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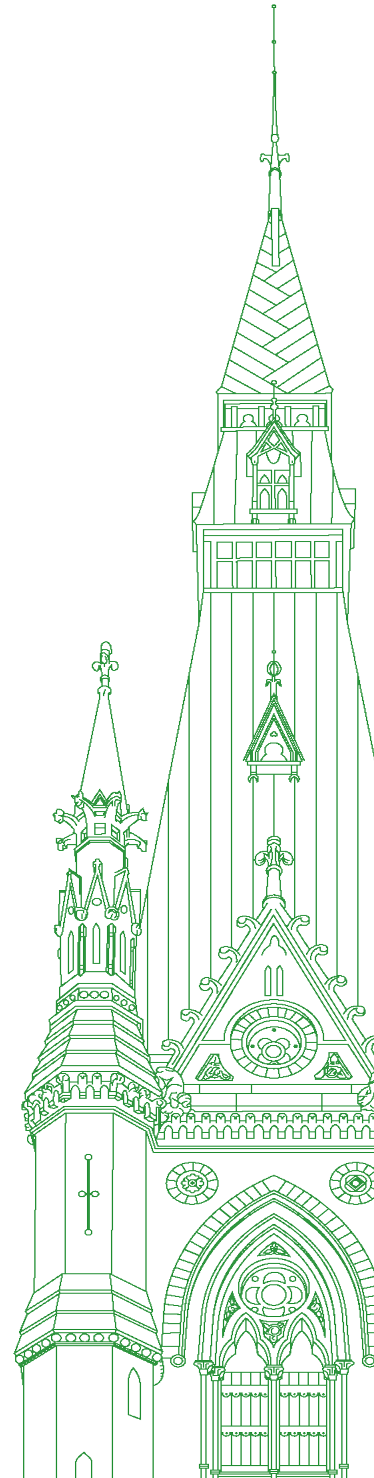

Chair: Mrs. Karen McCrimmon

Standing Committee on National Defence

Friday, December 4, 2020

● (1300)

[*English*]

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

Welcome to meeting number nine of the House of Commons Standing Committee on National Defence.

Today's meeting is taking place in a hybrid format pursuant to the House order of September 23. The proceedings will be made available via the House of Commons website. Just so that you are aware, the webcast will always show the person speaking rather than the entire committee.

Our meeting today will be twofold.

I wish to welcome our three witnesses today: Nora Spinks, president and chief executive officer of the Vanier Institute of the Family, and from the Department of National Defence, Colonel Helen L. Wright, director, mental health, health services group headquarters of the Canadian Armed Forces, and Lieutenant-Colonel Suzanne Bailey, national practice leader, social work and mental health training.

I would like to welcome Nora Spinks to the floor for her opening statement, please.

Ms. Nora Spinks (President and Chief Executive Officer, Vanier Institute of the Family): Good afternoon, and thank you, Karen.

Thank you for the opportunity to provide testimony today.

I would like to acknowledge that our meeting is being held on the traditional unceded territory of the Algonquin Anishinabe people and to pay my respects to indigenous elders past, present and emerging.

I would also like to acknowledge and express my gratitude and appreciation for all of you here today who have served or are serving this country. Thank you for your service. To your families, I thank them for their support and their sacrifice.

It is an honour to appear today with my fellow panellists, people I admire and people I respect, and I look forward to hearing their testimony.

I am here today as the president and CEO of the Vanier Institute of the Family. The institute is a research and education organization dedicated to understanding families, family life and family experiences. Our ultimate goal is to optimize family well-being in Canada.

Our founders, General The Right Honourable Georges Vanier, and his wife, the Honourable Pauline, understood the strength and importance of family. They understood that the military member was not apart from but rather an integral part of a family. They knew the impact that family had on operational readiness. General Vanier served in both world wars. He suffered injuries—among them, losing his leg in battle. He understood the importance of mental health. He understood the impact of military service and that impact both on the service member and on the rest of his family.

As we think about military mental health, it's important to recognize that mental health is not simply the absence of mental illness. Mental health is a state of being, not just a diagnosis. Mental health is fluid. Mental health is not about conditions, problems and crises. Mental health, like physical health, requires conscious, deliberate attention. Like physical health, managing one's mental health includes prevention, early intervention and individual calibration.

Managing one's mental health requires self-care and access to information and resources and sometimes to professional care. Managing one's mental health requires support from managers, colleagues and co-workers, and it requires a strong personal circle of support. For most people, that personal circle of support starts with family.

When we think of military mental health and supporting members to effectively manage their mental health, we need to see them as part of a family and part of a community. We need to define family broadly. Family is more than spouse and children. Family includes parents, grandparents, siblings and ex-partners. Family is connections. Family may be biological, circumstantial or consciously chosen. Family is dynamic, continuously evolving and constantly adapting. Family, in fact, is the most adaptable institution in our society, and no two families are alike.

To ensure that CAF members achieve success, to ensure that they get the help they need when they need it and not just when they have reached a point of crisis, we and DND, the country and the community need to see family as a whole. We can do that with three straightforward strategic supports.

Number one is systemic supports, which include framing and managing mental health as a key skill, recognizing and including family as key members of the wellness team and educating and training for mental health competency, both at the individual and the family level.

The second is administrative supports. We need to create a culture where help-seeking is seen as a strength and not a weakness, providing access to services within the military and in the broader community.

The third is professional supports. We need to use a family lens when developing communication strategies and treatment plans. We need to treat the whole family. We need to acknowledge that individual well-being affects and is affected by family well-being.

In conclusion, if we frame managing one's mental health as a core competency, if we focus on the whole person, including their circle of support, if we focus on the importance of social connection, and if we focus on honouring, respecting and supporting military members and their families and frame help as a tool for success, then together we will be able to optimize the mental health of military members, strengthen families and create a culture of individual and family well-being within the military, and be a model for other workplaces across Canada and around the world.

● (1305)

I look forward to our conversation.

Thank you, Madam Chair.

The Chair: Thank you very much, Madam Spinks.

I'd like to hand it over to Colonel Wright now, please.

Colonel Helen Wright (Director of Mental Health, Health Services Group Headquarters of the Canadian Armed Forces, Department of National Defence): Thank you very much, Madam Chair and members of the Standing Committee on National Defence. It is a real privilege to be here today with my colleague, Lieutenant Colonel Suzanne Bailey, and to have the opportunity to discuss mental health in the Canadian Armed Forces.

My name is Colonel Helen Wright. I'm a family medicine physician with a background in research and occupational medicine. I am currently the director of mental health within the Canadian Armed Forces health services. My team is responsible for the professional, technical and clinical lead guidance and policy for the Canadian Forces mental health services and psychosocial services.

Today I'm pleased to have at my side, at least virtually, Lieutenant Colonel Suzanne Bailey. She is the senior Canadian Forces social worker as well as the national practice leader for social work within health services. She has also, for the past decade, led the Road to Mental Readiness, known as R2MR, mental health training program, overseeing its development, delivery and evaluation of mental health training among Canadian Armed Forces personnel.

Mental illness is experienced by one in five Canadians over their lifetime and some estimates are even higher at one in three Canadians. This extraordinary impact that mental health illnesses and injuries have on Canadians is also reflected in the Canadian Armed Forces. Our studies suggest that one in six of seven regular force members experiences a new, or perhaps ongoing, mental health issue in any given year. We know that anxiety disorders are the most commonly diagnosed, followed by depressive disorders.

Accordingly, the Canadian Armed Forces encourages members to raise concerns and seek appropriate help when needed. Efforts are ongoing to engage and educate our members to reduce all types of barriers to care, as well stigma. CAF members have access to a comprehensive, evidence-based health care system. It's grounded in family medicine but augmented by mental health and psychosocial services that are delivered by teams of people consisting of psychiatrists, psychologists, social workers, mental health nurses, addiction counsellors, chaplains and many others as well as an extensive cadre of civilian mental health specialists who practise in the community who also see our Canadian Armed Forces members.

● (1310)

As we were just reminded, health is much more than a matter of clinical health care, particularly in a military context. Health is a very complex concept involving a broad spectrum of factors, so while excellence in health care is necessary, it is just one element in a comprehensive array of Department of National Defence efforts on wellness and health.

In the Canadian Armed Forces we're looking for a fully integrated approach for lifelong health for our members, which includes health promotion and all sorts of health care services and activities and contributions from a number of different groups in CAF, groups such as the chaplains, morale and welfare, the transition group to name just a few. It also includes engagement from the chain of command and our leaders, members' families as we were also just reminded, and of course at the centre we have the members themselves.

I've alluded to this extensive array of supports, services and health promotion. Clearly I don't have time to introduce them in these short comments, but Colonel Bailey and I look forward to being able to tell you more about some of these programs and to answer your questions on mental health in the Canadian Armed Forces.

The Chair: Thank you very much, Colonel Wright.

Lieutenant-Colonel Bailey, please.

Lieutenant-Colonel Suzanne Bailey (National Practice Leader, Social Work and Mental Health Training, Department of National Defence): Thank you, Madam Chair. I have no additional opening remarks to what Colonel Wright has just presented. Thank you.

The Chair: Thank you very much, Lieutenant-Colonel Bailey.

We will open the round of questions with Madam Gallant, please.

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

Colonel Wright, at what point are CAF members either relieved from duty or relieved from use of their weapons in training when it comes to issues related to mental for someone in the forces? They feel they have a problem. They come forth. Many members fear they will be taken off duty or won't be able to use the firearms. They don't want anyone to know that they have mental health issues because of the stigma, of course. That is what prevents some of them from coming forth. They're afraid of losing everything they know about the military and their job.

What is the trigger point at which they can no longer do their job or have their weapons taken away?

Col Helen Wright: Thank you very much for that question, which really speaks to some of the core important concepts. One is the privacy and confidentiality that we know is just so vital to maintain for our patients to make sure that we have reduced any kind of barrier on that front. At the same time, we owe it to the member to protect their health from further injury or illness, and to protect their colleagues if that person is not ready to perform at their best in some very demanding circumstances. We do have the system of imposing some limitations on members, but only when necessary. I can assure you that we do not take that lightly.

We do know that although we go to great efforts to make these limitations that we share with the member's chain of command...to put them in such a way that it does not reveal anything about the member's health care situation. However, a major limitation like saying a member cannot use weapons is of course something that will get noticed. As I said, we use it to protect the member, to protect their health, to protect their colleagues, and, I suppose lastly, to make sure that operations can continue in a safe way.

I can assure you that this balance is well understood. We are always trying to make sure we are using those limitations only when necessary.

● (1315)

Mrs. Cheryl Gallant: When a soldier is identified as having a mental health issue or a family situation that makes them vulnerable to or predisposed to suicide, what does the Canadian Armed Forces do in communicating that to their chain of command?

Col Helen Wright: That also is a great question. Because we have this extremely important responsibility to the member to keep things confidential and private, it again is that razor edge of making sure we are looking after the member—the first priority is to make sure the member is well, or is as well as can be expected, and is getting the supports they need—but in the context of operations also making sure that everyone else is safe and well supported.

It would be very unusual for us to approach a chain of command and talk about someone being suicidal. We would do that only in the most extreme circumstances, where we really felt someone's life, or a colleague of that person, was in immediate danger. Generally speaking, we would talk to them about the employment limitations and [*Technical difficulty—Editor]* for management of that person, but without revealing details of their illness or injury.

Mrs. Cheryl Gallant: The 2018 report on suicide mortality in the Canadian Armed Forces showed that post-traumatic stress disorder was a factor in the deaths of more than 33% of the cases. What additional supports and follow-ups are given to soldiers identified as suffering from PTSD while serving and also after release?

Col Helen Wright: Madam Chair, supports for all mental health injuries—although of course PTSD is an important one for many of our members.... I don't think there are special things that we do for PTSD specifically that we wouldn't do for every other mental health injury. I guess that's what I'm driving at—that we would do everything we can for every illness or injury, but for PTSD we have a number.... We think of our mental health care on three pillars, if you will.

One is that we understand everything that we can about that illness in our population. The second is that we educate the members, their families and the community broadly to understand illness and injury, and then the last pillar is to care for that member.

For someone suffering from PTSD, as an example, we would make sure they were, of course, getting the right care, the best clinical, evidence-based care that we could possibly give, and make sure that they're getting all the supports they can. We have peer supports through programs like OSISS, for instance, where you can get formal peer support.

I think it's definitely a multi-pronged effort to make sure that we are doing everything we can to understand the situation, support that member and their community, as well as provide that last element of clinical care.

The Chair: Thank you very much.

Go ahead, Monsieur Robillard.

[*Translation*]

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): Greetings to the witnesses.

Thank you for being here today.

As you will understand, this subject is particularly important to me as I have an emotional stake in it. My nephew, a member of the Canadian Armed Forces, recently attempted suicide. That's why I'm especially interested, although all the topics we discuss here are important.

Could you tell us about the impact that mental illness has on the members of the Canadian Armed Forces and, especially, on their families?

● (1320)

[*English*]

Col Helen Wright: Madam Chair, I'd like to pass that question to Lieutenant Colonel Suzanne Bailey, our social work expert, to discuss some of those impacts on our members.

LCol Suzanne Bailey: Thank you.

From Statistics Canada epidemiological studies that were done on Canada Armed Forces members in 2002 and 2013, we know that Canadian Armed Forces members are impacted by mental illness and mental injuries at relatively the same rates as our counterparts in the Canadian general population, with a couple of exceptions.

We do know that our rates of depression within the Canadian Forces have been consistently higher than among the general population since at least 2002, and then the 2013 survey indicated that our rates of post-traumatic stress disorder—while they can't be compared with those in the Canadian general population because the same survey instruments were not used—have increased between 2002 and 2013, likely with some of that increase due to a decade of combat in Afghanistan.

We know that Canadian Armed Forces members are affected by other mental illnesses as well, such as anxiety disorder, panic disorder and alcohol abuse. Obviously, we can expect that these impact not only the members themselves but also their families. The consistent numbers indicate that in any one year about 16.5% of Canadian Armed Forces members can be expected to meet the criteria for at least one mental illness. This will affect how they perceive themselves, how they perceive others and how they interact with their families.

A large part of my role in the last several years has been, first of all, making sure that we have services and supports in place for those who do reach out for care. We have over 450 mental health clinicians in 31 different clinics. We have 37 clinics across the country, but 31 of those have specialized mental health care, so we have more than 450 mental health professionals offering multidisciplinary, evidence-based care to support those members, and we also—

[*Translation*]

Mr. Yves Robillard: Pardon me for interrupting you, but I have several questions and very little time.

What support is currently available for Canadian Armed Forces families suffering from mental illness?

[*English*]

LCol Suzanne Bailey: For the families, the Canadian Forces health services does not have a direct mandate to deliver medical care or mental health care to families. However, we can provide care to the families in support of that member.

There are also a significant amount of services available for families through the Canadian Forces morale and welfare services. In the last decade, they have established clinical social work services that are available in over 30 military family resource centres across Canada to support those family members of the CAF members who are impacted by mental health.

There's also a 24-7 family information line, staffed by bilingual mental health clinicians, available to families. The Canadian Forces member assistance program is also a 24-7 bilingual telephone service similar to many employee assistance programs. It is available to offer crisis intervention, and also to provide referrals to both military members and their families in their local community to get the help and support they need.

[*Translation*]

Mr. Yves Robillard: Are those treatments still available when armed forces members return to civilian life?

● (1325)

[*English*]

LCol Suzanne Bailey: Once military members transition out of the Canadian Forces and become veterans, their care is taken care of by their family physician, the civilian health care system as well as Veterans Affairs Canada.

We do have a memorandum of understanding between our clinics and Veterans Affairs operational stress injury clinics to provide care for each other's personnel in areas where we may not have coverage. There is a transition process that takes place through case management to ensure that there is follow-up care in place once the member leaves the Canadian Armed Forces and becomes a veteran.

[*Translation*]

Mr. Yves Robillard: Accessibility—

[*English*]

The Chair: I'm sorry, Mr. Robillard, but your time is up.

[*Translation*]

Go ahead, Mr. Brunelle-Duceppe.

Mr. Alexis Brunelle-Duceppe (Lac-Saint-Jean, BQ): Thank you, Madam Chair.

Many thanks to the witnesses for being here with us today.

Thank you, too, Colonel Wright and Lieutenant-Colonel Bailey, for your service in the forces, and thanks as well for your commitment, Ms. Spinks.

First, I have some questions for the lieutenant-colonel and colonel.

A 2020 study on armed forces veterans and active members was published in the *Journal of Military, Veteran and Family Health*. That study contends that women suffer from a higher rate of post-traumatic stress disorder and chronic pain than their male counterparts.

How do the armed forces respond to the gender-specific mental health needs of their members? Are there any differences, and how is that done?

[*English*]

Col Helen Wright: Indeed, we know there are differences between how women and men present with mental illness, exactly as was described in the question, but our model of treating our members is very much an individual model. We tailor the treatment to the individuals, to their illness, to their wants, and even things like their family situation and perhaps their occupation.

It's not so much that we have a difference in our approach for men, women or any of the other identity factors that we find among our population, but it's an individual approach to those individuals and tailoring the treatment to them.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Thank you for your answer, Colonel Wright.

So there are no real gender differences in the care given for health problems. It's really provided on an individual basis. I imagine you take into account the fact you're dealing with a man or a woman. That's at least what I understand.

[*English*]

Col Helen Wright: Yes, indeed, we take into account those kinds of factors, but all of the factors, right? Individuals are much more than just their gender or sex, of course. That's what I was trying to illustrate about an individual patient approach. It's everything about those individuals, their illness, and their experience with that illness.

We know, especially in mental health, that there are many different ways to treat any given illness, and it is often a trial and error process with individuals to find what works best for them. It is the whole person, the holistic person, and the whole circumstance, that we are looking at, and treating as best we can, and, of course, that would include gender and sex.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Thank you very much, Colonel.

Now I have a question for Ms. Spinks.

In 2016, the Vanier Institute of the Family published "A Snapshot of Military and Veteran Families in Canada".

According to that document, 15% of the military families that continue to live on military bases in Canada have access to support at military family resource centres. Those centres offer programs and services, including mental health support.

Do the military families that don't live on those bases have access to the military family resource centres? If they don't, where can those families obtain similar services?

[*English*]

Ms. Nora Spinks: Thank you for that question.

As you mentioned, more families now are living off base than on base. This reality has taken place over the last several decades. Now the vast majority are living off base and their spouses or partners are more likely to be in the paid labour force.

We're seeing in our research that families are often seeking mental health services in their communities, such as from family physicians or community-based mental health programs. They're going to their faith leaders. They're going to the natural place to get mental health services that you and I would go to. They are able to access the services on base, but they have to get there. There are hours of operation, so if they're working in the paid labour force, it is sometimes hard to align with those services.

One of the things we've done in our military veteran health initiative is to really focus on those community members who might be the first point of contact. We've been working with our partners across the country to build military literacy, so that if a family member or a military member phones up an EAP, goes to their family physician or goes to their local mental health provider, they are aware enough of the language. They know what a posting is, what the lifestyle is and they understand what it means to be part of a military family or to be military connected.

We're trying to build the points of contact, so that when a family member is concerned about the military member needing some kind of support, if they themselves are a caregiver or a member of the circle of support needs assistance, they'll be able to access it when and where they need it.

It's not a perfect system. There's still a lot of education and awareness to be done, but we have been able to reach all family physicians across the country. We've been able to reach early childhood educators, pediatricians and a variety of professionals from whom, hopefully, if they are the first or one of the first points of contact, a family can receive the care they need and they can get the care quickly, so there's less likelihood of cascade into crisis.

● (1330)

[*Translation*]

The Chair: Thank you very much.

[*English*]

Now we'll go on to Madame Blaney, please.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you, Chair.

I would like to thank all of the witnesses here today for your important testimony. A special thank you, of course, to Colonel Wright and to Lieutenant-Colonel Bailey for your service. I really appreciate you being here with us today.

Mental health, as we all know, has a huge stigma across Canada. I do believe though, that the stigma for military and other high-stress front-line workers is even higher because everybody looks to them to be the strong ones in the middle of a crisis.

We are still losing, on average, more than one serving member per month to death by suicide. I also understand that the estimates are up to 10 times higher for the members who attempt it. I think this is such an important study because we have to make sure that in every step we take, we're supporting our military to be in the best health, mentally and physically, as we possibly can.

Again, I want to thank both of you for your service and for the work you're doing on this important file.

I'm concerned about the idea of self-harm. I know that in the National Defence Act, we have paragraph 98(c), which is really based on self-harm as a deliberate avoidance of duty. I'm very concerned that this it is not the message that we want to send out to our military folks.

I'm just wondering if you have any concerns around having this kind of language in our National Defence Act when we're looking at opening up the doors and taking away stigma for people who are considering harming themselves.

Colonel Wright, I would like to start with you.

Col Helen Wright: What I can tell you here is that I have never heard a patient or a health care provider in our system express concerns about paragraph 98(c) or any language like it.

My perception from my experience and the teams I work with, the patients I've worked with, is that I have not heard that message As you outlined in your question, we are working very hard, and it will be an ongoing effort to continue to reduce barriers, but this is not one that I am hearing is a barrier.

● (1335)

Ms. Rachel Blaney: Thank you for answering that. I still have concerns. I think language really matters and there are things that are invisible and they're right there in front of us and people see them. I know we had a mother who came forward as a witness for another study of ours and that this was her concern after losing her son. We need to make sure that language is clear.

I'm just wondering about what the current state of mental health resources are in the CAF. We've heard previously that there are reports of sometimes long waiting lists. Now with COVID we know that the demands could only be increasing. We heard testimony not too long ago from military folks who went in to help with the long-term care centres and saw the crisis, and we saw how stressful that was for them.

I'm just wondering if we could hear a little bit about the resources and whether there are any extra demands because of COVID, and if there are any recommendations we could provide.

Col Helen Wright: It's difficult for me to describe our supports because there really are so many that it's outside this medium to be able to explain them all. I will maybe address part of your question, at least, with respect to the concerns about COVID-19 and the potential increased demands and how we're handling that.

Initially with COVID-19, in fact, our demand went down, and we were seeing similar things. Some of our civilian colleagues were seeing the same thing. Some of our military partners were reporting the same thing. It was a little difficult to understand exactly why that was happening, but we were all, including the patients, I think, pivoting in that suddenly new circumstance.

We brought in things like virtual care. We had been working on virtual care before COVID-19, but there is no question that the circumstances and context of COVID-19 have really pushed us forward with our virtual care. That is an example where we are really trying to make sure that we are making the mental health care, as well as the psychosocial supports, as accessible as possible even in this new context. It is truly as simple as perhaps picking up the phone and having your mental health interaction with your care provider.

Interestingly, I think this does introduce different barriers depending on who you are and what your circumstances might be, because now if you're having your mental health interaction from your home, and there are perhaps other people living in your home, it may be difficult to find a truly private place to be able to have a phone or a Zoom conversation or something like that.

Interestingly, although I think on balance things like telehealth and virtual care in response to COVID-19 and making sure that we're meeting those needs are helping most of our clients, they may not actually be helping everyone. That is why we are still offering in-person support that is much more on the pre-COVID-19 model as well.

Ms. Rachel Blaney: Thank you.

I have only eight seconds so I will let them go.

Thank you, Chair.

Col Helen Wright: Sorry.

Ms. Rachel Blaney: No, that's okay. Thank you for your answer.

The Chair: Thank you very much.

We have Mr. Dowdall, please.

Mr. Terry Dowdall (Simcoe—Grey, CPC): Thank you, Madam Chair.

Witnesses, thank you for your presentations and thank you for your service.

My first question goes to Colonel Wright, I would think.

As we know in 2017 we were extremely pleased that we had a joint suicide prevention strategy. We have numbers. In 2018 we had 15 deaths; in 2019 we had 20. In my riding I represent Base Borden. I can tell you, on a personal note, that any of those suicides certainly affect the military family here on the base, but off the base as well because they're often involved in the local hospitals as well. It's a really touching time for us.

I'm just wondering if you have some numbers—we're at December 4 now—for this year to see whether or not we are actually making some progress.

Col Helen Wright: Madam Chair, that is really a super question, because it allows me to talk about something that I feel is really important.

The first thing, I'm afraid, is that I am not going to share the 2020 numbers with you today. Those numbers will absolutely be made public at the end of the year.

We deliberately delay releasing some of that information because of some of the privacy concerns, which we've already alluded to in other questions. We are such a small population, and although each and every suicide obviously has a tremendous impact on family, friends and colleagues, in the end our numbers are quite small, so we would expect a variation from year to year in our small population in the numbers of suicides.

For me, it is not about the number of suicides in any given year. That is not, I don't think, how we should look at whether our suicide prevention efforts are working, because we expect that fluctuation, so it's not about chasing the number. Even if I were to tell you today that the numbers for 2020 were much better than in another year or much worse than in another year, we would still do everything we could to prevent every suicide we could, although acknowledging that we cannot prevent or predict every single one. To me, I think it's important that—

Mr. Terry Dowdall: I agree that—

Col Helen Wright: Go ahead.

● (1340)

Mr. Terry Dowdall: I was just going to say that I agree with your comment that every year it's going to fluctuate, but part of the reason I'm asking is that you want to, hopefully, move forward in some way, and it leads up to my next question. I've delved into this. It's a subject that's close to my heart.

Since the study came out, there were 160 new or existing actions that were supposed to take place, and I don't know how many of those 160 have been acted upon, but one of them, when you delved into it, was one that really touched me, because I think it's the most important one when people are in their darkest moments. One of the recommendations suggested having a 24-7 crisis support line, whether phone, text or chat. I was really touched when another member of Parliament, the member for Cariboo—Prince George, was bringing forward a simple number, a 988 number, so that at such a time, no matter what, a person would have someone to talk to.

I'm just wondering about it. Did we implement a 24-7 line? Or do we have anything right now presently within the military? I think that, for our government, coming up to Christmas, this is the time more than ever that we need to reach out and make sure that we have those supports. The simple question I guess would be this. Number one, have we acted on that recommendation and, if not, number two, do you believe that it's probably a good idea and that we might save a life?

Col Helen Wright: I think you are absolutely right about the importance of people having somewhere to turn when things are dark for them, in addition to this array of services that we have, as I keep alluding to—but of course they don't all speak to every single person.

However, with respect to your specific question on a call line, as Lieutenant-Colonel Bailey mentioned, we already have a 24-7 bilingual, completely confidential line in the CFMAP, the Canadian Forces member assistance program, and that does include a crisis line style of service. There's also the family—

Mr. Terry Dowdall: So there's somebody on the line 24 hours a day and it's quite common that all the military would have easy access to get to that number?

Col Helen Wright: Yes, sir. It's 24-7, bilingual at all times, and yes, it's a number that we publicize as broadly and as widely as we possibly can. Members and their families can use it. There's also a family information line, and it too is 24-7 and bilingual, and includes a crisis line component as well as other components. They're not purely crisis lines, but that is one of the services they can offer.

The Chair: Thank you very much.

Mr. Terry Dowdall: Thank you. Of the 160 recommendations—

The Chair: I'm sorry. I'm going to have to ask for Mr. Spengemann, please.

Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.): Thank you very much.

Colonel Wright and Lieutenant-Colonel Bailey, thank you for being with us. Thank you for your service. Through you, I would also like to thank the women and men who serve under your command for their service.

It's great to have you here, Ms. Spinks, and thank you for your important work.

Madam Chair, I served in a war and conflict zone for just under seven years as a civilian UN official stationed in Baghdad. During the latter part of that time, in a fairly short window, our team lost two colleagues to suicide. One of them was a serving U.S. armed forces officer who was attached to the United Nations mission as a liaison officer to the coalition forces, and the other was a UN civilian security and protection officer who was regularly exposed to potentially hostile scenarios in greater Baghdad.

My question, I guess, is around the idea of access. We've heard a lot of testimony about the programs that are in place, the funding that backs these programs and the importance of these programs. In your assessment, are there still barriers to access that go beyond or are different from the stigma itself and are simply a function of the fact that the person in question has suffered an injury that may prevent her or him from even having the motivation to seek help?

Access, in my assessment at the moment, is still very much a demand-based option. There is very rigid mandatory screening upon entry into the Canadian Forces, including psychological screening. Are we looking at access as too much of a demand-based option? Should there be greater emphasis, in whatever rational and reasonable way, on pushing the programs more into the lap of somebody who may have an injury?

● (1345)

Col Helen Wright: Madam Chair, I think a number of excellent points were made in that question. The first was your allusion to whether there are still barriers to care that are perhaps different from the one that often seems to come to the top of the list: stigma. I think unquestionably our system is not perfect. There are still barriers to care. I think you're right. A lot of it is a demand, still based on the member recognizing they need help.

However we are trying to combat that with education of our members so they can recognize when they might need help. It's extremely important.

For that I will pass the question to Lieutenant Colonel Bailey, because some of the education that she and her team do I think is really critical to that.

LCol Suzanne Bailey: Stigma and other barriers to care are very interesting, because we often think that stigma is the primary barrier to people seeking mental health care when in fact many studies over the past two decades, not only in the Canadian Forces but in other populations, show that the number one barrier to seeking mental health care is that the individual does not perceive they have a need for care. That was one of the reasons we developed the road to mental readiness program, which has the four-colour mental health continuum model, to increase mental health literacy and, hopefully, result in earlier recognition of distress and access to care.

We do know other barriers to care exist. Some of them are related to stigma: worrying about what others may think of me, how my leadership may perceive me and how others may treat me. For the most part, the data regarding those stigma-related barriers is fairly encouraging. The interesting part of that is we find that once people are impacted by a mental illness or a mental health injury, their perception of those barriers tends to increase significantly, and those barriers become much more important.

Some of the barriers are more structural, with people feeling they don't have time or may not know where to access help. We spend a fair amount of time in our education programs talking about how one might overcome or challenge some of those particular barriers to care.

The other aspect is negative attitudes toward care-seeking, which we also spend a fair amount of time in our education program talking about, specifically letting people know that mental health treatment is effective, that it's evidence-based and what mental health treatment might look like.

Mr. Sven Spengemann: Lieutenant Colonel Bailey, thank you very much.

If I may in the remaining 30 seconds broach a question that perhaps there's some time to elaborate on, for those Canadian Forces members who've served in a combat setting directly or indirectly, are we moving closer to the recognition of a potential presumption of injury, or are we still quite a ways away from that?

Col Helen Wright: Madam Chair, we're not presuming injury, because I think there is still enough variety in the experience that this would be a step too far. To be honest, I haven't reviewed the literature on that. We screen people, and I know time is short here, but I think what is key is that when people come back from deployments or these demanding circumstances, we have a screening program to try to pick up those folks who may be suffering and do not yet realize that they are, and try to get them into service sooner.

Mr. Sven Spengemann: Thank you very much, Madam Chair.

The Chair: Thank you very much.

We'll move on to Monsieur Brunelle-Duceppe, *s'il vous plait*.

[*Translation*]

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

The Canadian Armed Forces and Veterans Affairs Canada published their joint suicide prevention strategy in 2017. According to the Department of National Defence, 15 members of the Canadian Armed Forces committed suicide in 2018, and the number increased to 20 in 2019.

How effective do you think the joint strategy is, and how can its effectiveness be measured?

● (1350)

[*English*]

Col Helen Wright: As I mentioned already, I think one of the ways we should not measure effectiveness is by looking at the fluctuations in our numbers from year to year. I think perhaps over many years we might be able to see trends, but certainly not year to year.

In terms of the suicide prevention strategy you mentioned for the Canadian Armed Forces, it was turned into the suicide prevention action plan. It had 95 different action items. As to your question about how we measure progress on the suicide prevention action plan, it is being tracked very carefully. We report on the different action items quarterly, for instance. As to how we measure each of those, you can imagine that in those 95 items there's a huge variety of things. Some of them, like the road to mental readiness program, might be measured on how many programs we've adapted to customize circumstances and occupations, or how many people we have trained. In another item it might be something like the clinicians handbook to prevent suicide. That one was tracked by whether we completed the task, which we did.

I think following how we're doing is dependent upon what that action might be. I would make a statement overall on how we recognize if we're doing better: It's the reports we get back from members, through surveys and things, about their ability to recognize when they might need help and recognize how they would help themselves or how they would help another person. I think it's those kinds of broad concepts. That's how we know our action plan is making a difference.

[*Translation*]

The Chair: Thank you very much.

[*English*]

Madam Blaney, please.

Ms. Rachel Blaney: Thank you, Madam Chair.

Ms. Spinks, I know that when untreated, mental health issues have a huge impact on families. We've heard that some organizations who are working with our military families are really struggling to manage this. I'm also hearing stories of loved ones, family members, who notice that the person serving in their family is struggling. I think that's interesting, because as Lieutenant-Colonel Bailey said earlier, often the challenge is not knowing yourself that you need that support.

I'm wondering if you could talk about any understanding you have of the impacts on the family when somebody has a mental health issue who is not acknowledging it, and what families do to try to support that member.

Ms. Nora Spinks: This is a really important line of inquiry, because families are often the very first people to identify that something's off. They will see it long before the individual person, in terms of their own self-assessment or self-awareness. They'll begin to see little things that just don't seem right, and may then begin to say to their loved one, “I'm starting to see you're a little short these days,” and begin to help them self-assess. That is a skill that we can train. It's something that we can teach families to do, to observe, to interact, to intervene, and to provide some of that support that will encourage help-seeking behaviours. If not, then advocate on their behalf.

The challenge is that oftentimes without that training or that support, the tension builds within the household and the family falls apart. We need to pay attention to those caregivers and people within the circle of support. That's why I was saying earlier that we need to think about families not just as spouses, because often the spouse is the first one to notice and the first one to leave. That means that the second circle in that circle of support is the parents. Oftentimes, they'll be the ones who will be attempting to support that person with help-seeking behaviours. They may not have received the information about the 1-800 number and the help lines, so they will start Googling. They start panicking, because they're not in the loop to begin with.

When we use a family lens and we see the family as a key component of the health care team in identifying what needs to be done, identifying when things are going a little off, being there to begin that early identification and early intervention, we support that entire circle of support. That makes a difference.

The organizational culture, recognizing that families are there as a tool and not a burden or a dependant, will have a huge impact on the value and the success of the programs and services that are offered. The programs that are offered to both members and families are amazing. They're well thought out, evidence-based, and the people who deliver those services are doing so with the very best of intentions.

Families are not always aware of what's available—particularly if there is no spouse, or that spouse is no longer available—and that they are able to access or fully leverage those programs.

● (1355)

The Chair: Mr. Benzen, you are next.

Mr. Bob Benzen (Calgary Heritage, CPC): Thank you, Madam Chair, and to all of the witnesses for appearing today and for your valuable testimony.

Colonel Wright, we've heard some testimony, and we know that in past cases when a CAF member dies by suicide, the family has great difficulty in getting information from the military. In some cases, it takes years to find out some of the details of what happened.

Can you talk a bit about what the military can do to break down some of those barriers and shorten the time frame, so that these loved ones.... In a way, they're suffering mental health issues too, because they can't get this information. We're sort of compounding the problem, and making it worse. How could we help them get more information?

Col Helen Wright: Madam Chair, again, there were some excellent points made there.

I think the military has come a long way in recognizing that this is an important component of what we do when we do investigations of suicide and/or when we're looking at supporting, say, the colleagues or the teams that were around the person who has died by suicide. It's important that we remember to include the family as a core group who also needs to be supported.

I do think that we've come a long way there. I know that, as part of our effort, one of the things that my group does is the medical investigation, if you will, on the deaths by suicide. That includes inviting members of the family, and not necessarily just the spouse but the parents and other family members as well, to be part of that process of the investigation to make sure they are aware of what we're aware of.

Now, of course, I'm speaking of the medical investigation, but I know that similar efforts are made for the boards of inquiry as well to make sure that, as we learn more about the event and the circumstances around it, we're feeding that information back. But I would caution that there is often also a competing interest in making sure that we are maintaining the member's confidentiality, so sometimes our hands are tied based on the member's paperwork—but that's the best way we know what the member intended. If the member has stated in paperwork that one person or so-and-so person is their next of kin, then we are obliged to work through that person, which may not always be the people who feel they should be getting information.

I know that we still have challenges there, but as you can see, it is based on the very best of intentions to make sure that we're doing what the member would have wanted based on information that we have. But I certainly recognize how challenging and painful that would be for other family members.

● (1400)

Mr. Bob Benzen: Thank you.

The Canadian Forces ombudsman had a recommendation that the families meet with the commanding officer to discuss the events leading up to the events surrounding the suicide. Is that happening routinely now all of the time? Has that been implemented?

Col Helen Wright: Madam Chair, I'm afraid I don't have visibility on that, so I can't comment on that either way. I would imagine that it is happening in most cases, but I'm afraid I can't speak to it.

Mr. Bob Benzen: Thank you.

In the Road to Mental Readiness there were 15 objectives, and one of them talked about suicide contagion and minimizing it, and the communication surrounding it so that it can be handled properly.

Could you talk a little bit about that concept of suicide contagion and what the leadership is doing to minimize that from happening?

Col Helen Wright: Madam Chair, that's a really important question.

We are torn between wanting to recognize that, in many cases, part of the picture when someone dies of suicide may be their military experiences and recognizing that person and their contributions, of course.

However, we do know—this is mostly from civilian literature, but also from some military studies in the United States—that there is this contagion and that if people read about a death by suicide that seems to glorify it or seems to make it seem as though it has additional benefits, either for them and their reputation or perhaps for their families, it can, in fact, be an additional inducement to people to choose death by suicide rather than seek supports and help for the way they're feeling and their other struggles, which, of course, is the way we would prefer people to go.

It's a difficult balance between recognizing the person, their contributions to the military and their struggles, and yet at the same time not wanting to portray suicide as an attractive option to other people because, as I said, we want them to choose different options. But it is known that it can happen, and so it's a real phenomenon that we must avoid.

Mr. Bob Benzen: Excellent. Thank you.

The Chair: Thank you very much.

[*Translation*]

Go ahead, Mr. Robillard.

Mr. Yves Robillard: Colonel Wright, what are the mental health conditions that must be met for a member of the Canadian Armed Forces to be deployed to a mission?

[*English*]

Col Helen Wright: Madam Chair, that's an interesting question. I'm going to pass that to Lieutenant-Colonel Bailey with her experience in doing pre-deployment, as well as during and post-deployment mental health training.

LCol Suzanne Bailey: Prior to any deployment, military members will undergo a couple of types of screenings. One would be psychosocial screening. They're encouraged to include their family in that. The objective is to see if there are any personal or family factors that may interfere with their being able to complete their mission. It's a fairly standardized 30-minute screening. The intent is to make sure that we're not putting members at any additional risk by sending them on particular missions. They also go through a similar medical screening with their primary care provider to make sure that there are no underlying health conditions that may be put at risk by their going on the mission.

Prior to deployment, we also provide Road to Mental Readiness pre-deployment training, which is tailored to the mission and the environment into which they're going, to make sure that they are aware of the resources available to them and also are able to recognize early indicators of distress. We spend some time making sure that they can use some of the skills and tools within the training to manage the particular demands of the mission they're going on.

[*Translation*]

Mr. Yves Robillard: Are the conditions for a second deployment the same?

[*English*]

LCol Suzanne Bailey: Each deployment is evaluated before a mission is initiated, so the conditions can vary greatly depending on whether it is a combat mission, a humanitarian mission, a peacekeeping mission or even sometimes a training mission.

A number of different assessments are done to make sure that all the stakeholders involved know what the conditions of each mission are so that all the training and preparation for the members proceeding on each particular mission can be adapted to the particular environment they're going into.

● (1405)

[*Translation*]

Mr. Yves Robillard: Can you tell us about the treatments that are administered when a member is diagnosed with an operational stress injury, an OSI?

[*English*]

Col Helen Wright: Madam Chair, in the context of this medium and the time constraints we have, I will fall back on the reminder that our treatments are, of course, evidence-based. We try to stay right at the leading edge of guidelines on managing different mental health conditions, including operational stress-related disorders.

However, in the end, any given treatment will be customized or tailored, if you will, to that patient, to the patient's experiences and to the types of techniques that seem to work for the patient. There isn't just one given recipe that will work for everyone. That's one of our challenges in mental health especially: finding the right combination of things that work for any given individual.

[*Translation*]

Mr. Yves Robillard: My next question will be for Ms. Spinks.

You are the president and chief executive officer of the Vanier Institute of the Family. How do you think the pandemic has affected the lives of Canadian families, particularly those of Canadian Armed Forces personnel and those of first responders?

[*English*]

Ms. Nora Spinks: That's a very important and large question.

Madam Chair, we've been conducting polls of families week over week since March. The impacts of COVID on families and family life has been quite dramatic, but not all tragic. A lot of families are actually doing quite well.

It does lead us to a number of observations. The first is that every system in our communities and in our society—the health care system, the justice system, the child welfare system, etc., including the family system—has had its strengths magnified, amplified and intensified as a result of COVID, and equally, its weaknesses.

Families that were struggling are likely struggling harder. Those that were doing well are likely still doing well. For the ones in the middle, many are still adapting, adjusting and finding ways to support each other and work together. Workplaces all across the country—and the military is no different in this case—have had to adjust and modify how, where and when work gets done. The big issue here is the degree to which disruption has impacted a household.

The greater the disruption, the greater the likelihood is that individual family members will feel that they've lost their sense of agency, control and autonomy. When families lose that, often stress levels go up.

When we're looking at COVID, it really is everything that was pre-COVID and then some. We need to monitor and keep an eye on how families are doing, month over month and into next year and learn from every one of those experiences.

We will continue to do that with all families across Canada, including military and veteran families. We have a survey in the field looking at how veteran families are managing and adapting. We would be happy to share the results of that with this committee and the veterans committee, as well.

[*Translation*]

Mr. Yves Robillard: I'm going to allow the other members of the committee time to ask their questions.

[*English*]

The Chair: Thank you so much.

Mr. Bezan, please.

Mr. James Bezan (Selkirk—Interlake—Eastman, CPC): Thank you, Madam Chair. I was expecting the NDP or the Bloc to go before me.

I do want to thank our witnesses for appearing. I believe the service you're providing to our military members, along with their families, is second to none. I know that we're always trying to do better, but with the unpredictability of suicide, it's always going to be a challenge.

Colonel Wright, my colleague, Mr. Dowdall, requested the data on the number of suicides in 2020. We are going to be publishing a report very early in the new year on suicide prevention in the Canadian Armed Forces.

Would you be able to provide us with those numbers as quickly as possibly, so that we could include them in our report when it is published in February? We'll need that data as soon as you have it, which will be, hopefully, within the first couple of days of January.

● (1410)

Col Helen Wright: Madam Chair, of course, the information will be made public. I can't tell you exactly when. There are other factors to do with public affairs and when these things are released.

I absolutely understand the interest in knowing that number, although I would take the opportunity to say again that, given that our numbers fluctuate from year to year, that is not necessarily the way we should be evaluating our system.

Mr. James Bezan: I appreciate that, but we do already have the data from previous years. There are a lot of people who want to look at the numbers and how they relate over time to what we're dealing with.

As we've mentioned, a number of programs have been rolled out over time. Road to Mental Readiness is one of those programs that I think has helped with self-assessment. It has helped troops assess each other and look for any indications of deterioration of mental health.

Ms. Spinks, would you be able to talk about whether military families should also be offered the road to mental readiness program to help with that self-assessment for themselves, as well as for their loved ones who are serving?

Ms. Nora Spinks: I think the road to mental readiness program is an excellent example of translating a very complex issue and coming up with evidence-based programs that are accessible and available—and yes, military families have had access.

Lieutenant Colonel Suzanne Bailey and I have presented the road to mental readiness program even to corporate Canada. This program has been adopted by the Canadian Mental Health Commission as well as one of their signature programs. It's a very useful program.

I also think it's really important to recognize that families, including military families, are resilient until they're not. Sometimes there's a lead up to a tipping point. We want to help people identify when they're at the suicide ideation stage—when they're thinking about it but haven't necessarily done anything about it. We want to let them know that they can seek help at that point. If they've taken it a bit further and they've developed a plan, then we need to make sure that they know they can reach out for help...and on down the steps and stages. People don't tend to go from being well one day to being suicidal the next, so we want to create as many opportunities as possible to support them and their family members along every stage.

Also, the interventions are different, depending on what stage they they're at and their families are at. I think we need to make sure that there's a broad base of support in communities, in neighbourhoods, as well as within the confines of the military family and the military operations. We want to make sure that people are aware, including those who aren't normally included, like parents, for example, who don't get access to the information, don't get included in the awareness initiatives and may or may not be aware of programs like Road to Mental Readiness.

Mr. James Bezan: I think the more we can do, especially when it comes to the treatment of mental health and if we can treat the entire family, we would see a lot more success in preventing suicide and reducing the number of suicides.

● (1415)

Ms. Nora Spinks: The evidence bears that out. You're absolutely right.

Mr. James Bezan: One of the concerns I've always had—and this is for health services in general—is that our reservists are often located in communities where we don't have a base. We may not have an operational stress injury clinic. We may not have military psychologists, social workers and psychiatrists readily available. They may be sitting in Thunder Bay, Ontario, and the closest base is Winnipeg, an eight-hour drive away.

How do we better provide mental health services to our reservists, who may not be able to get to the Canadian Armed Forces health services group?

Col Helen Wright: Madam Chair, I think there are two main prongs to attack that particular problem.

The first is to remind you that we do use mental health providers extensively in the civilian community—a civilian psychiatrist who sees military patients, for instance. Although a person may find themselves a distance away from a supporting military base and one of our military clinics, that does not mean they don't necessarily get health care. For many of our reservists, depending on the type their contract or the type of work they do, their medical care is grounded in the civilian health care system anyway.

However, I am very excited about—

Mr. James Bezan: Over the years, Colonel, the people whom they have access to on the civilian side often do not understand operational stress injuries in particular and how to treat them.

Col Helen Wright: I recognize that. You are absolutely right about that.

One of the things I, and many of us, are very excited about is this almost seismic shift in use of telehealth and virtual health that COVID-19 has helped us push forward.

I think that is going to be the way forward for some of these folks in more remote places, where we can now use other options so they can see a provider who is familiar with the military, is perhaps more familiar with operational stress injuries and speaks their official language of choice. This is another important aspect for our members, when they're distributed around the country.

As I said, I am really excited and optimistic that this is going to help us move that forward.

The Chair: Mr. Baker, please go ahead.

Mr. Yvan Baker (Etobicoke Centre, Lib.): Thank you very much, Madam Chair, and thank you to all of you for being here today to speak with us about this really important topic.

My first question is for Ms. Spinks. For the sake of folks who aren't as familiar with the issues we've been talking about, or for my constituents who might be watching this at home, could you share a bit about what the impact is on families when someone is struggling with mental health challenges and is also a serving member of the armed forces?

Ms. Nora Spinks: Families play a very important role in first identifying that there may be a problem. They play a very important role in searching through the various types of information to sort of nudge their family member to supports that might be most effective. They play a really important role as advocates if their family member is not receiving the care he or she needs. They are often a really important part of the team in-between treatments. They're the ones who are there night and day to remind patients to apply certain techniques or the therapies they have been receiving, and remind them to take their medication. Families have a very deep and important role.

When somebody is in crisis and more emergency intervention is needed, when they may have harmed themselves or put themselves at serious risk, the families then are often cut out of the circle of support, once the person is hospitalized or intensively treated. We need to make sure that families continue to be recognized as important players on the team, because when that person leaves the crisis treatment, he or she will go back to that family. Stop and start doesn't work as effectively as when the two are integrated and treated together.

The other thing that we need to recognize is that caregivers are often experiencing stress themselves and need caregiver relief and support as well. Benefits and programs directly targeting caregivers are absolutely critical in the continuum of care and the suite of programs and services we need to be considering very carefully. Without them, quite often the cascade happens very quickly into more dire situations or circumstances. It is really important to keep caregivers through the entire process, and also give them the support they need.

● (1420)

Mr. Yvan Baker: That's helpful. Thank you for that.

To follow-up on that, what are the things that need to be done? Given that the family plays such an important role in supporting the member of the forces through this, what needs to be done, and what more could be done, beyond what's being done today to ensure that members of CAF are being engaged appropriately to provide that support you are talking about that is so important?

Ms. Nora Spinks: I think the first thing is to treat the whole family unit as the core, so that it's not the military member and their family, but it's the military member's family who needs to be at the centre of any intervention and any treatment. It sounds like it's a little thing, but it's really a big thing.

I also think it's really important to recognize that family is diverse and ever-changing. It's not like you can say that once you've informed the family, check, you're done. It needs to be done on a continuing basis. Engagement of family members in the conversations and in the dialogue is critically important. The research is really clear that when there is success, it's usually because there's a strong circle of support, strong family connections and really healthy relationships. When there isn't, the same applies in the negative.

I think that, when we look at the ways in which we want to move forward and we want to plan, the family lens is critically important. Family engagement is an absolute definite. Recognizing the diversity of families is critical. When we think about the ways that we can leverage those relationships and nurture them, we can recognize them, honour them, acknowledge them and engage them early on. I know there are a number of programs in place right now that are attempting to do that. We need to celebrate the situations and circumstances that have been successful. Not only do we want to spend time studying the cases that have not ended well, but we also need to spend a lot of time researching when we get it right. How can we take those learnings and translate them across?

We do have a wonderful generational opportunity now because we're talking more about mental health. We start with children when they're toddlers: “Share your feelings, tell us how you're feeling, use your words, how can we help you, what kind of help do you need?” Kids at age two and three are now being taught how to ask for help. That's going to give us a huge opportunity going forward, because the foundation has already been laid. It's very different from previous generations that were raised with, “Suck it up, shake it off, move on, don't let it bother you and don't let them see you cry”. It's a lot harder to engage in talking about mental health in that case.

We're creating a perfect storm here with really good evidence-based programs, really good acknowledgement of what works and a commitment from people like you around this table who want to get it right. I think we're creating a perfect storm to go forward with really positive results. We can measure impact by also recognizing how people are thinking and feeling, as well as what they're doing: So thinking, feeling and doing. It's not just the end results; it's the impact of their behaviour, their thoughts and their feelings as a result of....

Even knowing that these programs are available, even if they don't need them, just knowing that they're there is sometimes program enough.

We can't underestimate the power of families and family connections in this space.

● (1425)

The Chair: Thank you very much.

[*Translation*]

Go ahead, Mr. Brunelle-Duceppe.

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

What we're hearing today is really very interesting. Many thanks to our three witnesses.

This past summer, we witnessed something unique in Operation Laser. When people join the forces or the reserve, they don't expect to be involved in anything like it. We often talk about combat operations or rescue operations during natural disasters, but what we experienced this summer was something no one has gone through since the Spanish flu. It was really a unique situation.

Incidentally, I want to thank the Canadian Armed Forces for Operation Laser. All of us, regardless of political affiliation, are truly grateful for it.

It happened recently, but do you know whether any military members or reservists suffered mental injuries as a result of their involvement in Operation Laser? Are you able to answer that question?

[*English*]

Col Helen Wright: Madam Chair, that is an excellent question about how this unusual operation may have affected our people.

As it happens, Lieutenant Colonel Bailey is really the expert on how we tried to prepare folks for this different circumstance before they went in, support them while they were there, and then do post-deployment support.

I think perhaps the answer to your question is that we are doing a study of all the folks who were involved in Operation Laser, as a follow-up to try to find out exactly how it did affect them. The things we put in place to try to prepare them and support them were based on what we assumed would help, what we thought would help. We are doing a fairly extensive study with a number of different departments within DND contributing, to do something that is a little bit unprecedented, to try to find out what actually did happen. Many of our partner militaries, for instance, are following very closely to see what we learn.

I don't have results yet to announce, but it's going to be very interesting to follow what we learned and then make changes to how we prepare people for the future, even if we don't do anything exactly the same as Operation Laser, but to take those lessons into whatever the future might hold for us.

The Chair: All right. Thank you very much.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: I'd be very curious to read that report.

Lieutenant-Colonel Bailey, could you tell us how military members are prepared, from a mental health standpoint, of course, when an operation that unique is conducted in Canada?

[*English*]

LCol Suzanne Bailey: That is, in fact, an interesting question, because as you have identified, this was different from anything that the Canadian Armed Forces members had been asked to do before. There were obviously some unique challenges, such as how to deploy people within a pandemic environment and into a community that might be the same community that some of the people lived in. It was a very different patient population. As you know, our Canadian Armed Forces members are between the ages of 17 and 60, and those would be the types of patients that our care providers would be used to seeing. We're a fairly healthy population because we're screened and we do a lot of physical training. A fair amount of training went in, not just mental health training. There were about eight to ten different training modules preparing the members to go in and provide a very different type of care to a different population.

The specific role that I had with my team was to look at how to mentally prepare them to deal with some of the demands of caring for those patients, and also to take care of themselves and to look out for their buddies and the teams they were working with throughout what, at the time, was going to be a task of unknown duration.

A lot of focus was put on making sure that they were rotating through different tasks and that they weren't working overly long hours. There was also emphasis on teaching them as well as their leadership how to support each other within the small teams they were working in, as well as depending on the mental health support resources that we had put in place for them.

● (1430)

The Chair: Thank you very much.

Madame Blaney, go ahead, please.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Thank you.

[*English*]

The Chair: Oh, I see Ms. Spinks.

Do you want to add something to that?

Ms. Nora Spinks: I want to mention that one of the things we've been studying about COVID is the fact that what makes it particularly unique is that as people are responding, whether they are health care, emergency services or military members, they are also going through it at exactly the same time, unlike going into a humanitarian situation where you're going into a post-hurricane, and you weren't living through the hurricane. These members were and still are living with COVID. They're worried about their kids. They're worried about their families. They might have gone to school in the neighbourhood. As Lieutenant Colonel Bailey said, they know these neighbourhoods; they know these communities.

The fact that they too are responding to COVID and are worried about their own families and their own grandparents makes it doubly difficult. It's something that we're really trying to understand, because we've done the best we can to support people in this situation but as you said, this is very new.

It's the same with researchers. Researchers normally research something that they're not directly involved in. COVID's a different story, so it's a really complicated time, and we will be studying this for decades, and we will be living with the impact of this for a hundred years.

Thank you for that really important question.

The Chair: Thank you.

Madame Blaney.

Ms. Rachel Blaney: Thank you, Madam Chair.

If I could come back to you again, Colonel Wright and Lieutenant-Colonel Bailey, I just have a question about the Road to Mental Readiness. I was very happy to see and understand that families also have access to this training. I guess my question is a couple of things.

First, Ms. Spinks talked earlier about how it's not always just the family; it's that circle of support that you have. I'm just wondering if the circle of support and whatever that family system may look like for an individual member are included, and if people who they identify as their support folks are welcome to join this.

The other part of the question is this: How does DND evaluate the results of the program and sort of take that opportunity to improve or increase some of the best practices?

That would be so helpful. Thank you.

Col Helen Wright: Madam Chair, I'm going to pass the question straight over to Lieutenant-Colonel Bailey, who is the expert.

LCol Suzanne Bailey: Thank you, Madam Chair.

This is a two-part question.

We currently make the Road to Mental Readiness for families available through the military family resource centres to whomever members identify as their family. Recognizing that not everybody can access the physical centres where they are, we are, in fact, in the final stages of developing a comprehensive, online suite of training modules for families of Canadian Armed Forces members on a variety of topics related to how we can help both CAF members and their families manage the various demands of service. This will be available in both languages, and it will be openly available across Canada as well. There will be no password required, and the nice thing about that is that it will also be available to the families of Canadian first responders, many of whom have received the Road to Mental Readiness through some of the partnerships that have already been identified.

In terms of the second part of the question with regard to how we evaluate the program, we evaluate it through a number of different means. For the first five years, we had pre- and post tests that we analyzed the data of to see if were seeing differences in stigma, attitudes and knowledge regarding mental health. That information was very encouraging and showed that, in fact, we did see statistically significant improvements. Even though some of the training is for a fairly short time period—let's say that in basic training they might receive three hours of training—we were still seeing very encouraging results.

We also included questions in the Canadian Forces mental health survey that Statistics Canada conducted, which indicated that over 70% of Canadian Armed Forces members had received mental health training, and there were questions on whether they found it effective for dealing with daily stressors or sometimes more extreme stressors, so there's data available there.

We've inserted questions into other studies that have been done, looking at whether people use some of the training on deployment, whether they have increased their use of positive coping skills versus negative coping skills after receiving the training. Then, we've just finished rebuilding our program logic model to identify additional outcomes that we can measure in the coming years.

We continue to look at innovative and creative ways to study it, not only what happens in the classroom but how people are going to apply it in their day-to-day lives and how it might actually contribute to their ability to cope with the demands of daily life.

● (1435)

The Chair: Thank you very much.

Mr. Bezan, please.

Mr. James Bezan: Thank you, Madam Chair.

Colonel Wright, you mentioned the crisis line that was being used both for military members and for military families. Would you be able to report back to the committee with data on how often those crisis lines are used?

Col Helen Wright: Madam Chair, of course, we'd be happy to do that.

I can give you a quick thumbnail. I think over 4,000 different members and family members used the Canadian Forces member assistance program last year, and I think about 3,000 or a little over used the family information line, but we would be happy to give you the numbers on that.

Mr. James Bezan: I appreciate that.

I assume that some of that might be with regard to domestic violence and people calling in for military police to come.

Col Helen Wright: Absolutely. It's a broad spectrum.

Mr. James Bezan: I appreciate that.

The CAF suicide prevention action plan lists 15 objectives, and objective 7 reads, “Barriers to care, such as stigma, are eliminated”, so we want to make sure that we're eliminating as much stigma as possible.

You've already mentioned that part of the culture within the Canadian Armed Forces is that nobody wants to ever claim that they're weak. Often with mental health, the stigma is that if you're having mental health challenges, you're weak. Have enough changes happened? What type of programs have you brought into place to change that culture?

Col Helen Wright: Absolutely it is vital that we shift the culture. I like to think it has come along a fair way, which isn't to suggest that we don't still have work to do, for sure.

Perhaps I will pass this one over to Lieutenant-Colonel Bailey to talk about as well. It isn't just programs like Road to Mental Readiness. It is a fantastic program, but it also teaches literacy about mental health so that members understand it better. That is part of our method of trying to break down some of these, if I may be permitted to say, “old school” ideas about how people should handle these things. It is by no means the only program.

Mr. James Bezan: Over the last decade, we have started to see buddy checks and making sure how everybody is feeling. The troops are now prepared to talk about their feelings and what they're going through and the challenges they have in their day-to-day lives.

Col Helen Wright: Precisely.

Mr. James Bezan: I think that goes back to R2MR.

Before we turn it back to Lieutenant-Colonel Bailey, one of the questions was about self-harm and the impact of paragraph 98(c) of the National Defence Act. You said that you are not aware of that creating any problems by way of either increasing or preventing suicide. Would you say that paragraph 98(c) is agnostic on the issue of mental health, or is it a deterrent if it's not something that's a barrier?

Chair, her audio is frozen.

Lieutenant-Colonel Bailey, would you be able to answer that?

LCol Suzanne Bailey: I will do my best to answer that. It appears that Colonel Wright's feed is frozen.

The interesting thing about paragraph 98(c) is that from my knowledge, and I've been in the CAF over 34 years, I would be inclined to think that most Canadian Armed Forces personnel are not even aware of paragraph 98(c) of the National Defence Act. That being said, I know there have been discussions for many years about changing that. I don't see what possible benefit it could provide.

For the most part, I think when Canadian Armed Forces members are impacted by mental health and are struggling and trying to identify solutions to their issues, I wouldn't think that this particular issue would come to the forefront when they're struggling in their darkest times.

● (1440)

Mr. James Bezan: In your opinion, paragraph 98(c) doesn't add to the overall stigma within the Canadian Armed Forces. You're saying that nobody is even aware of it. We know that it's rarely used, because hardly ever do you hear of somebody actually going out and literally shooting themselves in the foot to avoid service. The only time it has been used...or in some cases, was for those who actually tried to commit suicide.

So the elimination of that paragraph of the act shouldn't create any problems.

LCol Suzanne Bailey: I wouldn't think so. From the numerous studies we've had on stigma and other barriers to care, it is not one that has registered with significant numbers.

Mr. James Bezan: Thank you.

The Chair: Thank you very much.

[*Translation*]

Go ahead, Ms. Brière.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Madam Chair.

Thanks to the three witnesses for being here and also for their service.

During our discussion this afternoon, you confirmed that mental health needs in the Canadian Armed Forces are real and that you take the subject very seriously. My son Louis, who is in the Sherbrooke Hussars regiment, took part in Operation Laser and was clearly informed, during his pre-deployment training, of the services available to him. In Montreal, where he was deployed, an on-site chaplain kept his door open and was always ready to listen. He was a benevolent presence. When Louis came home after the operation, he received a call and emails asking how he was doing following the deployment.

Colonel Wright, you discussed an integrated approach in your opening remarks. Is this a tangible example of that approach? Could you give us some other examples?

[*English*]

Col Helen Wright: Yes, I think that the integration of our prevention and health promotion methods were part of what we tried to do on Op Laser. An excellent health care system for those who are struggling and need help is important, of course, but it is equally important—maybe more important—to have all these kinds of prevention and supporting services in place.

The question was about an example other than Operation Laser. I'm trying to think of something that's not operations-based. I think we do something very similar to what we did for Operation Laser on our other operations, as Lieutenant-Colonel Bailey answered to another question. We screen people before they go, as well as in conjunction with their families, to make sure that it's the right decision for them and the right time for them to go. We have supports in place for them while they are deployed. We do post-deployment screening to verify how folks are feeling when they come back and to try to facilitate getting them into care, if that is the right thing for them. We also have a host of other psycho-social supports and educational things that we can help direct people toward.

Some of the other things that Lieutenant-Colonel Bailey mentioned might also be relevant to the question about how we're integrating. I know we keep coming back to the road to mental readiness program, but it's a great example of how that is being integrated throughout members' careers. It is provided in basic training and it's provided in many of the other steps in a military member's career.

It's no longer something to support people on difficult deployments, as it started out to be. It's becoming something that we are integrating into everything our members do, to help make them stronger in a career even if they never deploy. We absolutely have members who never have to put themselves in that situation, but we still put them in demanding jobs where things like managing their mental health and being proactive are still as important.

● (1445)

The Chair: All right. Thank you very much. That brings our session today to a close.

I would really like to express my sincere thanks to our witnesses today. Your testimony was absolutely foundational and I think it will help us build an even stronger report going forward.

I would ask the committee members to stay online. We have a little bit of discussion, but I'll allow our witnesses to leave us at this time.

Thank you very much for your time today. We know it's precious and we appreciate it very much.

Take good care.

Col Helen Wright: Thank you.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Thank you.

[*English*]

The Chair: Go ahead, Mr. Bezan.

Mr. James Bezan: Thank you, Madam Chair.

I just want to have a quick discussion. We have two meetings left before our Christmas break. We are scheduled to have the JAG and the head of psychiatry from the Canadian Armed Forces here on Monday.

What are the plans for Friday? I know that we want to lay out for the analyst the objectives we want to see covered in our reports, so he can be drafting. Are we doing that on Friday for both reports—COVID-19 and the mental health in the Canadian Armed Forces?

The Chair: There are two ways of doing this. If we're sitting on Friday, we can do it as a committee. We can also do it secretarially. I would expect both of those reports.

What we were going to ask was, if we don't end up with a full meeting on Friday, to make sure that any recommendations or input you have for either of those studies is in to us by December 18. Is that good?

Mr. James Bezan: I agree with that.

Can I make a suggestion for Friday, because we are writing the report on the Canadian Armed Forces and COVID-19?

The Chair: Yes.

Mr. James Bezan: Since we heard our last witnesses, there has been some news, which is that we now have Operation Vector led by Major General Dany Fortin. I think it would only be in the best interests of our committee's having a valid report to have General Fortin back to the committee, along with Lieutenant General Christopher Coates, the commander of CJOC. He is going to be the force multiplier in making sure that all of the logistics are taken care of in the distribution of the vaccines. This is critical information for our citizens: Canadians want to know how and when we're going to get vaccines distributed.

We also heard about this cybersecurity threat to the cold supply chain and how that will impact delivery. If we look at the policy directive from the CDSE, it even includes that we're to make sure to prevent criminal and cyber-attacks against transportation.

We've heard in the past of where some PPE, which was supposed to come to the United States and elsewhere, was stolen and diverted into other countries. So I think we would want to find out.... Even on the commercial logistics part of this, my understanding is that Pfizer, for example, is using United Airlines to deliver the vaccines to points of delivery in Canada. Will there be logistics officers on board? Are there going to be security personnel there, whether from special operation forces or military police? How are we going to be able to prevent cyber-attacks by criminals?

I think it is worthwhile for us to have this meeting on Friday with Generals Fortin and Coates.

● (1450)

[*Translation*]

Mr. Yves Robillard: Pardon me, Madam Chair.

[*English*]

The Chair: Yes, Yves.

Mr. Yves Robillard: Can I add to this?

[*Translation*]

I think we should use next Friday to really finish our study. We haven't heard from enough witnesses who have experienced these situations. It's easy to find them, though. I know we're coming to the end, but we want to conduct a complete study and I think we're missing the boat.

[*English*]

The Chair: We might need to take this to the steering committee. We have two competing ideas of what to do next Friday, so I think we'll put together a steering committee meeting. We will do it at the steering committee.

Mr. James Bezan: Lots of people have their hands up.

The Chair: All right. Maybe it's better done at the steering committee. When the committee goes forward, we all want to be on the same page, and this is something that we need to work out.

Mr. Yves Robillard: What about the other members? Maybe they also have some opinions.

The Chair: Yes, but they can express their opinion at the steering committee.

Mr. James Bezan: They're not all on the steering committee.

The Chair: No, that's true.

Go ahead, Madame Blaney, and then Mr. Brunelle-Duceppe. You have one minute each, please.

Ms. Rachel Blaney: I want to say that I agree with Mr. Bezan. I think this is an important part of what will be happening in the future around COVID-19. Canadians need to know how they are going to be getting their vaccines. I know that they trust the military, so it would be a good voice to hear on this issue.

Thank you.

The Chair: Go ahead, Mr. Brunelle-Duceppe.

[*Translation*]

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

It's good when the NDP, the Conservative Party and the Bloc can agree on something, but I'm also convinced the Liberals agree with Mr. Bezan too. It seems to me that this is really important and that we don't have a choice but to do that next Friday.

You say we'll take this to the steering committee, and that's fine, but this is a decision we could have made today. However, I leave it up to you to decide, Madam Chair. So I wish to note that I entirely agree with Mr. Bezan.

[*English*]

The Chair: Thank you, we'll take this to the steering committee, because I'd like to have all of us on the same page moving forward.

Mrs. Gallant.

Mrs. Cheryl Gallant: I would like to suggest that we have an extra meeting. There were outstanding questions, and we have questions about the distribution of the vaccine now. We want answers to these questions. In addition to Mr. Robillard's insistence that we have more, we could have an extra meeting Wednesday before the break.

The Chair: The problem is that there won't be any parliamentary services, like translation. All those things have to be taken into account. We will discuss it at the steering committee.

Mrs. Cheryl Gallant: Can you clarify, Madam Chair, if we would still have translation services until December 18?

The Chair: Nothing is firm. There might be a way to make it happen, but we cannot guarantee it, so we'll need to do some research.

● (1455)

Mr. James Bezan: I believe the upgrades that are being made to the virtual committee meetings are happening after December 19, and we'll lose those services for about five weeks.

The Chair: There are still restrictions in place once Parliament adjourns. We don't know when Parliament is going to adjourn, but after it adjourns, there will be restrictions, so it's something we'll have to look into. We can talk about that at the steering committee.

The meeting is adjourned.

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