HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 043 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Wednesday, February 15, 2017

Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

Wednesday, February 15, 2017

● (1540)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I'd like to call the meeting to order, if everyone could take a seat.

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

Today we have a panel of three organizations, which will start with 10 minutes of questions. We have the Distress Centre of Ottawa and Region, the Mood Disorders Society of Canada, and the Vanier Institute of the Family.

We'll start with the Vanier Institute of the Family, with chief executive officer Nora Spinks and retired Colonel Russ Mann.

Ms. Nora Spinks (Chief Executive Officer, Vanier Institute of the Family): Thank you. I'm speaking today as the CEO of the Vanier Institute. As you know, the institute was founded over 50 years ago by the late general, the Right Honourable Georges P. Vanier and his wife Pauline, mother of his five children and, at times, his caregiver. He was one of Canada's most decorated military leaders, a veteran of both world wars who lost part of his leg in the Second World War.

I'm here with my colleague, retired Colonel Russ Mann, who's working with the institute on the military and veteran families in Canada initiative and coordinates the Canadian military and veteran families leadership circle. This is a consortium of over 40 diverse community organizations committed to working together to build a solid circle of support for families of those who choose to wear the uniform for Canada.

I'm not a suicide expert. I'm here to talk about families. I'm here to talk about the role that families play in suicide prevention. I'm here to talk about the diversity of families and the complexity of family life. I'm here to share the evidence from research related to the family's role in suicide prevention, which is particularly difficult because of the inherent challenges of measuring something that didn't happen.

First, families are our first group experience, and our parents are our first group leaders. Families are unique and diverse, family dynamics can be open or guarded, emotions can be suppressed or expressed, and adults can be nurturing or distant. Families can live with abundance or scarcity. Families can be part of a supportive community, or alone and even isolated. Families experience stress together when they move, when there's a change—a birth, a death, an illness, or an injury—when money is tight, when uncertainty is high, when they are separated by circumstance, or when they reunite after time apart.

We each play a role in our families as children and as adults. Some of us are peacemakers, others are troublemakers. Some of us are followers, others are leaders. Some of us are talkers, others are listeners. Some of us are quiet observers, while others test, experiment, and innovate. Families grow tighter and grow apart. They share love, concern, pain, and anguish. They also share joy, hopes, and dreams.

Some families are under stress, some are in distress, and some are in crisis. Research shows that people who are contemplating suicide are feeling despair, anger, fear, and pain—emotional or psychic pain. They're feeling a need to escape, a need to protect others. They feel like there are no other options. Families share that despair; they often bear the brunt of the anger and witness the fear. Families often experience and feel hopelessness and helplessness. People who contemplate suicide feel hopeless and helpless.

Families provide help and hope, but they also both provide and need support. Families that are well supported, functioning, and healthy can be a significant protective factor for those contemplating suicide. Few families are naturally resilient: most need support to become or remain resilient, and some need help to become resilient. The literature shows that strong relationships with family and friends can reduce social isolation. Families can be advocates and system navigators. They can be the centre or foundation of the system of support for people in distress: we've heard some people who have lived through distress—who have come out of the darkness to the other side—report that this was the result of somebody being in their lives who didn't give up.

Families are diverse. They can be effective in supporting a family member with mental illness, depression, or PTSD, but they need support, training, and resources to do so. They need to feel competent, and they need to feel confident that their loved ones will receive the care they need. They need to feel they are not alone. When they reach out on behalf of their loved ones, they need to feel they can focus on accessing need, not scrambling to look for services and spending time on Google. They need to feel that their loved ones get well, not that they have to go on a long wait-list. They need to be able to access services and not fight to be heard.

Families need to find compassion, not confrontation. They need to feel respected, not challenged, and they need to be trusted.

Families cannot be forgotten after somebody dies by suicide. Families need to heal after that experience, that grief, that loss. They need guidance, assistance, and support. Families without support can become part of the problem, rather than a key part of the solution. Families empowered, included, and resourced can be a powerful tool.

Suicide is an extreme end to the wellness spectrum. Suicide is preventable, suicide is complex. Effective suicide prevention isn't a single event, or action, or policy, or program. It's a long-term, comprehensive approach to helping individuals and their families get well, be well, and stay well. It's about care and compassion. It's about the system of government and community supports working with families from the time they become connected to the military, throughout a military career, transitioning out of the military, and living as a veteran.

The Vanier Institute is here as a national resource. We are here to offer our assistance in the research you are doing. We are here to assist you to find the right answers to support families who are experiencing the trauma of people considering suicide.

Thank you very much.

● (1545)

The Chair: Thank you.

Next we'll have the Distress Centre of Ottawa and Region, Ms. Pizzuto, acting community relations coordinator. Welcome.

Ms. Breanna Pizzuto (Acting Community Relations Coordinator, Distress Centre of Ottawa and Region): Thank you for having me here to speak to you today. This is a topic that I'm really grateful to have the opportunity to speak on. I'm really happy to hear that this committee exists and is looking into this topic.

I've been with the Distress Centre for three and a half years. I started as a volunteer on the phone lines, moved up into being a volunteer supervisor, and now I've been full-time staff for a year, so I have a bit of an idea of what we do from the front lines, and also now in a role supporting volunteers as well as our callers.

I'll tell you a bit about what we do at the Distress Centre. We're a 24-hour, telephone-based service offering crisis intervention, suicide prevention, emotional support, information, and referrals to those who need this. Our service area is quite large. It covers Ottawa; Gatineau; Prescott-Russell; Stormont, Dundas and Glengarry; Renfrew; Frontenac; Grey Bruce; and Nunavut and Nunavik in northern Quebec. We have over 220 active volunteers staffing our lines 24/7/365; and in 2016 we answered over 50,000 calls.

To give you an idea of where we fit in the province, Ontario has 14 distress centres, including Ottawa's, that answered over 302,000 calls in 2015, with over 1,800 active volunteers.

To tie in to why we're here today, I can tell you that in 2016, 1,118 of our calls had some mention of the caller or a family member experiencing PTSD; and 12,448 out of 50,000 mentioned a caller or family member with a mood disorder, which is the most common mental health concern we hear about next to schizophrenia and psychosis.

While we don't track military personnel or veterans specifically in our demographics, I did want to tell you a bit about a caller whom we hear from quite regularly, just to bring a face to this issue for you. In the interests of confidentiality, I'll refer to him as John.

John lives within our service area, and he's in his fifties. He is divorced and he lives alone. John has been on tours as an army captain in Afghanistan, Iraq, and Somalia. John has lost all the members of his squad, either in active duty or by suicide upon their return back to Canada. He is constantly haunted by the flashbacks of the experience he endured carrying his buddies off the battlefield in body bags. He was discharged from the army a few years ago without a pension, and is struggling financially, having blown through all his savings upon his return here. He struggles with drinking and smoking, which are his go-to coping strategies; and he often calls us when he's inebriated. He's been diagnosed with PTSD, as well as a host of other physical ailments that leave him in constant pain.

John's calls to us waver between feelings of strength and resiliency for getting through what he's experienced in his life, balanced with a constant suicidal ideation and helplessness at the fact that he very often feels discarded and left behind. John feels like he's the last man standing.

He has admitted to us that he needs counselling, but has told us many times that he doesn't want anything to do with Veterans Affairs. He's dealt with them in the past and expresses frustration at the fact that they just put him on medication when what he really wants is someone to talk to and to share his experience with. He's told us that he feels the military has thrown him on the trash heap.

John's story is one of too many veterans who are suffering, and we can learn a lot from him.

The Internet tells me that 85% of the Canadian military are men. Men's mental health is becoming an increasingly recognized area of concern in our society, with men dying by suicide at a rate four times higher than women. Given this statistic, combined with the proportion of men in the military, it would make sense then to spend some time looking into how men specifically could be supported—not to discount the women, of course, they're important, too.

It's often said that men are less likely than women to reach out for help when they need to. This is seemingly true, but our statistics at the Distress Centre show that 40% of our callers in 2016 were men, which is almost a half. From this number, we can conclude that men will reach out for help when they feel safe to do so.

Our service is confidential, judgment-free, and not directly linked to a specific workplace, the government, the military, or any other professional body. Callers know they will receive respect and an actively listening volunteer on every call and that their stories will be heard, but not shared. No matter what they've done in their lives or what's happened to them, our volunteers will extend the same kindness and support to every caller they speak to.

In preparing for this presentation, I spoke to some colleagues, as well as some current members of the reserves, who told me that there is a broad range of useful resources that currently exist within the military, and I think this is great. These resources are well promoted in the workplace and encouraged by employers. What we hear most often from our callers is that the stigma attached to getting help is the biggest barrier that prevents anyone from seeking help. It's the workplace culture: the peer pressure to be strong and unbreakable members of the military, or proud and resilient veterans.

● (1550)

It was not too long ago, 2009 in fact, that the American army forced suicidal soldiers in basic training to wear a bright orange vest to identify themselves so they could have an eye kept on them. While this was intended to increase safety, it had the opposite effect of stigmatizing those who were struggling.

We often hear of the worry that people will have their job compromised at any mention of weakness, and it's the loss of identity that a person feels when they are stripped of their duties and thrown back into life without any support that's the most devastating. The dedication, strength, and willingness to sacrifice their bodies, lives, and minds for their country is something we must all honour in our vets and military members.

At the same time, we need to respect that with the loss of that ability to serve in the military comes an extreme loss of the sense of identity and self. These men and women are trained to act at peak performance on minimal amounts of rest. They have no choice but to become hypersensitive to the sights, sounds, and smells around them. Otherwise, they risk their lives and the lives of their comrades.

How can we reasonably expect our military personnel to return from such extraordinary circumstances and assimilate peacefully back into an ordinary life in Canadian society without help in doing so? We simply can't ask that of them.

Good mental health is more than just the absence of mental illness. Mental well-being or lack thereof comes from a combination of factors, and in speaking to how we can best support the transition between a career in the military and veteranhood, we must address all the factors that contribute to mental well-being, including financial stability, meaningful work, supportive personal relationships, family, and physical well-being. Alongside the obvious need for trained professionals to provide counselling or therapy comes the need for skills training, family support, income support, employment assistance, and couples counselling.

When John cannot afford more than a bowl of rice for dinner, how can we possibly expect him to obtain or maintain a job, or form meaningful relationships that will nurture and fulfill him? Human beings need safety and security above all else to survive and thrive.

A proactive approach would be helpful in transitioning military personnel into life after the military. I would put forth the recommendation that perhaps we could focus some time and energy into looking into how to better the supports that already exist, instead of creating new ones. It seems to me that there are resources out there that could be bolstered to better serve and become more accessible to the population that needs them. To break the barrier of stigma and promote safety in seeking help, perhaps partnering with a third party outside the military to provide support would be an avenue to explore.

There are over 100 distress centres across Canada, and a study reported on by Distress and Crisis Ontario has shown that volunteer-based support outperforms paid professional support on suicide phone lines. When compared, volunteers conducted more risk assessments, had more empathy, and were more respectful of callers, which in turn produced significantly better call outcome ratings than paid professionals on phone lines. It makes sense then that perhaps a partnership between Veterans Affairs and some or all of these Canada-wide distress centres would be a good idea, in the interest of saving money and building on an existing, proven, and effective source of help.

This is certainly an area that we at the Distress Centre of Ottawa are open to investigating. In fact, our board has already begun to explore the avenue of how we can better support the military personnel and vets in our existing work.

In closing, I would like to offer my respect and honour for the sacrifices made by these men and women. They might need help, but that doesn't mean they are helpless. They might be hurt, but that doesn't mean they are broken.

The Chair: Thank you.

Next is the Mood Disorders Society of Canada, Mr. Gallson, associate national executive director; and Mr. Upshall, national executive director.

Welcome.

Mr. Philip Upshall (National Executive Director, Mood Disorders Society of Canada): Thank you, Chair, for the opportunity to appear before you. My associate executive director is with me.

Just at the outset, I'd like to say I've appeared before a large number of standing committee meetings over the last 40 years of my activities in Ottawa, and I am so happy to see the members taking such a terrific interest in this topic. Frequently, standing committees show up with four or five members and it's rather impromptu. It's obvious you take this seriously and I'm really happy to see that.

Mood Disorders Society of Canada is a national, not-for-profit charity managed and membered by people with lived experience in their families. We are active at the national level only, and we have been around since 2011. We are active in many areas, some of which Dave will mention. We become engaged when we think there is an opportunity to do something for the people who need help. Those are the people who live with mental illnesses, whether they're on the street, whether they're veterans, whether they're first responders—whoever we can be involved with to help.

We've focused on that primarily because you can become involved in Ottawa with an awful lot of meetings and a lot of consultations, a lot of round tables, that produce not a whole lot of effective knowledge translation that will assist the people who need help. The material is important, and if you're involved in that stuff, that's fine; it's just not our bag.

One of the things we have done in the past, and we currently do, is become involved with the research community. We became involved with them initially when CIHR came into existence and with Bill C-300. We sat on their institute advisory board for many years. We're founders of the Canadian Depression Research and Intervention Network. The reason we did that is because there is a lot of research out there that I'm sure you've found is not translated into helping people who need help. We try to motivate the researchers and the community generally to pick up what we know will work and get it working, and still support research.

In 2004, we worked to help people with mental illness improve their quality of life. In 2011, we hosted a round table at the War Museum on PTSD. It was called Out of Sight, Not Out of Mind. The entire proceedings are on our website. It involved 75 people from all walks of life, including the Minister of Veterans Affairs, the military chief of staff, and a lot of people who were involved in the then-nascent discussion that PTSD is important.

Out of that came a report and many suggestions for improvement of our attention to PTSD. The recommendations presented in the report included addressing stigma; enhancing the knowledge of physicians and health care providers, which we think is number one on identification and treatment of PTSD; educating PTSD sufferers and their families on available support networks and resources; and promoting ongoing collaboration and dialogue among government and leaders in the field of mental illness specializing in PTSD.

We've looked at the presentations you've had in the last few days and they're terrific. You have a lot of really good information before you and there is no sense our repeating that information for you.

From our perspective, in order to address PTSD and prevent suicide, we would suggest you might look at early diagnosis of mental illness. Early diagnosis of mental illness will help us stop the movement into PTSD and into suicidal ideation. Early diagnosis requires the attention of the medical community to the issues of mental health, which is pathetically lacking at this time.

We would recommend that you increase mental health education among health care providers for the reason I just mentioned.

We strongly believe that peer support needs to be number one on your agenda. Whoever you talk to will tell you that it's the human touch, the human element. Research tells us that peer support needs to be there for you.

I'm going to turn it over to Dave Gallson to give you a bit of an overview of some of our programs.

● (1555)

Mr. Dave Gallson (Associate National Executive Director, Mood Disorders Society of Canada): Thank you.

About 70% of adults living with a mental illness have onset before the age of 18. We know that early intervention can reduce the severity of the illness. For chronic conditions, research indicates that many youth experience symptoms of their illness between the ages of 12 and 17 years. This is, therefore, the timeline where targeted treatment could significantly address mental illness.

Mental health problems in children and youth can, if not properly diagnosed and treated, lead to more serious adult mental health disorders, which are both more difficult and costlier to effectively address. When prior unaddressed mental health issues are compounded with PTSD later in life, then the path to wellness becomes much more difficult and lengthy. Investing in mental health services early would lead to more rapid recovery and symptom management, and would drastically reduce costs associated with chronic mental illness.

We believe strongly that investing in educational programs for Canada's health care providers to enhance their ability to better treat PTSD and other mental illnesses can significantly improve the quality of life of those suffering from PTSD, preventing suicide.

Expanding on educational programs will help train primary health care providers in urban, rural, and remote communities nationwide. In almost every case of PTSD, an associated condition is depression. Canadians are now coming to understand that depression alone is an epidemic in Canada. It is implicated in every aspect of Canadian life, from the workplace to death by suicide of over 4,000 Canadians every year.

Considering the societal, personal, and economic toll of PTSD, we believe that investing in a comprehensive program focused on Canada's primary health care providers to enhance their ability to provide early diagnosis and treatment of PTSD to their patients is a prudent use of public funds that will save significant health care and societal costs in the future, and greatly enhance the quality of life of those suffering from PTSD, their families, and caregivers.

We know working directly with veterans living with mental illness and providing supports to them is key to reducing suicide. I'd like to thank the federal government for its support in our transitions to communities program, a partnership program between MDSC, Employment and Social Development Canada, and Veterans Affairs Canada.

Through this skills development program, our goal is to assist nearly 450 veterans over three years who are experiencing obstacles within their communities. The program aims to provide the direct supports needed to address the emotional and coping strategy challenges of veterans, with a focus on employability skills, mental well-being, and peer support.

We've just opened three facilities in Montreal, Calgary, and Toronto. While we are at the beginning phase, we are looking forward to working closely with veteran organizations, community groups, and employers.

I'd also like to speak to you about the importance of peer support programs. As we've heard from veterans themselves, they are key to recovery.

For example, the national peer and trauma support training and the project trauma support programs are innovative approaches to addressing mental wellness that use a patient perspective approach. Their goals are to provide support, education, and programs for military personnel and first responders who have been impacted by PTSD and other mental health issues in order to support their healing and recovery.

Project trauma support, located in Perth, Ontario, is a week-long concentrated program for military and first responders who have had their lives ravaged by PTSD, and is delivered in a cohort of 12 of their peers. Project trauma support incorporates equine therapy, adventurous rope courses, and peer support to educate participants about their emotional environment, while creating trust and fostering help-seeking behaviour. The program allows participants to process their experiences and authentic emotions, and to improve the lives of their families and peers in the process.

As a brief example of the transformation this leads to, I offer two quick testimonials.

The first one is from an RCMP officer, who said, “I came away feeling that something had fundamentally changed in me and the way I would deal with my PTS. Not only have I noticed a difference in the way I now live my life, others around me have noticed as well. I only wish I could have had this 14 years ago.”

The wife of a military officer said, “I think the magnitude and impact of this past week can best be summed up by our nine-year-old daughter coming up to me and saying, 'It's weird, but it looks like Daddy's eyes are alive.'”

While professional help is very necessary, it's not always available at eight o'clock at night or midnight, when veterans need someone to talk to about their stresses or thoughts of suicide. With peer support programs, people have a network of peers who understand what they're going through, because they've experienced the same things and can relate on an equal level. Funding more programs like these, as well as effective research, would go a long way to supporting the mental health needs of veterans.

● (1600)

In closing, our veterans have placed their lives on the line for our country. Providing care to these men and women must be a priority for all Canadians. Working as a team in training is what they know and how they have been conditioned. Healing and recovery need to use the same team approach.

We thank you for allowing us to share our thoughts.

The Chair: That's excellent, and thank you.

We'll start the first round of questioning with Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Colonel Mann, it's good to see you again. Thank you for your service. Ladies and gentlemen, thank you all for coming.

We've learned an awful lot in these short programs we've had, and there's so much we've learned that trying to condense it all into one report is going to be very difficult. There are four things we've definitely heard of. I hear it from you and I've heard it from many people that identity loss is a big issue; stigma, not only of being labelled but also the stigma within the ranks as to how it's perceived; trust is a form of treatment, and it's one of the first stepping stones we need to look for, and that's part of what we want to do. How can we provide the appropriate treatment and the appropriate programs? Then the last are the stressors, when people don't have that stress, how stress adds to that.

I appreciate your comments. I'm going to try to get some answers. Ms. Spinks, what could you tell this committee about the support program you're talking about? What would be the best way for us to start from one, two, three, in setting up that support for families?

● (1605)

Ms. Nora Spinks: There are a couple of things. Listen to the military families, those who are already in the military and those who have left the military and are now veterans. They talk with each other all the time. They're really clear on what they need. I think Phil mentioned this.

There's a ton of research out there that's not getting translated, and some knowledge mobilization, both on what's working well but also what's not working well and why it's not working well, so we're not replicating that. The family advisory committee that was set up by the minister is a good place to begin that dialogue and find ways to get that out.

We have some academic articles we were thinking of bringing to you for your background, but they're very dense. Taking that information and making it accessible and available, not only to committee but also to families themselves, is a piece that's missing from the puzzle. We have CIMVHR and all the great work the institute is doing on military veteran health research. We have all kinds of research that's being done in the mental health community; within and among the distress centre community. We're not really good at getting that on the ground.

That's from the organizational, academic perspective, but I'll let Russ answer from a veteran's perspective.

Col Russ Mann (Special Advisor, Vanier Institute of the Family): I think Nora hit perhaps the most important aspect, and that's to listen. Those who have gone through suicidal ideation who I have encountered and had the privilege of speaking with of course have come away and are in recovery, but they and I both agree that the common thread of success has always been that somebody who refused to give up on them and who had no judgment just sat there and listened to their story and listened to their perspective and tried to understand without judgment.

Listening has to be a part of the program that goes into place. I think the Distress Centre has a lot of experience with active listening. When you spoke about kindness, I thought of someone acknowledging that person, their feelings, and their position as they are in that state of distress or heightened anxiety has to be a fundamental part of any program that comes forward.

It does not have to be from Veterans Affairs. If you want to create safety, which I think is perhaps the second most important piece, then yes, peer support works, because we trust our buddies. We trust our peers. We've been through shared lived experience, so it's natural that we'll form a connection. There's a lot that doesn't have to be said, because we already have a set of ground rules that we understand.

Creating safety creates an opportunity for listening, for a dialogue, and for the next steps whether they are a referral, developing a mutual plan of action, trying to mitigate any sources of potential harm or danger by actively listening and then engaging the person about what they would like to do about the medication, or what they would like to do about the knife, the gun, or whatever form the suicidal ideation is taking at that point in time. Trying to mitigate that through peer support in a safe zone, I think, is another important element of the program.

Where I come from with the Vanier Institute of the Family, it's creating the opportunities for families to become informed, resourced, and supported. If I go back to what I said at the beginning of this, it's having somebody who doesn't give up on us. For me, it was my wife. For someone else, it might be an aunt, an uncle, a friend, or a sibling. It could be a son or a daughter. That person who doesn't give up needs the opportunity to be armed with knowledge, resources, and support.

Those are the three things that I think would be fundamental parts of any program.

● (1610)

Ms. Nora Spinks: Can I just add one quick comment? One of the things we've done with the Leadership Circle, to pick up on what Breanna said, is building on what already exists and making those programs military-welcoming and veteran-inclusive. We don't have to start from a blank slate. We just need to staff up, resource up, and support and connect those who are already there.

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you. It's been a great panel with great comments.

Could you just flesh out a little more how the relationship and partnership work in the military and veteran families leadership circle?

Ms. Nora Spinks: There are about 40 community-based organizations and they're not the typical military organizations that you might find at a stakeholder summit or the like. There's the College of Family Physicians Canada and the Canadian Child Care Federation. There are community-based organizations that work either exclusively or substantially with military families, but also those that may come in contact with a military or veteran family, not in a big way, and want to learn and want to be a part of it.

The circle has four purposes: to build awareness, so that's public awareness information; to build capacity, which is organizational capacity, enhancing what's already there; to build competency, which is the professional competency and making sure that every family physician has basic military literacy, and we were able to get 35,000 family physicians some material on military literacy in the last month; and then finally, to build community, so that if somebody comes to the Distress Centre or to Mood Disorders or to a child care centre and is reaching out, whoever they reach out to will know how to get them to the right place.

Now if you call 911, you may get patched over to the Distress Centre. If the Distress Centre has military literacy, then it will be able to do its job even better than it's already doing, and it's doing an amazing job. Those are the four purposes.

Mr. Bob Bratina: What resources go from Veterans Affairs Canada to your organization?

Ms. Nora Spinks: Right now, nothing. They are active participants in the leadership circle. We have three co-chairs for that circle: the deputy minister of veterans affairs, the chief of military personnel command, and one of our board members. They co-chair together, and the resources they offer are that they're part of the team. There are no direct dollars or cash from Veterans Affairs to the institute.

Mr. Bob Bratina: Would you suggest a bigger role?

Ms. Nora Spinks: I think one of the things we're hearing from the leadership circle is a desire for more of the awareness. In the space of a couple of months, from an idea to a launch, we were able to get to 35,000 family physicians coast to coast to coast: 4,000 of them in their hands, and the rest got it all by mail. It begins the conversation. At the next conference there will be workshops. At the following conference, we're hoping it will be even more. We're currently working with the College of Family Physicians to create a “best advice” guide.

It doesn't take much. That's family physicians; we would love to be able to replicate that with guidance counsellors in schools, principals, the early childhood education community, occupational therapists, physical therapists, recreation therapists. They all have a role to play in making sure that people either get to the services they need or are in a position to act appropriately when somebody comes to them and is reaching out to them. Whether it's a military member or a veteran or a family member—parent, spouse, child, or sibling—that would be a huge benefit.

If we could have half the success we've had with the family physicians, in terms of giving them some military literacy, with the mental health community, with the faith community, and with all of those people who are there and who won't give up on them, it would be huge.

● (1615)

Mr. Bob Bratina: Breanna, I gather you didn't really have many of those resources, if any, in dealing with John, in the discussions you had.

Ms. Breanna Pizzuto: No, unfortunately not. I also produce our volunteer monthly newsletter, and in January I had so many volunteers stopping by my office after they spoke to this specific caller, saying that we need to find something for him. He is sitting at home. He has no money. He's barely eating.

As part of our volunteer newsletter, I tried to find resources to put into our database above what we already have. We have maybe four that he's been referred to loads and loads of times. It's kind of like our volunteers are there to listen to him, he needs somebody to talk to, we haven't given up on him, and he continues to call us, but as far as pushing him out into something....

Mr. Bob Bratina: You've hit on the reason for our being, and that's service delivery and awareness of the things that are in place. Many veterans, and John could be an example, maybe take a stab at something. Documents are sent back as not complete, and they're just thrown in the garbage in anger. There's a whole range of activities, and the veterans who are falling through the cracks unfortunately miss because of lack of awareness. That would be good if your group had those things.

To the Mood Disorders Society, I was really touched by your comment that if mental health problems in children and youth are not properly diagnosed and treated, they can lead to more serious mental health issues. In Hamilton in 2007 we found that we had too much lead in the water. When I was a municipal councillor and now as a parliamentarian, I'm very concerned about it because of the effects of that lead on the brains of developing children. One of the main outcomes is behaviour and depression. In addition to the work we're doing here, I think we need to look at those things and see what leads to those behaviours.

I'm also pleased that the Mood Disorders Society has attached itself to the question of veterans, because you would agree that it's unique. The veterans story is a different story.

Mr. Philip Upshall: We would agree to a certain extent, in the sense that PTSD and depression impact people generally the same way in the brain. You probably heard this from your researchers. There's a 5% issue for veterans, and there's a 5% issue for first responders, but that 5% is very important. Early diagnosis, getting involved with the community at the very early stages of mental illness, and understanding it are not unique to veterans. It's a unique issue for all Canadians, and particularly for primary caregivers and primary care spectrums.

Coming from Hamilton, of course, you've got the leaders of the shared care model out of McMaster, who we've had the privilege to work with. In collaborative care, we were the patient leadership in that whole movement.

Early intervention is by far the best thing, but, in order to do that, people have to understand what it is they're looking for. Far too often patients, veterans, and others show up in doctors' offices, in nurses' offices, and in rural, remote, and indigenous communities expressing some issue. The health care provider does not immediately say, “Oh, given your background”—because they don't take enough background—“we'd better have a look at this and see”. It's really up to the health care provider at that stage to start the ball rolling.

The Chair: Thank you.

Ms. Mathyssen.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you to all of our witnesses.

We have had an incredible array of information provided by witnesses and so many possibilities. Each of you brings a specific expertise. How do we bring this all together in terms of finding that template, finding that solution, or I guess more appropriately, finding the path that will help all of our veterans?

Mr. Dave Gallson: I might just start the ball rolling as far as a reply is concerned.

I have the honour of sitting on the Minister of Veterans Affairs' advisory panel for mental health, and part of his mandate letter was to create a centre of excellence, one focusing on mental health, and also to address suicide within the veteran and military population.

I think we have to realize that there's no one, simple, quick fix. There's no one, simple, quick answer. When we're talking about early diagnosis and early treatment, I have a real particular feeling that we've got to remember the children of the veterans who are going through these issues because we're looking at mental health issues coming down the pipe in 15 to 20 years, if not sooner, so there are a lot of issues that have to be addressed.

When I look at a centre of excellence centred on mental health and addictions, the first question we ask ourselves is this. Is it a brick and mortar research academic institution or a service delivery institution? We now realize that it's got to be a hub and spoke model. It's got to be a centre where a veteran can go into a wellness or a treatment program with other veterans so they're not sitting there with folks who have never been in service because they don't relate to them. They can't open up and talk because somebody's dealing with other issues that don't centre around PTSD issues.

Realize that there's not one answer—I don't want to take up too much time—but it's going to be a whole plethora of different services that are all tied in together and that are all working together to address a wide array of issues.

● (1620)

Ms. Irene Mathyssen: You touched on something that we heard earlier in regard to veterans being told to go into group therapy with people who have no experience in military life, and how unhelpful that was.

Mr. Dave Gallson: It's very unhelpful, and it can set them back a long time. I've had some veterans tell me that they went to see a psychiatrist for a year, and they were being completely honest and completely open, but it was only through the peer support that they really started to understand, being in a group setting with other veterans, that they were talking about things that weren't the root of the issues. They thought they were giving the psychiatrist the right answers, what the psychiatrist was looking for, but they weren't dealing with the root cause of the PTSD, which actually happened many years before service.

It's a learning process on how to use the services out there effectively, I think.

Ms. Irene Mathyssen: Ms. Spinks, do you want to respond as well?

Ms. Nora Spinks: I think there are a couple of things too. Most of the services that have been established to meet the needs of military or veteran families are close to installations, such as Petawawa or Gagetown. But when you talk about veterans, you're talking about every community from coast to coast to coast, and we're never going to have a military-specific program in every community.

What we can do is to make sure that every community organization that exists has some basic military literacy, that they understand when somebody explains that they went to Afghanistan, and that they know what that means and don't just have some reference from a movie they saw one Saturday night with their friends but really understand what that means.

I think there's enormous interest across this country by professionals of all kinds who want to be ready to reach out to help, and they want to learn. I think the way we need to manage that —we're doing the same with direct service—is to balance high tech with high touch. We want to make sure that people have the personal contact and those personal relationships, and that they get access to those services they need from human beings, but also have access to technology—perhaps to be part of a group—and the use of technology so they can participate over the computer.

There are lots of experiments and innovation and successes being had by those kinds of specialty programs, but if you're not in it, you have no idea that it exists. One of the things the leadership circle did last year was to try to pull together the beginnings of a one-stop shop for information so you don't have to Google what you need to add to your list but you can just plug and play a list of what's available. We created it as a 1.0 document.

In order for it be successful so you can plug and play for a distress centre, we need that to be accessible online, searchable, and almost like a Wikipedia, because things are happening so quickly. Right now that doesn't exist. The foundation is there but the technology isn't. It's in a book. It's like the old blue book in Toronto. You had it but it gets dog-eared after awhile. We need to make that accessible for everybody so that if you're a volunteer at a distress centre—boom —it's there, whether it's information about housing and homelessness, or whether it's information on food services or mental health supports.

● (1625)

Ms. Irene Mathyssen: Thank you.

Mr. Upshall, you made reference to moving the research. We heard some remarkable research on Monday from scientists and folks who are looking into the brain and at what is happening with those suffering from post-traumatic stress.

The Chair: I'll just remind you we are right at zero time. We'll have to shorten the question and make the answer short also.

Ms. Irene Mathyssen: Okay.

You talked about moving from research into the clinical domain. How do we facilitate that?

Mr. Philip Upshall: This is very difficult to keep short.

Ms. Irene Mathyssen: I do it all the time.

Mr. Philip Upshall: One of the things you do is you get patients, in our case veterans, involved in the discussion and educate the researchers as to who they're dealing with, who they're working for, and who needs that information. In the vast majority of cases, it's the health care provider.

We work with the Royal Ottawa and the Mental Health Commission, which were your witnesses on Monday, and both are excellent organizations. The Royal Ottawa is part of the Canadian Depression Research and Intervention Network that I talked about. It's about getting them to understand that there are people out there who can help them translate that information, but they have to be motivated to make the link.

In research, one key issue is that researchers far too often stop their work when they publish. It's the way they work. I've worked with post-docs and I've worked with all sorts of people who say, “If you want me to help you translate the information beyond my publication, you'll have to pay me.” I don't have the money to pay them, and I have to twist their arm to volunteer to help me work.

One of the ways we did it was that we developed a PTSD CME. It was an outcome of the Out of Sight, Not out of Mind project. Collaborating with the Canadian Medical Association, Veterans Affairs, and others, we developed a continuing medical education resource of $200,000 which came out of the 2012 budget. This is still valuable today. Unfortunately, it's a CME and we haven't been able to get the money to move it out. Nevertheless, it's there and it has been very valuable. It has great research. We have some information here if you—

The Chair: Maybe we can get you to send that to the clerk afterwards, and we'll get it to the committee.

Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you all for being here today. You have provided great perspectives for us.

I want to start by saying that I'm very encouraged. Personally, whenever I've been talking to mental health professionals recently, the idea basically of “no wrong door” has been coming up. I've talked to some in New Brunswick who have had great success with this from the viewpoint of a youth mental health process and just as a general community pilot project. It's great to hear you talking about the same thing.

What we're studying, obviously, is suicide, and specifically during the transition, and the risks in that transition piece for veterans. Another big piece of it is identity.

I'm wondering, in the context of a family, whether from your experience the family experiences that sense of loss of identity as well. How much impact does this have, and how does it factor in?

Ms. Nora Spinks: We hear from military families all the time that they identify as a military family. What they don't identify with is a military family in transition to civilian life or a “veteran family”. Once you're military, you're military for life.

Little things that we've heard affect families deeply are simple things, such as the veteran's licence plate that you can put on your car, with the veteran's poppy on it. When the veteran dies or becomes divorced, the family has to give up the licence plate. Little things make a big difference.

We don't have identifiers in most data collection intake forms. We don't have them at the distress centre, we don't have them at doctors' offices, we don't have them in schools. They have them in other jurisdictions around the globe and they find it very useful—not to pry or to get into people's lives, but to help them feel welcomed and respected and included, and then to make sure that they get information and access to support, should they ever need these things.

We have much that we can draw on from other countries. We're involved in an international consortium that's looking at translating research, because so much of this is biology, so much of it is experiential, and we share this with the U.K., Australia, and the U.S., and with our other allies. We don't have to start from scratch; there are services out there that, with very little resource, could be tweaked and Canadianized and made readily available.

● (1630)

Mrs. Alaina Lockhart: Thank you. I appreciate that insight.

Mr. Gallson, I have some questions for you.

From other testimony, we've heard that it's often a barrier for families to access services that are provided by third parties because there's a requirement for them to pay up front and then be reimbursed. Is that the case with your programs as well? Have your participants expressed any difficulties with that situation?

Mr. Dave Gallson: Absolutely not. I am completely against fee-for-service services, to tell you the truth. I developed a program many years ago because of people in our community not being able to access services, just for that reason.

Our programs are funded by the federal government. We're a very collaborative organization. We believe strongly that programs, especially programs funded by the federal government, should be expandable programs that are shared across all organizations in Canada. There is too much of a silo effect out there whereby programs are developed and then an ownership issue arises: “This is my program”, and yada, yada, yada.

That hurts people. We have to make programs more available across Canada, to all organizations. That's something we do very well.

I can't say enough about the leadership circle and the networking that goes on within it. I'm having a meeting on Friday with another organization. There will probably end up being a new program in Canada for PTSD and for families. That's a direct result of the collaborative nature that this whole organization has. That's the way we have to move forward.

We've developed a PTSD program for the Canadian Bar Association for lawyers. It's been taken by more than 2,000 lawyers so far. We've developed programs with the Canadian Nurses Association for anti-stigma in hospitals, because we found that health care providers are, amongst others, one of the most stigmatizing associations around in terms of recognizing people who come into emergency rooms with potential mental health issues. They are triaged lower, there's a lot of hesitation to even recognize that there is a mental health issue, and many people have lost their lives because of this.

I'm sorry to make it a long answer.

We work with all organizations across Canada. We're fire-starters. We like taking projects, starting them, and then sharing them across Canada. We've been working with Public Safety over the last 18 months. Right now we have a proposal in front of the federal government for a national PTSD action plan. We're hoping that it gets a good look. It's a collaborative approach to doing this.

We are a meat-and-potatoes kind of organization. We like doing things, with the funds that are provided to us, that are going to make an impact on the family unit at the home.

Mrs. Alaina Lockhart: Mr. Upshall, I have a quick question. You talked about early detection of PTSD. Have you seen any screening during military service, pre-, post-, anything like that? Do you think it would be helpful?

Mr. Philip Upshall: There has been an effort to do some screening and particularly when members are close to discharge. Russ would be a better person than me to answer this. The reality is that a lot of PTSD doesn't show its ugly face until many months and sometimes years after a person is discharged. Men, particularly veterans, are used to saying, “I'm okay. I'm fine. There's nothing the matter with me. I've been through this.” It's only when they get home and experience all of the difficulties that come with the recollection of what happened that they feel the impact.

I would like to add on your question to Nora. One of the issues, in terms of family identity, is that kids watch dad or mom go away, and they're so happy. There are pictures in the paper and big kisses at the navy wharf or wherever, and dad or mom goes off. Then dad or mom comes home, and there's a celebration, and the kids are proud of their parents, proud of their dad and mom. They talk about it in school. Their kids are there.

All of a sudden, six months later, out of the blue—mom may have seen a little bit but the kid hasn't—dad beats the tar out of mom. Holy mackerel, what a trauma. And nothing happens. Mom has heard a little bit about military issues and decides to do some checking, and then it happens again. Then all of a sudden, dad is charged. He goes to jail. There's a divorce. All this stuff happens. That is a trauma that will drag that kid for 60 more years after dad comes home from Afghanistan. We frequently forget that that happens and the impact of that trauma, which goes untreated and unrecognized. Forty years later that kid may have a real problem, and they'll never be able to track it back to that incredible trauma. They're high one minute and right at the bottom the next.

Sorry for that, Chair.

● (1635)

The Chair: Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you all very much for being here today and sharing your thoughts. Those excellent presentations will be very helpful. Thank you also for all the work that you do that's so important in our country.

Ms. Pizzuto, I'd like to start with you. You mentioned that you don't track military or veterans as part of a demographic that you would ask questions about or find out about in terms of numbers. I'm wondering why not. Do you think it's something that could be done in order to gain a better background about the person you're talking to and keep some statistics that might be helpful for us to make different decisions going forward?

Ms. Breanna Pizzuto: Yes, I think it's something that could easily be done, added into our system. The reason we don't right now is because all of our statistics are provincially mandated, what they want us to keep track of reporting-wise, so we pretty much stick to what we've been asked to report back on. That's something that we've never been asked before, but it would be helpful, I agree. It's certainly doable.

Mr. Colin Fraser: If the information is offered by the caller, for example, would you then put them in touch with VAC services and do that sort of connecting?

Ms. Breanna Pizzuto: Absolutely, yes.

Mr. Colin Fraser: Do you know if that happens quite a lot? You mentioned some of the numbers of how many calls you receive from military personnel or veterans.

Ms. Breanna Pizzuto: I would say it happens a fair amount but probably not as much as it should. As Nora was saying, we're perhaps not recognized as a veteran-specific service. We're not a veteran-specific service, so perhaps if there was some more training given to us, or if we could grow that partnership and be more recognized as a support for veterans, we would see that number grow.

Mr. Colin Fraser: As I understood it, your centre is incoming phone calls. There's a hotline number, and calls come in.

Ms. Breanna Pizzuto: Yes.

Mr. Colin Fraser: Is there any thought of online services that could be accessed for you to respond to people who may not necessarily want to pick up the phone and call?

Ms. Breanna Pizzuto: Yes, absolutely. This year, we're going to be rolling out a text and chat function that some distress centres in Canada have already started, which will allow people to access our services online or through their mobile phones.

The other thing, which is separate from the distress line but also a program that we run out of the distress centre, is called the wellness check program. If a patient presents to an emergency department at a specific hospital and consents to a call from us, they will receive a call within 24 to 72 hours after their discharge. If they're admitted to the hospital, we'll give them a call after their discharge, however long that may be. We'll check in with them and see if the hospital left them with a discharge plan, if they're following their medication regimens, and if they're seeing who they're supposed to be seeing. That's something that could be done with veterans, following up after the fact, because these people have said that PTSD doesn't necessarily show up right away. You can do a psych assessment the minute they're discharged, and they'll say they're fine. Then six months or a year down the road, the PTSD starts to crop up.

Mr. Colin Fraser: Thank you very much. I appreciate that answer.

Let me turn now to the Vanier Institute. You talked about the leadership circle a couple of different times, but once in response to Mr. Bratina's question. I'm just a little unclear. How does this look across the country, as far as rollout in towns and cities is concerned? Is it available to all people across the country?

Ms. Nora Spinks: The leadership circle is primarily national, so we work with the national partners. Having said that, we recently co-hosted a regional leadership circle in Newfoundland for Atlantic Canada to ensure that everybody from the regional organizations also had the necessary military literacy that they needed to do their job well. We were able to address some of the provincial issues.

This subject comes up often, particularly with veteran families. Because they've moved around a lot and because of the nature of our health care system, provinces need to be connected. Right now, the leadership circle is not well connected to the provinces, but it's a priority for the leadership circle. The leadership circle meets every January, and the job we've been tasked with by the members for this coming year is to find a way to engage the provinces and the regions, because we can't do what we want to do without their involvement.

● (1640)

Mr. Colin Fraser: Are there any recommendations we could make that would assist in this?

You could think about it and email us.

Ms. Nora Spinks: There could be an identifier on the medical record, absolutely, which would then allow us to track and to connect.

Right now, Ontario has some data that we can mine, but not enough. Certainly, we could have the provinces understand the veteran data in their own provinces. If you're a provincial person, you're going to think of Gagetown, or Petawawa; you're not necessarily going to think of downtown Hamilton.

Col Russ Mann: I think it's also important to realize that we attack nationally because....

I'll give you one specific example, of the Canadian Paediatric Society. We talked about the impact on children. They came up with a position paper and recommendations for pediatricians across the country. By dealing with a national association, they push it to their provincial and regional chapters and to clinics and offices that are going to encounter people, not unlike the way we do with a distress centre that isn't built for veterans or veteran families but that is, in their practice in providing service and support, encountering veteran families amongst other Canadian families.

This is a problem that has to be attacked right down to the local level, but of course we can't do so with every single pediatrician. The Paediatric Society owns that network of informing and educating, so we engage them.

There are impacts being felt very locally, however. One of the more recent ones dealing with mental health that is pertinent to this committee concerns Broadmind, in Kingston, where one of the members of the leadership circle is helping to bring mental health first aid to the Kingston community with what I'll call mental health first aid on steroids, because they've taken the national programming for mental health first aid and put in local resources and local support to boost the effect in that specific area.

Those are the kinds of things that need to happen. The provincial side could have an amplifier effect for getting it to local communities.

Ms. Nora Spinks: Can I just give one quick example?

The Chair: Can you make it quick, please?

Thank you.

Ms. Nora Spinks: Pediatricians, as a result of this, now have a program whereby they do a warm handover. Instead of your being a patient of a pediatrician and then moving across the country and going to the bottom of the waiting list and working your way up, there is now a warm handover. That military family, that veteran family now, as a result of the work that they've been doing, doesn't have to go back on a wait-list and doesn't have to start over. It's a great model that we can replicate for a whole host of other services.

The Chair: Thank you.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you so much for being here today and for the amazing work that's being done.

Clearly we have a crisis across our country, and we're focused on our veterans and our armed forces. It seems to me there are two areas of mental health that we look at: the crisis situation they experience, and then the other, which is the ongoing building of frustrations in transition. These are two very different sources for dealing with your mental health.

I heard a lot of conversation about peer support, and we've heard that over and over again, about veterans helping veterans. I've never been in the armed forces, but I had a girlfriend try to tell me how to take care of my two year old before she had one. That peer support is so important. And we're hearing from all kinds of veterans organizations that are popping up and doing really good work and are very organized with top-notch therapists, psychiatrists, doctors, researchers connected with them, and then I see that we need to be funding more programs like this.

What are you thinking as far as funding is concerned? I like to think of them as innovative start-ups in a lot of ways. They don't have the money to do what they could do really well and mitigate a lot of these issues, even prevent them from happening.

● (1645)

Mr. Philip Upshall: A very brief response would be we should encourage them, we should identify those that are out there that are doing a good job and replicate it and provide the funding. It's very cheap to provide peer support, provided it's recognized. And again as a patient community, one of the issues we've had with the research and medical community is that they have absolutely refused to accept the validity of peer support as an evidence-based medical intervention.

We had to twist the shared care community's arm. We refused to become involved with the collaborative care, insured care, until they recognized that on the continuum of support, shared peer support should be there. So the issue is if Veterans Affairs wants to do something, funding peer support community that provides valuable peer support. Project trauma support is very inexpensive compared to other models, and it really does work. And we know of others. The issue is whether the Government of Canada's Veterans Affairs has the desire to reach out and do this. Part of the reaction you will get is that this isn't evidence-based. We need to put more money into research.

Could I tell you a very quick story? Last year when Fantino was Minister of Veterans Affairs, he called me and Alice Aiken who was then the head of CIMVHR into the office and said we needed to do something about PTSD, particularly service dogs. I told him service dogs are really important. They work. I know they work, if he gave us the dough, we could get more service dogs, we only have a limited number of training facilities so we have to build that up... blah, blah, blah. Alice, and she was right in a certain context, told the minister we weren't sure yet. There wasn't a really good evidence base, and so he should give her the money and she should do the research and then let him know. We went back and forth. Minister Fantino said we were going to go the research route. We went the research route. The research proved what we knew worked. Common sense told us it worked. A hundred veterans told us it worked. I said now we've got evidence, would he give us some money to start working this out. And he said no, they were right out of money.

It's so discouraging to get involved in that kind of a process, and my apologies for being so long about it.

Mrs. Cathay Wagantall: No, I appreciate that.

Mr. Dave Gallson: Can I add to that really quickly?

In the last few months, we brought people from across Canada to Perth to take this project trauma support, and they've already gone back to their communities and created four different peer support programs.

Right now I'm working with True Patriot Love. I'm trying to raise $350,000 to expand this program with the research component over the next 12 months. I was at Queen's yesterday. Heather Stuart is happy to do the research on this for free, so there we'll have the evidence base, but I need $350,000. We're going out fundraising with our hat in hand.

Mrs. Cathay Wagantall: I know of a group from Saskatchewan with all the research done. They are functioning as a charity to create exactly that, service dogs that would be provided to our veterans, not at $20,000 or $30,000 a piece, but free of charge. This is where I get really frustrated in looking at the dynamics of what should be done because it can be done, and the bureaucracy slows everything down.

Mr. Dave Gallson: I'd be happy to send you our PTSD ask, so there you go. There's a good answer. There's some meat in the oven for supper.

Mrs. Cathay Wagantall: Yes.

Mr. Dave Gallson: It's a start. It's bringing everything together and it's starting the ball forward. We can sit around and talk about this, but I wouldn't be doing my job if I wasn't sitting here saying that we need to throw some money at this right now. People are losing their lives.

● (1650)

Mrs. Cathay Wagantall: Exactly.

Mr. Dave Gallson: There's a program in the United States; twenty-two veterans a day are taking their own lives. We have to change this and we have to do it with some concrete steps.

Mrs. Cathay Wagantall: We have to deal with the crisis we're in, but I would like to see us cut the head off the dragon. Right off the bat there are so many ways that people are saying they could help if DND would keep these people in service, paid, until they are truly ready to be released with all of the supports they need. I think that's a direction we need to go in as well.

I've probably used my time.

The Chair: In fairness, I'm going to give you an extra minute, because I think everybody else has had at least that much today.

Mrs. Cathay Wagantall: Where do I go?

Col Russ Mann: If you like, I could add something.

You talked about transition and the loss of identity, but I think it's important to also, perhaps, reframe that. It's the loss of sense of purpose that puts people like me in crisis. If you want to compound that with the stresses Mr. Kitchen referred to, all you have to do is break our circle of support. Right now, the government has structured transition to break the circle of support. DND and Veterans Affairs do not act as a continuum in the transition spectrum. They act as two separate entities, with separate frameworks and separate operating methods. To the family and the veteran in transition, that feels like it is breaking their circle of support.

We don't lose everyone. The question came up about how we screen for post-traumatic stress. An example of the circle of support is actually outside the establishment, but connected by the establishment. My own case of mental health diagnosis, post-traumatic stress, was done by a civilian psychiatrist who I was referred to by my GP at the base. My military doctor said, “I'm not sure what's going on. Let's refer you to someone who might be able to explore further.” The reason I showed up at my GP's was because of my circle of support, my family and friends. My wife said, “There's something wrong.” My friend said, “What's going on?” when I broke down one day at work for no good reason.

There's an important element there of continuity of care even if you're not case-managed. Continuity of care means you feel supported during transition. That's the effect that government should be an active partner in delivering.

The Chair: Thank you.

Mr. Eyolfson is going to split with Mr. Graham, I believe.

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

Thank you, everyone, for coming.

I'm a physician. I've practised emergency medicine for 17 years, so of course, we would often see the different aspects of mood disorders either previously diagnosed presenting or sometimes we would see a first diagnosis. Mr. Upshall and then Mr. Gallson, in reference to mood disorders, one of the things we have always known about is the link—in young people, particularly, but in all groups—between substance abuse and mental illness. The link is clear; the causality isn't as clear as a chicken-and-egg thing. We do know, and I've diagnosed this on more than one occasion, that when a young person is brought in with a drug problem, it turns out their symptoms of mental illness actually predated the drug use.

Mr. Philip Upshall: They're self-medicating.

Mr. Doug Eyolfson: They're self-medicating, exactly.

We suspect that there are many people walking around who are in the justice system because of their substance abuse. They have been drunk driving, and have been fired from their jobs for their substance.

Is there a concerted effort, as part of your education of health care providers, to say that if there's a substance problem of any sort, one of the first things you should look for, in addition to treating the substance abuse, is an underlying mental illness?

Mr. Philip Upshall: It comes up, but it's not a principal goal of ours, to be frank. It would be if we had more money to provide the services. Then, we could. One of the issues with emergency physicians, who I love dearly.... However, with the triage pyramid, the difficulty was, unless you were suicidal, you were down with slight abdominal pain. Very few people going into emergency could wait the eight to 10 to 12 hours that slight abdominal pain required.

On our website is Jenny's story. Jenny is the daughter of one of Canada's past assistant chief public health officers. She was what we call a cutter—you would have seen a number of them. The effort it took us working collaboratively with her to get her help was beyond belief. This was a senior public health officer in Canada, and it was in Ottawa.

We met with the emergency physicians. The willingness to accept mental health issues as important when they appear in emergency room settings has not been what I would call receptive. I would hope, over time, that the recognition, as we continue to educate, will indicate that it doesn't have to bleed to be an emergency. Psychosis is just as much an emergency as a heart attack. We would argue that if you like, but my opinion—

● (1655)

Mr. Doug Eyolfson: No, I couldn't agree more. Psychosis and depression kill the same way heart attacks do.

Mr. Philip Upshall: Yes, exactly. We're on the same page.

We support the federal government in its efforts to push the provinces to put more effort and money into mental health resources. What we're hoping, with the minister of Health and her efforts on mental health issues, is that the minister herself will start to say, “Look, addictions and mental health are too closely aligned to be separate.”

We need all the provinces to bring mental health and addictions together, and then we can work with community groups that are combined in the provinces. Federally, addictions are here, and mental health is over there. I'm sure I'm not telling you anything, but the silos in addictions and mental health, particularly in research and in clinicians, are beyond belief. It's incredible.

The Chair: Thank you.

Mr. Graham, you have a couple minutes.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Ms. Pizzuto, I have a quick question for you.

I come from a large rural riding. It's a little smaller than the state of Vermont, and so I'm always concerned how somebody who needs services like yours can find them. How does someone who needs to call the crisis line find the crisis line to call in the first place?

Ms. Breanna Pizzuto: That's a good question.

It's on the Internet, if they have it. If they don't, we try to get our cards and pamphlets out to as many doctors' offices, libraries, lawyers' officers, and counsellors' offices as we can so that the number is there. We try to spread the word from mouth to mouth so, if they happen to disclose to a friend or family member, that friend or family member might know of our service and refer them to it.

Mr. David de Burgh Graham: In the case of John, have you reached out to Veterans Affairs yourself to see how they can help from the other side, or do privacy laws block that?

Ms. Breanna Pizzuto: Yes.

Mr. David de Burgh Graham: At what point does the urgency of a situation trump the privacy laws to allow you to intervene in some other way besides—

Ms. Breanna Pizzuto: When there's a life immediately on the line. John's life is, to some extent, always on the line, but if his life were immediately at risk, we would have to overstep confidentiality. In this case, it would be outside of our service mandate to reach out to Veterans Affairs on his behalf.

Mr. David de Burgh Graham: Can you do it in a non-specific way? Like, we have this situation, what can you do for us? Or not even that?

Ms. Breanna Pizzuto: I suppose. It goes back to John's willingness to even deal with Veterans Affairs. At the end of the day, if he's had it with them, he's not going to seek out their support no matter what we do.

Mr. David de Burgh Graham: That's a good point.

If we get to the point where Veterans Affairs does have the confidence of some veterans, and we want to rebuild John's confidence, how do we bring him back in? I'm not sure how to phrase this. Veterans Affairs is going to have to change over time to accommodate people like John. How do you bring them back in? How do you convince them that it's okay now, you can trust them now?

Ms. Breanna Pizzuto: Don't let them leave in the first place.

Mr. David de Burgh Graham: That ship may have sailed. I'm trying to figure out how to....

Col Russ Mann: Peers.

Ms. Breanna Pizzuto: Yes.

Col Russ Mann: Peers bring more of us out of basements than anybody else. It's peers who get us to understand that we can go somewhere and seek help. The service offered here, if it connects people to another peer or makes them aware of other peer services, could become a potential referral that eventually leads to a referral to seek professional help.

I'm not scientific, but the best case I know of with people I have commended and people I have worked with is peer referral.

● (1700)

The Chair: Thank you.

Mr. Kitchen. I believe you're splitting your time with Mr. Shipley.

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

Very quickly, Ms. Spinks, you tweaked my interest when you made a comment about support for families after a crisis. Can you expand on that?

Ms. Nora Spinks: One of the things we've heard from families is they identify as a military family. They're a military family forever. Oftentimes what happens is the care that's available, as limited as it might be in some locations, is focused on the individual. It's partly silos, partly privacy, but an individual is going to get care. But it's the family affected by that crisis that also may need care. So it's those kids who Phil was talking about. It's those classroom teachers who see this little 10-year-old crying at his desk and need to reach out.

We haven't yet come up with a good way to provide comprehensive, family-based support, whether it's health care community services or the like. Yet we know that if families are there, they're the ones who are going to provide the linkages. They're the ones who are going to provide the connection. They're the ones who are going to be there in that basement at three o'clock in the morning to call the crisis line. We need to think more holistically.

In most provinces now all their health care services are patient first. What about the family first, the circle of support that is going to make that treatment a success, that is going to provide the continuity, the navigation, that's going to be there when they need to reach out for support?

Mr. Robert Kitchen: Do you perceive that families after a crisis, in particular a suicide, are abandoned by that?

Ms. Nora Spinks: I can't speak specifically for VAC, but by and large families are neglected after a crisis.

Mr. Robert Kitchen: Would having some of those services provided by VAC be a valid service?

Ms. Nora Spinks: We're certainly hearing from spouses and family members that they too have a need for peer support. It's being able to chat with another spouse at three o'clock in the morning because they finally got their partner back into bed, calmed down, asleep and resting. Now they're wired and so they need somebody to talk to as well. Having peer support for the spouses or the parents who are managing the situation on a day-to-day basis has been seen to be really important.

As Phil mentioned, to connect that back to the data building, the knowledge sharing, is critically important. We talk a lot about evidence-based programs. We also had evidence-inspired and evidence-informed. A lot of that happens among families. It's not just evidence-based experience, but it's experience-based evidence. When listening to those families, it doesn't take much to get them talking. It does take much to trust them to talk a second time if you don't listen to them in the first round.

How do you support those veterans? You start talking to them from the day they enter the military, and you continue that all the way through and try not to pass the buck. It doesn't work.

Mr. Robert Kitchen: Thank you.

Mr. Upshall, you talked about knowledge translation. I appreciate your comments on that because it's very important. Being a primary care practitioner myself, I've always gone to seminars, etc. What's my take-away from this seminar? What can I do the next day in my office?

This is an issue that I think a lot of primary care practitioners do not know about. Would you agree that it would be worthwhile that all regulatory bodies mandated that their primary care practitioners had a CME program such as you're suggesting, such that every practitioner might be able to have an understanding of what to do the moment someone who has a veteran's experience walks into their office?

Mr. Philip Upshall: I agree absolutely. We go further than that, however. We've approached the Royal Society; we hit a brick wall on that. But it's important for the entire spectrum of health care providers to understand mental health issues.

I'm outside the veterans side of things now, but we've moved back also to trying to get the medical educational community, particularly at universities, to understand doctors and to get new doctors trained in mental health, just as they're trained in cardiovascular and other issues. Unfortunately, up until very recently they spent hours on cardiovascular issues or on cancer and maybe half an hour or two hours on mental health issues.

As I'm sure you all know by now, mental health issues are comorbid with cancer, cardiovascular disease, diabetes, PTSD—you name it. Depression particularly is almost always present in all those chronic illnesses.

We would be entirely supportive, but it's a major project, because we have these historical silos. We have organizations that insist, and this is true in Health Canada and in Ontario Health as well, that, "We've always done it this way. For years we've done it this way, and this is the way we're going to do it." We have to beat our heads: we continue to do that.

We support it. That's the short answer.

● (1705)

The Chair: Thank you.

Mr. Shipley, Mr. Kitchen has left you a minute.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Mr. Chair.

Thank you all for coming out and being so forthright.

I was on the veterans committee a few years ago, and the unfortunate part is that we were talking about the same sorts of things. This is not to say that things haven't changed; it's just that the situation seems to multiply on top of itself a little bit. DND and veterans constitute a big problem. It has been big, and it seems it hasn't resolved itself yet.

One thing I wanted to ask, though, concerning mental health and PTSD, is about the psychological effects and then about what professionals they are referred to. At one time it was a concern—and you mentioned it—that 95% of PTSD is attributable to the experiences shared by all Canadians, and so when they go to a psychiatrist or psychologist, 5% is attributable uniquely to the military, either to combat or to specific causes.

Is it true, though, that this percentage may be higher than that, if the professional has never walked in their boots, has never shared that same experience of combat and the sorts of things they have to deal with when they get back?

Are there enough professionals to meet the demand? I guess that's really my question.

Mr. Philip Upshall: No, there aren't enough.

The Chair: You'll have to keep your answer in the minute also.

Mr. Philip Upshall: These demands are very difficult.

The issue is that you're talking about a specific veteran's trauma activity that the professional may not have been involved in and may not have had boots on the ground for or whatever.

If the professional is properly trained they will be able to ask, “What's your background?” and in their discussion get issues of trauma coming out. The trauma could be early childhood abuse; it could be residential schools; it could be whatever. In this instance, it's a military activity.

The doctor should then be able to say that there is somebody to refer you to who has specific experience in this, but it would be focused on that 5% or maybe 10%. That to me is the way to go, again from the community point of view.

Mr. Bev Shipley: Thank you.

The Chair: Ms. Mathyssen, we'll end with you now.

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

Thank you to the witnesses.

I wanted to say to you, Mr. Upshall, it's interesting that you talked about the research that had to happen before the service dogs could be utilized, and the research took up all the money, so there were no service dogs. That question was asked early on of the assistant deputy minister, who said, “Well, the research is not conclusive with regard to how effective these dogs are.” I sympathize and understand your concern about this never-ending circle.

We're going to be writing a report here, and I want to underscore some of the things that I think should be in the report.

I'll start with you, Nora.

We're talking about the importance of the family. It's a critical part of a veteran's wellness. You talked about them dealing with the issues and the need to have the tools to deal with them. We've heard from spouses that they need training, specific training. How do I deal with and cope with and help this veteran, who is a different person from the one I met and married 10 years ago? We need marriage counselling, because marriages are unravelling, relationships are unravelling. We need mental health care for the spouses and the children, and that comes back to what you said about respite care, because you can't do this 24/7. Finally, we need access to VAC for better care with regard to the family's and spouse's needs. That should be in the report, yes.

The second thing—and it goes back to what Ms. Wagantall was talking about—is making sure, as the military ombudsman recommended, that everything is in place before that veteran leaves the military—the pension and the health care. Would more active involvement by mental health workers be an important thing to add in there? That's so that they're not financially vulnerable, so that they have these coping mechanisms for what is going to be a remarkably stressful, difficult change in life because they are, and always will be, military. They just don't have the accolades.

If we include those things, are we on the right track?

● (1710)

Mr. Philip Upshall: I'll shut up because I've had too many lately —

Voices: Oh, oh!

Mr. Philip Upshall: —but I have some views on the matter, if I can have a minute later on.

A voice: Oh, sure.

Ms. Irene Mathyssen: That's up to the chair, and you know he's brutal.

The Chair: Go ahead, and we'll wind this up.

Mr. Philip Upshall: Well, first of all, you haven't mentioned this, and I meant to mention it earlier. One of the things that you can do—and I'm sure everyone would agree—is recommend the provision of system navigators. It's really important, and a trusted system navigator—not a guy like me, but a guy like Russ—who knows his stuff can take a person by the hand. When you're in crisis, you don't know who to call, you don't what to do, and you don't know where to go. Even before you're in crisis, when you're in the discharge phase, if there's someone who says, “I will take your hand and I will work with you”.... We found it terrific in hospitals. If you have a system navigator, you can get somebody discharged and get them the help they need as opposed to saying, “Look it up on Google”. System navigators would be very helpful, and I'd certainly recommend that.

I'd recommend funding peer support for family caregivers as well as for veterans. Mood Disorders Canada is a peer-support community for both patients and families.

Those would be the key things. I'm going to leave it to everybody else, because otherwise I'll keep going.

Mr. Dave Gallson: I'll just add one thing to it. Speaking of family physicians, you have to remember that family physicians have a business to run as well, and they've only got a limited amount of time to see a patient. We have found that there are a lot of family physicians who don't know all of the resources that are available in the community and therefore cannot take a patient and say, “Hey, listen, you have to go down to this group over here and go meet with them because they have some services down there that would really support you.” It's not just all about a pill, a prescription, and stuff. A whole wealth of resources needs to be implemented, too, for wellness.

The Chair: Thank you, all. This ends today's panel. Bells are going to ring in a minute here.

I'm sure I speak for all of us in that we could probably do another round. The information and testimony you've given us today have overall been excellent. On behalf of the committee, I want to thank all of you and your organizations, not only for your testimony today, but for what you do for the men and women who have served.

If there's any other information—and I know, Mr. Gallson, you said you had some to send to us—you could send it to the clerk, and he'll get it distributed throughout the committee.

Can I have a motion to adjourn?

This meeting is adjourned.