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Chair

Mr. Rick Casson

Standing Committee on National Defence

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● (1530)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): I call the meeting to order. Today we start our study on health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

We have Major-General Walter Semianiw, chief of military personnel, and Brigadier-General Hilary Jaeger, commander, Canadian Forces Health Services Group, director general of health services, and Canadian Forces surgeon general.

We'd like to welcome you both. I don't think appearing in front of a committee is new to either one of you. We'll give you the time you need to make a presentation. I understand there's going to be just one presenter, and then we'll start our rounds of questions.

We have been waiting with anticipation to start this study. It's been on our agenda for some time, and now we've got some of the issues we've dealt with out of the way, we're looking forward to this study and the forthcoming report. We think it's a critical time right now in the history of our armed forces due to the fact that we are deployed, so we want to make sure that not only are we providing them with the proper equipment and support services while they're in the field, but when they need help, the appropriate help is there for them as far as health issues are concerned.

I'll turn it over to you and we'll give you the time you need to make your presentation. Then we'll start the questioning.

Go ahead, sir.

[*Translation*]

MGen Walter Semianiw (Chief of Military Personnel, Department of National Defence): Mr. Chairman, members of the committee, ladies and gentlemen, thank you for having invited me to appear before your committee to speak to the health challenges involved in consecutive deployments.

I am MGen Walter Semianiw, Chief of Military Personnel of the Canadian Forces. With me today is Brigadier-General Hilary Jaeger, Commander Canadian Forces Health Services Group, Director General Health Services and Canadian Forces Surgeon General.

[*English*]

My mission as the chief of military personnel for the Canadian Forces is to recruit, train, prepare, support, and recognize military personnel and their families for service to Canada. I'm therefore responsible for implementing programs and services that promote the medical, mental, and spiritual well-being of military personnel.

It has been abundantly clear since the beginning of Canada's mission in Afghanistan that the Canadian public demands full-spectrum, high-quality health care for our men and women in uniform, those whose health has suffered as a result of military operations. Accordingly, we have made care of the fallen, the injured, and their families a top priority for our organization. At the time, it's critically important for military personnel to be healthy, fit, and ready for deployment in order to fulfill Canada's military commitments at home and abroad.

Soldiers, sailors, airmen, and airwomen are the most complex, sophisticated, and valuable systems in the Canadian Forces. It takes an equally complex system to keep military personnel in top form, to care for them, and to help them recover when they suffer injury.

Health care services for personnel of the Canadian Forces are provided by uniformed and civilian health care providers working in the Canadian Forces Health Services Group under the command of Brigadier-General Jaeger.

The Canadian Forces Health Services Group is a multi-faceted organization with approximately 120 different units of varying sizes in different areas around the world. The units can range from a large group of about 300 health service personnel on bases such as Valcartier or Petawawa to two personnel providing health care support on any of Her Majesty's ships or at Canada's most northern military station at Alert.

Canadian Forces personnel are offered a full range of health services, from health promotion and illness prevention to treatment and rehabilitation. If the health care clinic on a particular base cannot offer a required service, then that service is purchased from the civilian health care sector. Arrangements have been made across the country to ensure that regional care is provided close to the member's immediate family and support system, which is a foundation of the conceptual construct that we have in place.

Relocation away from extended networks of family and friends is a part of military service that military members selflessly accept. This creates difficulty during times of illness or following an injury. A strong social support network is an essential ingredient to the successful recovery from any significant illness or injury. In recognition of this, the Canadian Forces has instituted a number of programs and services, such as the operational stress injury social support network, the return to work program, and an evolving enhanced local casualty support capability.

I'd be remiss if I did not take this opportunity to also mention the services available to our families. Although the Canadian Forces is not mandated to provide direct clinical services to family members, some examples of the types of assistance available that we provide include Canadian Forces social workers and other mental health professions who provide counselling to the entire family, if required, as part of the healing process for the individual suffering from a mental health illness, that being the member. There is also the Canadian Forces member assistance program, a confidential service available through a 1-800 number 24 hours a day, 365 days a year. It is available to family members who need psychological, financial, legal, or spiritual assistance. On a personal note, I have personally used this system and I can attest to the fact that it has provided me a response within 24 hours. The operational stress injury social support network also has a family support program in place. And finally, military family resource centres at bases all across Canada offer a myriad of services for family members.

For certain patients requiring longer-term, ongoing care, navigating through a maze of civilian health care providers and Canadian Forces clinical services can prove challenging. That is indeed a fact.

● (1535)

Members also face uncertainties when they're released from the Canadian Forces for medical reasons and are required to obtain health care services and benefits from Veterans Affairs Canada or through a provincial system. To coordinate and simplify this process for the individual, the Canadian Forces has put in place a robust care management program.

Case managers service a primary point of contact for the member to help them navigate effectively through the military and civilian health care systems. In addition, several Canadian Forces health services clinics are located in larger cities where much of the initial casualty management and treatment for seriously ill or injured members is done in civilian facilities. To maintain close liaison and to follow up the Canadian Forces individuals who are admitted to civilian facilities, the Canadian Forces Health Services Group employs link nurses, that is, nurses who act as a link between the military and civilian health care system.

I now wish to elaborate on mental health services that have recently seen dynamic changes to increase capacity to deal with post-deployment mental health care, an issue that I'm sure will be examined here as part of this committee.

In the latter part of the 1990s, instances of post-traumatic stress disorder and other psychological injuries began to appear in military personnel following deployment to the former Yugoslavia and peace support missions in Africa. To effectively manage this need for specialized mental health care, the Canadian Forces established five operational trauma and stress support centres, which we also call OTSSCs, which opened in September 1999.

The mental health care providers, working in the operational trauma and stress support centres, provide comprehensive assessment and treatment for operational stress injuries such as post-traumatic stress disorder, using a standardized, interdisciplinary model of care. In her November 2007 report on Canadian Forces health services, the Auditor General did state that the Canadian Forces is employing a best practice in the mental health field, that is, an evidence-based practice whereby its qualified professionals in social work, addictions counselling, and the treatment of mental health illness take part in training and have access to the information and development in treating mental health illnesses in order to keep up in their profession.

Canadian Forces personnel also receive psychological fitness training throughout their career, beginning with their initial recruitment training. This training provides them with tools to help them look after their individual well-being or with the skills they require to help others. For example, leaders learn how to recognize and react to stress conditions in their subordinates. Medical personnel receive clinical training in recognition and treatment of mental illness, and mental health professionals receive in-depth, specialized training.

For the current mission in Afghanistan, mental health providers, consisting of a psychiatrist, a social worker, and a mental health nurse, are assigned to each rotation. These professionals take part in the pre-deployment training and are part of the overall health care team based in the Kandahar airfield. Deploying mental health professionals has been an invaluable tool in preventing and providing early intervention for operational stress injuries.

One area of ongoing concern that has been recognized is the reluctance of soldiers to come forward when they experience symptoms. This is being addressed through an outreach educational effort to change attitudes within the Canadian Forces toward those suffering from mental health illness. The Canadian Forces operational stress injury social support peer network has also made significant inroads to break down barriers to receiving care and to reducing the stigma associated with mental illness.

One very important tool in early detection and in addressing the stigma is the post-deployment screening of personnel who have returned from Afghanistan. The screening is intended to take place between months four and six after returning, although nothing prevents an individual who has any concerns from coming forward to seek help at any time. Unit commanders are accountable to ensure their personnel complete their screening. As well, commanders who recognize there is an issue with a particular individual are aware of the resources that can be used for support and are fully encouraged to move as quickly as possible, when an instance arises, to provide that support.

Since 2003, when the Canadian Forces received the results of a Statistics Canada survey on mental health within the Canadian Forces, massive changes have taken place in mental health. A national mental health strategy, known as the Rx2000 mental health initiative, was developed. It is close to being finally implemented.

● (1540)

By 2009, the Canadian Forces will have nearly doubled its mental health human resources, going from 229 to 447 mental health professionals involving an estimated $98 million.

Let me close by stating that the Canadian Forces health care system is the 14th medical system in Canada and must mirror all aspects of care for its military personnel that are provided by an individual provincial health care system. It has the added and most significant responsibility of caring for those who are injured on operations, nothing a provincial system must do up front.

I'd like to stress that medical mental care is available for the asking to any member of the Canadian Forces. There is a robust and adaptive system to ensure that those with post-traumatic stress disorder and other deployment-related health problems get promptly identified, appropriately supported, and effectively treated.

Men and women of the Canadian Forces are getting the care and support they need. This is corroborated in the May 2006 report by Senator Kirby, entitled *Out of the Shadows at Last*, where he states:

> The Committee is pleased that the Department of National Defence offers such a wide array of services to Canadian Forces members who may experience mental health problems. The provision of services for family support as well as medical treatment and casualty support is commendable.

Ladies and gentlemen, Chairman, I thank you for this opportunity to address you, and I look forward to your questions at this point.

The Chair: Thank you very much.

We will immediately get into the questioning.

The opening round is for seven minutes from each party, and we'll start with Mr. Coderre.

[*Translation*]

Hon. Denis Coderre (Bourassa, Lib.): Thank you, Mr. Chairman.

I would like to begin by thanking you for being here. I had the honour of visiting the military hospital at the base in Kandahar, and I witnessed the professionalism of our people and your extraordinary contribution. I also spoke with the psychiatrist, who gave me a good briefing as to the situation on the ground. Congratulations are in order: I liked to what I saw.

I have several questions, and here is the first.

[*English*]

General Jaeger, I'd like to know how many injured we have in our Canadian Forces since our mission began in Afghanistan.

● (1545)

Brigadier-General Hilary Jaeger (Commander Canadian Forces Health Services Group, Director General of Health Services and Canadian Forces Surgeon General, Department of National Defence): Interesting, sir, that you've addressed that question to me, because as the Auditor General's report points out, I work for an organization that is very good at collecting individual data points but not very good at rolling them up collectively.

On the other hand, General Semianiw has brought that injury data with him, so I'm going to turf that one over to him.

MGen Walter Semianiw: Thanks a lot, Hilary.

I know that question has been posed here. Clearly, to balance those two very much competing interests, the need of the public to know and the need for military security, we can tell you that the Canadian Forces policy on the release of the wounded in action statistics was changed in mid-October 2007—

Hon. Denis Coderre: Excuse me, General. I went through that with General Atkinson already.

[*Translation*]

MGen Walter Semianiw: I have more information.

Hon. Denis Coderre: I would like to get the numbers right away, because we only have seven minutes.

[*English*]

MGen Walter Semianiw: The information will now be raised and provided at the end of each calendar year. That decision was made in mid-October 2007, and I have that information with me today. Just to remind you, the information is broad; it's not specific. It needs to be broad.

First we have to take a look at it in the broad sense of how many Canadian Forces personnel have served in Afghanistan over the years from 2002 to 2007. From our information at this point—because this information has come to me some time today—we're looking at approximately 20,000 Canadian Forces personnel who participated in the theatre of operations and supported it throughout those seven years.

Having examined that, that's from 2002 to 2007, and the information I have is up to date as of the close of 2007. That information is organized into a number of areas for you, organized into first—and there are different types of injuries, non-battle injuries that range from individuals who may have broken their small finger...and I'll go through them in a minute—

[*Translation*]

Hon. Denis Coderre: General, I've many more questions for you. Can you give us the numbers right away, if you don't mind?

[*English*]

MGen Walter Semianiw: *Oui.*

If you take a look at the overall numbers of injuries, among the 20,000 personnel who have been there since then, the total number of deaths and injuries has been 749. When one looks at it from a purely percentage point of view, the numbers do come down, and looking at the different categories, they have been organized as non-battle injuries, wounded in action, non-battle deaths, killed in action, and total deaths and injuries. I think an important point to make is that we ensure that we look at this number within that perspective, to ensure we have an informed discussion on this, not just the overall number affected.

[*Translation*]

Hon. Denis Coderre: I understand, General. I see that you have a chart. That should be handed out to everyone and then I can move on to my other questions. Is that all right with you?

There are physical injuries, but there are also psychological ones. With regard to that issue, there are many taboos and we still don't really understand post-traumatic stress syndrome. I would like to know two things. First, we have been told that when our soldiers are sent on three or more deployments, there is a higher level of post-traumatic stress syndrome. I would like you to explain this phenomenon to us.

This leads me to the decompression stage. After every deployment to a theatre of operations, before going home, there is an important period of decompression. I was told that this happens in Cyprus and Thailand. In any case, the soldiers are guided through a process of decompression. I would like you to explain to us what happens when a soldier goes through the decompression process. But could you first tell us whether you are concerned that the post-traumatic stress level increases after several deployments.

BGen Hilary Jaeger: Thank you for your question. It makes sense that a soldier has a higher level of post-traumatic stress after several missions, because the more often one is deployed, the higher the likelihood that one has experienced something extremely stressful. Based on our most recent data, we know that, with regard to the people who have come back from Afghanistan, those who have experienced the most extreme shocks are most likely to suffer from post-traumatic stress disorder, which only makes senses. I do not think it surprising that the level of post-traumatic stress is higher after three deployments.

As far as decompression is concerned, please understand that this process was not created to decrease the level of post-traumatic stress. Rather, the point of decompression is to make it easier for a soldier to go home again, which is not the same thing. It is to reduce the tension which can arise when a soldier goes from a theatre of operations to his family the next day. Everyone thinks that it will be great once they are home, that there won't be any problems, but that is not the case. While the soldier was gone, the family has reorganized the way it functions—

Hon. Denis Coderre: There are ups and downs.

BGen Hilary Jaeger: —and when the soldier returns home, things have changed.

● (1550)

Hon. Denis Coderre: But do we agree that decompression is also a good way to identify post-traumatic stress? I was told that some people had expressed concerns during the decompression process because it seems that the level of stress had gone up amongst the soldiers.

BGen Hilary Jaeger: We are always willing to provide treatment and we take advantage of the process to inform the soldiers that help is available depending on what they need. This is an important part of the decompression process.

[*English*]

The Chair: Thank you, Mr. Coderre.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you, Mr. Chairman.

If I understood correctly, you said a few moments ago that over seven years, 749 troops had been killed out of a total of about 20,000 who had been in a theatre of operations. You have a chart before you; we had agreed that we would look at it.

What is the most frequent type of injury? How is that broken down? I understood that you broke down the types of injuries, and I understand that someone who falls off his chair at the office is not injured to the same degree as he would have been in combat. You said that some injuries were sustained in combat. General, is there a breakdown by type of injury in your chart?

MGen Walter Semianiw: It is in the chart.

As I said, it is broken down by

[*English*]

non-battle injuries.

[*Translation*]

So, you are correct.

[*English*]

If I fell off my chair and got injured and had to be sent home, I'm included in that 749.

[*Translation*]

Conversely, there are injuries sustained in battle.

[*English*]

So it goes from one extreme all the way to the other extreme, which is why I come back and say that it's important to look at all the categories, to get an accurate reflection of what actually happened.

When you look at it—and you're going to see it, so I'll give you a little bit more here. Take this figure: wounded in action, 280. So now the number starts becoming a little bit more crystal, a little clearer: 280 wounded in action, from an overall 749.

There were 395 non-battle injuries. I wanted to mention this when the first question was posed, but I was asked to go to the end. Nevertheless, 395 is the number of non-battle injuries.

[*Translation*]

So as you said, it is as if I had suddenly fallen off my chair.

[*English*]

Then you have wounded-in-action, non-battle deaths; that's another issue. I would tell you, I've been in Afghanistan for six months, and to answer your question, what is the biggest piece, the biggest piece is non-battle injuries.

● (1555)

Mr. Claude Bachand: Non-battle?

MGen Walter Semianiw: There were 395 non-battle injuries, which happen, because, remember, we still....

[*Translation*]

For instance, when I was in Afghanistan, I went to the gym every day to work out. But if suddenly there was a problem

[*English*]

and I injure myself. It's still an injury, which is recorded.

At the end of the day, I have to provide that support to that individual as much as I do to the individual who is injured in combat.

[*Translation*]

So it is very important to look at the files in detail.

[*English*]

looking at each column.

[*Translation*]

Mr. Claude Bachand: How is the medical services budget spent?

Ms. Jaeger, do you have an annual budget?

It is fairly difficult to establish a budget at the beginning of the year. For example, if one year we decide not to go to Afghanistan, and the following year, we stay home, the budget will be different. How much did those 749 wounded troops cost taxpayers?

You could always send me the answer in writing.

BGen Hilary Jaeger: That is a fairly complicated question. My annual budget is approximately $300 million, which does not include pay for the troops, but only salaries paid to civilians and Blue Cross employees. That amount also includes things like medications and preparations, but not the troops' salaries. The amount also does not include things which are directly related to the operation in Afghanistan. It's what we call

[*English*]

SDOA, special duty operations.

[*Translation*]

We have an additional budget for that.

Mr. Claude Bachand: What is your additional budget?

BGen Hilary Jaeger: I will have to check. I think it is about $24 million.

MGen Walter Semianiw: I would like to add something important to this discussion, Mr. Chairman.

[*English*]

Remember, throughout the year each department asks for additional money as part of its annual allocation. So in the Department of National Defence, I do go back to the department, clearly, and say, “Could you provide me with additional money, because General Jaeger needs that?”

So we provide that throughout the year to be able to meet this demand, to be able to say money does not prevent.... The department has provided me with a very simple line: money will not prevent our providing the support our men and women in uniform need. And that's where we're at right now.

[*Translation*]

Mr. Claude Bachand: Thank you.

Mr. Semianiw, a little earlier you talked about how important it was for your officers to be well prepared. Can you explain to us the role of a group's tactical commander after a very intense engagement? Is there someone in charge of calming people down or is everyone given a strong cup of tea, for instance, to calm people down? What can be done to prevent post-traumatic stress disorder from developing?

You also said that your officers were well trained in identifying post-traumatic stress syndrome. Is there a prevention program for everyone who enters a combat zone, not only for officers, but also for regular troops? Are they told what to expect? Would it be possible to create a program based on prevention to educate troops on how to deal with post-traumatic stress disorder?

BGen Hilary Jaeger: In order to prevent illness and to prepare the troops, the most important thing for a soldier is to be well-trained in his or her area, to have faith in his abilities as a combat soldier, as a member of an armoured unit, as an artillery officer, and to receive realistic leadership training which will be put to the test during the mission. It is this type of teamwork which can really help to deal with various situations.

It is the job of the leaders, after a major or shocking incident has occurred—in an informal manner—to sit down with the soldiers and to talk about what has happened, to go over what was done well and not so well, to see how everyone is dealing with what happened, and to determine whether things are good.

This process, the simple fact of sitting down as a team, is very important. It is much better than bringing in a psychologist; that approach does not work very well.

After a major shock, the thing that can help an individual not to develop post-traumatic stress syndrome is to receive good social support, be it either from one's military family or from one's real family. That is what a soldier needs to deal with a major shock.

If I may, Mr. Chairman, I would like to point out that our leaders are not trained to diagnose post-traumatic stress disorder. They are trained to see if something is not right, is not normal, but they do not make a diagnosis, because the problem may not involve post-traumatic stress disorder.

● (1600)

[*English*]

The Chair: Thank you.

Mr. Comartin is next.

Mr. Joe Comartin (Windsor—Tecumseh, , NDP): Thank you, Mr. Chair.

Thank you, Generals, for being here.

I have a quick question, Major-General, on the non-battle injuries. Would that number include motor vehicle accidents using military vehicles as opposed to regular vehicles?

MGen Walter Semianiw: Mr. Chair, could I read the definition, please?

> The non-battle injuries include those injured as a result of traffic accidents, the accidental discharge of a weapon, any other accidental injuries not related to combat. It also includes those members reported ill, repatriated for compassionate reasons and repatriated for medical reasons. At the end of the day it's a very broad category.

Mr. Joe Comartin: There was one incident in which we actually lost one of the soldiers. They were moving between bases and the vehicle tipped. Would that fit into the non-battle injury category?

MGen Walter Semianiw: No, it's not an injury then. If he died, he fell. Then it would be a death. There's another column that shows death due to battle and death outside of battle. There are cases, as you know, in which a soldier has died in a traffic accident. That would be down as a non-battle death, which I think is being very unfair. At the end of the day, it doesn't matter how our soldiers, sailors, airmen, and airwomen fall in the theatre of operation; they still fall for the nation. At the end of the day, they fell.

Mr. Joe Comartin: Are that definition and those figures all in that material you're going to send to us?

MGen Walter Semianiw: I brought it all here for you today.

Mr. Joe Comartin: General Semianiw, it was you who at the public accounts committee talked about a seminar or conference you were having yesterday and the day before. You were going to look at best practices, if I can put it that way. First, did that go ahead?

MGen Walter Semianiw: I can respond to that. It's a great question.

We had the conference over the last few days at the Ottawa Congress Centre, and 450 individuals came from all provinces across Canada. The injured, their families, care providers, and individuals in the chain of command all sat down over those two days and looked at themes. The aim of it all, Mr. Chair, was how we can do things better. It did happen. It was opened by the Chief of the Defence Staff, General Hillier.

I was there throughout much of it. It fell to me...General Jaeger was with me. Clearly, it's a partnership of both of us. I'm not a doctor, I'm an infantry officer, but in the end we were both there.

It closed yesterday. It went very well, and they agree. It very much became a community of practice. I promised to bring them all back —I think I said in six months, but it will probably be closer to eight months—to see how we are doing and what we have done, but they have identified things they'd like to see us improve on.

Mr. Joe Comartin: Will there be a report coming out of that?

MGen Walter Semianiw: Yes, there will. We actually promised all of the participants that we would prepare a report for them of the results of the areas they would like to see. To be very clear here, I would tell you we were not surprised in any way with what we heard. I know we don't have the time here today, but I could very quickly tell you what those five or six areas are that we need to stay focused on within what we both do to ensure that our men and women in uniform get the support they need.

Mr. Joe Comartin: Will that report be public?

MGen Walter Semianiw: I have to look at that right now. There was no press allowed in so that people could speak openly on both sides. I'll have to look at that.

Again, I could tell you the results here today, but clearly you are not going to see details of an individual saying, here is what happened to me. You will probably see it more couched in terms of perhaps we need better integration and better coordination.

Mr. Joe Comartin: I want to follow up on Mr. Bachand's question around prevention. In particular, in this conference was there any discussion about additional training at the very basic level? Were there any suggestions of additional work that could be done there to prevent some of the stress-related injuries?

● (1605)

MGen Walter Semianiw: To assist the committee, I want to throw this back to the chair here. What are we talking about, mental health or physical ailments?

Mr. Joe Comartin: I am talking of mental health.

MGen Walter Semianiw: One of the six areas is mental health. We did discuss a number of issues around what we could do to help. If we had the time, we could lay out the many things that have been done. We did talk about doing more training. We have an OSISS peer support network in place. You are right, it is focused on the back end coming home, not the front end, the prevention piece. But we are starting an educational program that is actually beginning at LFWA. My special adviser on operational stress injuries, Lieutenant-Colonel Stéphane Grenier, is heading off to land force western area, working with General Jaeger and her teams, to start and to continue to move ahead with the educational prevention piece. What we are doing is actually putting it in our training for the privates and corporals as well.

Mr. Joe Comartin: Has your unit looked at other military units across the world? Have you done that kind of analysis in order to be able to present it to those people who do the training?

MGen Walter Semianiw: Not just on the mental health piece. Both General Jaeger and I can tell you.... I was just at Walter Reed last week. General Jaeger has been to many more places than I have. She is very connected with her counterparts on this whole issue. So the short answer is yes, in many, many ways to ensure that we don't have to reinvent the wheel, we pick best practices. In the American military they are looking at a thing called Warrior Transition Brigades—and I apologize, I know I'm going on too long here—and it is a way to better coordinate and to look after the injured. It is an idea we're looking at. So we are exchanging ideas amongst the different allies.

Mr. Joe Comartin: Have any recommendations you've made for changes in training been adopted or not adopted?

MGen Walter Semianiw: They've all been adopted because people have been told to do them. I went through the last committee, where I made the comment...people said we're bureaucrats at the end of the day, but we're not, we're leaders at the end of the day. We provide direction and people agree.

Mr. Joe Comartin: I am not sure who to address this to. We've seen the stories of families not getting adequate care. I saw in my home province of Ontario the conflict that went quite public around here at Petawawa for the children. Has that been cleared up or is it still a problem?

MGen Walter Semianiw: I'll kick off and then turn it over to General Jaeger, and she'll talk about the constructive framework.

Immediately on hearing that, the department provided moneys to the province, to a local care provider, to assist the case in Petawawa you're talking about, a couple of hundred thousand dollars to help them out.

As General Jaeger is now going to tell you, that, in part, becomes our challenge, because from a legislative regulatory framework, much of it falls outside of our purview. We both know that the family is the bedrock of operational effectiveness—and it's a point worth pursuing here. I come back and say there are instances throughout where we need to do better with families. We have done a lot of things with families. There are specific cases, and when we find out about them we get on. But the department provided money to the province in that case to help out. I know General Jaeger can explain that.

The Chair: Thank you.

Mr. Comartin, I thought you were going to lead further with your questioning on the seminar they had and ask if we could be invited to be witnesses or observers at the next one. We didn't get quite that far.

MGen Walter Semianiw: No.

The Chair: The answer seems to be no!

We'll move over to the government side.

Mr. Joe Comartin: Could we get General Jaeger to finish that answer on the treatment available for families?

The Chair: In the next round you'll have time.

Ms. Gallant.

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

Through you to the witness, Mr. Chairman, I noticed that the Canadian Forces have five operational trauma and stress support centres in Halifax, Valcartier, Ottawa, Edmonton, and Esquimalt. I think these are excellent steps forward for care, but how are we providing care to soldiers not based in these urban centres?

Many CF bases are in rural or suburban centres, not in the major metropolitan areas. In fact, I would think that a majority perhaps live outside those areas. It's not always practical for people with mental health issues to get treatment away from their families, especially if they've already spent six months on deployment.

Are we considering satellite operations in smaller areas or innovative solutions like travelling clinics or something else?

● (1610)

BGen Hilary Jaeger: Thanks for your question.

I know exactly where you're coming from. I was a senior medical officer in Petawawa from 1996 through 1999, so I know the Ottawa valley fairly well.

The OTSSCs are part of a specific program. You have to remember a couple of things about them: they were thought up in 1998 and implemented in 1999, i.e., before the current mission in Afghanistan. With the available resources we had, we could only have so many, and we had to look at providing services in both languages and in a way that provided the best footprint across the country. And that really meant having one clinic in Ontario.

When you look at the number of bases in Ontario, there is Petawawa, Ottawa, Kingston, Trenton, Borden, and Toronto. We thought actually that the best single place at the time was Ottawa. Now, with the pace of operations and the mission going on, of course, there's quite a lot of need coming out of the base up the road in Petawawa.

The concept was always that those were not the only places to get mental health care. Every base has a mental health service of varying size; it can be one social worker in a place like Gander, or it can be 10 or 12 people at a larger base.

Petawawa faces a double challenge. It's a big and very busy base, but it's in a part of the world—a beautiful part of the world, I know, as I love to go hunting and fishing—where not a whole lot of psychiatrists really want to live. I don't know why. Not a lot of clinical psychologists want to be there either.

When and if we finish the mental health initiative, there will in fact be more mental health providers in Petawawa than in some of the other OTSSCs, with the same mix of providers following the same methods.

But we are, I admit, having a serious challenge attracting mental health providers to work for us in Petawawa.

MGen Walter Semianiw: If I could expand on that, Mr. Chair, both General Jaeger and I realize that we need to get more people into Petawawa. We have heard that message loud and clear. We try not to attach to it, but clearly, we need to put an OTSSC-like thing in Petawawa as quickly as possible, and that's what we're working on right now—and in Gagetown.

If I could add—which may assist the committee—we have to remember that at the same time we put in the OTSSCs, these are part of a broader concept. That concept is connected to the Department of Veterans Affairs, because they have OSI clinics, and the two look pretty much the same across the country in different locations. So the Department of Veterans Affairs is putting an OSI clinic into Gagetown very shortly. To help meet or address the issue, the two departments are working together very closely. Don't quote me here, but I believe the department was given money in the last budget to add an additional ten OSI clinics, and one of them is going to be in Gagetown.

So you're right, especially for reservists. And that's an issue that did come up, Mr. Chair, at the lessons learned symposium. I agree it is one of those six areas. What do we do for reservists who are in Kitchener, but maybe not in Toronto and maybe not in Petawawa? Again, we don't have the time to go through this, but we know it's an issue.

We're moving ahead on a number of different fronts to ensure that men and women in uniform, regular or reserve, get the support they need. But we realize the challenge is when someone is not near a major base.

BGen Hilary Jaeger: Getting back to the short-term fix, we do recognize that it takes a long time to hire people. We've hired people in Ottawa whom we've told, you can only be hired if you agree to get on a bus and go to Petawawa a couple of times a week. Similarly, for Gagetown, the OTSSC folks in Halifax conduct routine outreach clinics into Gagetown.

We know we have some gaps, which we'd rather not have, and we try to move the resources around to fill them. That's a stop-gap measure.

MGen Walter Semianiw: But is it perfect? No. Is it better than it was? Yes. We know where we're going and what we have to do.

Mrs. Cheryl Gallant: I'm glad to hear that.

With respect to staffing, in my riding of Renfrew-Nipissing-Pembroke, the riding where Petawawa is situated, we have upwards of 20,000 civilians who are now orphan patients; they don't have a family doctor. There's a shortage of doctors. It's the way the provincial government limits health care costs. By keeping the number of family physicians down, you keep down the number of referrals and the diagnostic testing; wait lines are therefore diminished. It works out for the government coffers, but not exactly in the best interests of the patients.

You mentioned that you were looking at various services. I notice that in the United States, in 2006, there was signed into law federally a sweeping bill that adds marriage and family therapists to their front-line health care workers.

What sorts of possibly non-traditional medical professionals are added to help cope with the stresses that might not necessarily require a psychiatrist but need preventive care along the way?

● (1615)

BGen Hilary Jaeger: We make heavy use of our social workers along those lines. The vast majority of our marital counselling is done by uniformed social workers. It's open to families and members, one with or without the other; that's not an issue.

I'm probably stepping on thin ice, but I'll say we exploit the ability of social workers to deal with families to the maximum. We push that envelope as far as we possibly can. I have no legal mandate, no legal authority, to treat civilians, outside of life- and limb-threatening situations, without ministerial authority, except with social workers.

Mrs. Cheryl Gallant: Is each physician who treats Canadian Forces personnel required to hold a provincial medical licence?

BGen Hilary Jaeger: Yes, they are.

Mrs. Cheryl Gallant: Okay. Now, despite the fact that the Canada Health Act stipulates that health care coverage for the Canadian Forces is a federal responsibility and that the Canada Health Act specifically excludes military personnel as insured persons, in Ontario the soldiers still have to pay the Ontario health tax premium, unlike the case in other provinces.

Is there any consideration given by the province to providing professionals or treatment facilities, over and above the extra the federal government already pays on the soldiers' behalf?

BGen Hilary Jaeger: It's an interesting question. I pay the health tax too. It varies widely across provinces, and of course it's not always the provinces themselves who provide the billing. It usually isn't. It's individual providers and the regional health authorities or the hospitals themselves.

But on average, we pay 30% above provincial health care rates for every service we purchase on the provincial system.

Mrs. Cheryl Gallant: My last—

The Chair: I'm sorry, Cheryl, we're a little over.

That ends the first round. We'll get into the second round. They're five-minute spots. We start with the official opposition, then go to the government, the Bloc, the official opposition, the government, the official opposition, the government. That's how this round goes.

Mr. McGuire, do you want to start for five minutes?

Hon. Joe McGuire (Egmont, Lib.): Thank you, Mr. Chair.

I'll follow up on that regular line of questioning. The whole country is short of doctors and health care givers. Do you have the same problem recruiting and training people in the military?

BGen Hilary Jaeger: We had a serious problem with general duty medical officers—family physicians—which hit its low point about 2002, when we were short more than one-third of those. We now believe we'll be back up to full complement in a year to a year and a half. We've done extremely well with recruiting, with a very focused attempt.

We've also done a pretty good job recruiting our specialist physicians as backup. The mission in Afghanistan has actually been a drawing card for us for that. Base people, trauma surgeons, and anaesthesiologists see this as really important, worthwhile work to do, and they want to be part of it. So that's helped our recruiting.

Pharmacists constitute a big hole for us now. But we're doing well on the uniform side.

It's really the public service, and a lot of my health care providers who stay in place are supposed to be public servants. At the moment, they're not; they're contractors, because public service pay scales, quite frankly, aren't sufficient to attract physicians at the moment. I pay a third-party contractor a lot of extra money to fill those holes.

Hon. Joe McGuire: Do you use foreign-trained doctors who are available in the country but are not in our system? Are you tapping that resource?

BGen Hilary Jaeger: I have foreign-trained doctors, but only those who have gone through the established hoops to receive licences to practise in a province in Canada.

Hon. Joe McGuire: So there's no....

BGen Hilary Jaeger: There are no shortcuts through me. I can support them. There are a number of steps between the Medical Council of Canada, the federal medical regulatory authorities, and the provinces that run the schools that do the training. There are different kinds of thresholds.

Generally, one of the big challenges these folks face is that they're required to do another period of residency that will be unpaid. What I can do, if they've passed the threshold examinations and found themselves a spot, is enrol them and provide them with a standard of living, and we can pay them as trainees. But they will not be seeing Canadian Forces patients until they finish their training programs and get a licence to practise.

● (1620)

Hon. Joe McGuire: Would you like to see provincial governments or the federal government short-circuit that so people will be available to tend our soldiers? Particularly nowadays, because of Afghanistan and Bosnia and so on, is there any request for the military to access this pool of qualified people?

BGen Hilary Jaeger: The short answer to the second question, sir, is no. I'm not in the business of second-guessing provincial regulators as to who is and who's not appropriate to hold a medical licence to practise. I think there's a fine balance between public safety and having appropriately trained and qualified providers, and quantity of care is a quality all its own.

We make liberal use of other mid-level providers, such as nurse practitioners and physician assistants, as a way to kind of be a force multiplier for primary care providers.

Hon. Joe McGuire: I suppose people can be missed in any system, either the civilian system or the military. But we see newspaper reports of people getting shot because they haven't been properly attended to or because people weren't listening to them or their families. These are people who had been in the military and so on. Is this because there's a lack of people to refer these people to?

BGen Hilary Jaeger: It's always a tragedy when you hear of somebody who gets involved in an altercation with police with a tragic outcome or of someone who somehow seems to have gone off the rails somewhere.

I think you have to be conscious that we don't cure everybody, particularly when it comes to mental health care. Generally, what you're trying to do is help people cope with their conditions on a chronic basis. You'll find that it's not linear. It's not like it's worse and then it gets better in a linear way. Sometimes people have relapses. Even with the best treatment for things like PTSD, if you search the literature and sort of take an average figure of how many people are helped by treatment and how many people are not, you'll get a split of about two-thirds who are helped and one-third who are not, even with the best available treatment. So you can mobilize a lot of resources and there will still be some people who unfortunately don't do well.

The Chair: Thank you.

We now go to Mr. Hawn and then back to the Bloc.

Mr. Hawn, you have five minutes.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

Thank you both for being here.

I have two or three quick questions and then maybe a little longer one.

How do you break down the stats on battle deaths versus non-battle deaths?

MGen Walter Semianiw: Non-battle deaths are deaths of individuals who are not killed actually in battle or in action. They are individuals who may have fallen, as was mentioned earlier, in a road accident. That's how the two are defined.

Mr. Laurie Hawn: I understand. I'm just looking for the number.

MGen Walter Semianiw: Oh, you want the number. Sorry.

The total since 2002 through to 2007 for non-battle deaths is eight, while the number of those killed in action is 66. Remember, this is up to December 31, 2007.

Again, if I can reiterate, because I have a hard time saying this, I go with the chief, in many cases, to the repatriations. At the end of the day, it doesn't matter how you fall for the nation. Falling for the nation is falling. Sadly, it needs to be depicted this way for whoever wants to see this. But clearly, falling for the nation, at the end, when you come off the airplane, isn't any different for the families.

Mr. Laurie Hawn: Believe me, I totally understand that.

I have a question from Ms. Gallant. You're paying 30% more for every service. Are we talking about just in Ontario, or is that across the country?

MGen Walter Semianiw: It's across the country.

BGen Hilary Jaeger: It's not uniform, and of course it's largely a case of individual providers. Remember, in most of the country, physicians are small business people, and they choose to bill us at their provincial medical association rates, not at the health insurance plan rates negotiated with the government. There's about a 30% spread in that.

There's also some facility-fee billing by hospitals for access to beds and things, which drives up their costs.

Mr. Laurie Hawn: Thanks.

Going back to stats, do you have any historical data from previous conflicts, World War II and Korea, for things like non-battle injuries? I'm not talking about deaths. Are we seeing more?

MGen Walter Semianiw: That's a fair question. I don't have that here. I just got most of this today, since the policy changed today. We looked at October, and the stats came here together. But I'm sure you could find the information and look at it.

The only caution I would give—and I knew there'd probably be a question about how this relates to U.S. or U.K. stats—is we have to be very clear that we have to look at the situation they're in. They are in different situations, and I think there's a danger in drawing parallels between certain statistics. I know you all know that, but I just wanted to raise it.

● (1625)

Mr. Laurie Hawn: A lot of reservists have gone and come back, and a lot of them have gone out to the boondocks and are not with battalions any more. I know you're addressing that.

You talked about screening at four to six months. I've met a lot of airplanes in Edmonton, shaken hundreds of hands, and looked into hundreds of pairs of eyes. With each 140-person load, I say to myself afterwards that six or eight of those folks will probably have problems.

Talk to me a little bit about what goes on at the company level or any other level back in the garrison before that four- to six-month period, or how we're trying to reach out to the reservists who may not be in that regimental environment.

MGen Walter Semianiw: I'll provide the upfront piece from a unit point of view, and then I'll turn it over to Brigadier-General Jaeger to talk about the medical aspects.

Once the soldiers get off the ground, they've come through the third-location decompression in Cyprus. We need to stress that in many cases we're not picking up everybody in Cyprus. Some of it's self-identified and some of it's picked up sitting down with trained experts. But as Brigadier-General Jaeger said, the critical piece is to educate people to make them more aware, so that if they or their families see something about them that's different, they do so.

The first thing that happens is they head back to their units—I'm a Patricia in the 1st Battalion. People go off and take their post-deployment leave. The soldiers coming back to Quebec from this rotation will have a chunk of leave to reintegrate and get to know their families, because it's not as simple as one would think. Your wife or husband has been running the show for the last six months, and you come back and want to change things. It ain't that simple. I will just remind the committee that that is a component of third-location decompression. It's not all about mental health. There is a morale and welfare component to it to ensure that people get a chance to unwind.

Once soldiers take their post-deployment leave, they go back to normal duty. They're probably still in their teams, and the leadership will see them and talk to them. There have been many cases where the leadership thinks a soldier needs help, and they connect them to the medical system.

I'll turn it over to Brigadier-General Jaeger, who will give you that background piece.

The Chair: We're out of time. We'll have to come back to that.

MGen Walter Semianiw: I'm sorry.

The Chair: No, that's fine.

We'll go to Mr. Bouchard, and then back to Mr. Rota.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chair.

Thank you for being here. My question deals with trauma as a consequence of operational stress. There are several theatres of operation within military missions. Can you compare the trauma of soldiers sent to the Balkans with that of soldiers injured in Afghanistan?

BGen Hilary Jaeger: It is really hard to make that comparison. The numbers show a slight increase with the Afghan mission compared to the one in the Balkans. There are certainly people who suffered operational stress in the Balkans. Our numbers from that mission are not very precise. We did not do the same kind of post-deployment screening. So we cannot really compare the numbers.

At the time, there was a gap of about four to six years between the end of the mission and the time people came forward for treatment. They tried to heal for a very long time. But thanks to the screening we do now, that gap has been reduced to four to six months post-deployment. The screening process for those needing treatment has greatly improved and care is available much earlier. There has been a great deal of improvement in that area.

● (1630)

Mr. Robert Bouchard: Do you know of any other theatres of operation which have produced a high number of traumatized soldiers?

BGen Hilary Jaeger: Certainly. Many soldiers sent to the missions in Rwanda and Somalia came back with post-traumatic stress syndrome. The mission to recover the bodies of victims from the crashed Swissair Flight 111 also traumatized some rescue workers. It depends on the incident and on the individuals involved.

Do not forget that 90% of Canadian Forces personnel are not deployed. People can be involved in a car crash or be attacked as they are driving. All sorts of events can cause post-traumatic stress disorder. Women and men can be raped. There are many things which can cause Canadian Forces members to suffer from post-traumatic stress syndrome.

MGen Walter Semianiw: At this point, it would be very important to define PTSD. Can you do so, Ms. Jaeger?

[*English*]

BGen Hilary Jaeger: I'll try it in English because I will lose my French.

The current DSM-IV definition of post-traumatic stress disorder requires a stressor that was so important, that made such an impression on you, that you thought your life was in danger. You were convinced you were going to die or that somebody next to you felt peril for you, somebody very close to you, and you had a reaction to it. Most people would have racing heart, trembling, you might have vomited, you might have messed your drawers—a very, very intense reaction, a flooding of stress hormones at the time. If that didn't happen, it's not impossible, but most psychiatrists would say you may have an operational stress injury; you may have persistent psychological problems linked to stress, but it's not PTSD, it's something else. It could be a simple anxiety disorder. It could be you've triggered a depression that is not PTSD. It's important because the treatments are different.

The Chair: Thank you, Mr. Bouchard.

Thank you, ma'am.

Mr. Rota.

Mr. Anthony Rota (Nipissing—Timiskaming, Lib.): Thank you, Mr. Chair.

If I could continue with the definition, post-traumatic stress disorder has a very abrupt beginning, so the operational disorder includes pretty well everything else that creeps up slowly. A lot of dysfunction and a lot of the problems that arise don't always do so right away. They build up over time in multiple exposures. The operational disorder—and this wasn't one of the questions I was going to ask, but the two of them are grouped together. Both have devastating effects. Could I have a bit of clarification on that?

BGen Hilary Jaeger: First of all, never say never in medicine. If you look in the psychiatric literature, I doubt you will find the term "OSI" anywhere. It's a term that was coined by the Canadian Forces to broaden the discussion of mental health issues beyond PTSD. It's any persistent mental health disorder that can be linked to your service with the CF.

While PTSD usually has a pretty abrupt cause, that doesn't mean that from that moment on you are suffering from the symptoms. Sometimes it takes a while for the symptoms to rise to a bothersome point.

MGen Walter Semianiw: The issue becomes one...and we've talked about this issue, looking at it as a soldier. I would not recommend you repeat what I say, but I look at it from a credit card point of view. Why me, not you? I may have a higher level of credit than you, and it affects me, or it could be the incident or it could be the situation. That's why it's not so clear-cut. That becomes the real challenge, not only the diagnosis but the treatment as well.

Mr. Anthony Rota: That leads to my question, the one I was going to ask initially about the assigned health team that goes with every rotation.

I'm imagining you've got a group of people who go along with the troops assigned to that rotation. Do they develop a relationship with them, or is it a health unit that sits and waits for people to come to them? What is the ratio of the people within that unit to the number of people serving?

● (1635)

BGen Hilary Jaeger: The people who stay on an intimate basis with the troops at the pointy end are primarily med techs, physician assistants—more about physician assistants to come, I'm sure, in your study—and general duty medical officers.

The mental health team is usually centralized at Kandahar airfield and sees people on a referral basis. But they also go out when they can get transport. One of the riskiest things you can do in that theatre is move from place to place. The FOBs themselves are usually pretty secure once you're there. It's getting there, whether you take a helicopter or a vehicle, that can kill you. So movement is not something you want to do too much of.

The mental health teams do go and visit the FOBs periodically, but usually they stay centralized back in Kandahar airfield. The front-line providers are the med techs, physician assistants, and general duty medical officers; they are what we call "role one". That just means they're the front-line guys.

Mr. Anthony Rota: Who identifies the OSI? Is it someone on the front line? Are they trained to identify it? What success rate do they have? Or is it the individual who just doesn't feel quite right, describes himself, and then you kind of...? It's not a clear black and white illness.

BGen Hilary Jaeger: No, it's not clear.

The answer is both, or any of the above. The individual may notice it. His peers or his section commander or his platoon commander may notice something is not quite right. You'd generally send them to see the med tech or the PA at the forward operating base, and he may have an idea, he may not. If he needs help, he'll send the guy back to Kandahar airfield.

At that point, you're probably not going to say this is an OSI. The term that would probably be most appropriate at that point is either combat stress reaction or acute stress reaction, depending on whose book you last read before you deployed.

It's actually a slightly different thing—that is, the old sort of World War II, George Patton slapping the soldier in the hospital kind of scenario. Most of those people, if you give them rest and recuperation, will return to duty.

In fact, it's very important not to label them as mental health problems at that point because it does very damaging things to you from a self-image point of view to get labelled as deficient. So you don't want to do that. Most of the operational stress injuries we see come to light...and that's why we picked the four- to six-month point. Starting at about three months after the mission is over, you still pick new cases up, going up to about a year.

MGen Walter Semianiw: Plus, to be fair, we've also added to the screening. When I went to my medical a couple of weeks ago, the doctor asked me a number of questions—buried in there—that I didn't know had to do with my mental health.

There's a danger in saying it's psychologists, psychiatrists, social workers—that's the team. The team is pretty big.

Every day, Brigadier-General Jaeger comes and talks to me, she looks at me, and she makes sure I'm still all there and all okay.

Voices: Oh, oh!

MGen Walter Semianiw: I'm okay. It's actually a pretty big team that supports the people.

The Chair: That's interesting, sir.

You probably have a document that says you're okay. Some of the rest of us don't have that document.

Voices: Oh, oh!

MGen Walter Semianiw: We could provide it to you.

The Chair: We'll go to Mr. Lunney for five minutes, then back to Mr. Coderre, and then back to Mr. Blaney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much.

You'll have to excuse me. My voice isn't at full wattage today. I hope the rest of me is, actually; it's just the voice that's weak.

I wanted to pick up on the prevention angle that a couple of the colleagues talked about here. Mr. Bachand talked about psychological preparation for prevention. Mr. Comartin talked about training.

I don't see anything in what's presented here, or in your presentation, that would indicate this type of approach, but I'm wondering if any consideration is given to nutritional support for soldiers going out. The rest of us, or a lot of Canadian society.... There are stress vitamins out there, for example, the B vitamins, B1, B6, B3—

An hon. member: Folic acid.

Mr. James Lunney: Folic acid is for the heart, my friend, but the B vitamins are for stress. The amino acids...I'm sorry, Dr. Jaeger; you're a doctor, so we do have a doctor here. Acetyl-L-carnitine and phosphatidylserine are known to influence cognitive function.

Is there any nutritional support? And in the team of folks we saw there—the psychologists, psychiatrists, social workers, etc.—is there any consideration for people from the orthomolecular world who actually have some expertise in this area of helping people nutritionally with this type of problem, with depression? A lot of these conditions are actually being managed fairly well with nutritional supplementation.

So in your discussions, or other models around the world, is anybody looking at that?

● (1640)

BGen Hilary Jaeger: I'm not aware of any evidence that demonstrates that any particular nutritional approach is any better than any other. The average Canadian soldier's biggest nutritional problem is over-nutrition. We are fighting our BMIs all the way to Afghanistan and back. Probably one of the best things about the mission is that most of them lose weight while they're there.

MGen Walter Semianiw: I lost 18 pounds while I was there.

Mr. James Lunney: Doctor, with all due respect, we call that over-consumption rather than over-nutrition.

BGen Hilary Jaeger: It is called malnutrition. It's just excessive intake of certain products.

Mr. James Lunney: Trust me, as members of Parliament we understand the over-consumption problem. Most of us are trying to lose weight here as well.

MGen Walter Semianiw: It is interesting because we are very shortly going to announce a new Canadian Forces health and fitness strategy. General Jaeger's team and my team have been working on this. It's going to be announced on April 1. There are actually two parts: fitness and the issue of health and nutrition. We have had new posters made to start driving home those points and awareness.

You're right, it's something we know, but again, part of it becomes a cultural challenge.

Mr. James Lunney: On the credit card issue that you raised, I thought the analogy was interesting, why you and not me.

There is certainly a body of people in the medical world—most of them in this area have worked in molecular medicine—who consider these levels of nutrition that most people take as normal, but some people are actually vitamin dependent and need more. When you're compounded with stress, and maybe not the kind of thing that would qualify for a post-traumatic stress disorder diagnosis, but the operational stuff, sleep deprivation and all the changes that happen when you're in that kind of environment, might explain why somebody suddenly has a much greater need for nutritional support than they would have in a non-combat or a non-operational theatre.

MGen Walter Semianiw: I think it's a fair comment.

The health and prevention piece falls under General Jaeger. She has a whole new directorate of health for self-protection.

If you look at the food we are providing—and I have been there myself—you'll see we actually provide great food in the mission. I don't know if any other members here can speak to that end for the soldiers.

I think everything you're saying in principle sounds right, and I'm in infantry, I'm not a doctor. I'm sure I'll need a better meal after this committee tonight than I normally would have, to ensure that I build up on the vitamins that I've lost. I think you're right, and what you're saying intuitively makes some sense.

BGen Hilary Jaeger: I'm married to evidence-based medicine, and I'll be having my staff dig through the literature and see what they can come up with.

Mr. James Lunney: That's great, and I certainly have some suggestions. I would be glad to discuss that further with you, if you are open to considering it. I think it's a promising area, and perhaps it would be interesting to do a little study and find out.

I want to follow up on defining operational stress injuries and what one looks like. We sort of touched on that, but I wonder if there is room to expand on it.

BGen Hilary Jaeger: It's defined as any persistent psychological difficulty. Originally the context was deployment to a mission, but it has been broadened to service in the Canadian Forces. It could be related to an accident you had while training in Wainwright on your way there. That's just as much of an issue.

It can manifest itself as depression, anxiety, phobias, or post-traumatic stress disorder and—this is almost anathema to put in the room—the worsening of a personality disorder. Somebody might have had certain traits in their personality that made them a little hard to get along with, and then under stress it can push them over the threshold into a personality disorder. Substance use or any combination of all of that....

The Chair: Thank you.

We have Mr. Coderre for five minutes and then over to Mr. Blaney. That will end this round and we'll start the next.

Hon. Denis Coderre: I have two questions.

If you want to identify a case of post-traumatic stress syndrome, of course, I guess it would start with recruitment. You never know what can happen, and it depends on your reaction through the operation. The fact is that maybe we can change, even at recruitment, the physical test and all that. I would like you to expand on that. What's your call on post-traumatic stress syndrome versus recruitment? What tools are we working with? Prevention is better than having to cure, of course.

Second, there's a school of thought that says rehabilitation is the best way to cure that person—to bring him back as soon as possible from the battle theatre. What is your thought on that?

● (1645)

BGen Hilary Jaeger: I'll try to get through the answer clearly and reasonably quickly.

We do not do elaborate screening for psychological makeup of recruits. We do ask questions about psychiatric history. By and large, if you have a significant psychiatric history, you don't get into the Canadian Forces. But we don't apply the MMPI, or any of these standardized personality-based screenings. They tried that in the Second World War and it didn't work very well. Perhaps with more research, there is some.... But you have to hit a pretty high threshold to exclude people on that basis.

Hon. Denis Coderre: There must be a middle ground, though.

BGen Hilary Jaeger: Human rights tribunals are going to watch that like a hawk, and that is outside of my lane.

But prevention is better than cure. There's emerging literature on resiliency. It's not very well defined. We're watching it. Until it becomes something we can actually use.... I'd rather promote resiliency than treat people. We don't really have a good definition of the characteristics and how to promote it. It's quite nascent.

I forgot the second thread of your question.

Hon. Denis Coderre: They're saying to bring that person back right away.

BGen Hilary Jaeger: For acute stress reaction you treat them as soon as you identify them. But that doesn't mean moving them out of theatre. As soon as you move them out of theatre, they self-identify as patients and therefore as a failure on some level as soldiers.

Hon. Denis Coderre: What do you prefer? What's your school of thought?

BGen Hilary Jaeger: It's a layered approach. You approach the acute stress reaction based on simplicity. In the Second World War they called it "three hots and a cot"—you got meals and you got to sleep for a while, which maybe you hadn't done. And as your symptoms subsided over 48 or 72 hours, you went back to work with your unit. They said to keep them within the sound of the guns so they knew they were still on the mission. I'm a firm believer in that.

If that doesn't work, then you end up at Kandahar airfield chatting with the psychiatrist, who may decide it's worth a trial of medication and perhaps some modified duty to keep you in theatre. If that doesn't work, then you will be evacuated out of theatre.

The linchpin of treatment for post-traumatic stress disorder is still cognitive behavioural therapy. It's an anxiety disorder. You have to expose people, in a controlled way, to the thing that makes them anxious and teach them to reprocess it.

Hon. Denis Coderre: If I may intervene, are you suggesting that we have some soldiers who might be on medication back at the operation?

BGen Hilary Jaeger: This is a very interesting question.

Hon. Denis Coderre: I'm only repeating what you just said.

BGen Hilary Jaeger: I would not say there are infantry men at the FOBs, but I know there have been soldiers who have continued to go on things like combat logistics patrols while on psychoactive medication.

Hon. Denis Coderre: What kind of medication? It's more than Sudafed, I'm sure.

BGen Hilary Jaeger: It's more than Sudafed, but I would have to go to my treating psychiatrists in theatre to find out what they've been using. I know they've been intervening to keep people moving.

Hon. Denis Coderre: Okay.

I have a small question, General. When we talk about the wounded in action and IEDs, in my book it's battle, but is it a non-battle injury?

MGen Walter Semianiw: I have copies right here. The definition of wounded in action is injuries from IEDs, mines, rocket attacks, direct combat with an enemy force.

[*Translation*]

I have copies here.

Hon. Denis Coderre: No, that is fine, thank you.

[*English*]

The Chair: To end this round, Mr. Blaney, you have five minutes.

[*Translation*]

Mr. Steven Blaney (Lévis—Bellechasse, CPC): Thank you, Mr. Chair. I would like to welcome our witnesses, whom we have seen a lot of on Parliament Hill lately, including at the Standing Committee on Public Accounts and the Standing Committee on Official Languages, where I saw Mr. Semianiw.

You are here today to help us determine whether, as far as the mission in Afghanistan is concerned, Canadian Forces are appropriately prepared when they return from their deployment back to their families, and whether they are receiving adequate health services, and more particularly treatment for mental health disorders.

General Jaeger, you talked about extreme shocks. Can you please explain to me what that is all about?

[*English*]

I don't mind if it is in English.

● (1650)

BGen Hilary Jaeger: Perhaps it's better to explain it in English—*Une choc extrême*, an extreme shock—I think it's intuitively obvious that if you were riding in the back of a LAV III and it blew up and killed the guy next to you, if you survived, then you have lived through a certain shock. If you were involved in a firefight and one of your best friends was killed, that's a shock. If you're a woman walking through Central Park in New York and you are gang-raped, that's also a physical and an emotional shock.

Mr. Steven Blaney: Would you say that those extreme shocks could be an initiator of the post-traumatic stress symptoms?

BGen Hilary Jaeger: Those are the classic examples of the kinds of things that, down the road, may lead to post-traumatic stress disorder.

Mr. Steven Blaney: You mentioned that when we are on the battlefield and we have a near-death experience, we come very close to death, our hormones go up, our heartbeat goes up. It's kind of normal. I guess everybody's on a battlefield. You say this is a case where we'd be diagnosed with the syndrome.

How does it develop?

BGen Hilary Jaeger: I'm not a neuropsychiatrist. I'm not even a psychiatrist; I'm a general practitioner. But I'll give the dumbed-down version, as I understand it.

In the presence of that kind of hormonal flood, the brain actually processes memories differently. The memory of the last time you went to Disney World is in your brain, right, but it's there in a very mundane and normal way. The memory of the situation you were in when you almost died is processed in a different way. It sits in a different part of your brain, where it's more hard-wired into that whole hormonal mix that leads to the fight or flight thing. It makes you anxious.

Mr. Steven Blaney: My question is more on how it ends up that for some it's like a normal reaction and for others it develops into post-traumatic syndrome. Does it depend on the individual?

BGen Hilary Jaeger: There's a great individual variability.

Mr. Steven Blaney: Okay.

You have some statistics. Did you provide us with statistics regarding PTSD?

BGen Hilary Jaeger: No.

[*Translation*]

MGen Walter Semianiw: As I said last week,

[*English*]

we're still gathering those for here.

Again, I would caution that the statistics are only generalities. Getting into the details.... There's a danger with PTSD. But we're looking at and gathering those.

These are the generalities, in a sense.

[*Translation*]

Mr. Steven Blaney: Post-deployment, how long does it take before the syndrome appears? I believe you said it can take up to two years.

BGen Hilary Jaeger: It can take a long time. We never know exactly when the symptoms will appear, or whether members have experienced the symptoms but have ignored them or repressed them for a while.

Mr. Steven Blaney: Another question seems important to me. Some troops unfortunately die in combat. What kind of support do the families, spouses and survivors of the fallen troops receive? What is out there for the survivors, the widows and widowers of military members who die on deployment? Are there programs available to them, are they monitored? After all, they have lost someone very dear to them and there may be psychological consequences.

BGen Hilary Jaeger: In the last six months, we have lost four medical technicians, including two from Quebec, from within our health services. We also have bereaved families and widows. In English, the most important point of contact is called

[*English*]

the assisting officer.

I'll go on in English. It's much easier and faster.

It's somebody who is appointed right at the time we find out the member is deceased to guide the family through the process and to support them.

Personally, I have a bias in this. I think it's very important not to medicalize grief, so we don't turn around and automatically truck out and refer them to physicians and things right away. Grieving is a normal process. The vast majority of people have it. It feels awful. They are not having a good time; you don't want to be in their shoes. But they come through it.

● (1655)

Mr. Steven Blaney: *Merci*.

The Chair: Thanks, Mr. Blaney.

Just before we get into the final round, I have just one quick question, if you don't mind.

What percentage of deployed troops actually develop PTSD? Do you have a number for that, quickly?

BGen Hilary Jaeger: We have an imperfect number, as far as we know, and this is based largely on the first rotation that went into Kandahar, the guys who did the first full rotation. From the post-deployment screening figures, the best number we have for PTSD is between 5% and 6% of those.

The Chair: Okay, thank you. I appreciate that.

For the final round, to clean up on the questions, we start with the official opposition, and then we'll go back to the government.

Go ahead.

Mr. Anthony Rota: Okay. I'll be sharing my time with Mr. McGuire.

This question has been skirted around, and I'm not sure exactly how to ask it. I'll just preface it by saying you mentioned that 20,000 troops to date have gone to Afghanistan, 739 have been injured, 298 have been wounded in action, and 350 have had non-battle injuries.

Where does OSI or PTSD fall in there, or does it fall into those numbers at all?

MGen Walter Semianiw: Let me first clarify that what I said was "into the theatre of operations". Remember, this is not just people in Afghanistan; it also includes those who may be on a ship in the gulf and who are injured. It includes those who are in a theatre of operations, not just focused on Afghanistan, to be clear. The theatre of operations also includes the gulf—the air force, the army, and the navy.

BGen Hilary Jaeger: I believe that where we have been able to establish a clear link for mental health issues, or OSIs, the numbers are in there. Remember, we are still expecting to get, six or twelve months down the road.... Those numbers will be underreported for mental health issues, because it's something that comes up later. The people who track stats as people come back in airplanes from Landstuhl don't have those figures.

Mr. Anthony Rota: So they're not placed in either the wounded in action or non-battle injury category. They're not placed in there?

BGen Hilary Jaeger: I have no confidence that all of them are in there.

MGen Walter Semianiw: What it says here is that wounded in action includes injuries from IEDs, personal injury—to get to what you're looking for—acute psychological trauma directly attributable to combat action that required medical intervention. Those are the wounded in action—

BGen Hilary Jaeger: But they're not the people picked up six months later.

MGen Walter Semianiw: —not the people picked up six months later, which is the second part to that piece.

Mr. Anthony Rota: Very good. Thank you.

Hon. Joe McGuire: Do you have any incentives to have people you have trained and paid a salary to through university and through med school stay in the service now that you really need them more than ever? The temptation is to leave after their five years of service or whatever is required. Is there any way to keep them? I imagine you're leaking people all the time.

BGen Hilary Jaeger: Actually, in the last few years, we have done better than in the rest of my career. Our basic commitment, for somebody whom we sponsor through university to become a physician, is four years after they qualify. It used to be that at least 80% of those who came up to that point left.

I do not have the exact figures—I can get them from my staff—but it's now much lower than that. In fact, in this year coming up we are going to be in the position of telling people who want us to sponsor them through medical school that we have too many and are not going to offer them sponsorship. We may, in the next couple of years, come up against what we call "career gates", a decision to offer people new contracts and not offer people extension of terms of service.

MGen Walter Semianiw: The actual recruiting of physicians has been a best practice for the Canadian Forces, if you look at what they've done. They've done a number of things, both provincially and federally, to bring in more doctors. As General Jaeger said, in the last five years the increase has been great.

The incentive is called promotion. At the same time, people are provided both promotion within the military and obviously monetary remuneration.

BGen Hilary Jaeger: And they like the work too.

Hon. Joe McGuire: Obviously, they like to be in on the action too.

BGen Hilary Jaeger: They think it's valuable work.

MGen Walter Semianiw: What clouds the issue, which hasn't been mentioned here, is serving the nation. This issue is coming up. I'm also responsible for recruiting. Recruiting is up across the country. Why? If you put your finger on it, in many cases it's that people want to serve this nation, given what this nation is doing right now around the world.

Hon. Joe McGuire: When we were in Kandahar, the people at the hospital there seemed to be very highly motivated and competent, but they were on the verge of being rotated out. Do many of them volunteer to come back into that situation?

● (1700)

BGen Hilary Jaeger: The military folks are on the same six-month rotation as most of the Canadian Forces are in that theatre. They will not be allowed or will not be encouraged to volunteer for at least a year after coming back. We try to space people out. In all probability, they won't be told they're going to go back—they won't be forced—for a couple of years.

Hon. Joe McGuire: Are they still helping to set up special units in Kandahar city in their spare time and that sort of thing?

BGen Hilary Jaeger: The Afghan National Army has built a new hospital in what they call Camp Hero, which is just outside the gate of the main Kandahar airfield base, and we're doing a lot of work with them. We're also doing some work with the public health authorities in Kandahar city to help them with health prevention.

The Chair: Thank you.

When we were at the hospital a year ago, there was a gentleman, a patient, who had been basically put back together. He was an Afghan national who had been hurt, and they had done a pretty tremendous job on him.

We'll go over to Mr. Hawn and then back over to Mr. Bachand.

Mr. Laurie Hawn: I have a couple of quick questions. I'll share some time with Mr. Blaney.

General Jaeger, you talked about staying within earshot of the guns and so on, and I appreciate that. Is it safe to say that, on a very basic level, soldiers are each other's best psychologists?

BGen Hilary Jaeger: Yes, I think that's a fair assessment.

MGen Walter Semianiw: It's a great question. What we have seen because of the awareness over the last number of years is that more soldiers are coming in to say, "Hey, my friend has trouble. I think you need to give him a hand." We're seeing that more than we ever have, as well as families, wives saying, "My husband needs help." So I think that has been an added effect of the education or the awareness.

Mr. Laurie Hawn: This is not pejorative in any way, but is it fair to say that we'll probably always be somewhat behind the requirement just because of the rapidly changing situation that the military finds itself in?

BGen Hilary Jaeger: I'm not sure about the rapidly changing requirement. I think if you went back to 1944 with what we know today, you would be flooded with patients with PTSD.

This gives me a bit of an opportunity to point out that there's a difference between having a diagnosis of PTSD and being completely disabled by that diagnosis. We're going to have a fair number of people who will always have a diagnosis of PTSD, but if we do things right, they will not necessarily have a severe disability as a result.

MGen Walter Semianiw: The figures are clear, and I think General Jaeger reminded me when we came in here, that for every 3,000 soldiers, we have one psychiatrist.

BGen Hilary Jaeger: At the moment.

MGen Walter Semianiw: At the moment. On the provincial side, it's one to 8,000. So we look at the capacity, but we agree, because it's not just a national issue, it's an international issue, finding mental health care providers, and we're doing everything we can. To be clear here, it's not just a money issue, giving people more money. That's not it. You just can't find these people to put them where you need to put them at times.

Mr. Laurie Hawn: Thank you. I'll give my time to Mr. Blaney.

I'm sorry, I have to leave and talk to Mr. Duffy.

[*Translation*]

Mr. Steven Blaney: Thank you very much.

I will be brief. I have three or four questions for you. I will ask them all and then give you time to respond.

You said that about 5% of troops came back with post-traumatic stress syndrome after their first rotation. Do you have the percentages for the other psychological problems? That is my first question.

This is my second question. If post-traumatic stress syndrome is diagnosed, does the person always receive medication? If so, how long is that person on the medication?

This is my third question. I would like to know what you think about the support provided to families of military personnel who suffer from PTSD.

[*English*]

BGen Hilary Jaeger: Thanks.

Rapid fire, and in English again, so I can speak more quickly, regarding 5% PTSD, about the same number have a significant depressive issue. For the largest number of people with mental health disorders coming back from a mission, it's hazardous drinking behaviour, which I think runs at about 17% in the figures we have. There's some suicidal ideation—that is, thinking about suicide, not attempting—which is running between 2.5% and 3%, if my memory serves me correctly. And the rest did not reach the level of those kinds of severity of diagnosis. That's where the figures are.

Are they always given medication? No. The thing about a multidisciplinary approach is that we employ best practice for whatever their condition might be. Very often it's a psychotherapeutic approach, frequently accompanied by medication. In the case of post-traumatic stress order and the anxiety disorders, you want to calm down the anxiety a bit so that some of the thinking can get through, calm down the noise in your brain, but it's far from 100% of the time.

Some patients just refuse anyway. There are lots of people who don't like psychoactive medications and would rather not take it. So you have to have multiple approaches.

The other thing is support for the family. We've invented a really nice term called "member-oriented family focused care"—or is it the other way around?—to describe, when the member is having difficulty, how we provide some psycho-education to the family, teach them how to live with a person who has a mental health disorder, and involve them in the family therapy that goes on.

Remember, we can't treat the family in isolation. We can't treat just the wife. If somebody has lost a leg in Afghanistan but is otherwise fine, has no mental health issues, but the wife becomes depressed as a result, we can't treat her, not through my resources. We have to leverage other resources through CFMAP and the family resource centre to get her the care she needs through the provincial system.

● (1705)

Mr. Steven Blaney: What about the length of time? Can they overcome and after a while say they got over this syndrome?

MGen Walter Semianiw: When I was just in Afghanistan, two of my personal staff were individuals who had suffered from PTSD. So I think the short answer is yes.

BGen Hilary Jaeger: You can get over it. In fact, the best treatment now.... It's not the case that you're going to be on the couch for three years, telling your psychiatrist everything you know for three hours a week; the maximum is about 20 sessions if you're going to get results out of cognitive behavioural therapy. Some people do well after six or seven sessions, so it can be quite short.

Mr. Steven Blaney: Thank you.

The Chair: Thank you.

Mr. Bachand is next, and then we'll go back to the government.

[*Translation*]

Mr. Claude Bachand: Thank you, Mr. Chair.

I also have three questions. I would like you to jot them down so that you do not forget.

First, you talked about your team, which involves many people. I once visited a theatre of operations and I noticed that the chaplain played a very important role. I realized that chaplains are a bit like confessors whom soldiers frequently confide in. But I do not believe that chaplains fall under health services. Perhaps we could take a closer look at the role chaplains play.

Second, the five Operational Trauma and Stress Support Centres were mentioned. I read your report and the poll, General Jaeger. The poll revealed that there is a certain stigma attached to psychological problems and that this was a reason why some soldiers did not want to come forward. I know that some of these support centres are located on military bases. The Canadian Forces ombudsman has already suggested that these centres not be located on military bases because when people go in, everyone knows. I would like to know what you think about that.

Lastly, it is important to have a social life. I know, since I visited a theatre of operations, that troops are often stressed. Everyone has their own way to deal with the stress. Some people go to a bar and have a couple of beers. However, I know that you have an anti-alcohol policy.

I went to Bosnia, and soldiers there were allowed to have two beers every night. I went to Afghanistan, but our troops are not allowed to drink. I also went to the German and Dutch theatres of operations. If German and Dutch troops had been told that they were no longer allowed to drink beer, there would have been a mutiny, probably involving some deaths.

Did you bring in this anti-alcohol policy for Afghanistan? What is it based on? Would it not be better to allow soldiers to increase their social life and get together around a couple of beers, as we sometimes do?

[*English*]

BGen Hilary Jaeger: That is a very interesting constellation of questions, and, again, I apologize for answering in English, but I'll be more efficient this way.

Chaplains, in fact, are part of our OTSSC multidisciplinary team. It's one of our leading-edge practices that we employ pastoral counsellors in our OTSSCs as full members of the team. Even without those teams, even on the ground, the chaplains are certainly a very, very important early warning system; they have a great role to play in measuring the pulse of the unit and sounding out the people who may be having difficulty, particularly those who have spiritual beliefs. If the unit member is an atheist, you're probably not going to get at them through the chaplain, but you have other ways.

Your question on stigmatization is an interesting question. It's a very difficult nut to crack. It's not unique to the military, as there all kinds of other instances of stigmas out there in the civilian world. My vision of perfection is having a single centre on base where nobody cares why you're going to the health care centre. You can be there for a sexually transmitted disease, which has a stigma all of its own; you can be there for breast cancer, and there are some women who are sensitive about that; you can be there to have a colonoscopy, and lots of people are sensitive about that; or you can be there for mental health. We're all just there to provide health care.

In the cadre of mental health, it doesn't matter if it's an operational stress injury or PTSD or if it's just that you have a mental health burden—which is in fact more of an issue in the Canadian Forces than operational stress injury, as we have more garden-variety mental health issues than the other stuff. But moving people off-base, in fact, in a certain way, perpetuates the stigma. It may work in a large city, in terms of anonymity, but perhaps it may also not encourage people to face up to some of their issues. In a small place like Petawawa, where are you going to move? Everybody knows that one PMQ is the mental health clinic, and if they see your car parked in the driveway, they know who you are.

As for the two-beers-a-day policy, our alcohol policy is the purview of the chain of command, not me. I have my own opinion about it: being dry is a very safe approach. But if you go to a two-beer-a-day policy, you have to be sure your chain of command has an absolutely iron-clad way of enforcing it or you're in dangerous territory. You have to be willing to fire every single person on that mission if they violate it, and not care if it's the task force sergeant major or the deputy commander or the commander, or your policy has no teeth and will collapse. That's not the surgeon general's opinion, but the opinion of an experienced officer in the Canadian Forces.

● (1710)

The Chair: Thank you.

Okay, back to the government, and then back to the official opposition.

Mr. Lunney.

Mr. James Lunney: Thank you.

Because we're just launching this study on PTSD, I have to pursue, in this last round, the line of questioning to do with Gulf War syndrome. There were concerns about some of the vaccines and medical interventions that were administered to soldiers before they went there, and there are soldiers who didn't even get to the battlefield who developed serious health problems.

Can I ask, what preventative health measures are the soldiers given before they go over? Is this public information? Can you advise us about these measures?

For example, even the common flu shot has thimerisol in it, a mercury derivative that is neurotoxic and a cause for concern. Many researchers are concerned about the influence it has on cognitive function, for example. So we're dealing with neurological phenomena.

Is this something you can provide us with some information on, or is it confidential?

BGen Hilary Jaeger: There's nothing particularly classified about the public health measures taken in preparation for Afghanistan. They're fairly routine. The risks we watch out for there are primarily arthropod-borne ones. We have the normal immunizations, but the acute risks are arthropod-borne malaria and leishmaniasis. For malaria, there's a medical approach to prevention, along with barrier approaches and vector control approaches.

I don't actually accept your premise that thimerisol is a significant risk. There are many studies that have been done on vaccine safety, and there has been absolutely no demonstrated link between the presence of thimerisol and excess side effects in the vaccine.

Mr. James Lunney: Well, there's still controversy about that. I accept your opinion on that, but of course there still is some concern out there about that.

BGen Hilary Jaeger: Oh, there are certainly a lot of people who have vaccine-related concerns, and we perhaps have to do a better job of explaining the science to people, because the biggest public health fear I have is that people will be too reluctant to accept vaccination when it is in fact the most prudent way to go, from both a personal health and a public health point of view.

● (1715)

Mr. James Lunney: Thank you. That's a common medical opinion.

Could you provide us with a list of the vaccines the soldiers are administered?

BGen Hilary Jaeger: I could go back to my force health protection staff and get that to you.

Mr. James Lunney: Please make it available to the committee. It would be useful in the course of our studies.

Thank you.

Mrs. Cheryl Gallant: General Jaeger, I think the idea of having a one-stop medical treatment centre for all the reasons you mentioned is commendable and practical, but at CFB Petawawa.... That hospital is bursting at the seams. There are wires hanging down. There are as many people as they physically can put around a desk as possible. It's been like this for over 10 years and it's getting worse. What are you going to do? Is there more infrastructure planned to better facilitate this?

BGen Hilary Jaeger: I've been told that Christmas is coming.

MGen Walter Semianiw: On the infrastructure side, if you take a look at the Rx2000 project, critical to it—and I'll be short—is this whole idea of infrastructure and actually having things in place. We need to build infrastructure in four locations, Edmonton and.... Petawawa is one of them. We need that. That is the challenge.

I've been at the warrior centre there myself. I've talked to a number of the soldiers face to face about the challenges they have. We need to find space there to be able to have them get the treatment they need, and we've put the money in place to be able to build the new site. The new location there is part of the Rx2000 infrastructure program. It needs to get done; it's going to get done.

BGen Hilary Jaeger: We have some money that.... It's going to look ugly. We need an interim fix, because new construction is going to take three to five years by the time you get through all the work that needs to be done to build something properly, so we are looking at a short-term infusion, whether it's trailer rentals or....

I hate providing care in trailers, but it's better than a tent in the parking lot.

Mrs. Cheryl Gallant: Thank you.

The Chair: Mr. Comartin, you had a question you wanted to ask. We'll let you wrap up.

Mr. Joe Comartin: I have just a couple of things.

With reference to Mr. Blaney's question, at the public accounts committee you indicated that in the screening process at the end of the six months you had roughly 27% of all the people responding showing some difficulty. Is that still accurate?

BGen Hilary Jaeger: That's still accurate; it's 16% to 17% for hazardous drinking and all the other categories.

Mr. Joe Comartin: Then for major depression, if I can put it that way, it's about 5%, and about 5% for post-traumatic. Is that fair?

BGen Hilary Jaeger: If the committee is interested in specific figures, I can make those available.

The Chair: Please do.

Mr. Joe Comartin: I have just one more, following up on some of the biases we bring.

You're leaving me with the impression that the treatment modality that you've used for the mental stress illnesses is particularly a medical one. As opposed to relying more extensively on psychologists, you're relying more on psychiatrists. That's the impression I'm left with.

BGen Hilary Jaeger: Actually, I'm glad you brought that up, because if you look at our mix of providers, in fact we have almost a two to one ratio of clinical psychologists over psychiatrists.

Both disciplines are involved in the assessment. They both participate in the assessment of the patient—in making the diagnosis—and then the treatment will depend on who is best placed. They may in fact both be involved, because there may be some medication management. There may be psychotherapy delivered by the psychologist and medications managed by the psychiatrist.

Mr. Joe Comartin: I have one final point on that, related to stuff coming out of the United States on both wars in Iraq, or at least wars. There seems to be an element of some cases being misdiagnosed as post-traumatic stress when in fact they do have a physical basis because of head injuries or brain injuries that aren't being diagnosed. Are we finding a similar phenomenon in Canada?

BGen Hilary Jaeger: We certainly have our cases of traumatic brain injury, but I would advise you to.... If you take a careful look at the very recent article in *The New England Journal of Medicine*, what it says is not that post-traumatic stress disorder isn't really post-traumatic stress disorder, but really MTBI. What it says is that having had a concussion and having had that kind of disruption to your brain, whether you've lost consciousness or whether you just had your bell rung and saw stars—having had that distortion on top of all the other things puts you at higher risk of PTSD.

What it's really saying is to screen very carefully people who've been through these kinds of explosions for PTSD. It's not saying you've got the diagnosis wrong and it's not PTSD. A lot of people who got the press clippings version of the article missed that point.

● (1720)

Mr. Joe Comartin: Thank you, Mr. Chair.

The Chair: Thank you, Joe.

Thank you both very much. You've certainly got our investigation into this off to a great start. We appreciate the frank comments and the good questioning from the committee members as well.

Just as a note to the committee, we're trying desperately to make sure we have a full slate next week. We're working on getting some more witnesses in.

Thank you all very much.

The meeting is adjourned.

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