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Chair

Mr. Neil Ellis

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● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good afternoon, everybody. I would like to call the meeting to order.

Pursuant to Standing Order 108(2) and the motion adopted on September 29, the committee is resuming its study on mental health and suicide prevention among veterans.

For the first part we have, from the Department of National Defence, Dr. Elizabeth Rolland-Harris, senior epidemiologist, Canadian Forces health services group; and Dr. Alexandra Heber, chief of psychiatry, health professionals division.

We'll start with your 10 minutes before we go into questioning.

The floor is yours. Thank you.

Dr. Elizabeth Rolland-Harris (Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, Department of National Defence): Mr. Chairman and members of the House committee on veterans affairs, thank you for the opportunity to speak with you today. For the past decade I have been a senior epidemiologist for the directorate of force health protection, more colloquially known as DFHP, which is part of the CF health services group. I hold a master's degree in science in epidemiology from the University of Toronto, as well as a Ph.D. in epidemiology from the London School of Hygiene and Tropical Medicine in the U.K. Prior to joining DFHP, I worked as an epidemiologist at the provincial and regional levels as well as in the academic sector.

As an epidemiologist my primary role, really, is to respond to the needs for statistics and data on the part of the decision-makers within CF health services and the larger Canadian Armed Forces—also known as CAF, which I'm sure you know by now. Clinicians and decision-makers who develop the policies, implement clinical practice, or work towards keeping the CAF healthy really need to know who their population is and what their needs are, and that's where I fit into the larger picture. I'm behind the scenes, providing those who "do" with the statistical information they need to proceed in an evidence-based fashion. I do so as part of a larger directorate, the directorate of force health protection.

DFHP functions similarly to how a provincial health authority would work, but does so specifically for the CAF. The key pillars of public health are surveillance and assessment of the population's health, health protection, health promotion, and disease prevention.

With respect to public health surveillance, an important part of what we do is to monitor the health of the CAF, primarily through surveys such as the health and lifestyle information survey, as well as through other health surveillance functions. These can be broader in scope, as is the case with the CF disease and injuries surveillance system, which monitors disease and injury during deployment specifically, as well as the CF health evaluations and reporting outcomes surveillance system, which can be adapted to look at a number of health-related conditions and concerns. These systems can also be a lot more specific, as is the case with the mortality database or the suicide surveillance system, the latter of which is the source of the information from which the report on annual suicide mortality in the CAF is created. The trends and the patterns that we identify through our work using these diverse sources of information are then used by policy- and decision-makers in developing and implementing evidence-based, health-related policies and programs across the CAF.

As mentioned, one of our reports that you're most likely familiar with is the "2016 Report on Suicide Mortality in the Canadian Armed Forces", which covers suicides between 1995 and 2015. I'll refer to it from here on in as the 2016 suicide report.

We within the CAF, both civilians and military, consider every suicide a tragedy. Suicide is firmly recognized as an important public health concern. As such, this report has been produced since 1995, with annual releases since 2008, in an effort to gain greater insight into suicide in the CAF. Monitoring and analyzing suicide events of CAF members provides valuable information to guide and refine ongoing suicide prevention efforts.

● (1535)

[*Translation*]

While we do collect and monitor data on all suicides, including males or females and regular or reserve force members, the annual reports cover only regular force male members. The reason is that reserve force and female suicide numbers are too small for us to release detailed information about the cases without running the risk of identifying the individuals and compromising their privacy. Although their experiences are included in the evidence used to drive mental health policies and suicide prevention endeavours within the Canadian Armed Forces, the information is not presented in the annual reports.

All suicides are ascertained by the coroner from the province in which they occur. The information is then provided to and tracked by the directorate of mental health, which cross-references it with the information collected by the administrative investigation support centre. The centre is part of the directorate of special examinations and inquiries.

Whenever a death is deemed to be a suicide, the deputy surgeon general orders a medical professional technical suicide review report, or MPTSR. The investigation is conducted by a team consisting of a mental health professional and a general duty medical officer. This team reviews all pertinent health records and conducts interviews with medical personnel, unit members, family members and other individuals who may be knowledgeable about the circumstances of the suicide in question. Together, all this information is used to create the findings in the annual suicide report.

Over time, the picture of suicide in the Canadian Armed Forces has changed. While the rates may vary somewhat from year to year, a consistent and clear picture has emerged over the last decade. Canadian Army personnel, more specifically those in the combat arms trades, are at a greater risk of suicide than the Royal Canadian Navy and Royal Canadian Air Force members.

There's some emerging evidence that deployment may also be a concern. However, we need to be careful with this broad description of deployment, since it can include many types of deployments—for example, humanitarian, peacekeeping or active combat—and many different experiences, both good and bad. Further research and analysis is required in order to determine whether, on its own, deployment is really linked in some way to the risk of suicide.

[*English*]

We're starting to get a much better understanding, through the work done by my colleagues from the directorate of mental health, as well as within DFHP, about underlying risk factors for suicide. For example, amongst the regular force males who took their own lives in 2015, over 70% of them had documented evidence of marital breakdown or distress prior to their deaths. Debt, family and friend illness, and substance abuse were identified risk factors.

These are also often seen in the general population. Most of them had more than one non-mental health risk factor at the time of their death. While troubling, this is consistent with what is being seen by other militaries, and I think it highlights the direction in which our research and surveillance efforts should be increasingly concentrated moving forward.

With this in mind, DND, as part of the Public Health Agency of Canada, led an interdepartmental working group on suicide-related surveillance data, which is one of the expected deliverables of the federal framework for suicide prevention. Membership within this working group is an excellent venue to see what work is being done by fellow federal agencies around suicide surveillance and prevention, and to share information on how to be more effective and consistent in our collaborative approaches.

We also have a long-standing relationship with VAC. We have been collaborating for a number of years on the CF cancer mortality study, which has looked at suicide risk over an individual's lifetime, both during and after service. We're currently collaborating with them and Statistics Canada on a second iteration of the study. We plan on looking at cancer and causes of death, including suicide, in still serving and released regular force and reserve class C personnel who enrolled in the CAF between 1976 and 2015.

We also sit on the steering committee for the veterans suicide mortality study, which will be looking at suicide risk amongst all former regular force and reserve class C veterans who released from the Canadian Armed Forces, also between 1972 and 2015.

In summary, surveillance is an important and integral component of understanding the risk factors and trends associated with suicide among serving and released personnel. Collaboration between departments and researchers has been ongoing, as demonstrated through the CF CAMS 2 and other research initiatives, and will prove to be extremely helpful in understanding this complex issue.

Thank you.

● (1540)

The Chair: Thank you.

We'll begin with six minutes with Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you, both doctors, for coming. I appreciate it. Hopefully you will help shed light on some of the issues in epidemiology and the studies that we may not know a lot about.

I'm wondering what you think about the parameters that you have available. What I'm trying to get at is that *The Globe and Mail* reported recently that 70 suicides have occurred in the last five years, I believe they said, which they were equating basically with our soldiers' coming out of Afghanistan.

I don't know whether you've seen or read that report. How do you see that playing into this report that we're talking about today?

Dr. Elizabeth Rolland-Harris: At the moment, through the annual suicide report, looking at deployment as a variable is very difficult. When we deal in epidemiology or statistics, there's a concept called “power”. In essence, you have to have a certain number of individuals to be able to parse the information. Although we've been collecting suicide information for upwards of 20 years now—and let's be clear, one suicide is one suicide too many—statistically speaking, we have very few, so we cannot parse that information. For me to be able to answer whether Afghanistan is or is not a factor, is something, from a purely mechanical point of view, I cannot do at this point.

However, if I may elaborate, through CF CAMS 2, we have a cohort of nearly 250,000 individuals. Obviously not every one was in service during the Afghanistan years—some predate those years. Nonetheless, we're able now to look at basically everyone who's been in Afghanistan and who enrolled post-1975.

We hope to be able to start looking at specific deployments, as opposed to just looking at deployment as a dichotomous yes or no.

Mr. Robert Kitchen: You've talked a bit about some of the parameters that you use. Can you expand on all the parameters you look at? For example, do you look at things such as identity loss, and whether that is an issue or not within your research?

Dr. Elizabeth Rolland-Harris: You need to remember that I'm only one piece of the puzzle. I am there to help analyze the information. That information is not provided to us. You would have to speak to someone who participates in the MPTSRs to get a better handle as to whether that's something they look at or not.

Mr. Robert Kitchen: If you're not getting the correct data, you can't report on—

Dr. Elizabeth Rolland-Harris: I wouldn't say it's incorrect data. It's—

Mr. Robert Kitchen: Let's say widespread data. It's hard for you to analyze if you don't have the data.

Dr. Elizabeth Rolland-Harris: There are two factors. I'm just speculating here, but it may be that it's so rare that we can't look at it, and it may be that it isn't there. I can't speak to that.

Mr. Robert Kitchen: Are you involved at all in...?

Sorry, go ahead.

Dr. Alexandra Heber (Chief of Psychiatry, Health Professionals Division, Department of Veterans Affairs): Can I add something to that from the Veterans Affairs perspective?

First, I want to introduce myself. Although I am not making a statement, I think you should have a little bit of a sense of my background. I've worked in the mental health field for over 30 years. In 2003 I started working for the Canadian military in Ottawa as a psychiatrist, and three years later I put on the uniform. So I served, including in Afghanistan. I released in 2015 and I started the job as chief psychiatrist of Veterans Affairs Canada in September 2016.

Although I'm not here to represent the Canadian Forces, I have some knowledge of this. Regarding your question about identity, I will tell you that it is something we are very interested in at Veterans Affairs. We are looking at the period of transition of person from being a military member to a veteran and what happens to people in that period. We want to know their vulnerabilities and what we can we do for them as organizations. There's a lot of talk about closing the seam, especially for our vulnerable populations, the people we know have mental health diagnoses or physical problems that are impeding their quality of life. These are people we know we want to help through that transition period.

● (1545)

Mr. Robert Kitchen: Do you have privacy challenges in collecting your data? I'm speaking about both points of view.

Dr. Alexandra Heber: It's different. We have different issues.

Dr. Elizabeth Rolland-Harris: It's different. To be honest, I am at the end of the chain. I get the data once it's been dealt with by the individuals from the CSEA, the individuals who deal with deaths within the Canadian Armed Forces.

The data is provided by them to the directorate of mental health. They are cross-referenced and confirmed by the directorate of mental health, and then they are passed on to us because we have the analytic expertise.

So as far as I know, the answer to your question is no.

Mr. Robert Kitchen: Does VAC have challenges in getting that information?

Dr. Alexandra Heber: We have a very different system from that of the Canadian Forces, where we have a wraparound health care system. Everybody in the forces is taken care of by the Canadian Forces' health care system. That doesn't happen once somebody leaves. Once they retire, their health needs are taken care of by the provincial health authorities. If a veteran has come forward or has in some way been identified as somebody who has a condition that is service related and for which they need help, then we provide all kinds of services. For example, we will financially support—and support in many other ways—their health care. We do not, however, have a health care system in the same way that the Canadian Armed Forces has.

You ask a good question. If something happens to a veteran, for example, if a veteran commits suicide and we would like some information, the health care information is contained within the provincial health care system. We don't have access to that information. We have access to some information, because these people usually have a case manager in our system, but the case managers are there to coordinate all the different services they get. They are not the health care providers.

The Chair: Thank you.

Mrs. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, Mr. Chair.

Dr. Rolland-Harris, thank you for your testimony.

You mentioned in your testimony that some of the trends you're seeing highlight the direction in which the research and surveillance efforts should be increasingly concentrated, moving forward.

Can you expand on that a bit for us?

Dr. Elizabeth Rolland-Harris: In essence, if you followed the transition or how the annual reports have been progressing since 2008, there are two main trends that have appeared.

The first is that the rate of suicide in the Canadian Armed Forces in general—here I'm talking about all types of uniform—is not statistically higher. The rate of suicide in the whole Canadian Armed Forces is not higher than in the Canadian general population. That's the first trend.

The second trend that we have been seeing, since 2008 or so, maybe a little bit before, is that members of the army component of the Canadian Armed Forces have been at significantly higher risk of taking their own lives, relative to the Canadian population and the other colours of uniform.

● (1550)

Mrs. Alaina Lockhart: Are you saying that although the number is on par with the general population, it's offset between the navy, air force, and army?

Dr. Elizabeth Rolland-Harris: Yes, there's a balance that happens. We've been very transparent in that we look at each colour of uniform separately. We're not trying to hide what's happening by just looking at a general trend. The fact there are different things happening in the different arms of the Canadian Armed Forces is something the leadership takes very seriously.

To go back to what you were asking, in essence, those two patterns have been around for a while. Yes, obviously, the rates move a little bit from year to year, but the narrative is the same. Going forward—and this is what we're doing both within DFHP and DMH—we're continuing to monitor those trends.

Don't get me wrong; we're not going to stop. Rather than expending so much energy and always focusing just on the piece after the fact, we're also trying to take some of those resources to figure out what some of the risk factors are before, so that those who set programs, the ones who write policy, can target things that matter. Maybe down the road, with this work, we'll see those trends go down. That's what I'm suggesting.

Mrs. Alaina Lockhart: Very good. Thank you.

Dr. Heber, have you seen any differences in how the programs required have changed over time? We've gone through many different phases with our military over the years. How are things different, and what are the needs now in comparison?

Dr. Alexandra Heber: It's a very good question. Thank you for that.

Again, I'm a psychiatrist. I work in the mental health world. Certainly, from my perspective, from the time I started working for the Canadian Armed Forces, the big change has been our participation in Afghanistan. People coming back from those deployments have been suffering from trauma-related injuries and other mental health injuries. Everyone who deploys does not necessarily develop PTSD; they can develop other mental health problems as well, and sometimes they develop several.

As those members were released from the military over time, Veterans Affairs Canada has seen a similar increase in younger veterans coming into their system with mental health problems and needing care. As I remember from when I was still in the military, Veterans Affairs Canada has been very forward-looking. In the early to mid-2000s it started setting up what are called operational stress injury clinics across the country. We now have 11 of them across Canada. We also now have satellite clinics coming out of those clinics. These are clinics where we have multidisciplinary teams, specially trained and with a great deal of experience, treating post-traumatic stress disorder and other operational stress injuries.

People were recognizing that something was happening. Because of our very good relationship with our colleagues in the CF, we were able to see what was happening and the growth in the numbers of those with PTSD coming back from deployment. We were able to say that we had better set up some services, because we're going to have these men and women coming into our system.

Mrs. Alaina Lockhart: Okay. Thanks.

Do I have a few more seconds?

The Chair: There's sixty left.

Mrs. Alaina Lockhart: Okay.

I want to go back to the statistics.

Have we done any research to see how many of those who committed suicide had received mental health care? Is this a matter of their not receiving care, or are we still struggling with how we're treating them?

I don't know who will answer.

Dr. Elizabeth Rolland-Harris: The MPTSR, the "Medical Professional Technical Suicide Review Report", which is an investigation of every suicide—male, female, regular, or reserve—looks at access to care. The rates of access to care are quite high, so this opens a whole Pandora's box of the underlying mechanisms of access to care, which I think are multiple, and it could be a very long conversation.

● (1555)

The Chair: Thank you.

Ms. Mathyssen.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair.

And thank you very much for this. It sounds very complex and that there are clearly multiple pieces to this puzzle, so please forgive me if I'm trying to sort this out.

Regarding the people coming into the CAF, I wonder if some pre-screening is possible with regard to their emotional health, because it seems to me that this is all tangled up together.

Dr. Rolland-Harris, you said that 70% had documented evidence of marital breakdown, distress, debt, family/friend illness, substance abuse, which it would seem to suggest a susceptibility to suicide rather than the other way around. Do you, then—if you can—say that this individual may be predisposed, may have a background such that we had better be very careful, and monitor and watch for potential suicide?

Dr. Elizabeth Rolland-Harris: I don't know the specifics of the recruitment process. However, I do know that the 2009 expert panel explicitly stipulated that they were not interested in looking at screening out individuals for mental health reasons.

Ms. Irene Mathyssen: Is it a matter of being fair and not prejudging an individual, or—

Dr. Elizabeth Rolland-Harris: Honestly, I don't know what the motivations are. You'd have to talk to the individuals who....

Dr. Alexandra Heber: For recruitment there is screening, as people do go through a medical examination, and part of that is a history-taking where people are asked about their previous medical history, including mental health history. Yes, that does happen.

Based on that, whether someone is screened in or out would often be on a case-by-case basis. It would depend what exactly that history was about.

Ms. Irene Mathyssen: Yes, I can understand that you wouldn't want to have a prejudice that would keep someone out, and yet if there's a vulnerability, it is a frightening thing to do to a human being to allow them to get into this quagmire that could lead to their death.

I understand the statistical reasons and the need to protect privacy with regard to the analysis of male versus female suicides, but with that in mind, could you perhaps speculate or give some idea of the trend in female suicides, whether it is or is not comparable to the trend among males?

Dr. Elizabeth Rolland-Harris: I can't comment on that. The numbers are statistically quite small—

Ms. Irene Mathyssen: Too small, too limited...?

Dr. Elizabeth Rolland-Harris: —which is a good news story, I suppose, by itself.

Ms. Irene Mathyssen: Yes, but you are possibly going to be able to identify some of the trends in future, or is that not possible?

Dr. Elizabeth Rolland-Harris: It's unlikely that we'll be able to do so with the annual suicide report. However, with the CF cancer and mortality study, the cohort is much larger and includes everyone who has ever worn a uniform since 1976, in essence. So the population is much larger, and we're not stopping looking at these individuals once they release; we're continuing to watch them, so the cohort is much larger. It is plausible that we will be able to have a better feel for what's happening with women's suicide as part of that larger study.

Ms. Irene Mathyssen: Okay. Thank you.

Dr. Heber, you talked about the fact that a member of the Canadian Armed Forces has wraparound health service, and it occurred to me that sometimes when people leave they may not seek medical help or may not be able to find a doctor in the public system. I wonder if there has been any finding that an inability to access health care might have been part of the reason for suicide, or do you have any thoughts on that?

Dr. Alexandra Heber: When we look at the veteran population, it becomes complicated, because out of the 700,000 veterans in Canada—and I'm sure you know this—120,000 are clients of Veterans Affairs Canada.

When we're talking about veterans, there are many people out there who have retired, and we know nothing about them. If they haven't come forward and asked for services, we don't know about them. That's the first issue.

Because we don't provide the health care directly, there are always a lot of problems with us gaining access to information, though if somebody leaves the forces, they have a case manager. That case manager will find out what's going on with their care, because the case manager is going to help organize further care for that veteran.

We don't have perfect information on everybody, so it's much harder for us to do that.

● (1600)

Ms. Irene Mathyssen: I can see there are many challenges here. This may seem simplistic, but with regard to this difference in the OSIs of army veterans as opposed to those for navy and air force veterans, might it have to do with the fact that when you're on the ground in a deployment, the realities of the violence and the impacts of that hostility are greater because you're there on the ground, as opposed to being on a ship or in the air? The others are still part of the deployment but not on the ground.

The Chair: I'm sorry, but we're out of time.

We go to Mr. Bratina.

Dr. Alexandra Heber: Darn. We don't get to answer your question.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you.

Dr. Heber, you have a terrific background, one that's ideal for the job you do. Could you flesh out what you do in the day? Do you ever interview patients anymore? Tell me how you actually carry out your very important role.

Dr. Alexandra Heber: Thank you. It's very much an advisory position. I work for the chief medical officer. She is in charge of the health professionals division within Veterans Affairs Canada. Also within that division is our directorate of mental health. Similar to the directorate of mental health in the Canadian Forces, we have set up a directorate of mental health. A lot of this is very new and has happened in the last couple of years. Some of the people who work in that directorate you will be interviewing next.

I will provide advice, guidance, and leadership in a clinical way to that directorate, to the director, to the chief medical officer, and to anybody else who needs my advice or my expertise, such as the ADM, the deputy minister, and so on. I'm kind of multi-tasking.

Mr. Bob Bratina: Is it a work in progress? Are we in a brave new world with regard to how we're approaching these issues that have cropped up recently?

Dr. Alexandra Heber: I'm sure part of it is in response to that. Several years ago, a look was taken at Veterans Affairs Canada, which had devolved from the time after the Second World War when we did have a robust health care system. Over the years, I guess, they felt there wasn't the same need. Then when medicare came in, people were taken care of by the provinces, so that sort of clinical role of Veterans Affairs decreased and decreased.

Certainly, in the last several years, especially with people coming out suffering from operational stress injuries and physical injuries because of some of the challenges during their career, I think very appropriately, it was seen that we needed to beef up the health professionals division within Veterans Affairs.

Mr. Bob Bratina: Dr. Rolland-Harris, epidemiology is a fascinating science. One of the issues is getting to ask the right questions, because it seems a lot of what you're doing is just collecting raw data, statistics on how many went in, how many came out, how many suicides there were, and that's all important data.

I don't know whether it's about exit interviews or the interrelationship with former soldiers, members of the armed forces, but in your work, do you do something beyond simply gathering data?

● (1605)

Dr. Elizabeth Rolland-Harris: I disseminate a lot of the work that we do, such as today, and at conferences, and those sorts of things but I want it to be clear that, at the end of the day, I am there to help the decision-makers, the action-takers, and so I'm behind the scenes.

Mr. Bob Bratina: Statistically, what methods are generally used by victims of suicide?

Dr. Elizabeth Rolland-Harris: Statistically, if you look in the annual report, the two main methods specifically for regular force males, I want to clarify, are hangings and firearms. Just so we're clear, that's consistent with what we see in the general population. The top two methods are the same both in the Canadian Armed Forces and in the general population.

Mr. Bob Bratina: In other words, the availability of means such as firearms isn't necessarily...if someone's determined—

Dr. Elizabeth Rolland-Harris: No, it's very rare, if not never the case, that individuals use their military-issue firearm. They use their personal firearms. That's something that is collected very rigorously.

Mr. Bob Bratina: You made the point, which needs to be reinforced with regard to deployment, that statistically we can't draw all the connections yet. I say so because it's common for us to think that someone who was in Afghanistan and had a bomb blow up near them is, of course, going to have...but you're saying that statistically you can't really draw all those connections yet.

Dr. Elizabeth Rolland-Harris: No, not at this point, and whether it's a lack of statistical power or if it's a true absence of a relationship is unclear at this point. As I said in my opening statement, you have to understand that "deployment" is a broad term.

You can have two individuals with the same military occupation code technically doing the same job in the same location on the same deployment who have entirely different experiences, or when they come back, one is scarred, and one is not. Deployment is an easy way of classifying things to look at relationships, but it's a very, very complicated concept, really, to be able to parse statistically.

Dr. Alexandra Heber: Do you mind if I add something?

Mr. Bob Bratina: Please go ahead.

Dr. Alexandra Heber: I think one of our concerns always with the issue of deployment and that tight relationship being made between deployment and suicide is that it makes it possible. We always fear that those who commit suicide and never deployed get lost in that picture. It's an over-simplistic picture, because for sure there are the MPTSRs that Elizabeth talks about. I did MPTSRs when I was in the military, and we certainly did them for people who had never deployed but who committed suicide for a number of reasons, some of which we didn't always understand. It's important to remember that there are many factors leading that person onto that suicidal pathway. Deployment may be one of them, but not necessarily.

The Chair: Thank you.

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair.

Thank you both very much for coming and sharing this helpful information with us today.

I just want to touch on a point in response to a question by Ms. Lockhart. I believe you twice referred to the MPTSRs. Now, as I understand it, those are done in each case where there is a suicide, and that data is then collected. All of the MPTSRs are put together as findings in annual suicide report. Is that correct?

Dr. Elizabeth Rolland-Harris: Yes, chapter 1 of the annual suicide report.

Mr. Colin Fraser: I see, okay. I don't believe we have a copy of that before our committee. I'm wondering if you can table the latest annual suicide report.

Dr. Elizabeth Rolland-Harris: Sure, I can give you my copy that I have here, and it's also available on the web if you just search 2016 CAF suicide report.

Mr. Colin Fraser: Thank you very much. That would be helpful.

Dr. Heber, with regard to some of what we're talking about here, are you able to identify some of the factors that put a veteran, as you see it, at a higher risk of suicidal ideation? What are some of the actual factors?

I know we talked about transition to some extent, and we've heard a lot of different opinions about what these factors may be, but I'd be interested in hearing your thoughts.

Dr. Alexandra Heber: The first thing I'll say is that the factors that lead to what I call that “suicide pathway” are similar for veterans and for any member of the general Canadian population. The first factor is that almost all people—90% or more—likely have a mental health problem at the time they commit suicide. This finding is from international research; it's one of the most robust findings we have. It's a very important factor. It's why when we are doing work to prepare suicide prevention strategies, a lot of that work does focus on good mental health care and on getting people into care, because we know it's one of the factors that's consistently there. The other factor that is usually present right before the suicide is some stressful life event. Often it is something like a relationship breakup, or perhaps the person has run into trouble with the law or has lost their job. It's usually related: it's relational, and it's to do with a loss. This person has a mental illness—usually there's some depression in that mental health problem—and then they have this crisis, this loss, that happens. That sets them off starting to think about suicide.

There are a number of other factors that we know contribute to this. This access to lethal means is a really important factor. We know from public health research that the easier the access is.... Often people do this impulsively. Often, if people can be stopped from committing suicide today, and especially if help is provided, they will not go on to commit suicide.

● (1610)

Mr. Colin Fraser: Identifying the underlying mental health illness is the preventative way to stop the escalation from happening?

Dr. Alexandra Heber: It's certainly one of the things we know contributes. Therefore, it's something on which, if we make an effort, we know that it will be helpful.

Mr. Colin Fraser: What can we be doing better for our veterans to help identify it and make it easier for them to come forward to get help for their underlying mental health challenges?

Dr. Alexandra Heber: In the last year, Veterans Affairs Canada has been working on updating our mental health strategy. As well, we are currently developing a joint suicide prevention strategy with the Canadian Armed Forces—we're working together on this. We are doing so in part because we want to pay special attention to that transition period to make sure that we are covering people when they need the support the most, so that they don't fall through the cracks. For many years, going back to at least 2000, there have been a number of programs and initiatives in place around suicide prevention in the veteran population, but we are now updating that information and are creating a joint strategy for our two organizations.

Mr. Colin Fraser: Are you seeing less stigmatization, though, of forces members coming forward with an underlying mental health illness? If we're trying to get them before these difficult life challenges happen—and the transition piece is a difficult time for any solider exiting the forces—is there some way to break down that stigma that we haven't been using? If so, what might that be?

Dr. Alexandra Heber: There are a few answers to that question.

First of all, with regard to the people who we know are exiting the military with a known mental health problem for which they've been receiving treatment, we're pretty good already at making sure we do that warm handover from one organization to the other. When I was in the military, I was the head of the operational trauma and stress support centre in Ottawa. We have an OSI clinic run by Veterans Affairs Canada in Ottawa. There were a number of my patients who I handed over to the Veterans Affairs clinic before they left the military. We have a lot of that going on for people who have already been identified.

One of our concerns, of course, is people who have not been identified, people who maybe don't even realize that they have mental health issues until they leave and face extra stresses from having left the military. One of the things we have put in place is an exit interview for all members who are leaving. It is a transition interview where they meet with somebody from Veterans Affairs Canada. Even if they have never had a problem and they don't see themselves as needing our help, we've met with them face-to-face and said, “Here's who we are. Here's where we are. Here's our number; call us if you need us.”

The Chair: Thank you very much.

Mr. Brassard.

Mr. John Brassard (Barrie—Innisfil, CPC): Thank you, Mr. Chair.

The veterans advisory group that the Minister of Veterans Affairs set up is hosting a meeting this week on mental health. One of the issues they are going to be discussing is suicide. Are either of you invited to that meeting?

● (1615)

Dr. Alexandra Heber: Yes, I am presenting at that meeting on Wednesday. It's the mental health advisory group of the Minister of Veterans Affairs.

Mr. John Brassard: First of all, I'm glad to hear that.

Dr. Harris, you're not going to be there?

Dr. Elizabeth Rolland-Harris: No, I'm not invited.

Mr. John Brassard: Here's the thing, and you've spoken about it. As a committee, we're studying mental health issues and suicide prevention. You mentioned that Veterans Affairs and the Canadian Armed Forces are studying mental health strategies and suicide prevention strategies. We now have an advisory committee that's going to be dealing with this in a one-day summit on suicide. Do we have too many cooks in the kitchen to deal with this issue? Are there way too many people involved in this? I ask because ask because nothing is getting done.

It's frustrating on my part to hear about all these studies, advisory groups, and meetings, and yet seemingly there is not much being done in the way of implementing a strategy. It seems that a lot of people are running around justifying their existence, but nobody is really doing anything. I'm just wondering about this. When do we get to that point where stuff is actually done in order to deal with this issue?

Dr. Elizabeth Rolland-Harris: I don't think I'm particularly well placed to answer that question realistically.

Dr. Alexandra Heber: Let me answer that question. We do a great deal.

We do a great deal in Veterans Affairs Canada. As I said, from 2000, on the whole issue of suicide, even though, as I said before, there are challenges for our knowing about suicides in the veteran population, we have worked on putting many things into place, both for suicide prevention and for getting people access to mental health care.

Again, as I said, we know that leads to.... It's one of the most important things for us to do to help prevent suicides. All of our case managers receive suicide prevention training, and that training is updated every year. Also, any front-line worker at Veterans Affairs Canada now receives suicide prevention training. If you phone and somebody answers the phone, they've received that kind of training. They have a sense of what to do if they are concerned about the person on the other end of that line.

In addition to having case management and front-line workers who, again, can coordinate care for anybody who comes in and has a service-related mental health injury, they can be referred to an OSI clinic. If they're in an area where there are no OSI clinics, we have 4,000 mental health providers in Canada who we can access from Veterans Affairs Canada to serve our population.

Mr. John Brassard: With all of the things you're doing and all of the studies that are going on, are we ever going to get to a point where we can actually prevent this from happening?

Dr. Alexandra Heber: You know—and Elizabeth said this—we really believe that one suicide is too many, but I think that if you look at any population, you can see that suicide does occur. Will we ever be able to prevent every single suicide? I don't know, but that's what we're working towards.

Mr. John Brassard: Dr. Harris, statistically, I want to ask you about prescription drugs and opioids as a means to treat those who are suffering from PTSD, perhaps, or from an occupational stress injury. Have you statistically kept track of how many of those who commit suicide are on these types of medications?

Dr. Elizabeth Rolland-Harris: The MPTSR keeps track of what medications individuals are on at the time and preceding their death, and anecdotally we haven't seen anything—

Mr. John Brassard: Does that form part of a report?

Dr. Elizabeth Rolland-Harris: We don't report on opioids specifically within the MPTSR annual reports, no, but the numbers would be very small, so we probably wouldn't be able to.

Mr. John Brassard: Recently, the Department of Veterans Affairs reduced the amount of marijuana that can be prescribed from 10 grams to three grams. Were either of you consulted in that decision at all?

Dr. Elizabeth Rolland-Harris: No, but I'm not a physician.

Mr. John Brassard: I understand.

Doctor, were you consulted in that decision at all?

Dr. Alexandra Heber: I'm sorry. I need you to repeat your question about what Veterans Affairs Canada has done.

● (1620)

Mr. John Brassard: They reduced the amount of marijuana allowed for veterans from 10 grams to three grams a day.

Dr. Alexandra Heber: Let me say first that Veterans Affairs Canada does not prescribe or authorize marijuana or any medications. What we do is fund treatments, and we fund marijuana to a certain extent. Before, Veterans Affairs Canada was funding up to 10 grams per day of marijuana for an individual. That amount will be cut down based on the amount that's funded—not Veterans Affairs. If a family physician, for example, is authorizing the marijuana and feels strongly that this person needs more than three grams, he or she needs to consult a specialist physician on the reason that the person is receiving the marijuana, and do another assessment and say, yes, this person needs more than three grams a day.

Mr. John Brassard: I'm aware of the process. I'm asking whether, as the chief of psychiatry, you were consulted on this decision. Were you consulted on this decision to reduce it from 10 grams to three grams?

The reason I'm asking is that we had the minister here, who said he had consulted broadly with a wide range of professionals. As the chief of psychiatry, were you consulted on this decision?

Dr. Alexandra Heber: This decision was actually made before I started working for Veterans Affairs Canada, but I know the people who sat on the expert panel who were consulted. They included—

Mr. John Brassard: Your predecessor?

Dr. Alexandra Heber: I had no predecessor. These were experts in using marijuana for medical purposes.

The Chair: Thank you.

Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you for coming.

Dr. Heber, I have a bit of a bias on this particular issue. I'm an RCMP brat.

We have been talking about the Canadian Forces members and their suicide rate. I know the numbers are probably smaller, just from the fact of the number of members who have served, but how did the suicide rates among RCMP veterans compare with Canadian Forces veterans?

Dr. Alexandra Heber: I do not know what the comparison is. I'm sorry.

Mr. Doug Eyolfson: All right. Thank you.

Dr. Rolland-Harris, this has been touched on in a couple of questions so far. We talked about tracking the female suicides.

I'm a physician. I've had to learn statistics, and I know the challenges of analyzing data when the numbers are small. I think we both agree it's fortunate that the numbers are small, but it does cause that challenge.

In medicine in general we've had an issue over the years where so much medical research has been gender-based, usually towards males, right from basic science research onward. I was a medical researcher before I was a physician. We always used male rats, because if you used two genders there was too much variation. Hence, you develop medications that might not work for females. Although I understand that putting it in a report is one thing, because, as I say, the numbers are so low you might identify....

Are you looking at methods that can better analyze and maybe get more conclusions from the female population, where it's so challenging?

Dr. Elizabeth Rolland-Harris: Yes. I mentioned the CF cancer and mortality study, CF CAMS, which is one of the big drivers behind the study. It's twofold. One is to be able to have a large enough population so we can look at more specific details, including differences in gender. But we're also, to use a term my colleague from VAC uses, trying to “close” that seam. Rather than just looking at still-serving and then released individuals as two sets of groups in two separate silos, we're looking at what we call the “life course” of the military member. We're trying to get a better picture of what's happening both during and after their service.

Mr. Doug Eyolfson: Thank you.

Dr. Elizabeth Rolland-Harris: You're welcome.

Mr. Doug Eyolfson: Dr. Heber, when you have an active patient under the care of a psychiatrist, you have the warm handover you talked about. However, as you pointed out as well, there are many veterans who present later, well after their service is concluded. Of course, these are people who will be under provincial health systems and are going to present to family physicians and emergency departments, which is where I've spent my career.

Has Veterans Affairs been putting out education for primary care medical providers in the field that is specific to the medical and psychiatric needs of veterans and what the warning signs are?

● (1625)

Dr. Alexandra Heber: Yes. We've started, in the last couple of years especially, initiating relationships with the College of Family Physicians of Canada, with providers, with some organizations, such as Calian, that have clinics and are interested in accepting veterans as their patients. We're looking at all kinds of things to help us make sure veterans are in care so that every veteran has a family physician.

Mr. Doug Eyolfson: Thank you.

To further expand on that, because again, I spent my career as an emergency physician, I wonder if there been outreach specifically to the associations that govern or train emergency physicians, let's say either the Royal College of Physicians or the Canadian Association of Emergency Physicians.

I ask because this isn't just a concern with veterans, but with people in general. There are so many people who either don't have family doctors or just can't get in.

Dr. Alexandra Heber: Right, and they show up in the emergency department.

Mr. Doug Eyolfson: Many show up in the emergency department.

Dr. Alexandra Heber: Absolutely.

Mr. Doug Eyolfson: Has there been any specific outreach to the emergency medicine community so that they can be better informed as to where to consult and where to direct the care of these veterans who show up on their doorstep?

Dr. Alexandra Heber: I just looked over my shoulder at my medical director, and she just smiled, so I actually don't know. But if there hasn't been, that's a great suggestion, and we will look into that.

Really, we would like every front-line physician in Canada to be aware of issues that veterans may present with.

Mr. Doug Eyolfson: Yes, that's useful. Unlike in a family clinic, you often don't know the patient. You've never met them.

Dr. Alexandra Heber: Yes, that's right.

Mr. Doug Eyolfson: They say emergency medicine is the art of making correct decisions with insufficient information. When a veteran shows up on your doorstep, that is so very true.

Dr. Alexandra Heber: Yes.

Even for emergency physicians to ask people if they've ever been a member.... Often that question isn't even asked of the patient who comes in.

Mr. Doug Eyolfson: I have no further questions.

Thank you.

The Chair: Thank you.

Mr. Clarke.

[*Translation*]

Mr. Alupa Clarke (Beauport—Limoilou, CPC): Thank you, Mr. Chair, for giving me the floor.

I want to welcome Ms. Heber and Ms. Rolland-Harris and thank them for being here today.

My first question was provided by the person I'm replacing today, Cathy Wagantall, a very honourable woman.

Many veterans have repeatedly told us that a number of their brothers in arms committed suicide after taking mefloquine, an antimalarial drug. One of the veterans who wrote to my colleague, Ms. Wagantall, told us that he personally knew 11 veterans who committed suicide and that all 11 of them had taken mefloquine.

In the 21 years covered and of the 239 suicides recorded, how many of the brave men and women had been in malaria zones?

Do you have this information?

Dr. Elizabeth Rolland-Harris: I don't have it on hand.

Mr. Alupa Clarke: In other words, you don't know how many of the 239 people took this drug.

Dr. Elizabeth Rolland-Harris: Exactly. I'm not saying that the information wasn't collected. I'm simply saying that I don't have it on hand. Therefore, I can't analyze it.

Mr. Alupa Clarke: Okay. I understand.

Ms. Heber, at the Department of Veterans Affairs, could we obtain an answer by making an access to information request or by simply asking the minister?

● (1630)

[*English*]

Dr. Alexandra Heber: On approximately how many veterans have...?

Mr. Alupa Clarke: Of the 239 veterans who completed suicide, as the words have to be said, how many of them would have taken the medication mefloquine? Can we find this type of information through ATIP or through a question during question period?

Dr. Alexandra Heber: It's a good question. Again, it would depend where they had deployed and whether.... I mean, there should be records. I assume that those records would be within the Canadian military.

Mr. Alupa Clarke: Yes, you're right.

Dr. Alexandra Heber: It would have been while they were serving that they took it.

Mr. Alupa Clarke: Perfect. Thank you for that insight into National Defence.

A year ago, when I was on this committee as the Veterans Affairs critic, on May 9, 2016, I filed an Order Paper question. For the region of Quebec City, I asked what percentage of persons had financial *prestations* for each physical and mental illness—for example, knees, hearing, and so on.

Interestingly, for one year, 2015-16, in the Quebec region, 8% of the claims for money concerned post-traumatic syndromes, 2% deep depression, 1% anxiety, 1% lack of sleep, and 1% alcohol and drug abuse. Overall, almost 13% of the claims for money were put forward by people suffering from mental health issues that we could probably sometimes connect to suicide.

Of the 15 members, or sorry, I think it's 14, who committed suicide in 2015, how many of them were in the process of claiming?

Dr. Alexandra Heber: You're talking about—

[*Translation*]

Mr. Alupa Clarke: We're talking about financial benefits here.

[*English*]

I forgot the word in English, but how many of those 14 veterans were on *prestations financières* or asking for one, or filling out some papers?

Dr. Elizabeth Rolland-Harris: Just so that we're clear, the annual suicide report is not regarding veterans but still-serving individuals.

Dr. Alexandra Heber: I am unclear what you're talking about, because we don't actually have numbers.

Mr. Alupa Clarke: “Financial benefits”, that's the word. So those 14 persons were serving.

Dr. Elizabeth Rolland-Harris: They were still serving, the ones in the annual report.

Mr. Alupa Clarke: So the question still stands: of those 14 soldiers who were serving, how many of them, by any chance, filed claims for any financial benefits?

Dr. Alexandra Heber: Do you mean claims once they were released?

Mr. Alupa Clarke: During—

Dr. Elizabeth Rolland-Harris: Sorry, we don't have access to that information.

The Chair: You have eight seconds remaining.

Mr. Alupa Clarke: Do you have a system to flag people who are potentially going to commit suicide? I know it's very difficult, but is there any system such as that, perhaps?

Dr. Alexandra Heber: Yes. At Veterans Affairs Canada, in the case management file, we have put in place a flag for that.

The Chair: Thank you.

Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you.

Perhaps I can come back to the question in regard to the higher suicide rate among those who are in the army as compared to navy and air force, and any correlation or thoughts you might have.

Dr. Elizabeth Rolland-Harris: Do you want to speak to that?

Dr. Alexandra Heber: Again, I think anything I would say would really be speculation. What you said might be reasonable. Is it related to people who've had more traumatic experiences overseas during their deployments? It could be. The bottom line is that we don't really know, but certainly that increase in the army, or certain parts of the army, has coincided right with our time in Afghanistan. I think it's pretty reasonable to say there's probably a connection there.

Dr. Elizabeth Rolland-Harris: The reason we haven't parsed it in any more detail is that statistically we don't have sufficient power. We can only really look at one variable at a time, such as deployment, yes or no; or army or non-army, and those sorts of things. If we start looking at what's called a bivariate analysis, looking at two variables at a time, we find ourselves not being able to say anything because there's no statistical power to back it up.

● (1635)

Dr. Alexandra Heber: The numbers are so small, that's why.

Dr. Elizabeth Rolland-Harris: Again, the CF CAMS is, I think, one of the pillars of our research going forward. One of the things that we may be able to do is to look at the colour of the uniform and whether it makes a difference, in concert with other risk factors that we know are frequently related to suicide.

Ms. Irene Mathyssen: It's interesting that the numbers tell us some things, and yet you can't infer anything concrete sometimes from those very same numbers. I understand your frustration.

Dr. Heber, you were talking about the warm handover. Obviously, we hear from veterans who do not feel very warm and fuzzy, and they talk about the frustration, the barrier, financial problems such as the pension cheque not arriving on time, and the fact that they feel abandoned, alienated, and something important has been take away from them. You talked about that, so obviously there must have been a recognition that there was a problem in terms of that warm handover. There's obviously been a conscious effort to change that. Is that ongoing? Is that something that you're going to continue, and how so?

Dr. Alexandra Heber: Yes. Again, part of the reason we are doing a joint suicide strategy is that we want to make sure that we put special emphasis on that time. Again, with some of the research that's being done in Veterans Affairs Canada, we're really looking at these issues like identity and what happens to a person's identity, especially people who joined the military when they were very young and this is not just the only employment they've ever known, but that they've grown up in the military and this is the family they've known, because it really is. We have a fairly small military in our country. People get to know each other. I served only eight and a half years, but I knew everybody in health services in the Canadian military. There is a strong sense of shared identity.

The Chair: Thank you. That ends our time for this panel.

I'd like to thank both of you for all the work you do helping our men and women who have served.

We'll take a quick four-minute break, and we'll start with our next panel.

● (1635)

(Pause)

● (1640)

The Chair: Welcome, everybody. In our second hour we have, from the Department of Veterans Affairs, Dr. Courchesne, director general, health professionals division; Johanne Isabel, national manager, mental health services unit; and from the Department of Health, Chantale Malette, national manager, employee assistance services.

I don't think we're going to use the whole 10 minutes, but we'll have an introduction by our panellists, and we'll start with Ms. Isabel.

[*Translation*]

Ms. Johanne Isabel (National Manager, Mental Health Services Unit, Directorate of Mental Health, Department of Veterans Affairs): Good evening, everyone. My name is Johanne Isabel, and I've been working at Veterans Affairs Canada since 2001. My spouse is a retired member of the Canadian Armed Forces.

Mr. Chair and committee members, we're pleased to be talking about the Veterans Affairs Canada assistance service, a counselling and referral service offered 24 hours a day, seven days a week to our veterans and retired RCMP members and to their family members. The service is confidential. If a veteran isn't registered for a Veterans Affairs Canada service or program, the veteran can still use this program.

Here's a brief history of the program.

In 2000, Veterans Affairs Canada worked with Health Canada to provide a service that was similar to the Canadian Armed Forces member assistance program. We wanted to make sure that veterans and their families could transition more smoothly from military life to civilian life. We wanted to provide this service to serve our clients properly during the transition.

On December 1, 2014, your committee recommended that the assistance program for veterans be improved. From 2000 to 2014, veterans could receive up to eight individual counselling sessions with a health professional. As I already mentioned, based on your recommendations and since April 1, 2014, the program has been providing 20 individual counselling sessions to all our veterans and their family members and to retired RCMP members.

I'll now turn the floor over to Ms. Malette.

● (1645)

Ms. Chantale Malette (National Manager, Business and Customer Relations, Employee Assistance Services, Department of Health): Hello. My name is Chantale Malette.

[*English*]

The services that are offered through the VAC assistance service are mainly confidential, bilingual services, accessible via a 1-800 number and through the Health Canada phone line 24 hours a day 365 days a year. Mental health professionals answer every call. All counsellors have at least a master's or a Ph.D. The veteran then has access automatically, right away, to a mental health professional.

Telephone services are also offered for the hearing impaired. There is immediate access to crisis support and counselling by a mental health professional with a minimum of a master's degree. If the person calling is in crisis, the mental health professional will take whatever time is necessary to stabilize the person before referring them for face-to-face counselling.

We refer to our national network of specialized private practitioners, according to needs, anywhere in Canada. We have face-to-face counselling. We also offer telephone counselling, especially when services are required in an isolated area or if they are required by the client. We also offer e-counselling when appropriate.

We refer to external resources or VAC if the time required to resolve the issue exceeds the coverage provided by the program. We use the sessions and the hours covered under the program to bridge the person, to support the veteran until long-term care is available.

In terms of suicide prevention, for every call the client's state is verified. We verify the level of stress. We verify the suicidal or homicidal thoughts. If the caller is identified as having suicidal ideation, the counsellor will ask for the caller's authorization to contact their VAC case manager and inform him or her of the situation.

In terms of counsellors, we have access to over 900 mental health professionals across Canada. They all have a minimum of a master's degree in a psychosocial field and at least five years' experience in private practice. They have had a government security screening. They have malpractice insurance. They're registered with a recognized professional association. Professional references are checked as well.

In terms of quality assurance, every time a veteran consults a mental health professional, we provide this person with a satisfaction survey to get more information on their satisfaction with the program. We also do yearly visits to counsellors' offices. We visit at least 5% every year. We also are accredited by EASNA, the employee assistance society of North America, and COA, the Council on Accreditation. We adhere to the highest standards in the industry.

● (1650)

[*Translation*]

Ms. Johanne Isabel: Here are a few statistics.

From 2012 to 2016, the number of people who used the service went from 614 to 1,140. Therefore, there was an increase. This was mainly the result of the decision to improve the services by increasing the number of counselling sessions to 20. For a veteran or a veteran's family member who wants to address a major issue, it's worthwhile to have counselling sessions over a longer period. It's very positive.

Of the 1,143 people mentioned here, 68% are veterans, 28% are veterans' family members and 2% are retired RCMP members. The people who use the services are, on average, in their late forties or early fifties. People use the Veterans Affairs Canada assistance service mainly for psychological issues not related to military service or for couples counselling.

Thank you.

[*English*]

The Chair: Great. Thank you.

Mr. Kitchen, I believe you're going to split your time with Mr. Brassard.

Mr. Kitchen, go ahead.

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

Thank you all for being here.

Doctor, thank you very much for coming back to the committee.

I appreciate your presentation and your giving us some of the statistics. When you talk about 24 hours, seven days a week, 365 days, how does someone access that with this number? For example, I come from Saskatchewan. You talk about having 900 mental health professionals. If someone in Saskatchewan is phoning at midnight, who are they phoning?

Ms. Chantale Malette: They are calling Ottawa. All the counsellors who answer the VAC assistance service are in Ottawa, so when the person dials the 1-800 number they will automatically have access to a mental health professional, who will verify the state of the client and refer them for face-to-face counselling anywhere in Canada, including in Saskatchewan if they want.

Mr. Robert Kitchen: We talked about knowledge translation. One of the things I see here is knowledge translation and getting this knowledge out to veterans.

Have you actually done a survey or a study to find out how many veterans know about this?

[*Translation*]

Ms. Johanne Isabel: Many efforts have been made to further promote the service. The information has been posted on our website. The information is also consulted a great deal on our Facebook and Twitter platforms. The information on the service is sent to veterans on a monthly basis. Ms. Malette works extensively with the Canadian Armed Forces, the RCMP and all the Veterans Affairs Canada offices to explain and show the benefits of the program.

[*English*]

Mr. Robert Kitchen: How do we get this information to the homeless veteran who doesn't have a computer, doesn't tweet, doesn't use Facebook, and may be living in northern Saskatchewan or northern Ontario or wherever it may be? How do we get that information to them?

[*Translation*]

Ms. Johanne Isabel: That's a very good question.

You're right. We can always do better. Our case managers receive information. Since 2012, the VAC assistance service has been used more often. Could it be used even more? Yes. Is it effective? Yes. Could homeless veterans benefit from it? Yes, and we're constantly working to make that happen. Could we do more? The answer is yes.

We try to vary the ways we let them know about the assistance service. We have various programs to ensure that homeless veterans also receive information about the assistance service. We distribute brochures to them to let them know about the service.

● (1655)

[*English*]

The Chair: Thank you.

Mr. Brassard.

Mr. John Brassard: Thank you, Mr. Chair.

The committee is studying mental health and suicide prevention among veterans. You're on the front lines of all that's going on here.

What sort of recommendations would you like to see the committee make in terms of dealing with the issue of suicide prevention and some of the mental health issues?

Do you want me to pick somebody? Doctor? I know you have been here before.

Dr. Cyd Courchesne (Director General, Health Professionals Division, Chief Medical Officer, Department of Veterans Affairs): Yes I have, and we look forward to the report. As Madame Isabel mentioned, it was based on recommendations that came out of this committee that we increase the counselling sessions from eight to 20, because our numbers show that this is a service. I would like to remind you that this is a service available regardless of whether someone is in receipt of benefits from Veterans Affairs. It is for anyone who is one of those 600,000 veterans out there in Canada.

In terms of suicide prevention, you heard from my two very articulate colleagues that we continue our research to understand this very complex problem. We're working together more closely with our Canadian Forces colleagues, especially around the periods of vulnerability that are identified through epidemiology or research, so that we can strengthen our programs.

Mr. John Brassard: Do you work with stakeholders? For example, do you work with the provinces and municipalities? Is there any of that outreach to deal with the homeless population? Municipalities, for example, do numbers, and there are other organizations, as we found out through testimony, that count homeless veterans. Do you reach out to those organizations?

Dr. Cyd Courchesne: I'll start, and then I'll pass it on.

Within the Department of Veterans Affairs, we do have colleagues who are working specifically on a strategy for veterans in crisis, for the homeless. These are issues we can't work alone on, so they're very much connected with municipal and provincial organizations, with all these people out there on the beat. We wouldn't be able to do that without these important stakeholders.

[*Translation*]

I don't know whether my colleague has something to add.

Ms. Johanne Isabel: No.

[*English*]

The Chair: Thank you.

Mr. Eyolfson.

Mr. Doug Eyolfson: Thank you, and my thanks to you all for coming.

Dr. Courchesne, welcome back. Am I saying your last name correctly?

Dr. Cyd Courchesne: Yes, that's very good.

Mr. Doug Eyolfson: Okay, thank you.

I'd like to follow up with what I was asking Dr. Heber before. It sounded like there was a communication. You might have had an answer there. In response to the outreach to primary care physicians, is there any specific communication with the emergency medicine community?

Dr. Cyd Courchesne: We don't communicate with emergency medicine specifically, but we work very closely with the College of Family Physicians of Canada. They've struck a special group to produce educational material for all the family physicians in Canada, educating them on the health issues of military families. They've also expressed that they wanted to produce a best-advice guide on veterans' health.

The Occupational and Environmental Medicine Association of Canada has invited us to come and present on veterans' health issues, and I'll be presenting there with my colleague Jim Thompson on what the research has shown us about being able to educate as many doctors as possible. We're also connected with the Vanier Institute of the Family. We're very interested in families and veterans. So, yes, we do a lot of educating.

● (1700)

Ms. Johanne Isabel: We did also work with the CAMH in Toronto. They have a series of mental health modules online, and one on mental health and addiction 101 was added. It's a 20-minute bilingual online module that could be used by all health professionals.

We also are working with the Canadian Mental Health Commission and Mental Health First Aid Canada. There's a two-day training course being provided to the veterans community. What do we mean by “the veterans community”? It's being offered to all primary care providers, families members, and friends. Our goal is to have 3,000 members, or as many as we can, who will take the two-day training course before the end of 2020.

Mr. Doug Eyolfson: All right. Thank you.

To expand on this, has there been outreach towards the medical schools in Canada to put these issues into the actual curriculum?

Dr. Cyd Courchesne: I'm trying to think if there was an outreach when I was in the military. Through the Canadian Medical Association, the Canadian Forces were represented at the specialist and the GP levels. I sat on the GP forum, and we had representatives at the Canadian Federation of Medical Students. So there has been a start towards socializing these issues with them. Certainly the Canadian Medical Association has been very good, in making a declaration in 2014 that they were encouraging family doctors to take veterans on in their practices. We've had very good support from our medical associations in Canada.

Mr. Doug Eyolfson: All right, thank you. That's good to hear.

Are there any trends in how these veterans with mental health concerns are presenting themselves? We know that in the military and in society in general, there's always a stigma with mental illness. Everyone's been working hard to reduce that stigma. With general public education to reduce that stigma, are we seeing a positive result in veterans presenting themselves earlier or presenting before they're in crisis? Is that having the effect we want it to?

Dr. Cyd Courchesne: You heard from a professional statistician epidemiologist, and I would be going out on a limb if I said that we were definitely seeing positive results, because they would ask me where are the statistics to support that.

I am going to bring it back to our veterans assistance line. One of the reasons for that—because we're talking about stigma—is that it's anonymous; it's available 24 hours a day, seven days a week. You don't need to qualify for any of our programs to use it, and I think that goes a long way.

That might be the first phone call, the first step they take to talk to someone, and to realize that maybe they have a bigger problem. The professionals that work the VAC assistance line work with veterans. They know our programs. They know when to say, “Well, maybe you should connect with a case manger and explore more supports to help you with your situation”.

That's what I wanted to say about stigma, and bringing it back to the VAC assistance line. You don't have to pre-qualify for anything; you just call, and you get access immediately.

The Chair: Thank you.

Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you, Mr. Chair.

Thank you, Dr. Courchesne, for coming back and filling in some of the gaps for us.

I want to go back to some specifics. You're now offering 20 face-to-face sessions plus sessions for the family. In terms of those 20 visits, is there a specific time frame you could count on? When those 20 visits end, is there a follow-up to evaluate their efficacy? What happens if there is still that need for more?

I wasn't sure if you had commented on that.

● (1705)

Dr. Cyd Courchesne: I'm going to let Madame Malette answer the question with respect to the length of the sessions.

Ms. Chantale Malette: Normally, we can provide up to 20 hours, and most of the time that is sufficient. When we have situations that require more than 20 hours, we will certainly have a conversation with VAC regarding the required services, and we will normally provide the intervention that is needed. It can be up to 25 or 30 hours, if necessary.

Ms. Irene Mathyssen: I was very interested in the reference made, both by Madame Malette and you, Dr. Courchesne, to interacting with practitioners, talking to the providers, talking to family doctors, and the idea of family doctors taking on veterans.

Is part of the intent to verify the quality of the service provided and to find out from those family doctors what they're discovering in the course of their interactions with veterans? Are you learning from them, I guess, is what I'm asking?

Dr. Cyd Courchesne: Are you talking about the health professionals that provide the counselling to the veterans through VAC assistance?

Ms. Irene Mathyssen: You talked about educating family physicians, and I wondered if it's a two-way street.

Dr. Cyd Courchesne: That was in response to your colleague's question as to whether we were doing outreach with associations and family doctors. We're not in a position to contact those family doctors. I'm not sure—

Ms. Irene Mathyssen: Perhaps Madame Isabel said that you have quality visits to practitioners' offices, and I wondered if, in that process, you're learning important things from those practitioners.

Dr. Cyd Courchesne: Those are not family physicians that provide the service through VAC assistance. It's Health Canada that monitors the quality of the services provided through the VAC assistance. Am I right?

Ms. Chantale Malette: Yes.

Dr. Cyd Courchesne: Again, this is anonymous, so none of the information is shared with us. We just know how many people use the service and perhaps whether they're satisfied with the service.

Once in a while, we do deal with some complaints and all that, which we follow up on, but the providers would never communicate with us to exchange that information.

Ms. Irene Mathyssen: It just seems that we're constantly in quicksand regarding how to prevent suicide and how to address the needs of people. It seems to always come back to this ambivalence and not knowing exactly what course to take. I'm trying to sort through that, not very successfully obviously, but I'm trying to sort through all of that.

Dr. Heber referred to VAC updating the mental health strategy and collaborating with DND to create this joint strategy in regard to suicide. I wonder if you could speak to that. I wanted to ask the question before about what those pieces look like. What does that strategy look like?

Dr. Cyd Courchesne: I'll answer that, if you'll allow.

You have heard that suicide is not a simple issue. Many factors play into it. I know people don't always like to hear about research, but research is very important because it provides us with so much information, so we can formulate programs, services, and strategies to confront this issue.

There are several aspects to the strategy. There is prevention, intervention, and what we would call “post-vention”. That's just a fancy way of putting things in baskets and organizing our activities.

I would say that everything that you've heard here about the VAC assistance line and, I would say, all the programs that Veterans Affairs offers to the veterans, is all part of the prevention strategies or prevention actions.

We also learn from research that the transition period is an important period of vulnerability for our releasing members, so we want to concentrate on that. What more can we do besides exit interviews, getting them case managers, helping them navigate the system, and getting them the benefits and the treatments that they need. All of that exists. All of that will be improved and that's all part of the strategy that we're developing with our Canadian Forces colleagues.

● (1710)

The Chair: Thank you.

Go ahead, Mr. Fraser.

[*Translation*]

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

I want to thank you three for being here today to give your presentations and answer our questions.

I want to start with you, Ms. Isabel. You mentioned the 20 in-person counselling sessions. The number of counselling sessions therefore increased from 8 to 20.

Can you explain the steps a person must take to receive these 20 counselling sessions? Is it easy to obtain approval? Are there forms to fill in? Do the members encounter difficulties before obtaining approval for these sessions?

Ms. Johanne Isabel: No. The first step for a veteran, a veteran's family member or a retired RCMP member is simply to call the 1-800 number. As Ms. Malette said, the team is in Ottawa. A staff member will ask questions and ask how things are going. The staff member will also determine the urgency of the call. If a client has suicidal thoughts, the protocol will be a bit different. However, if the client says they want to meet with a counsellor or mental health professional in person, depending on the client's region, the staff member can refer the client within a time frame ranging from 24 hours to five days. The time frame is based on the level of urgency. The veteran or the person making the request can receive the service in person, with a counsellor.

The client isn't the one who will determine the number of counselling sessions required, whether that number is 2 or 20. The decision is made after a health professional conducts an assessment. The veteran or client and the health professional will discuss the issue and the difficulties to address. This assessment will determine the number of sessions.

Earlier, it was asked whether the number of sessions ever needed to be increased to more than 20. The answer is yes, and it's important. A judgment call must be made, based on a client's needs. Sometimes, it's necessary. However, I also want to mention that this doesn't happen in the majority of cases. In a given year, Ms. Malette may call me three or four times to increase the number of sessions. In this case, we're talking about approximately five or six additional sessions.

Mr. Colin Fraser: Ms. Isabel, do you think the program steps are working well right now? Do you have any recommendations for improving the program?

Ms. Johanne Isabel: I've been working with Health Canada since 2012. We've received very few complaints or negative comments regarding the number of counselling sessions, especially since we increased the number of sessions to 20. The service is used more often. I don't have any recommendations in this regard.

● (1715)

Mr. Colin Fraser: Okay. Thank you.

I would now like to speak to Ms. Malette.

You said the service was accessible through the 1-800 number. You also mentioned Facebook, Twitter and other similar things. Is there a way to communicate instantly with a staff member, online, by computer?

Ms. Chantale Malette: No. At this time, there's no way to do so because it would be very difficult to assess the person's condition and to get back in touch with the person. For the moment, the safest method is for the person to call the 1-800 number. A mental health professional will respond and immediately verify the person's condition. The mental health professional can then get back in touch with the person, take note of the person's telephone number, and so on. Therefore, there's direct contact with the person.

[*English*]

Mr. Colin Fraser: One of the things we've heard in previous testimony is how important it is to have peer support, to have somebody who has served be a person who can talk to a veteran who may be in crisis now.

Is there somebody who can immediately be put in touch with them if they call the 1-800 number? You talked about some of the criteria for working at the contact centre. Is there somebody, a peer, who could be put in touch with them immediately?

Ms. Chantale Malette: We would refer to existing resources, for example OSISS. We work closely with them as well. If a veteran needed to speak with a peer, then we would use the services already in place.

Mr. Colin Fraser: But that could be quite a bit of time from that telephone call. It wouldn't be within the hour.

Ms. Chantale Malette: Maybe not within the hour, but we would certainly make the call right away, and we would either stay on the phone with this person or we would do frequent follow-ups during the evening. We would find out the best way to support this person at that time.

Mr. Colin Fraser: Has anybody ever used the service and asked if a veteran works there? Does that question ever get asked?

Ms. Chantale Malette: It's never happened.

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

Those are my questions.

The Chair: We are running out of time. I just have one clarifying question on your pamphlet here. It says:

> A voluntary and confidential service to help all Veterans and their families as well as primary caregivers who have personal concerns that affect their well-being. The service is available free of charge.

As a caregiver or a family member, do you need a veteran's reference to use this service?

[*Translation*]

Ms. Johanne Isabel: It's a service provided by Health Canada. The person simply needs to mention that they're a veteran's spouse and they can have immediate access to the service.

[*English*]

The Chair: Thank you.

That ends our round. On behalf of our committee here today, I would like to thank all three of you for coming with your testimony and for all you do to help our men and women who have served.

Mrs. Romanado, go ahead.

Mrs. Sherry Romanado (Longueuil—Charles-LeMoyne, Lib.): I know I wouldn't normally have the floor.

Would it be possible for the members of Parliament to receive a copy of this? I am not sure all members of Parliament are aware that this service exists. I would highly recommend that you make sure they have it.

The Chair: Great. Thank you.

Mr. Fraser, go ahead.

Mr. Colin Fraser: Mr. Chair, I am just wondering why we are finishing at 5:20.

The Chair: We could go to Mr. Bratina for six minutes, if he wishes to take that.

Mr. Bob Bratina: Thank you.

Did the increase in number from 614 to 1,143 and the extension of the 20 visits put any demands on resources? Were you able to do that within the complement of staff you had, or did it cause you to spend more money?

Ms. Chantale Malette: We have actually hired more mental health professionals.

Mr. Bob Bratina: These young people.... There was a reference to the military background, but what about orientation? How do you bring them into a military setting? I could see a certificate course in something like this, to add to their M.A. Is there an orientation process?

● (1720)

Ms. Johanne Isabel: It is a good question. I have to admit that right now we don't have a certificate or a specific program. We had a discussion last week, following recommendations from the family advisory committee at Veterans Affairs Canada. It was recommended that we provide more training for our mental health providers working with the VAC assistance service. Next week we'll have a call in to discuss this and try to identify how it could be done.

Mr. Bob Bratina: I'm sure you need these very qualified people, who typically would be younger people coming out of the university setting. It would be more difficult for, say, veterans with some years of service to become qualified. They would have the natural ability to relate to a veteran, but there are specific issues that these people are trained for, which is beyond the scope of just an interested former service person.

On the question of the satisfaction survey, can you give me an indication of how that takes place?

Ms. Chantale Malette: When the client sees one of our counsellors, the counsellor provides a voluntary survey with questions regarding the services that the client has received. They provide the person with a pre-stamped envelope as well, so the person can send us the information, which is then shared with VAC.

Mr. Bob Bratina: It's always important, whatever we do, to review it and see whether we are making progress. So that's good to hear.

On the face-to-face counselling sessions, how long would a session typically go?

Ms. Chantale Malette: Normally, a session is one hour.

Mr. Bob Bratina: In the satisfaction survey, is there a reflection that this is generally a good amount of time?

Ms. Chantale Malette: Yes.

Mr. Bob Bratina: Would 20 be an extreme or maximum? I gather from what you said that some people would have one or two sessions and your group would determine whether further sessions were needed, as opposed to somebody saying, “I'd like to come back next week too.”

Ms. Chantale Malette: That's right. There needs to be an intervention that is provided to the client. Based on the intervention needed, the amount of sessions is decided.

Mr. Bob Bratina: When someone calls the number, how do they identify themselves?

Ms. Chantale Malette: They will identify themself as either a veteran or former military member.

Mr. Bob Bratina: They simply say, “I'm former military and I need some help”?

Ms. Chantale Malette: Most of the time, yes, but if they can't or if they've just heard about us and don't know if they qualify for the service, we will ask questions of the person as to whether they have military life experience and if, at that point, they are regular members or former military.

Mr. Bob Bratina: One of the things we're looking at that we've talked about many times at this committee is continuing the identity of the veteran with their service time and, therefore, maybe having a card or something so they know right away that they have a way of identifying themselves as a veteran. Would you see the use in that?

Ms. Chantale Malette: Yes. I think....

Ms. Johanne Isabel: Yes, that would be a plus.

Having said that, as I mentioned, people don't have to justify it if they were in the military; they just have to mention it. We may believe that some people are receiving services because they've mentioned that they were veterans, but I doubt that people would do that. As for the fact that they don't have to provide any justification, the card would not really be a plus value in that specific case for that specific program.

Mr. Bob Bratina: It would be very rare, but we've seen cases of people showing up for Remembrance Day with uniforms and medals and....

Ms. Johanne Isabel: You're right, sir.

Mr. Bob Bratina: Thank you very much.

Those are my questions.

The Chair: Thank you.

Mr. Kitchen.

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

Quickly, I would like to follow up on Mr. Fraser's question. He commented about using peer support.

I want a little more clarification on that and whether you have ever looked at it or thought about this. It's one of the things we're hearing a lot about from our veterans. They're asking, “Isn't somebody there?” We haven't taken our veterans to actually help our veterans. There's this opportunity when you get a call like this where you might be able, on a conference call, to access someone 24-7, someone who can speak the language, because oftentimes people can't speak the language. I know a lot of psychologists and a lot of M.A. and Ph.D. students who do not know the language.

To me at least, having access for that veteran easily attainable in that crisis situation would be a valuable asset for your services. I'm wondering (a), if you have thought about it, and (b) if you haven't and this is the first time, if you see that being of some value.

● (1725)

Dr. Cyd Courchesne: I'll take the first crack at this.

Based on the numbers and the calls, it's not just the veterans. There are RCMP members and there are family members and children. Most of the calls are not for service-related issues, so I would say that so far it has not been an issue. But again, the people who answer the phones are very aware of all the services we have, including OSISS, which has a very large network of peer support people who are ready to assist us. If it's not within the hour, they have a strong network of people that will jump in to assist whenever we reach out to them....

Mr. Robert Kitchen: Right, but I'm not talking about service, about someone asking for a service availability. I'm talking about a veteran in crisis with a mental health issue. No matter what that mental health problem may be—because there are many different types of mental health issues—the fact that they might actually have a veteran or someone in the military who, having been there, understands, sometimes just that comfort is enough to maybe bring them down or calm them down. As for having that in a conference call, is that not something that you would see having value?

Dr. Cyd Courchesne: Well, absolutely. There's no doubt as to the value of peer support. Absolutely, it would be of value.

Mr. Robert Kitchen: Is there a way that could be put into this program?

Dr. Cyd Courchesne: We can certainly look at it.

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

The Chair: Ms. Lockhart.

Mrs. Alaina Lockhart: Thank you, Mr. Chair.

I want to talk a bit about families and the training provided to them. With other witnesses, we've talked about the first aid training that is presently happening for mental health and suicide prevention. Has there been any thought put to having similar training for family members even before military release? Has that been discussed?

Ms. Johanne Isabel: I'm not sure.

I guess what I can say is that right now, as I mentioned, we are working with the Mental Health Commission of Canada to provide two days of mental health first aid training. Right now we have been providing close to 14 sessions across the country, and our goal is to provide at least 150. This is one way that family members can have a bit more knowledge on mental health. This is going to allow them to have a better understanding and maybe see how their husbands or spouses are reacting with different signs.

Also, Dr. Courchesne alluded to our partnership with Saint Elizabeth on a caregiver program that is going to be available in the spring.

Dr. Cyd Courchesne: Also, these programs are offered through the military family resource centre, so they are available to family members before the CF member releases.

Mrs. Alaina Lockhart: The only other question I had about that is whether those are paid for in advance or whether the families need to pay for those and be reimbursed.

Ms. Johanne Isabel: When we are talking about the mental health first aid...it's free of charge.

Mrs. Alaina Lockhart: All right.

What about travel, though, to get there?

Ms. Johanne Isabel: I have to admit that the travel to get there is not.

Mrs. Alaina Lockhart: I bring that up just because it's been identified as a barrier for some families.

Ms. Johanne Isabel: Okay, thanks a lot for letting us know.

Mrs. Alaina Lockhart: Okay. Thank you.

The Chair: Mr. Graham.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): I just have a quick question.

When somebody calls the 1-800 number, I was wondering what the process is. What do they hear? Would the first thing they hear be that their call is important and to please stand by, or do they go straight to a person? Are there any recorded messages? Take me through the process of it.

Ms. Chantale Malette: A mental health professional answers the phone. There is no answering machine that welcomes the client. It's a live person.

● (1730)

Mr. David de Burgh Graham: So if somebody calls, in an immediate, “help is needed” crisis, what happens?

Ms. Chantale Malette: The counsellor will evaluate the situation and ask questions on the level of stress, the suicidal thoughts, and ideation. Also, the counsellor will spend whatever time is necessary with the person over the phone before that person is referred to a mental health professional or other services, or even before we call 911, if necessary.

Mr. David de Burgh Graham: So you will do that if you need to.

Ms. Chantale Malette: Yes.

Mr. David de Burgh Graham: Okay.

Also, I should follow up on the point Sherry made earlier. She suggested giving this information out to MPs. As an MP, what information and resources are available to me to get out there? We have 338 MPs who have offices in every riding. A lot of places they're very far from any kind of veterans services office. What can we do to help your mission, basically?

Dr. Cyd Courchesne: All this information is also available on our website also.

Mr. David de Burgh Graham: Well, I haven't heard about the Internet in my riding, but there you go.

Voices: Oh, oh!

Dr. Cyd Courchesne: We also publish every week through Twitter and social media. We have repeat tweets that go out advertising all of the services available at the department.

[*Translation*]

Ms. Johanne Isabel: We care about our veterans. You're all invited, in one way or another, to promote the service and to provide brochures in your offices. I would be very pleased to prepare boxes of information for you. That way, you can distribute them in your respective regions. Our veterans are important. We want to improve their situation.

Is everything in place to do so?

Maybe not, but with your support and recommendations,

[*English*]

this is what we are striving for.

[*Translation*]

Mr. David de Burgh Graham: Could you be proactive by sending those documents to our offices?

Ms. Johanne Isabel: Absolutely. I'll do that.

Mr. David de Burgh Graham: I appreciate it.

[*English*]

We're past that pass.

Thank you, Mr. Chair.

The Chair: I just have a question on that. We all do householders, and I just wonder if you could make something that might go in a householder and send it to my staff, and maybe we could promote it through this committee in a householder. That's just an idea.

Ms. Johanne Isabel: Okay.

The Chair: With that, on behalf of the committee I'd like to thank you for your testimony today and everything you do for our men and women who serve. If there's any information you didn't get to us, send it to our clerk and he'll distribute it to the committee. Again, I'd like to take you up on the householder idea.

I need a motion to adjourn.

Mr. Robert Kitchen: I so move.

(Motion agreed to)

The Chair: Thank you.

The meeting is adjourned.