them.

Our goal now is for every single one of these soldiers.... They didn't die on the battlefield. If they die in an airplane between Dubai and here, their name is on a wall. If they come home and they're on sick leave and they die, for whatever reason, their name goes up on a wall. There is a recognition of their service. It's really important to this family, and I think it would send a really good message to other military serving members and their families that their service was important as well.

Sorry. That was a very long answer.

● (1140)

**Mr. Bob Benzen:** No, it was a very good answer.

**The Chair:** It was.

Unfortunately—thank you, Mr. Benzen—we'll have to go to Mr. Bagnell, please.

It was an excellent answer.

**Hon. Larry Bagnell (Yukon, Lib.):** Thank you very much, Madam Fynes. As the chair said, it takes a lot of courage to do this, and there's no way we can understand the effect on you and your family. We certainly appreciate the advocacy you're doing for those still in the military. There's no way we could come to wise decisions if we didn't have input such as yours.

We're really trying to make sure that people who have lost the support of a loved one get the support they need and that, as you said, this doesn't happen again.

Over and above the really good evidence you have given so far in your opening statement and your answer to the first question, what other things do you think the government, the department of defence or the miliary could have done differently before your son's death, and also done differently for you after your son's death, beyond the really good points you have already made?

● (1145)

**Ms. Sheila Fynes:** In the initial circumstance, I would really wish that Stuart had been seen as a mental health problem—and I hate those words, but he needed help—rather than as a discipline problem.

This incident when he was at the duty desk really sticks in my mind. There were a bunch of cadets in the base. He asked if he could go and help out. Now, this is a soldier who has served overseas. He represented Canada and the United States, because he was a really good gunner on the tanks. He represented them there. He had a lot of accomplishments, and all of a sudden he wasn't even good enough to go and help with the cadets. That really hurt. That was the day he killed himself. There was a funeral for another soldier that he wanted to attend. He wasn't allowed to do that.

Their default position was “We have this guy, he's living behind the duty desk, and we're going to get rid of him.” I think he could have been saved. All he really wanted was to return to being a good soldier.

Paragraph 98(c) is a little-known section in there. When I found out about this, I was absolutely astounded. What do you mean, you have a soldier who is sick and you're threatening him with life imprisonment? I'm not quite sure how that saves anybody, and the message it sends to everybody else is awful. When other soldiers see a soldier struggling, they really are scared to put their hand up. There's a stigma attached still to all of this. I think mental health professionals' number one message is “It's okay. Come on in. It's fine. We are going to help you,” not “Come on in, and by the way, we need to start the paperwork to do something else.”

**Hon. Larry Bagnell:** Thank you very much.

I know this must be difficult, and we really appreciate it. It's very helpful.

Ms. Carlé, I know you didn't quite finish your remarks, so I will give you a chance to finish them before I ask any questions.

**Ms. Jackie Carlé:** No, that's fine.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** On a point of order, Madam Chair.

Out of respect for Ms. Fynes, I did not want to interrupt her while she was talking about her son, but since Mr. Bagnell started speaking, we no longer have the interpretation.

Could we solve this problem?

[*English*]

**The Chair:** Yes, please.

We are going to suspend for five minutes. The technicians have been trying to fix the program in the background. It's not working.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** It seems to be working now.

[*English*]

**The Chair:** They are reconfiguring another room, which is directly above us. Those of us attending in person will move upstairs to room 415.

To our witnesses and to other committee members, please stay on the line. If for some reason you get disconnected, just come back on. We will recommence in five minutes from the new location.

Are there any questions? No.

● (1145)

_____(Pause)_____

● (1210)

**The Chair:** Thank you, everyone. We will now resume.

Mr. Bagnell, I think you must be finished your round. Your time was almost up.

We have amended the order rotation to eliminate round five. The last two Conservative and Liberal five-minute spots will be eliminated for this particular meeting, and we will have MP Brunelle-Duceppe and Mr. Garrison for six minutes to complete the first round with this particular panel. We will then take a short break to bring in the new panel and recommence with questioning in rounds two through four.

MP Brunelle-Duceppe, if you are ready, you have the floor.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Thank you very much, Madam Chair.

I want to thank the witnesses for their participation. I was very touched by Ms. Fynes' testimony. I also thank Ms. Carlé who is with us today.

Ms. Fynes, my question will be quite simple. It's important for us, as parliamentarians, to know the answer, if you are able to give it to us.

What do you think were the greatest obstacles you and your family faced in seeking mental health services from the Canadian Armed Forces?

[*English*]

**Ms. Sheila Fynes:** Stuart had multiple hospitalizations and multiple suicide attempts. He did have a short stint at Edgewood in Nanaimo, but it was not an appropriate place for him. For him, a huge obstacle was being sent somewhere where military members speak to other military members and have an idea of what's going on. That's why he wanted to be sent to Homewood, and they refused to do it.

In terms of family, once we realized that Stuart was in trouble and not doing well, I did have a conversation with the chaplain at the base and spoke with doctors at the civilian hospitals. The attitude I got from the hospitals was that he was a big boy, so let him get on with it. The attitude I got from the base was that he was a big boy, so let him get on with it: He's going to do what he's going to do. Neither of them was very satisfactory to me as his mom. I pushed hard, and after Stuart died, there was a closing of the ranks, because I think they knew there were some mistakes that, as I said, had a catastrophic effect.

There's one thing I really hope everybody hears today. Mental health issues among our soldiers are workplace injuries, not defects. Soldiers are not genetically predisposed to killing themselves; they don't want to die. I have yet to meet a soldier who wants to die. They want to get back to doing what they have done best. That puts an onus on all of us, in each of our capacities, to ensure that happens.

● (1215)

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Thank you very much, Ms. Fynes.

I don't have a lot of time, Ms. Carlé, but did you feel that there was a difference in the mental health services offered, with regard to the pandemic, either within the Canadian Armed Forces or Veterans Affairs Canada?

Did you notice any changes, either negative or positive?

[*English*]

**Ms. Jackie Carlé:** Yes, thank you very much.

The challenges we experienced during this pandemic around access to mental health supports really relate to the pivot that organizations were able to make to serve people on a virtual platform.

From our perspective, we were able to make that move very quickly because we are an independent organization. What we have seen, however, is that the Canadian Armed Forces have a lot of restrictions around connectivity on a virtual platform. Early on in the pandemic, there were some huge challenges in terms of members accessing mental health supports. I would say that the situation has improved over the course of the pandemic.

I think that one of the major trends we have seen and continue to experience is an increase in interpersonal violence in the home relating to the situation of isolation, and the extra stress and pressure that could be financial, and certainly has been emotional and psychological, during this pandemic.

The Canadian Armed Forces have responded to that in terms of increased resources around interpersonal violence. We are finding that our caseloads have become quite heavy.

This is something that we do experience all the time, but we've certainly experienced a spike during the pandemic.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** I thank the two witnesses very, very much. We are very grateful to you for being here.

I think my speaking time is up.

**The Chair:** Thank you very much, Mr. Brunelle-Duceppe.

[*English*]

We will go to Mr. Garrison, please.

**Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP):** Thank you very much, Madam Chair, and thank you to Ms. Fynes. It's hard for me to call you Ms. Fynes, because we've worked together for so many years now, and out of this tragedy, one of the things I've gained is the privilege of knowing you and your husband Shaun and your second son, and the incredible courage you continue to show.

I have heard recently from other families who just don't feel strong enough to come forward and do what you are doing. I know that they all thank you for being here.

Time is limited, so I want to go back to the question of taking self-harm out of the military code of conduct. We've stressed that that's symbolic. I'd just like you to comment a bit more on what you think it would help with by taking this section out. Most of our NATO allies don't have such a section in their military code of conduct, so it's hard for me to see why we maintain it.

Ms. Fynes, can you tell us what you think would happen as a result of removing this?

**Ms. Sheila Fynes:** First of all, I don't see a downside in removing it, and I definitely see an upside to that happening.

A good soldier, a well-trained soldier, learns very early on what the rules are and what's expected of them. This rule doesn't have to be enforced for it to have an effect. They know that it's kind of dangerous to them, right? There's always this little thing lingering in the background.

I think that when they're not well, they don't need one more thought of, “Oh, my goodness, would they really do that to me? Would they lock me up?” I think that the National Defence Act is a fairly succinct act. I think every soldier is well schooled and disciplined, and I would respectfully suggest that if there's just one more thing that might make a difference, then what's the downside? Just get rid of it.

As I said before, I was personally astounded when I found out about this. I'm sure Stuart would have known about it, so yes, if it disappeared, it would just be a really good thing.

● (1220)

**Mr. Randall Garrison:** Thank you very much.

I want to turn to Ms. Carlé.

First of all, I do hope you get an apology for the “toing and froing” over you appearing as a witness. I was assured last night personally by the Minister of Defence that there was no intention to try to prevent you from appearing today, so I hope that apology does come.

I know that the Military Family Resource Centre has played an important role, but I think that's not always recognized. That's why I thought it was important for you to be here today.

When it comes to us still losing one serving member a month, on average, across the country to suicide, and when it comes to figures that suggest that 10 times as many may attempt suicide, I wonder if you could just tell us a bit about how that affects your operations as a military family resource centre.

**Ms. Jackie Carlé:** Certainly, yes. Thank you. I really appreciate the opportunity to be here.

What the testimony is telling us today is how important the voice of family is and how compelling it is to create a culture shift so that families can have a voice when these occurrences happen.

As recently as two weeks ago, we experienced the suicide of a military member at CFB Esquimalt. The way it affects our services is that we rally to support that family, and we often find that it takes on an advocacy role. For example, this member was part of a very small unit, and the other members in the unit were devastated by the loss and also by a feeling that somehow they missed something. There was a comment this morning from a witness who, upon hearing the news, said, "Yes, I knew this was going to happen." We hear this very frequently in these cases of completed suicide and attempted suicide and family members are working really hard to get that military member to the care they need.

Our involvement, as a military family resource centre, is literally to walk alongside of that family and to help them in terms of their inroads so that they can have a voice and so that the military can become more trauma-informed. What I do see with our military members is that they struggle so much with this kind of loss, and so our work, along with the base mental health team, is to support the colleagues of these members. I'm sure colleagues of Stuart would have appreciated some support, because there is quite a legacy that lingers.

There is probably a very aggressive approach to operational security, and sometimes information isn't forthcoming that should be forthcoming, so we're really talking about a shift in culture here.

**Mr. Randall Garrison:** I know we have very little time. Do you see delays and barriers to serving members getting the mental health assistance they need? Does that affect their families?

**Ms. Jackie Carlé:** Yes, we do, and in the recent suicide, this member had been attempting to get the right kind of care for two years. As our witnesses told us this morning, oftentimes the referrals are not relevant in terms of where our members are going. I think this has to do with a system that feels overloaded and overwhelmed, and I also reiterate my previous point that it concerns me that there are no mental health services after hours and on the weekends, which is when oftentimes a crisis will hit.

**The Chair:** All right—

**Mr. Randall Garrison:** I know I'm out of time. I'll just say thank you once again to both of you for your very important testimony today.

● (1225)

**Ms. Jackie Carlé:** Thank you. It's nice to see you.

**The Chair:** I would actually like to reiterate our thanks, our recognition of the work that both of you do to support members of the military and their families. Your testimony here today was absolutely pivotal and crucial to this undertaking, and I want to say thank you.

With that, we will end this panel, take a one-minute break, and then start again with the second panel.

● (1225)

_____(Pause)_____

● (1225)

**The Chair:** All right, thank you, everyone. We are resuming our meeting, and I'd like to welcome our two witnesses for the second panel.

We have Dr. Elizabeth Rolland-Harris, senior epidemiologist and now director of force health protection at the Public Health Agency of Canada. She authored the "2019 Report on Suicide Mortality in the Canadian Armed Forces" as well as an article entitled "More than Just Counting Deaths: The Evolution of Suicide Surveillance in the Canadian Armed Forces".

She will be followed by Dr. Jitender Sareen, head of the department of psychiatry at the University of Manitoba and chair of the 2016 suicide expert panel.

With that, I'd like to welcome Dr. Elizabeth Rolland-Harris, for her opening remarks, please.

**Dr. Elizabeth Rolland-Harris (Former Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, As an Individual):** Thank you, Madam Chair.

My name, as you were just told, is Dr. Elizabeth Rolland-Harris. I am an epidemiologist by training. I hold a Master of Science in epidemiology from the University of Toronto as well as a Ph.D. in infectious disease epidemiology from the London School of Hygiene & Tropical Medicine in the United Kingdom.

From June 2006 to September 2019, I worked as a senior epidemiologist for the directorate of force health protection within the Department of National Defence, and during my tenure there, I was responsible for the military suicide epidemiological surveillance file as well as being the project lead and co-primary investigator for the Canadian Forces cancer mortality study II. This study was conducted in collaboration with Veterans Affairs Canada and Statistics Canada, and it endeavoured to describe the types and numbers of deaths in both still-serving and released military personnel. These deaths included suicide deaths.

[*Translation*]

In September 2019, I left the Department of National Defence and accepted a new role with the Public Health Agency of Canada. I want to make it clear that my appearance today is based solely on my duties and knowledge related to my former position with the Department of National Defence.

I am not here today as a representative or employee of the Public Health Agency of Canada, as the subject matter of this study is not related to my current position with the agency.

Thank you for your invitation to appear before the committee.

[*English*]

**The Chair:** Thank you very much.

Dr. Jitender Sareen, please go ahead.

**Dr. Jitender Sareen (Professor of Psychiatry, University of Manitoba, As an Individual):** It's a real honour and a pleasure to be here today, and the testimonies of the previous speakers were really heartfelt. Thank you to everyone.

I'd like to also acknowledge that I'm a psychiatrist at the University of Manitoba, a department head, and I have worked at the Veterans Affairs Operational Stress Injuries Clinic in Winnipeg as a consulting psychiatrist since 2009.

The research I'm presenting today is funded by the Canadian Institutes of Health Research, as well as the Canadian Institute for Military and Veteran Health Research and the True Patriot Love organization.

The focus of the presentation will be on the 2016 report of the mental health expert panel on suicide prevention in the Canadian Armed Forces. I co-chaired this panel with Dr. Rakesh Jetly. It included a number of national or international suicide experts, DND policy-makers and VAC representatives.

The key observation of the mental health panel in 2016, which met for two and a half days, was that there are approximately 11 suicide deaths per year in the Canadian Armed Forces.

The 2013 Canadian Armed Forces survey that was conducted by Statistics Canada showed that the past-year suicidal ideation rate among active military personnel was 4.3%, and the rate of suicide attempts was 0.4%.

The panel recognized that suicide is a behaviour that is extremely difficult to predict at an individual level. Although the goal is to have no individuals die by suicide, the expert panel recognized that at times not all suicides can be prevented.

On the risk factors for suicidal behaviour among military and veterans, we looked at all of the literature internationally as well as specifically in Canada, and a number of the risk factors that are well known include being male and having relationship difficulties or being unmarried. Depression, post-traumatic stress disorder, and substance use disorders such as alcohol use can often combine to lead to an increasing risk of suicidal behaviour.

More recently there's been understanding that traumatic brain injury as well as chronic pain conditions and new onset of physical health conditions can also increase the risk of suicidal behaviour. We also know that adverse childhood experiences have been strongly linked to suicidal behaviour, not only in military personnel but also in civilian populations.

Our work and the work of others internationally has shown that exposure to traumatic events during deployments is associated with suicidal behaviour. Witnessing atrocities, combat exposure or seeing a fellow member die in combat can increase the risk, but deployment itself is not a risk factor for suicide. Incidents of self-harming behaviour as well as the transition to civilian life are seen to be very important vulnerable periods.

One of the other important areas that have been discussed by previous witnesses is that important time of crisis when people are either admitted to the hospital or in an emergency setting. The periods before and after can be times of great vulnerability.

The report that was completed and submitted had 11 specific recommendations for the Canadian Armed Forces.

The first recommendation was to have a new position called a suicide prevention quality improvement coordinator. This recommendation was based on a strong understanding that suicide prevention requires a coordinated effort between the health system and the social system, and that similar coordinators have been implemented in the U.S. Department of Veterans Affairs.

There has been an increase in awareness and improvement in access to mental health services, but as previous witnesses have said, there is still a stigma about receiving care.

● (1230)

The suicide prevention coordinator would develop a patient and family advisory committee, review characteristics of suicide in military members, determine the needs for education among staff for suicide-specific interventions—and I'll talk about those, as there are a number of them that have evolved more recently—and then determine the need for education in primary care and specialty services and highlight the gaps that can be improved.

Recommendation two was to make a systematic review of all CAF member suicides since 2010. The medical professional technical suicide review occurs for every individual suicide death, but it would be very, very important to look at all the deaths consecutively to address specific questions such as where the suicide occurred, what the pattern of recent work and psychosocial stressors was, what types of physical health problems were prevalent at that time, what proportion of individuals were actually getting evidence-based suicide prevention treatments and, among firearm-related suicides, what measures were taken to limit access prior to death.

This type of review could help us guide policy to target suicide prevention in an evidence-based model.

There is, as I mentioned before, this pivot in the field of suicide prevention. Previously, the idea of suicide prevention was to treat the underlying depression, alcohol and substance use problem, but now the field is really shifting to the view that we need to both treat the depression and underlying condition and also target interventions specifically for suicide.

One example is a suicide risk assessment. There is a program called the suicide assessment and follow-up engagement, so if a veteran in the U.S. has an emergency visit due to a crisis, there is brief intervention and safety planning afterwards around means restrictions, coping skills and social supports and outreach after that program.

We recommend that the Canadian Armed Forces review some of those novel programs that are being implemented in the U.S., which could be helpful.

● (1235)

**The Chair:** Thank you very much, Dr. Sareen. I appreciate that. I just want to make sure we have a little bit of time left for questions.

We did receive a presentation from Dr. Sareen. It is being translated and we will forward it once we have the translation.

With that, we'll hand it over to Mr. Dowdall for questions. Go ahead, please.

**Mr. Terry Dowdall (Simcoe—Grey, CPC):** Thank you very much, Madam Chair, and I too want to thank the witnesses today for their testimony. They were compelling, for sure, and heartfelt, and I think everyone's looking for some answers as we move forward. I'm certainly proud of our Armed Forces. Whenever they've been needed, they've been there, and I think it's our time and our duty to make sure that we take care of them now as well as when they are post-military.

I was very happy to see the joint suicide prevention strategy come out in 2017. According to the Department of National Defence, there were 15 suicides among armed forces members in 2018, and this number increased to 20 in 2019. I've asked for, but do not yet have, the number for 2020.

My question is this: How effective has this strategy been and how is its effectiveness being measured?

**Dr. Jitender Sareen:** My role with the panel was really to chair the committee and make the recommendations, so I have not been following the specific changes that have occurred, but Dr. Harris may want to add something.

**Dr. Elizabeth Rolland-Harris:** I have limited insight on this, not having been part of the organization in over a year, and things may have evolved.

What I can say is that while the annual suicide report from DND is very important, I think that because of the way our governance of the military and veterans is set up, we have a tendency to look at problems in silos, so we look at suicide in the military and then we look separately at suicide in the veterans population, whereas really it's a continuum. We talk about it from a life-course perspective, not as a question of whose responsibility it is. It's an individual who goes through different stages in their life.

I can't answer your specific question, but if we're looking at improving things more broadly, I think there has to be a look at changing the way things are done, and not dividing members into two discrete populations—those still serving and those who have been released. Really they are one and the same population with the same challenges and the same experiences, and they're just at different points in their life course.

Thank you.

● (1240)

**Mr. Terry Dowdall:** I think those are great comments. I think this speaks to the earlier witnesses as well. This is a 24-7 issue that we need to address. I know that in working with the local hospitals here, they've thought of different ways that they could probably set this up and not be in a silo.

One of the things that I've been really proud of in the last little while—I don't know if you've followed it—is that my colleague, the MP from Caribou—Prince George, brought forward an idea to have a suicide prevention line number that would be simple to remember: 988. We were hoping to have this implemented before Christmas, probably, which is a tough time of year, as you know, for many individuals in the military, as well as civilians.

I'd like a quick comment from each of the witnesses on what you think of that, and if it's a good idea to really bring it all together and make sure that we're there for everyone 24-7.

**Dr. Jitender Sareen:** Yes, absolutely. I think that having the suicide lines is extremely important. As the previous witnesses have said, we need that availability during a 24-hour period. Crises often occur and families are often left to try to support their member. I think the important part is what happens after the crisis line. I think that's when we really want to make sure that the person gets onto the right pathway and gets the right care, and that they're not waiting on different waiting lists.

That happens not only for military members, but for many people in our system. I think the pandemic has really pivoted us into virtual care, and we can do a lot more things virtually now that reduce some of the stigma for people who would otherwise have to walk into a building for an out-patient appointment. We need to take this opportunity with the pandemic to improve access for our patients and families in getting care at the right time, because it is a 24-hour issue.

**The Chair:** Thank you very much.

[*Translation*]

Mr. Robillard, you have the floor.

**Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.):** Can you hear me well?

**The Chair:** Yes.

**Mr. Yves Robillard:** My question is for Mr. Sareen.

A death by suicide in the Canadian Armed Forces is obviously one death too many.

Could you tell us about the gaps in the mental health support system currently in place in the Canadian Armed Forces?

[*English*]

**Dr. Jitender Sareen:** Could there be a translation? I don't speak French.

**Mr. Yves Robillard:** Here we go again.

**The Clerk:** Mr. Sareen, I suspect that you are not on the right channel. If you go to the bottom of your screen, you'll see a globe with “Interpretation”. Just go there and select “English”.

**Dr. Jitender Sareen:** On Zoom?

**The Clerk:** Yes. It's on the main Zoom screen where you have the pictures of everybody. It's at the bottom, in the middle. If you move your mouse there, you will see “Participants” and, to the right of that, “Interpretation”.

**Mr. Yves Robillard:** Can I resume?

**Dr. Jitender Sareen:** I have it on English. I didn't hear a translation.

**The Clerk:** Okay. We'll do a test right now.

[*Translation*]

Mr. Robillard, can you do a sound test for Mr. Sareen?

**Mr. Yves Robillard:** Are you getting the interpretation now?

[*English*]

**Dr. Jitender Sareen:** Yes. I can hear it.

[*Translation*]

**The Clerk:** We can continue.

**Mr. Yves Robillard:** A death by suicide in the Canadian Armed Forces is obviously one too many.

Could you tell us about the gaps in the mental health support system currently in place in the Canadian Armed Forces?

[*English*]

**Dr. Jitender Sareen:** The recommendations we made in 2017 I think really encouraged trying to be very specific around suicide-specific interventions. There has been a lot of effort on improving access to treatment for depression and post-traumatic stress disorders, but there are specific suicide prevention strategies and psychological therapies. As well, in the moment of crisis, there are specific things that could be done.

Our recommendation was to review and look at what the needs are and to see if we can have more training in those suicide-specific strategies, in collaboration with other medications, supports and family supports, to ensure that our members who have made a suicide attempt or who have had thoughts about suicide are really getting that suicide-specific therapy and medications.

That's a report that we made in 2017. I'm not clear on what level of change has occurred in the military.

● (1245)

[*Translation*]

**Mr. Yves Robillard:** What support is provided to the families of Canadian Forces members who die by suicide and to those who have attempted suicide?

[*English*]

**Dr. Jitender Sareen:** I think that was also another recommendation. It was that we should look at those specific processes and policies, but I'm not sure exactly what specifically is being done in the military today when somebody has lost a family member to suicide. That's a very important question.

[*Translation*]

**Mr. Yves Robillard:** Based on your personal experience, what measures now in place could have prevented a suicide death in the Canadian Armed Forces?

[*English*]

**Dr. Jitender Sareen:** The most common things that have been shown to be helpful in reducing suicides include restriction of access to means—which include firearms or large quantities of medications—making sure we're recognizing depression and post-traumatic stress disorder and treating them with appropriate treatments, and engaging family members and supports in any sort of crisis planning that occurs when somebody is suicidal.

**The Chair:** Thank you very much.

[*Translation*]

Mr. Brunelle-Duceppe, you have the floor.

**Mr. Alexis Brunelle-Duceppe:** Thank you, Madam Chair.

I thank the witnesses for being with us today to discuss this issue that is so important to us.

I would also like to take this opportunity to thank the House employees who are doing their utmost under the current conditions. Frankly, I take my hat off to them.

This is not mentioned very often, but the 2019 Report on Suicide Mortality in the Canadian Armed Forces does not include the percentage of suicides among women because suicide among women is uncommon. In 2017-18, I don't think there were any suicides among women.

Would you be able to explain to me how the mental health problems experienced by women in the Canadian Armed Forces differ from those experienced by men in the Canadian Armed Forces?

My question is for either of the witnesses.

**Dr. Elizabeth Rolland-Harris:** This question is of a more clinical nature. So I think my colleague should answer it first.

**Mr. Alexis Brunelle-Duceppe:** Yes.

[*English*]

**Dr. Jitender Sareen:** In the general population, men are much more likely to die by suicide than are women. We know that men experience more alcohol use as well as depression. Women in the military have a higher likelihood of having post-traumatic stress disorder and anxiety disorders, but a lower likelihood of having alcohol and drug use. That's some of the work we have done.

I'm sorry. I don't have a good answer as to why we have such low rates of suicide in active military. However, when we look at veterans, there is an increase in suicides among women veterans at that period of transition. As Dr. Roland-Harris is saying, that transition from military life to a veteran's life is an extremely important time.

● (1250)

[*Translation*]

**Dr. Elizabeth Rolland-Harris:** Indeed, as my colleague was saying, especially on the issue of women, it's really very important to have a more comprehensive picture. According to the data for veterans, the percentage of suicides is increasing shockingly among women, especially in the 40 to 50 age group, if I remember correctly. Again, I haven't looked at this file in a little while, and I may be wrong in terms of the age range. However, it more or less corresponded to when people make the transition from the military system to the civilian system.

In terms of family life, this is also the time when we see an increase in the end of marriages or relationships. In addition, it is often when children move into their teens that family problems develop. The role of the woman in the family, the family nucleus, therefore changes and this creates stress. I think it's very important to look at the situation of women not only during their years in the military system, but also after they've come out of it.

[*English*]

**The Chair:** Okay.

[*Translation*]

Thank you very much.

**Mr. Alexis Brunelle-Duceppe:** Thank you.

[*English*]

**The Chair:** We'll go on to Mr. Garrison, please.

**Mr. Randall Garrison:** Thank you very much, Madam Chair.

We do, of course, focus on those who successfully die by suicide, as we should, as it's a big loss to the Canadian Forces and to their families.

I wonder if either of the witnesses would like to comment on the fact that perhaps this is an undercount of the problem, since the problem is the attempt to die by suicide. We know that some 20% to 25% of medical releases from the military are for mental health reasons, and we know from U.S. estimates that as many as ten times more attempt to die by suicide than actually succeed. By focusing on that number alone, are we undercounting the problem?

**Dr. Elizabeth Rolland-Harris:** It's a numbers one. Is it okay if I take it, Jitender?

**Dr. Jitender Sareen:** Yes.

**Dr. Elizabeth Rolland-Harris:** Okay.

In a nutshell, yes. Obviously, it is just a.... We call it the iceberg. It's the tip of the iceberg. There's obviously a lot of stuff that's happening underneath the water.

Just from an accounting perspective and taking away the emotional or the humanistic side of things, the reality of it is that it's very hard to count attempts. We only ever see the most severe ones on our radar, because those are the ones that seek medical care because they require it to survive, in essence.

Even best efforts to try to capture that sort of underlying reality are very difficult by virtue of the breadth of severity with respect to attempts.

**Mr. Randall Garrison:** I would agree with your comments that the suicide rates are likely underestimates. With regard to accidental deaths, some of them could also be suicides, so that's also important. Suicide attempts are also, as Dr. Rolland-Harris has said, difficult to capture, so you're absolutely correct.

Dr. Sareen, did the expert panel look at the interface between stigma and military discipline and the attempts to prevent suicide? We heard very powerful testimony from previous witnesses that it's the stigma and the discipline that's often applied to those suffering from mental illness that contribute to the difficulties in getting help.

**Dr. Jitender Sareen:** That was not a topic specifically discussed at the two-and-a-half-day panel. Clearly, barriers to care and fear of the impact that getting care will have on the person's career were absolutely seen to be important factors in why people may not come forward for care.

**The Chair:** All right. Thank you very much.

Madam Gallant is next, please.

**Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC):** Thank you, Madam Chair.

I will go to Dr. Sareen first.

You chaired the 2016 expert panel report and made a number of recommendations. Which of the 11, if any, are outstanding—that is, have not been acted upon?

● (1255)

**Dr. Jitender Sareen:** Thank you.

I have not been keeping track of all the different recommendations, but some of them have been implemented. It would be best to ask the Canadian Armed Forces. They were accepted. The report was accepted, but as for actually getting the information on what was implemented and what was not, it would be best to ask the DND.

**Mrs. Cheryl Gallant:** Okay.

Well, actually, recommendation 9 was to "consider novel methods for delivery of psychological and pharmacological interventions". Would you say that the care and the computer-assisted multi-model memory desensitization and reconsolidation would be that, as well as the EMDR therapy?

**Dr. Jitender Sareen:** Yes, I think our focus of that particular recommendation was really to ensure moving away from the one-on-one office visit to using more virtual means—telephone-based therapies, video conferencing-based therapies—because people often have difficulty accessing services. Any type of therapy can be usually done virtually, and now with the pandemic, we're seeing that. Our aim in that recommendation was to try to have more outreach and to look at novel ways of delivering care, rather than the usual one-on-one office visit.

**Mrs. Cheryl Gallant:** All right. You're talking about virtual therapy now as well, I take it, with the onset of the virus.

For Elizabeth Rolland-Harris, since what year did statistical data on CAF personnel suicides begin?

**Dr. Elizabeth Rolland-Harris:** I don't recall off the top of my head, but I believe it is in the report. It is, I believe, sometime in the 1980s. This has been going on for a fairly.... I'm sorry. It's 1995. It's in the title of the report. It's since 1995.

**Mrs. Cheryl Gallant:** Statistics have been kept since 1995, yet over the years—at least 20 years—there has been an outright denial of statistics being kept, until very recently. Would you actually produce the documentation substantiating these statistics so that we can go back and see how we're comparing now as opposed to then?

**Dr. Elizabeth Rolland-Harris:** I was at DND from 2006 onwards. I can't speak to prior to 2006, but I can tell you that those statistics were being tabulated, analyzed and published since 2006 at the very least. The reports were at the time being published on the National Defence website.

**Mrs. Cheryl Gallant:** What about stats on PTSD? I recall that in the early 2000s, Colonel Stéphane Grenier was the trailblazer in trying to have the public as well as the military understand that PTSD was an operational stress injury, not just an excuse to get out of doing your duties. What about the stats on PTSD?

**Dr. Elizabeth Rolland-Harris:** That, if it was being collated—and I can't speak to it—was done by the directorate of mental health. Suicide was kept under FHP, Force Health Protection, for historical reasons, and the rest was done through the other directorate. You would have to ask someone from that directorate about that.

**Mrs. Cheryl Gallant:** Okay. PTSD would be under a different protectorate.

**Dr. Elizabeth Rolland-Harris:** It would be under the mental health directorate, yes.

**Dr. Jitender Sareen:** I would also like to add that I did submit a few specific articles for this committee to review that talk about the national trends in suicidal ideation and attempts from 2002 to 2013 in the Canadian Armed Forces. We have also followed a survey of Canadian Armed Forces veterans. We followed 3,000 military members over 16 years. We are starting to publish some of the key papers that will describe how common the mental health difficulties are over time, as well as some of the gaps in services.

**Mrs. Cheryl Gallant:** Thank you, Madam Chair.

● (1300)

**The Chair:** Thank you, Madam Gallant.

Mr. Bezan is next, please.

**Mr. James Bezan:** Thank you, Madam Chair.

It's indeed a pleasure to be able to, first of all, thank our witnesses.

I know that Sheila Fynes is still with us. I want to thank her for her advocacy and for telling her story, which is difficult to do.

Again, it's because of your voice that we've been able to address a lot of these issues over the years. I'm all too familiar with the loss of Stuart, as well as Shawna Rogers. I was parliamentary secretary when we dealt with those. All too often we ran into roadblocks, with provost marshals and DND blocking the timely release of information and treating families with disrespect.

I think that because of Sheila Fynes's advocacy, a lot of that now has changed. Despite the incredible agony and the tragedy of every suicide that we experience, at least there is I think a better process in place now than there was 14 years ago—in Stuart's case, 12 years ago.

I want to ask our witnesses some questions about the clinical analysis of suicide. I know that we always like to talk about PTSD. I can tell you that 10 years ago there was still a debate as to whether it even existed. Ms. Gallant was just talking about the trailblazing work of some psychiatrists on that, but we were still trying to put everything in a box, saying it was depression or it was anxiety or there were other mental health issues.

Have we ever been able to break down which of those issues—if we don't lump them all together as PTSD—is the leading cause of suicide within the Canadian Armed Forces? I've had conversation in the past with Colonel Rakesh Jetly about how often the trigger can be attributed to service versus how many suicides are happening because of relationship breakups, financial difficulties, and so on. Are those the triggers, or is the trigger actually service-related?

**Dr. Jitender Sareen:** I think that is a very complex question. We know that if you look at—

**Mr. James Bezan:** The reason I'm asking a complex question is that if we're going to be putting in place the proper mechanisms and trying to identify what the triggers are so that we can get help to those who need it the most as early as possible, we know that resources are always finite. If we do go down the path of a 988 number, you've already said quite clearly that you can have the 988 call-in number, but then are the resources there in the community, at the provincial level, and in DND to get there and help immediately? That's something we need to deal with, so how do we identify which are the high-risk factors and what the triggers are, and how do we prevent it?

**Dr. Jitender Sareen:** Depression and often another mental health issue like PTSD, as well as alcohol, are the most common things that trigger the increase in risk for suicide, as well as a history of having made a previous attempt. Those would be the most common and the most important risk factors.

Life stressors, whether they are work-related or home-related, and especially financial stress, have all been shown to increase the risk as well. Specifically in the military and with veterans, that transition to civilian life and that sense of identity after leaving the military—who am I, and how is that impacting my social life as well as my family?—often become very important components.

We know that specifically deployment-related experiences that are traumatic have been shown to trigger PTSD and trigger depression. Legal issues in the military, if somebody's had those, can also trigger suicidal behaviour. The important thing is that the vast majority of people do not die by suicide when they have depression or anxiety; there's usually a culmination of all of those things together.

As you mentioned, often the military member, if they require admission to a hospital, has to go into the provincial civilian hospital, and that transition out is a high-risk period for everyone who is admitted. The panel recommended looking at those key time points during crisis when things have built up and then looking at some of the means-restriction processes for which there is the strongest evidence—for example, not having access to a firearm during the crisis or not having access to a number of different medications.

● (1305)

**The Chair:** Thank you very much for that.

We are going a little bit over time.

Monsieur Brunelle-Duceppe and Mr. Garrison, you each have two and a half minutes left, if you wish to use them.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** I'll try to be quick.

In the 2019 report, the army has a higher suicide mortality rate than other command categories in the Canadian Armed Forces.

What are the factors that can explain this finding?

[*English*]

**Dr. Elizabeth Rolland-Harris:** Jitender, do you want to take that one?

Okay. Thanks.

[*Translation*]

Personally, I can't explain it. Given the data we have, we're not really able to answer that question.

As Dr. Sareen said, suicide is a multifactorial reality. So many factors may be involved that it is not so simple to pinpoint; it is very complex. However, while the underlying reasons cannot necessarily be explained, perhaps Dr. Sareen could say a little more about it.

Nevertheless, it's like a red light, a flag that goes up, telling us that we need to do more, for example to do what is necessary to support this particular group. Since we can't necessarily always define the underlying criteria, it tells us that this group may be more at risk. More time, effort, and resources may need to be invested to explore this issue further.

**Mr. Alexis Brunelle-Duceppe:** In short, it's not as simple as 1 + 1 = 2; the issue is more complex than that.

Do you have something to add, Dr. Sareen?

[*English*]

**Dr. Jitender Sareen:** I think Dr. Rolland-Harris has captured it.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Fine.

Thank you.

[*English*]

**The Chair:** That brings us to the end of this meeting.

Thank you to our witnesses for joining us today. You have made a significant contribution to this study. Thank you for spending your valuable time with us.

To committee members, thank you for your questions. I think it was a very valuable session that will inform our work well moving forward.

With that, the meeting is adjourned.