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Chair

Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): The witnesses are in place. We have a quorum. I call the meeting to order.

This is meeting 13 under our motion to study health services provided to the Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

Today we have Commander Briggs, who is the medical advisor to the Chief of the Maritime Staff; Colonel Darch, medical advisor to the Chief of the Land Staff; and Captain Courchesne, medical advisor to the Chief of the Air Staff. We welcome you all.

The process is usually to allow you the time to make a presentation. I understand you all have one, whatever time that takes. We'll start a round of questioning thereafter.

I understand, Commander, you are going to start. The floor is yours.

Commander R.P. Briggs (Medical Advisor to the Chief of the Maritime Staff, Department of National Defence): Thank you.

Thanks for the invitation to appear before your committee to discuss maritime health service support issues.

As an introduction, my name is Commander Rob Briggs. During my career I have served primarily in the navy environment, though I've also spent considerable time with the army. I've had operational deployments in both environments and have completed postgraduate training in public health and hyperbaric medicine—diving and undersea medicine.

My title is director, maritime health services, and CMS—which stands for Chief of the Maritime Staff—medical advisor. My primarily roles are as follows. I provide professional, technical, or clinical advice to the Chief of the Maritime Staff on all aspects of health service support pertinent to navy personnel, platforms, equipment, and navy operations. I act as the CMS' senior authority on all issues pertaining to occupational health.

In the role of director of maritime health services, I act as an advocate to ensure that the health requirements of the navy are met by a centralized CF health services group. I also provide advice to the Surgeon General and senior Canadian Forces health services staff on navy priorities and strategic direction as they will impact on current and future health service delivery and force health protection.

I am the Surgeon General's senior advisor on all issues pertaining to navy occupational health, including submarine and diving medicine. I serve as a clinical conduit, if you will, between the Surgeon General and the regional surgeons in Esquimalt and Halifax for all clinical issues. Where required, I modify CFHS policy and provide advice on program delivery to reflect the operational and occupational requirements of the navy.

It is important to appreciate that I serve a staff and not a line function within the Maritime Staff and Canadian Forces health services group headquarters. By that, I mean that I do not command the CF health care centres on either coast. They are commanded by clinic managers, who in turn report to one health services group for Esquimalt—which is located in Edmonton—and four health services group headquarters for Halifax—which are located in Montreal.

As a staff officer, I monitor professional, technical, and clinical aspects of health programs and health care delivery as delivered by all health care providers providing operational or operational readiness care to navy personnel.

The navy has historically played a large role in maintaining Canada's sovereignty and security and projecting Canada's foreign policy goals abroad. Since 1990, the navy has participated in many UN, NATO, and other operations in southwest Asia, Somalia, Haiti, the Adriatic Sea, East Timor, and in aid of our southern neighbours following devastating hurricanes. In addition, the navy has responded to domestic missions, including the Swiss Air recovery, the GTS *Katie* boarding, drug interdictions, fishery patrols, etc.

As you know, the navy has played a major role in CF operations since 9/11. During Operation Apollo, Canada deployed 15 of the 17 major naval warships, comprising 96% of our total seagoing positions, to southwest Asia. The navy's presence there continues to this day. HMCS *Charlottetown* is currently deployed, and HMCS *Toronto* recently returned from an operational deployment in that area.

In addition, navy augmentees are presently fulfilling important roles in Afghanistan. On a daily basis, clearance divers, naval boarding party members, Sea King air crew, and explosive ordnance disposal experts place themselves at risk on behalf of Canada.

It is important for the committee to understand that the complement of health service support personnel on a frigate or destroyer at sea comprises only two persons: a physician assistant and a medical technician. The ship may be as far as a seven days' sail from land at times, so these personnel must be extremely well trained and well equipped and be independent thinkers. Needless to say, there is a great deal of responsibility on their shoulders, and they are extremely valuable assets to the CFHS and the navy.

A number of issues improve the navy's capability of delivering health care support to their personnel. I will touch on only a couple here.

The navy practice of maintaining home port divisions maintains stability and support for family members of sailors away on deployment or courses.

● (1540)

The navy personnel enjoy a great deal of buy-in and support from the navy chain of command at the highest levels, at the formation commander's level on each coast, and CMS, which is ultimately responsible for the health and well-being of their sailors, soldiers, airmen, and airwomen.

I'm telling the committee this as a reminder of the importance of ensuring that, whatever recommendations come out of the committee's good work, you involve the navy and ensure that the navy is factored into any of the recommendations that are forthcoming.

I would be pleased to answer any of your questions following the other opening addresses.

Thanks very much.

The Chair: Thank you.

Who's next?

Go ahead, please.

Captain(N) M.E.C. Courchesne (Medical Advisor to the Chief of Air Staff, Department of National Defence): Mr. Chairman and members of the committee, I'm Captain (Navy) Cyd Courchesne, the medical advisor to the Chief of the Air Staff, and the director of aerospace medicine for the Canadian Forces.

I would like to provide a brief background and explain the roles and responsibilities of my position. I'm a general practitioner by training, and I enrolled as a general duty medical officer in the CF and completed post-graduate training in aviation medicine. Most of my career has been spent in support of the air force. I first started out as a flight surgeon in Cold Lake, Alberta, and progressed over the years to my position as medical advisor to the Chief of the Air Staff.

Although it might seem strange to you that I'd do this in a naval dress uniform, that is just a reflection of the joint nature of the CF.

Like my colleagues present here, in general terms, I'm the liaison between the air force and the health services group. I provide advice to the Chief of the Air Force and his staff on medical matters, and I am the point of contact for the air force headquarters staff for issues related to health services. Likewise, I provide the commander of the health services and our senior staff with advice, information, and situational awareness on the air force and air force issues.

I provide professional technical guidance and leadership to all the regional surgeons in matters of aerospace medicine support, though I have no command authority over them. I function as a senior staff officer of the health services group, and I represent Canada in international military aerospace medicine working groups.

I have no direct role in the health service delivery at the clinical level or on deployments, and no direct role, either, in the mental health realm, whether that be programs, policy, or service delivery.

As director of aerospace medicine, I'm responsible in general terms for formulation of doctrines, strategic plans, and policies with respect to health services support to air operations. In particular, I establish air crew medical standards and air crew medical policy for the Chief of the Air Staff and for the CF.

I also hold the appointment of medical advisor to the air-worthiness authority under the Aeronautics Act, and that just also happens to be the Chief of the Air Staff.

[*Translation*]

I will be pleased to answer your questions in French or English. Thank you.

[*English*]

The Chair: Thank you very much.

Go ahead, Colonel.

Colonel A.G. Darch (Medical Advisor to the Chief of the Land Staff, Department of National Defence): Mr. Chairman and members of the committee, thank you for inviting me to appear before you today.

I am Colonel Allan Darch, the medical advisor to the Chief of the Land Staff.

I'd like to briefly explain my background and the roles and responsibilities of my current position. I feel that it's important to note that I do not have a direct role in mental health care, and I do not work specifically on occupational stress injuries or on PTSD.

As a doctor, I'm a general practitioner by training, and most of my career has been spent providing medical support to the army. During my career I've had four operational deployments. I started as the unit medical officer for a mechanized infantry battalion—and I'm very pleased to see my first commanding officer here today, General Cox. I gradually progressed over the years to my current position as the medical advisor to the Chief of the Land Staff.

In broad terms, I'm the liaison between the army and the health services group. More specifically, I advise the commander of the army and his senior staff on medical matters, and I'm the point of contact for the senior army headquarters staff for matters related to health services. I also function as senior staff officer for the land staff. Parallel to this, I provide the commander of the health services group and her senior staff with advice, information, and situational awareness on the army, and I'm their point of contact for army-related medical issues. I also function as a senior staff officer within the health services group and represent Canada on international military health care working groups.

Additionally, I provide medical, professional, and technical guidance and leadership to the four army regional surgeons, although I do not have a command and control relationship over them.

I'm also the military occupation advisor for general duty medical officers. In this role, I'm responsible for the coordination and control of where medical officers are employed across Canada and I contribute to their career management. As part of this, I chair the post-graduate training board and participate in merit boards.

To assist me, I have a staff of one subordinate, a major, who is a health service officer.

I welcome your questions.

● (1545)

The Chair: Thank you all very much.

I'll mention before we get started that you recognized our researcher. I understand that at one point in time you had to patch him up a little bit. We thank you for doing that so he's able to be with us.

Mr. Coderre will start our questioning with a seven-minute round.

Hon. Denis Coderre (Bourassa, Lib.): Thank you very much, Commander, Captain, and Colonel.

This is probably one of the most sensitive and important issues in relation to the condition of our troops. Of course, there's a lot of prevention, but there's a matter of cure.

As a start, it would be important to talk about the status. I know from a medical health journal today that when they studied data in over 8,000 files, they said that half of the people who have post-traumatic stress disorder don't even look to get some treatment. That's my first point. I would like some of you to talk about that.

I would like to know specifically the status regarding our forces. Maybe we should talk about the issue of post-traumatic stress disorder, but there are also other issues, such as addiction to drugs and alcohol and all that. I'm wondering how our troops are.

Secondly, I was a bit troubled by an answer from General Jaeger when we were talking about providing some medication to some of our soldiers and bringing them back on the field. I won't get specific now, but if we can address those two issues, I would be pleased.

The Chair: Is there anybody who wants to take a shot at that?

Go ahead.

Capt(N) M.E.C. Courchesne: I'm not sure what the question is. Could you...?

[*Translation*]

Hon. Denis Coderre: I can repeat it in French, if you like.

It's not a complicated question: according to a study involving some 8,000 individuals, half did not request treatment, and yet post-traumatic stress syndrome is a growing problem. I would like to know what the current situation is as regards our troops. How is it going in the field, whether it be the Navy, the Air Force or the Army?

The other problem is that General Jaeger told me right here in this Committee that people were treated and then sent back to the front line while still under medication. I would like to get further information about that. Then we can talk about more specific issues.

[*English*]

Capt(N) M.E.C. Courchesne: On the first part of your question, I'm not sure I know what you're referring to—this study of 8,000 people.

Hon. Denis Coderre: A medical health journal, which is a—

Capt(N) M.E.C. Courchesne: I'm not familiar with that study, so I don't feel comfortable commenting on the—

Hon. Denis Coderre: Basically, they were saying that although we have a lot of people who need treatment, half of them don't even seek it, so what are we going to do about it, in the prevention—

● (1550)

Capt(N) M.E.C. Courchesne: In general terms, if we're talking about mental health, it's general medical knowledge that a large percentage of individuals do not seek medical help, basically because they are in denial about their symptoms or because there is a lot of stigma attached to mental health problems. I think that's generally well known.

I would say it's a matter of education in the Canadian population as well as in the Canadian Forces as to the resources we have with respect to treatment for mental health and destigmatizing mental health.

Hon. Denis Coderre: What would you do as an advisor, then, to seek out those people, to make sure they know it is normal that they might have some problems, and that we are there to help them?

Capt(N) M.E.C. Courchesne: I would defer that to our mental health colleagues responsible for formulating programs with respect to the delivery of mental health care services.

Hon. Denis Coderre: How about the issue of medication and what kind of medication we provide to those soldiers who are going back to the front?

Cdr R.P. Briggs: Sir, if I could briefly go back to your first question, there's no doubt that the stigma of mental health is a big issue, not only within the CF but within the greater Canadian community. It is very hard to break those barriers down.

A lot of it is perception of the individual, so that does produce problems. We can have all sorts of services, but if people don't identify themselves or aren't identified, it's hard to give them treatment, and that is an issue we wrestle with.

We have done some things. For example, our new health assessment, which is about to be unrolled, is going to be every two years. Formerly, every five years CF members up to the age of 40 needed to get a physical examination per se, which involved a history and a physical exam. Then from age 40 to 50 it was every two years, and thereafter it was every year.

The advice of our subject matter experts has indicated that we're much better off from the get-go to do this every two years. As part of this, not only are we increasing it to every two years, but our experts have weighted in a variety of screening questions, on not only physical health but also mental health.

We would hope that in effect by doing this every two years we would identify folks who are in some sort of physical or mental distress. That's one way we have of perhaps reaching out a little more frequently to hopefully identify these folks.

I think the committee is already aware, because of testimony, that we have an enhanced post-employment screening process now, which, as far as I can tell—and again, I'm not a mental health expert—is the premier post-deployment process that any military has in the world. From what I'm told, it's even superior to what the U.S. system has in place.

We're ideally catching everybody from a deployed operation abroad. Within three to six months of their return from a deployment, we're doing an enhanced screening process, as part of which there is a questionnaire and an actual interview with a mental health professional. That's supposed to be ensured through the chain of command. The chain of command will tell Corporal Bloggins, “You have to go in on this date for your enhanced post-deployment questionnaire.”

Hon. Denis Coderre: But they don't do that if they're going back to the field?

Cdr R.P. Briggs: Everybody should undergo this process regardless.

Hon. Denis Coderre: Do we have a lot of cases? I was doing some reading about medical treatment with medications such as Zoloft and Paxil, for those people who suffer with that disorder. What is the side effect of putting somebody on medication in a theatre of operation?

Cdr R.P. Briggs: I would say generally our philosophy—and this is a general rule—is that if the interruption of a medication is going to cause an acute exacerbation of physical or mental symptoms, then someone is non-deployable at that point. There are a lot of other parameters as well, but I'm talking from a medical point of view, about a medical problem.

The other issue is whether that medication affects your cognitive abilities. For example, if you're supposed to be officer of the watch on a ship and you're going to be drowsy and fall asleep, or if you're going to be sentry and you fall asleep, or you could have a convulsion, or if side effects from that medication will affect your ability to look after yourself and your buddies, then at that point you would not be able to be deployed using that medication. Medications vary.

● (1555)

The Chair: Sorry, but we'll come back to that later. We're way over time. We have lots of time. You'll get another shot in.

Mr. Bouchard, before we proceed with you, can you update us on Mr. Bachand? I understand he was walking around on crutches. Is he okay? Can you explain what happened to him?

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): He has a sore knee and is currently walking with crutches, but I thought he would be here this afternoon. I think everything is going to be fine, though.

[*English*]

A voice: We have doctors.

The Chair: We have them. It would have been a good time to be here.

A voice: He missed a great opportunity.

[*Translation*]

Mr. Robert Bouchard: Yes, he is pretty tough, so I think everything will be fine.

Thank you, Mr. Chairman.

Thank you all for being with us today.

I would like to come back to Mr. Coderre's question about the study. I saw a study dealing with military personnel who consult experts on mental health and post-traumatic stress syndrome. According to that information, military personnel who consult such specialists are not well thought of. Few soldiers actually use those professional consulting services. Some even say that it could affect their career. I would like to know if you share that opinion or if you have heard that there is an issue as regards military personnel avoiding seeking help from a mental health professional.

[*English*]

Col A.G. Darch: The problem of stigma regarding mental health illness is a common one, I believe, in our Canadian society, and it's the same in the military.

We've done a lot to try to destigmatize mental illness and to create an awareness of it. Some of the things we've done include a series of intentionally overlapping strategies to help people understand mental illness and to help people who have mental illness come forward for assistance. We've worked both on reaching out to them and on providing opportunities for them to seek help themselves.

In general terms, delaying seeking help for mental illness appears to be common in Canada as a whole. To help encourage people to seek help, we deploy teams of mental health care providers to theatre. They're accessible there—a psychiatrist, a social worker, and a mental health nurse.

When people are returning from a mission, they are educated on operational stress injuries. On career courses for officers and non-commissioned officers, we provide education with respect to operational stress injuries and mental health. We also have the post-deployment screening, during which a person fills out a questionnaire that includes questions for OSIs and PTSD. They also have a one-on-one interview with the mental health care professional at that time. That gives them an opportunity to bring up any issues they have without having to travel to a place themselves to take that initiative. The initiative is brought to them by us.

Further, we have the member assistance program, whereby they can confidentially access help outside of the military. They can get up to 10 sessions of counselling done by civilians outside the military, so it's confidential. Further, the operational stress injury social support network is available, and finally, as well, on their biennial medical exams there are questions and things that are done to look at their mental health.

● (1600)

Cdr R.P. Briggs: May I answer, sir?

The troops, upon redeployment—and granted, we're talking about the folks who deploy to overseas, to Afghanistan—have a third-location decompression; it is currently in Cyprus, and I believe it lasts from three to five days. At that point, mental health care professionals are made available. There are a variety of educational programs and other programs. It's really been aimed at demystifying mental health and breaking down those barriers in order to normalize a lot of these issues these folks may be experiencing, and by all accounts it's being very well received by the troops.

[*Translation*]

Mr. Robert Bouchard: Thank you. We have also been told that, since the Afghanistan mission began, 17 per cent of soldiers are being treated for mental health issues and that, in the last contingent from Valcartier, the percentage was higher.

Have you noted a trend in terms of a higher incidence of mental health issues in the Canadian Forces?

[*English*]

Col A.G. Darch: Generally, sir, I think we have seen an improvement in terms of people coming forward to seek help for mental health problems.

Specifically, with respect to the deployment coming back to Valcartier, it is way too early to have all the information on that. We won't have that for at least six to maybe nine months after they've returned, so that we have the opportunity to do the post-deployment screening at that point.

Cdr R.P. Briggs: When you hear figures like that, it's difficult, sir, to determine whether the actual number of cases has increased or the willingness of the folks to come forward has increased. That is, is the stigma being broken down so that people feel more comfortable coming forward, or is it actually a true increase in operational stress injuries?

Again, I believe the 17% figure was based on one rotation, Roto 1 of OP ATHENA. I don't think we have any more up-to-date statistics than that. On the folks from Valcartier in Roto 4, which is currently about to repatriate, I believe, as Colonel Darch said, we don't have all the statistics. Hopefully that will be forthcoming.

The Chair: Mr. Bouchard, just a short question.

[*Translation*]

Mr. Robert Bouchard: I see.

Are you able to confirm that you have enough mental health professionals at your disposal to meet the needs of members?

[*English*]

Col A.G. Darch: Yes, sir. In and around 2003-04, we had 229 mental health care professionals in the military. That included military and civilian psychiatrists, psychologists, social workers, mental health nurses, and addiction specialists.

With the approval of the mental health initiative, we have increased that to 321 providers now, and we are working towards bringing that up to 447 mental health care professionals in 2009.

Along with that, from 2004 to 2009 we are investing $98 million into mental health in the Canadian Forces, which is quite a substantial amount. To put it into perspective, if you look at the number of mental health care professionals right now, we have one mental health care professional for every 202 members in the Canadian Forces. In 2009, at 447 mental health care professionals, we will have one mental health care professional for every 145 members of the Canadian Forces. It is a very robust capability. Indeed, every member of the Canadian Forces has access to mental health services. They only have to ask for it.

The Chair: Thank you very much.

Ms. Black.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you all for coming and for your presentations.

Earlier, you were asked about a study. I think the one my colleague was referring to was the *New England Journal of Medicine* study that has come out recently. General Jaeger referred to it in her testimony on traumatic brain injury and post-traumatic stress disorder. It was called "Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq", or words to that effect.

Have any of you referenced that study at all? I wondered if it would have an impact on how you do your screening and also in how the treatment is given. But if you haven't seen it....

● (1605)

Col A.G. Darch: I've just read a summary of it, and of course I've read the comments General Jaeger made to the committee.

We're continually evolving the processes we use to assess and to treat mental health and the processes we use for screening people both before and after deployment. So this study, which has just come out, may well contribute to the evolution of the process, but it's too early for me to comment on it.

Ms. Dawn Black: Okay, thanks.

Colonel Darch, I guess it would be fair to say that your service is the most burdened one right now on these issues with the mission in Afghanistan.

As the defence committee, we were in Afghanistan. We saw the small hospital on the base and met with some of the people who were working there. There was a social worker and a psychiatrist and the doctors there.

What are the specific challenges you're facing right now for your command? I know they must be many, but I wonder if you could boil it down to the ones that take the top of your attention and agenda at this point.

Col A.G. Darch: Some of this is a bit out of my area, but I'll talk about two general things.

First is the challenge of ensuring that we provide the best possible medical care for our soldiers. Second is ensuring that we have enough commissions ourselves as well. With respect to the number of commissions, we have put considerable effort into attracting doctors to the military and retaining them in the military.

For about 12 years we've genuinely had a problem with being short on doctors. We have employed one lieutenant-colonel physician full time in attraction and recruiting, and we have hired two reservist recruiting officers to help specifically with recruiting doctors. As a result, we have 150 captain and major doctors in the military. For a long time that number was below 100, which was quite a significant deficit. As of 2006, we brought that number up to 115, and right now we're at 126. We're on track to have it right up to 150 by about April 2009, which is where we're supposed to be.

Ms. Dawn Black: I've been told that one of the challenges when you contract civilian doctors is that they get a better deal, and sometimes it makes it harder for the doctors who are part of the military to want to stay. So that's part of the retention problem too.

Col A.G. Darch: Yes. In order to get the civilian doctors to work for us we've had to offer fairly good salaries. But the salaries are so attractive that when there is a position available, we've had military doctors retire so they can get that position.

Ms. Dawn Black: That's my point.

Commander Briggs, I had the pleasure and the great opportunity to go on the HMCS *Calgary* last summer. It was quite an experience and I really enjoyed it.

Cdr R.P. Briggs: There's no ship like the HMCS *Calgary.*

Ms. Dawn Black: Was it yours?

Cdr R.P. Briggs: It wasn't, but they traditionally have great morale on that ship.

Ms. Dawn Black: Yes, and they certainly treated me very well.

● (1610)

Cdr R.P. Briggs: Very good.

Ms. Dawn Black: I just wanted to get that in.

Apart from things that we in the general community would understand, like seasickness—which I did get, by the way—

Cdr R.P. Briggs: You're not the only one, ma'am.

Ms. Dawn Black: —there's also isolation at sea when people are on deployment. What special psychological challenges does your command have to deal with because of long deployments at sea? I know people are in the gulf now.

Cdr R.P. Briggs: The navy has a history of being away from home a lot without it actually being called a deployment. In the old days of the 1960s, 1970s, and 1980s, it was common to be away from home for six to eight months of the year, and that was just business as usual. Typically you'd come ashore, and then you'd be on a career course, usually in Halifax, away from your home port. So it was a very tough life for families in the navy.

There have been more and more so-called operational deployments with the navy. In Operation Apollo, from 2001 to 2003, folks were literally going on deployment a year after they had come back. They had a very heavy load, because of course the navy is much smaller than either the air force or the army, at just less than 10,000 sailors. It was a heavy load on those folks, especially when they started getting ill or burned out. People who were supposed to be in shore billets suddenly did a pier-head jump back to sea.

From a health services perspective, right now our greatest challenge is that our physician assistants are being hired in droves by the civilian world, primarily Manitoba, Alberta, and Ontario.

Ms. Dawn Black: I understand that's pretty much true of a lot of trades.

Cdr R.P. Briggs: Absolutely. We've made inroads, as Colonel Darch mentioned, on the general duty medical officers. We're critically low on pharmacists and PAs. We're low on medical technicians and a variety of other specialized trades like lab technicians, x-ray technicians, and biomedical engineering technicians.

Ms. Dawn Black: Is there anything specific to the navy, in terms of psychological stresses, that is different from the other two forces?

Cdr R.P. Briggs: When we talk about psychological stresses, I would say the trigger is obviously different. It could be a flipped-over rigid hull inflatable boat that you happen to be in, or a line that breaks and hits your friend next to you during replenishment at sea, or some other type of trauma, such as body recovery for clearance divers. So I would say the incident that triggers the operational stress injury may be different, but the symptoms are otherwise undifferentiated.

We have folks on army deployments, our explosive ordnance disposal experts, and of course our so-called purple trades—our medical folks, our cooks, and our other support trades, who deploy with the army and then come back into the navy formations, and then dwell with us.

So it's really a hodgepodge of issues. We're talking about the same issues, but obviously we don't have the numbers the army does.

The Chair: Thank you.

Mr. Hawn.

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

With respect to avoidance of medical care and so on, I can tell you that as pilots we generally tended to avoid flight surgeons too, but I think Captain Courchesne knows that.

I want to talk about the study that was brought up. It was actually called the Douglas study. It was just released, but it was actually done in 2002. Of the 81,000 regular and reserve force members at the time, 8,000 were surveyed. Of that number, 1,220 had symptoms of one or more mental disorders, and of that number, four out of six had not sought help. So the real number is about 800 out of 8,000 who were surveyed. For a lot of those folks, obviously it's not Afghanistan-related; it's probably related more to experiences in Bosnia and Somalia, and in other branches.

With all the things that have gone on to ramp up the availability of services and education, to remove the stigma, to bring knowledge and awareness, and all those things that we know the CF has worked very hard on, Captain Courchesne, in what direction do you think that reluctance to seek assistance is going? Are people becoming more reluctant or less reluctant?

Capt(N) M.E.C. Courchesne: I'm speaking outside of my realm here, because I don't advise the Surgeon General on mental health issues, but through collaboration with our colleagues and all the initiatives that we have put into increasing access to mental health, I would hope that we are breaking the stigmas. We're making it more available. We're pushing it out front. As my colleague, Colonel Darch, has indicated, we have mental health professionals deployed with the troops so that they have ready access. We're doing this to improve access for CF members.

● (1615)

Mr. Laurie Hawn: Maybe I'll ask Colonel Darch a similar question, because obviously the army is probably the most beset at the moment with this situation.

One of the things the report said is that this is probably applicable to all militaries for all the obvious reasons. Have we done any work with particularly the U.S. military or the Brits with respect to the same issues and the experience they're seeing?

Col A.G. Darch: We do collaborate with them quite a bit. I don't know what specifically mental health may have done with them.

You asked Captain Courchesne about the stigma and what we are doing about that, sir. Some of the things we have found to be very helpful in terms of reducing the stigma are to educate people when they come back from deployment, and educate the non-commissioned officers and the officers taking career courses regarding operational stress injuries and mental health in general. Those have been very helpful.

We have found that the education they've had with both the third-location decompression and with the post-deployment screening has really done a lot to break down those barriers, because people have talked to mental health care professionals, and they find it much easier then to come back to talk to them if they need to.

Mr. Laurie Hawn: Okay. I just want to talk about the medication aspect again. When people hear the words “soldiers on medication”, that conjures up all kinds of things that are not reality. Is it safe to say that any time any soldier, sailor, airman or airwoman is under medication, it's done under very close supervision, and, as Commander Briggs said, any potential impact on their operational effectiveness or safety would render them unemployable for that period?

Col A.G. Darch: Yes, sir, absolutely. We would never deploy somebody who we knew was suffering from an untreated psychiatric or physical disability.

However, we do deploy people who have successfully been treated for those things, and I know that if a person is given medication in theatre, it's under very carefully controlled conditions and they are watched very carefully. We do have a mental health team in theatre, and if there is any concern that the person was not fit for that type of work, they would be removed from it.

Mr. Laurie Hawn: Concerning resources, obviously all three branches have mental and medical professionals. Do you have the ability within the three branches to do some shifting of resources to the army if the need is greater there, and so on? What capability do you have to shift the personnel resources back and forth? Commander Briggs, I'll ask you.

Cdr R.P. Briggs: Sir, since we've had the centralization of the Canadian Forces health services into one group, in effect, it's really allowed us to use all our assets; whether they're headquarters assets, training establishment assets, or army, navy, or air force assets really doesn't matter.

In any given deployment—and currently I think we have 160 folks in Afghanistan or in that area of operation—people are taken from any of the 30 clinics all over Canada. In fact that's what happens.

Mr. Laurie Hawn: Okay, good.

With respect to the whole ball of wax of health care and mental health care particularly, obviously with the tempo of operations we've had in the last few years and in Afghanistan in particular, is it safe to say this is going to be a continuously evolving aspect of the service that part of the military provides? Are we always going to be a little bit behind whatever is happening?

Col A.G. Darch: The nature is that we're a learning organization, and one of the things that's very important to the whole process is what we call “lessons learned”. After an event or an operation, we assess and analyze the operation to look for things that we could do to improve the service we provide. We put that into effect for the next operation or event.

Mr. Laurie Hawn: With respect to those lessons learned, I know that on the combat side, lessons learned in the field get back to Wainwright within a matter of 24 to 48 hours and are implemented as the training is going on.

How quickly do the lessons learned—medical and psychiatric—get back into the system?

Col A.G. Darch: That's a good question, sir. I'm afraid I don't know specifically how long it would be.

Mr. Laurie Hawn: I know there's probably not a specific answer, but what's the process?

● (1620)

Cdr R.P. Briggs: There's a lessons learned process that we've developed through our operations folks, so I would say that on the operational piece, sir, we do much better than other aspects. Nobody does it better than the army, I'll be quite honest with you. They've had this process in effect for a long time.

We, the CFHS, send things up through the army as well as through our own operations cell, and it's certainly a priority of our group to develop a robust lessons learned capability beyond just operations. I would say, for example, when you talk about the TO and E, the table of organization and equipment, which is basically who goes on the deployment from a medical perspective, we're constantly tweaking that, whether it's critical care nurses, social workers, physiotherapists, or bioscience officers for force protection. That goes on and on. I would say it's pretty quick. We're pretty quick to make changes.

As well, I know Colonel Bernier, our director of health services operations, is in contact with the task force surgeon overseas on a daily basis.

The Chair: Thank you very much. You'll have to catch him next time.

That ends the first round. We'll go to a five-minute round. We'll start with the official opposition and Mr. Cannis. Then we'll go back to the government and then to the Bloc.

Go ahead, Mr. Cannis.

Mr. John Cannis (Scarborough Centre, Lib.): Thank you, Mr. Chairman.

Panel, welcome, and thank you for being here.

My question probably follows the same line as the questions of my colleagues, Mr. Coderre and Mr. Hawn. You indicated you assess our men and women in uniform pre- and post-deployment, but you also made a comment, if I may quote, that “some do not seek help”. I can't possibly accept that, because before they are sent off for duty, they are obviously assessed and cleared as being in stable condition physically and mentally, etc. I'm sure that's the case. Then we ask them to do their duty.

The concern I have is that once they return after a six-month duty or whatever, it's mandatory that they be assessed. Am I correct? Once they are assessed, there's an evaluation report that this individual, for example, has this ailment. They do not seek help, so what is the next step after that? You obviously provide them with information that you've identified this problem and this is your recommendation. Is that the process?

Col A.G. Darch: Sir, on my saying they do not seek help, actually I think what I did say was that they delay seeking help.

Mr. John Cannis: It's that they delay it. Maybe I misheard.

Col A.G. Darch: It's very common in Canada in general on mental health issues for people to delay seeking help. I'm not sure if it's denial or if they're hoping they can solve the problem themselves. I'm not sure.

With respect to the post-employment process, when they have the screening done there are two parts to the screening. The first is the mental health questionnaire that they complete, and there are a number of validated instruments within that looking for different specific things. Then they have a one-on-one confidential interview with a mental health care professional.

Based on those two things, the screening questionnaire and the interview, if there is any concern that there is any symptom of an operational stress injury, or any other mental health concern, then they are referred for further assessment by mental health care professionals that goes into much more depth and detail.

Mr. John Cannis: That they delay seeking help concerns me.

My concern here, as it relates to the Douglas study, which we all understand and accept, is that in order for us to reach a conclusion today...a study is not something we do in two or six months, but a period of time. We've obviously learned, as was pointed out earlier, from other engagements that we were involved in—Yugoslavia, Somalia, etc.

There is a concern among us, you, and all Canadians for these people. How do we then possibly contemplate sending them back after a said period to go back and engage in a specific theatre?

Col A.G. Darch: To put the delay in seeking care into more perspective, of the people who are screened during their pre-deployment screening as possibly having an OSI, over 50% of those people are already receiving care for it. If you go back to 2000 or thereabouts, the average time between the person starting to have symptoms of PTSD or operational stress to getting treatment was five to six years. Now we have that time down to months and in some cases even weeks from the time a person experiences symptoms to when they actually start getting treatment.

● (1625)

Mr. John Cannis: In your view, have we learned from our experience in previous conflicts? Has the plateau or the bar risen, would you say? Given our experiences in Yugoslavia, Somalia, etc., and what we're currently engaged in, are there new approaches, new methods, new techniques that we have learned?

We didn't have to wait for the study because, as was mentioned earlier, it's an ongoing process. Do you feel we're where we should be, or could we be better off? Are we restricted from being better off? And do you know what percentage of the overall budget that is?

I don't know what is allocated in the military budget or what portion would go there. I don't think any of us know that, but if you know, what percentage of the budget is allocated towards this type of service? I don't mean necessarily just yours, but for the overall medical service industry, is it strained? Does it need improvement? Do you have any comments on that?

Col A.G. Darch: I do know that from 2004 to 2009 we're investing $98 million into health care. We are increasing the number of health care professionals in the military to 447 by 2009. Other than that, I couldn't tell you what percentage of funds are devoted to that.

Mr. John Cannis: But we're strained in terms of having the professionals, as was mentioned earlier in other presentations. They are there servicing the private sector, and we've got to entice or somehow contract out. Is there any suggestion you might have as to how we can retain or manage that cost? Do we have to look for more money to attract and offer other inducements? Do you have any suggestions?

Cdr R.P. Briggs: I know, sir, that the number of uniformed specialists has been one issue. We've been trying to get that number increased, because we realize that we don't have enough specialists to meet the mission. I know that CMP as well as our Surgeon General are engaged in trying to get that to happen. Obviously you can deploy uniformed health care givers, whereas you can't deploy non-uniformed folks.

As well, unfortunately the public service wages can't compete with the civilian public sector. I think that's an issue that hopefully is being engaged as well. We rely on our third-party contractor, Calian, to try to entice these folks, but if you look at downtown Toronto, they're short of psychiatrists as well.

So it's hard to develop this capability. It's tough. It's just tough. But I would say that we are getting a whole lot better. Certainly our screening I think has improved. The enhanced post-deployment process is much better.

I would say that Dr. Mark Zamorski, in the directorate of medical policy, is somebody who you should talk to. He is ramrodding the post-deployment process, and he has done a lot of research and a lot of work with the U.S. DOD in that respect.

Certainly our PHA going to two years and having more mental health questions are the things that have come around since 2002. In 2002 we did our first Statistics Canada-Canadian Forces study on the prevalence of mental health within the CF. That gave us a lot of good information that we've moved forward with.

Our Canadian Forces health lifestyle information survey, CFHLIS, is now moving up from every four years to every two years. The Chief of Military Personnel has okayed that significant expenditure of funds. These survey answers give us a baseline idea of the prevalence of mental health illness for the CF population.

So we have learned, I think. We probably have a ways to go. We'll always be chasing our tail, probably, but I think we've come a long way.

The Chair: Thank you.

Over to the government and then back to the Bloc.

Mr. Lunney.

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

Thank you for coming. It's great to have you here today.

I want to pick up on a comment by Colonel Darch about decompression in terms of post-deployment, and I want to take the conversation back another way for just a moment, over to Commander Briggs.

Regarding decompression, part of your advice to the navy was in this area of hyperbaric oxygen. Or I thought I heard you mention that at the beginning of your statement.

Cdr R.P. Briggs: I did my postgraduate work in hyperbaric medicine, which involves not only clinical hyperbarics but submarine and undersea diving medicine.

● (1630)

Mr. James Lunney: Could you explain to the committee for just a moment what effect hyperbaric has and how the military uses it with your divers and so on?

Cdr R.P. Briggs: Currently we're not using clinical hyperbarics within the military for anything other than decompression illness, which is decompression sickness as well as arterial gas embolism.

From time to time we will be involved in therapeutic dives in hyperbaric chambers for civilian folks. For example, on Vancouver Island we've done that several times over the last 10 or 15 years where folks have not been able to get to the Vancouver General Hospital. I believe DRDC Toronto has been involved from time to time in doing that as well.

So we do it from more of a civilian point of view. But ever since we really devolved our in-patient care in the mid-90s, as I recall, except in selected areas like Halifax and Valcartier, I believe, we really haven't had the capability to deal with in-patients on a regular basis.

Mr. James Lunney: Could you comment on the types of conditions that people would have sought help with on those few occasions?

Cdr R.P. Briggs: Certainly. There was necrotizing fasciitis, as I recall, decompression sickness, and carbon monoxide poisoning possibly.

Mr. James Lunney: It drives more oxygen into the system.

Cdr R.P. Briggs: Exactly. And that decreases inflammation and a host of other effects as well.

Mr. James Lunney: So it would be anything that would benefit from more oxygen.

You'd be aware of studies involving chronic neurological problems related to hyperbaric. For example, even kids with cerebral palsy have used hyperbaric in some instances. Does it improve neurological function?

Cdr R.P. Briggs: There have been some investigational studies, I believe. I don't think it's an approved indication yet in the United States, though.

Mr. James Lunney: No. I know there certainly are centres that are using it in the United States.

I guess the interesting point is there's evidence that when you compress the body and drive more oxygen into it, even brain injuries can be reduced. It's outside-the-box thinking, but there is some research going on in that realm.

It's a question I've raised before, but I'll raise it again since we have three medical experts and advisors here—and I know how well briefed all of you military people are, so you'd be aware of the questions I've raised before.

In about the last 20 years there's been a tremendous increase in research into the effect of nutrition—vitamins, minerals, and nutrients in physiology and certainly on neurological functions, research into vitamin B1 and thiamine in supporting the nervous system. A lot of people take anti-stress vitamins that always contain vitamin B, and so on.

I know they're waiting for me to mention folic acid in terms of heart disease.

Some hon. members: Oh, oh!

Mr. James Lunney: I know you have all our soldiers taking it!

We know that many of the members here probably should be taking some niacin to keep their blood pressure down—it might improve performance in the House.

There are indications that vitamin fortification might help people coming under stress. Has anybody even looked at it that way?

I'm glad to see you use terms like “we're a learning organization” and are looking at “lessons learned”. Here we have an outside-the-box situation where our Canadian soldiers are in a compressive zone, in terms of the combat zone and the assignment they're currently pressed in right now. Is anybody looking at outside-the-box solutions to maybe help with this? Are you aware of any studies that way?

Cdr R.P. Briggs: I'll defer to Captain Courchesne.

Some hon. members: Oh, oh!

Capt(N) M.E.C. Courchesne: Thank you, Commander Briggs.

I feel totally out of my comfort zone in answering that. I would have to defer to our mental health specialists who advise the Surgeon General. I would just like to point out to the committee that any treatment introduced into the Canadian Forces is based on evidence and is well-researched. If there were any indications, then I'm sure our mental health subject matter experts would be advising the Canadian Forces to consider it.

Mr. James Lunney: Well, you know, the challenge here.... I'm getting to know military acronyms now, but I understand there's another one called RTC, which I understand means resistance to change. I know that wouldn't apply to the medical services here, but it seems that medicine in some realms is very resistant to change. But when you're talking about the stigma of being on drugs and the treatment for PTSD, period—and we know there are complications if you're on medication when you apply alcohol or any other drug to that mix—there's certainly resistance from some of the soldiers coming forward for help in this realm.

Maybe it would be worth looking into whether a simple vitamin supplement might fortify what's available to them in that realm. I just put that on your radar. Maybe somebody could take a look into it, because I'm aware of some very good studies out there and some very qualified neurological specialists who are actually working in that realm.

● (1635)

The Chair: Thank you, Mr. Lunney. We'll take that statement as an offer of help.

Over to the Bloc. Go ahead, sir.

[*Translation*]

Mr. Richard Nadeau (Gatineau, BQ): Thank you, Mr. Chairman.

Good afternoon, ladies and gentlemen. As part of your mandate, you deal with members of the military who are in the Air Force, the Land Force or the Navy. I would like to know whether soldiers, male or female, are able to receive medical services in their language, wherever they happen to work in the Canadian Forces? If they are Francophone, are they able to receive medical services in their language when they request them?

Capt(N) M.E.C. Courchesne: I will try to answer your question, Mr. Nadeau. Every effort is made to provide services to military personnel in the language of their choice.

Mr. Richard Nadeau: When you say that every effort is made, does that mean that there are cracks in the ceiling and that some soldiers are not able to receive care in their own language?

Capt(N) M.E.C. Courchesne: All Canadian Force clinics are not bilingual, but we certainly have staff…

Mr. Richard Nadeau: I'm not talking about bilingual staff; I'm talking about services in French.

Capt(N) M.E.C. Courchesne: If a Francophone soldier from an Anglophone unit requests services in French, we will make every possible effort to accommodate him.

Mr. Richard Nadeau: Mr. Darch, is it the same for the Army? Is there a guarantee that one can receive care in French?

[*English*]

Col A.G. Darch: Yes, sir. It's a priority to do that.

What you find is that in our clinics there is usually quite a mixture of anglophones and francophones all across Canada. If, for example, a clinic has one doctor and that doctor is an anglophone and doesn't speak French, there will be a med tech or a nurse who does and who is able to translate for him. That's not ideal; perfectly, we'd like everybody to be fluently bilingual, but we've not reached that yet.

[*Translation*]

Mr. Richard Nadeau: Do members of the Air Force automatically receive service in French, if they request it?

Capt(N) M.E.C. Courchesne: The Air Force is my area of responsibility.

Mr. Richard Nadeau: Yes, sorry; I meant to say the Navy.

[*English*]

Cdr R.P. Briggs: Sir, I wish I could respond in French. Hopefully, one day....

The navy has the benefit of having two very large clinics, one on each coast. I've been in both clinics, and they're well populated with bilingual personnel. That's not to say everybody is bilingual, but certainly we have that capability, and I think within the CFHS what we strive to have is not for everybody necessarily to be bilingual, but to have that capability.

However—

[*Translation*]

Mr. Richard Nadeau: I see; thank you. I'm cutting you off only because we have limited time and I have other questions—not because I want to be rude.

Do you only deal with soldiers currently on duty? If a soldier has left the Canadian Forces for some reason, can he avail himself of your services for the rest of his life? How does it work once someone is no longer in the Canadian Forces? Can he call on the Canadian Forces for special services or at least a diagnosis, to have an understanding of what he is dealing with, if the consequences of PTSD start to affect him in his daily life?

[*English*]

Cdr R.P. Briggs: There is a great deal of cooperation, sir, with VAC and DND currently. VAC has some OSI clinics—operational stress injury clinics—and DND has the operational trauma stress support centres. My understanding is that veterans, as well as members of the RCMP, can come to the OTSSCs for assessment, so there is cooperation even with the RCMP in that respect.

To be absolutely certain of the—

● (1640)

[*Translation*]

Mr. Richard Nadeau: If I understand you correctly, Commander Briggs, whether it's two weeks, a year, ten years or fifteen years later, he can go to National Defence to receive health care services.

Capt(N) M.E.C. Courchesne: Generally speaking, no. When members leave the Canadian Forces, or when they are released, they must rely on medical services provided by the province where they decided to retire to. Our mandate ends the day a member leaves the Canadian Forces. Our mandate is to provide health care services to members of the Canadian Forces.

Mr. Richard Nadeau: And, is it the same situation if, based on the diagnosis, the problem began when the individual was still a member of the military?

[*English*]

The Chair: I'm sorry, but your time is up, Mr. Nadeau. We have to move on. You may have an opportunity to answer that later.

Next is Mr. Rota. Then we'll go back to the government, and then back to Mr. McGuire.

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

That was something that I'm leading to. Maybe I'll get to that question anyway, so it works out.

This is about the diagnostic process leading to the treatment. You mentioned in an answer in an earlier discussion that a checkup takes place every two years. I take it that's for every person in the forces. Is that correct?

The post-deployment process has an examination or diagnostic process as well. Both are geared to identify mental illness. When given the information, what recourse does that individual have? You mentioned denial, and that's something that concerns me. Can they walk away and just say they don't want any treatment, that there's nothing wrong with them? Can they return to service? Can they challenge their tests? I'm sure they can just ask to get retested or to have a second opinion.

My concern is with someone who is identified as having a mental illness. What is their recourse? What if they are in denial? What is the recourse for the forces, and what is the recourse for the individual?

Capt(N) M.E.C. Courchesne: I'll wade into this one.

I think the issue of denial is not at the time we diagnose a person. In most of our experience—and I'm talking as a medical officer right now—once we have diagnosed them, we try to get them access to care. What's reported as denial is people's not coming forth or not being truthful about the symptoms they're experiencing. We can only give the best diagnosis based on the information the individual is willing to share with us. If they are not willing, there are no tests out there...not yet anyway. We don't have those *Star Trek* things with scanners. I think the denial is in those people who are unwilling to identify those symptoms. But once someone is diagnosed, usually we will get them to care.

Can they refuse? Absolutely. Nobody can be forced into treatment—not in the military, not in Canada anywhere. They can walk away, and that is their right, as an individual, to refuse treatment. It doesn't mean we will recommend them for full employment, depending on the diagnosis.

Mr. Anthony Rota: The impression I got was that with the checkup every two years, there's a part of the questioning, part of the interrogation, I guess, or the process, that would identify it. Often what happens is people don't really realize what's going on. They know there's a buzz in their head, they know there's something going on, they're not thinking straight, but they don't really know why. Even with simple depression or something like post-traumatic stress disorder, you don't really know what's going on. You know something's not working, but you're not really sure what it is. And you don't always go forward and say, “Well, you'd better check me for this area.”

I would have thought the checkup would identify or would ask the questions that would lead the person or the professional to identify the illness that is present.

Col A.G. Darch: I think often when the diagnosis is made, what happens is there is a sense of relief on the part of the patient, because now they have an explanation for what's been happening to them and now they can see that there's a treatment ahead for it.

I don't think there's so much of an issue once they have the diagnosis, sir.

Capt(N) M.E.C. Courchesne: The biennial periodic health examination does ask questions that will seek out symptoms of that.

● (1645)

Mr. Anthony Rota: That was the impression I got.

Capt(N) M.E.C. Courchesne: It is not the only tool we have. I think my colleagues were very articulate in saying that we have put in many checks and balances. There's the periodic health examination every two years. There's the pre-deployment screening. There's the immediate post-deployment, if there's anything they want to report right away. And then there's the enhanced post-deployment screening that happens three to six months after they have returned, because we know that not everybody will identify immediately or manifest it immediately. But we put in another opportunity to be able to diagnose that, and the questions are geared to identify it.

Col A.G. Darch: In addition to that, a person can go in on sick parade to see their doctor at any point in time that they wish.

Mr. Anthony Rota: Again, I'm looking at the individual who doesn't really want to admit to it or is in denial.

Now, how do you treat someone who is in the forces and comes to see you, you've identified something, and that individual says, “No, I'm not going to....” Because there is a stigma out there, and there's no question that's something we have to get over, as a society. And it exists in the site at large in the military. Until we get over that hurdle.... We see it happen in physical illnesses as well. People don't want to admit to any kind of illness.

Does that person continue to do their job, or is there a way of removing them? Is there a way of putting them somewhere else?

Cdr R.P. Briggs: Certainly with the Canadian Forces health services, we are occupational doctors, so we are patient advocates, but we have to keep in mind the patient's safety to himself as well as to others and the organization.

There's a process by which we can give somebody medical employment limitations, whatever they require for their safety and for the safety of others. I guess you could always give somebody medical employment limitations prohibiting them from doing certain activities. That's not necessarily deployment. We'd couch it in employment limitations. But the medical employment limitations have to be known to the commanding officer, as well as the prognosis—not the diagnosis, but the medical employment limitations.

The Chair: We'll hear from Ms. Gallant for five minutes and then go back to Mr. McGuire.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman. I have just two brief questions.

On the occasion of a soldier being released from the military on the grounds of being disabled from an operational stress injury or perhaps for violent behaviour arising as a consequence of a psychological condition that has arisen out of service with the Canadian Forces, what measures are taken to protect civilian society from the former soldier's violent behaviour?

Cdr R.P. Briggs: I would say that violent behaviour has presumably been manifested in some way. Simply having a diagnosis does not mean you're not answerable to society for your actions. At that point, oftentimes, either the military or the civilian disciplinary activity occurs. At that point, the onus is on the individual to prove why, or why not, they undertook their actions.

I would say that, generally speaking, it may be out of the military's hands. If you're talking about somebody who has a medical diagnosis and who is being released from the military, really, the onus is on the military to try to gently hand over that person's care to the civilian sector, as opposed to just releasing that person and sort of washing their hands of the person.

I would certainly hope—and I'm not an expert in this area—that is generally occurring, but I can't speak to any particular cases that you may be talking about.

Col A.G. Darch: In addition to that, if the physician has any concerns that the patient has any specific plans or knows of any specific individuals the patient has threatened to harm or is going to harm, the physician has the duty to report that to the police.

Mrs. Cheryl Gallant: There is a duty. Okay.

That leads to my next question. In recognizing that not all soldiers who suffer operational stress injuries or have psychological conditions as a consequence of their service to their country are violent—I am in no way implying that—we don't have enough doctors, let alone psychologists and psychiatrists to treat the civilian population, let alone additional cases that are coming from the military.

I am quite concerned that these people will not get the care they will need once they reach civilian society. If, as a consequence of their service, they are violent and are arrested for violent behaviour as a consequence of the illness, how are the civilian courts advised that there was a mitigating condition as a consequence of the service to the military?

● (1650)

Col A.G. Darch: That's kind of outside my lanes as well.

In general terms, what I believe would happen—but I think you'd be better to ask a lawyer that question—is that the person, even if they had PTSD, would be responsible for their actions. That would not be an excuse. So if they did something, they would be found guilty. However, the circumstances of their illness would be a mitigating influence in any sentencing that would occur.

I believe that is correct, but I would ask that you please check that with the legal authorities.

Mrs. Cheryl Gallant: So the medical doctors in the military have to advise the local police that the soldier is being released—

Col A.G. Darch: The military police are the local police.

Mrs. Cheryl Gallant: —wherever that soldier is going to live.

Col A.G. Darch: I believe so.

Cdr R.P. Briggs: That is if they have a credible reason to believe that the person is at imminent risk of harming himself or others.

Col A.G. Darch: Having said that, to the best of my knowledge, this is a very rare thing. Also, within the military—and our mental health people and the director of health services delivery could perhaps answer this better—if a person starts to have symptoms of PTSD, usually there is quite a protracted time before they would be released, if they are not able to return to service.

I believe in the past, that time has been anywhere from two to three years.

The Chair: That's it for now.

Mr. McGuire, and then back to Mr. Hawn.

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

A number of months ago, on CBC television, there was a GP interviewed whose son had been to Afghanistan. This particular individual asked to go on CBC with his story. Apparently, when his son came back, he was an entirely different person, with personality changes. His father didn't know exactly what was wrong with him, but nobody would believe that there was anything wrong with him. He couldn't get anybody to respond, so he went public with it.

What happened after, I'm not sure. I'm trying to track him down to see if he was responded to.

We talk about people who refuse to admit it, but here was somebody who was crying out for help and wasn't getting it. How many others are there? Is there any documentation on how many people? To this point, 13,000 people have served in Afghanistan. How many of those really want to be treated and are not able to get it?

Col A.G. Darch: Sir, I would say that's a very, very rare thing.

Right now, what we aim for, when a person wants or needs mental health care, is that they get that within four weeks at a maximum. Almost invariably we are able to achieve that. We have a fairly extensive mental health care network within the military, and we will refer people to civilian resources if we need to.

In terms of the specific case that you've brought up, I'm sorry, sir, I'm not familiar with that at all, so I couldn't comment on it.

Hon. Joe McGuire: Maybe I'll make you more familiar, if I can get the details of it. Hopefully what you say is true, that it's a rare thing.

I think one of you said in the presentations that in the decompression period in Cyprus, soldiers are there for three or four days. How many people are rotated out at a time there, and how much time would actually be spent with particularly those around the front? There are those who are on Kandahar airfield the whole time they're there, but there are those who are on the front and under certainly different kinds of pressures.

Are they treated any differently, and how much time would you actually be able to spend to detect if there was anything actually wrong with these people, if they're only there for such a short period of time? I imagine they have other things on their mind, too, when they go there, except to submit themselves to medical examinations.

● (1655)

Col A.G. Darch: Sir, the purpose of the third-location decompression is to bring closure to the individuals with respect to the deployment, and also to facilitate their transition back to Canada and to their home life.

We also provide, while they are there, education on operational stress injuries, and they have the opportunity to talk one on one with a mental health care professional if they wish to do that.

In terms of the third-location decompression preventing operational stress injuries, that is not the intent of it at all, but it also helps provide education to the members on operational stress injuries and it provides an opportunity for any who have any concerns at all to bring those forward.

In terms of numbers, it's based on one airplane load at a time. I'm not sure if we have the approximate number for that. Whether it would be 120 or 150 people, I'm not sure.

Cdr R.P. Briggs: It occurs over the process of approximately six weeks, where the actual mental health professionals are in place in Cyprus. If you could divide the 2,500 folks or so—probably less than that, minus Camp Mirage—who are rotating through, it will give you some idea as to what sort of throughput they're dealing with.

You're right, though, that it's for purposes other than just mental health identification—physical decompression, other things too—but it is made available.

Hon. Joe McGuire: Most MPs deal with veterans mustered out after the Korean War or the Second World War, who just wanted to get home, so they just said, “There's nothing wrong with me; get me the hell out of here.” Then years later they started suffering from injuries that occurred while they were on duty. So they have to go back and prove all this stuff.

I would imagine that a lot of these people, too, are pretty anxious to get home and pretty anxious to get away from medical examinations and just get clear of it for a while. You're saying that they're not dropped there when they muster out, that they're followed up on, six weeks later, and there are safeguards.

Cdr R.P. Briggs: Three to six months.... There's not a lot of hard, fast proof of the ideal time, but it's some time after the initial honeymoon phase of redeployment back with the family, as well as post-deployment leave, which lasts anywhere from four to eight weeks typically. That's why three to six months is generally what you aim for, because that's before the regiments get into their regular training routines, etc.

That seems to have worked reasonably well, but we rely on the chain of command to ensure that the members actually do go through the enhanced post-deployment screening. Part of the reason the third location decompression is effective is because you have a captive population. They're not going to simply go home as opposed to sitting through some of the educational sessions, for example.

Hon. Joe McGuire: We were told when we went up to Petawawa that a lot of divorces occur after soldiers come home, because they just can't fit in with life as it was.

The Chair: Joe, we'll have to come back to that one. I apologize.

Finishing this round will be Mr. Hawn, and then we'll get into the cleanup round, starting with Mr. Coderre.

Mr. Laurie Hawn: Thank you, Mr. Chair.

I want to address a couple of different things. We talked about the ratio of 1 to 145 by the time we get to 447 mental health professionals in the military. Obviously, we face a lot of trauma in society generally, more and more every day, but nothing nearly as concentrated as what happens in places like Afghanistan.

But if we apply the same ratio of 1 to 145, we would have to have 221,000 mental health professionals in Canada. I don't know what the number is and you probably don't either, but I'm suspecting it's quite a bit less than that.

There are two points I'd like comment on. First, is the CF very different from society in general in terms of exposure to trauma given the concentration in that? And at the level of 1 to 145, I would suggest we are obviously treating what is necessary to be treated, but treating it in a very aggressive, proactive way. Is that a fair statement?

● (1700)

Col A.G. Darch: Yes. The study that was done in 2002 showed that the Canadian Forces at that time had an incidence of post-traumatic stress disorder that was equivalent to the civilian population.

With the deployments in Afghanistan, it has gone up a little bit. I don't have the exact numbers, but it makes intuitive sense in terms of the things the soldiers have been exposed to there.

I'm sorry, sir, what was the second part of your question?

Mr. Laurie Hawn: Just that with the ratio we have of 1 to 145 we are giving much more access to care than the general population gets.

Col A.G. Darch: Yes, sir. Our intention is that none of the soldiers will suffer from a mental health disorder, an operational stress disorder, any longer than possible, and that they're picked up as soon as possible, given appropriate treatment, and returned to normal duty.

Mr. Laurie Hawn: From what you just said with respect to the Douglas study that was done in 2002, which has changed somewhat, obviously, with Afghanistan, is the CF substantially different from society in general? I realize this calls for a somewhat subjective answer.

Col A.G. Darch: We're just really getting the numbers coming in on that. It would seem to me, given that our soldiers are thoroughly prepared for the deployment, they're given realistic training before the deployment, they have social supports, they're educated on stress-related injuries, and there's the unit cohesion of the military family, all that makes a big difference as well.

The numbers I've seen so far would indicate that perhaps we're seeing approximately twice the rate of PTSD following deployment to Afghanistan.

Cdr R.P. Briggs: Sir, I don't know if this will help at all, but I've gotten some numbers from Halifax and they inform me that in terms of being assessed at the OTSSC, the Operational Trauma and Stress Support Centre there, it takes anywhere from one to eight weeks until somebody gets in and is fully assessed, which includes a battery of psychometric testing that is standardized across the CF.

The average waiting list in Ontario to see a specialist is 15 weeks, I'm told, which is actually the best in Canada. That's generic specialists. That's anything from cancer to orthopedic surgery, so it may not be as helpful. In Saskatchewan it's 27 weeks.

So even with our current resources that aren't end-state, I still think we're doing pretty well in the CF in terms of getting folks to specialists.

Mr. Laurie Hawn: Okay.

I wanted to explore something briefly that came up with Mr. Nadeau's questions, and it related to the continuity of service between somebody in the military and somebody out and how that transition works, because as a veteran I have access to services that are provided under my pension plan, but it doesn't mean I go back to a military clinic.

Can you describe how things are transitioned from DND or the CF to Veterans Affairs? Can somebody do that?

Capt(N) M.E.C. Courchesne: I'll take that on.

As I was trying to explain to Mr. Nadeau, when people leave the military they no longer have access. It's outside of our mandate to look after them. This is for any member who takes a release from the military.

If they are injured, they will be transitioned to VAC and VAC will take over. We are working in close collaboration. The Chief of Military Personnel organization is especially working very closely with VAC to improve the transition and make it much smoother. I can say for our part that if there were any concern that people would not have their care taken over immediately by a civilian practitioner, we would continue looking after them until such time as we could hand them over to the civilian sector and they were well connected with Veterans Affairs to ensure their needs would be looked after.

Cdr R.P. Briggs: Occasionally we'll even extend termination leave just so we can get the person stable.

My point earlier was that if somebody believes he has PTSD attributable to service, then as a veteran, in that particular instance, he can come back and be assessed. That was the caveat there. Perhaps I didn't explain it well enough.

● (1705)

Mr. Laurie Hawn: So that person can come back, within the military system, to be assessed—

Cdr R.P. Briggs: Exactly. It will be in the OTSS Centre.

Mr. Laurie Hawn: —and then treated outside the system.

Cdr R.P. Briggs: That's an MOU between us and VAC.

The Chair: Good. That clarifies that.

That ends the second round.

To start the final round, we'll have the official opposition, the government, and the Bloc for the first three slots.

Mr. Coderre.

[*Translation*]

Hon. Denis Coderre: Thank you, Ms. Courchesne.

Indeed, your last point was important in terms of our ability to comprehend the current situation.

My first question is clear and specific: in cases where a person under medication is sent back to theatre, what medications would he be receiving to treat his anxiety or mental health issue?

Capt(N) M.E.C. Courchesne: Well, that depends on the diagnosis.

Hon. Denis Coderre: Give me two examples. I know we are not talking about Sudafed.

Capt(N) M.E.C. Courchesne: Are you specifically referring to mental health issues?

Hon. Denis Coderre: Yes. For example, if an individual thinks that he is fairly well, he is given a specific medication and sent back to theatre. What medication would he be given?

Capt(N) M.E.C. Courchesne: I cannot give you specific examples. I have no immediate knowledge of that, but if it were a mental health problem, he would be treated by a mental health expert. The medication would likely be an anti-depressant or anti-anxiety type of drug.

Having said that, as we stated earlier, if that is the case, it is under very specific conditions and, if it has been recommended by the mental health professional, once that individual is in theatre, he will have immediate support.

Hon. Denis Coderre: Yes, I understand all of that, but I would like to know specifically which medications are prescribed?

Capt(N) M.E.C. Courchesne: I cannot name a specific medication.

Hon. Denis Coderre: Did I understand you to say that you also provide a diagnosis? For example, if a soldier deployed to Bosnia were exposed to uranium or radioactive material, and subsequently discovered that there was collateral damage—in other words, that he had contracted cancer because of that—would you be the people making the diagnosis?

Capt(N) M.E.C. Courchesne: No, we would not. We do not see patients directly. The diagnosis is made in a clinical setting.

Hon. Denis Coderre: Does the Department of National Defence not have physicians able to make a diagnosis and either confirm or refute the causal link if, for example, someone has been exposed to certain materials on the ground during his or her mission?

Capt(N) M.E.C. Courchesne: Are we talking about military personnel or people who have been released?

Hon. Denis Coderre: I'm talking about military personnel.

I come back

[*English*]

what the commander just said regarding the MOU. If we have a situation regarding a specific mission in which something happened and then they are released, you need to have some expertise on the situation itself.

Cdr R.P. Briggs: Sir, I can speak a little bit to that, because I used to work in occupational environmental health and was responsible for the deployable health hazard assessment teams.

With respect to depleted uranium, we do have an agreement, a memorandum of understanding—which hasn't been terribly well used—whereby families' physicians can send away for uranium urine testing on individuals who believe they might have been exposed to depleted uranium, such as the individuals who served in the Balkans conflict, or they can be referred to an actual clinic to have that done. These are folks who are no longer serving. That, again, is an MOU. Colonel Ken Scott, our director of medical policy, could say more about that; we have folks, like the director of force health protection, who could as well.

From time to time, we're asked by other governmental departments to examine whether there's any possibility somebody was exposed. We will go back and examine records to find out, to the best of our knowledge, what health hazards may have been present or not. We even get letters from members of Parliament requesting that we look into particular cases. I know that in the directorate of force health protection we do the best possible job of looking at health hazards. Of course, in retrospect, it's extremely difficult to say definitively—

Hon. Denis Coderre: I understand, but the MOU applies?

Cdr R.P. Briggs: For the depleted uranium, yes, sir.

● (1710)

Hon. Denis Coderre: Okay.

Let's go back to the decompression in Cypress. My understanding is that there's also something in Thailand for our people from Afghanistan.

Is it just a vacation, Colonel Darch? Is it just a good time?

Col A.G. Darch: During their deployment, people have a leave period of about two weeks somewhere in the middle of their deployment. They can do what they wish with that. They can travel back to Canada, which is covered by the CF, or they can go anywhere else they wish at their own cost. That would be an example of that.

Hon. Denis Coderre: Okay.

I'm trying to understand what happens if they are there for three to five days. Of course, when we're talking about anxiety disorders, or PTSD, we know that flashbacks can come afterwards, but not necessarily during that period of time.

Can you give me a specific example of what you mean by education? I know it's a matter of bridge-building to make sure that when they come back to their family they know it's not the same thing. I just witnessed some of the people in the artillery, and they're not a pretty sight; when they come back, they speak louder—but they've seen a few things.

Give me some concrete examples.

Col A.G. Darch: With the decompression in the third location, they are taken specifically through some of the things that will help them reintegrate with their families. Amongst those is the need to have realistic expectations when they go home, and not to be living in fantasies. Another, for example, is that if the husband has been deployed and the wife has taken over responsibilities for the finances and all of the household care, and everything, when he gets home, it's unrealistic for him to expect to go right back to where he left off and to take control of those away from his wife immediately. There has to be time for the two of them to reach a new equilibrium, because they'll both have changed during the time of the deployment. So there's education given from that perspective.

There's also education with respect to the fact that having been on deployment and experienced the circumstances they've worked under, those are not what they will face when they get home. They don't have to worry about grassy areas being mined; they don't have to worry about people hiding behind buildings to shoot at them, or worry that if a vehicle approaches them it might blow up and harm them. So there's education towards that.

There's also education about the signs and symptoms of operational stress injuries, so they can recognize them and seek help, or they can recognize them in their friends and recommend that they get help too.

Hon. Denis Coderre: Can the period be more than five days if there is some situation...?

Col A.G. Darch: The decompression in Cypress? No, sir, it's five days, and it's structured fairly clearly.

Within that, there are four specific lectures given, and the soldiers pick two of those. So they are invested in the process as well, because they choose what they want. Again, as I said, the focus of this is mainly to prepare them for reintegration back home.

The Chair: Thank you.

To the government, are you good to go?

The Bloc? Okay, Mr. Nadeau.

[*Translation*]

Mr. Richard Nadeau: Thank you, Mr. Chairman.

I have another question about services, but I'm not sure whether this is within your purview or not. I will ask my question anyway. I am thinking of Service Canada. A colleague told me about a young soldier who had left the Canadian Forces, after his return from Afghanistan, and wanted to get information because he didn't feel well. Instinctively, he felt he should get in touch with Service Canada. Service Canada is a telephone service that can be reached at 1-800-O-CANADA. I remember this because I am the Bloc Québécois spokesperson on issues relating to Service Canada. The young man was not at all satisfied with the information he received, because he was sent from pillar to post when he requested information about his mental health. He didn't feel well.

I would like to know whether soldiers have a simple way—or at least, a less complicated way—of accessing your medical services, even though you are unable to help them directly? Can you at least provide them with appropriate referrals, so that they can receive the information and services they require?

I tested this myself. The person on the other end of the line was sincere and wanted to help out, but this is a general service. The people on the other end of the line are not physicians. Is there something simple that could be done for soldiers—in the form of a telephone number or service? I don't believe a barracks on the street corner can provide that service.

What concrete services are provided to our soldiers who require them when they return and are no longer members of the military?

● (1715)

[*English*]

Col A.G. Darch: Sir, I believe it would be best if they went to Veterans Affairs. We deal with people in the service, so I would really have to defer answering that question in detail to Veterans Affairs.

[*Translation*]

Mr. Richard Nadeau: You are saying that I should ask Veterans Affairs? Well, it's fine for you to tell me that, but are you also making that information available to our soldiers when they leave the Canadian Forces? My father is 89 years old and, about three years ago, he found out that he could receive services from Veterans Affairs Canada, such as a walker, house work, etc. He is entitled to those services and he found that out from his brother, who is 90 years of age. So, we're talking about very elderly Second World War veterans. Since then, there have unfortunately been other conflicts across the globe in which we have participated.

But, for soldiers leaving the Forces now, is there something simple that Veterans Affairs can provide them with?

[*English*]

Col A.G. Darch: I believe that each soldier who is released from the military has a transition interview with Veterans Affairs. That should give them the information they need on how to access those capabilities.

[*Translation*]

Mr. Richard Nadeau: You say that you believe that… Do you see what I'm getting at? You yourself are not certain, and I know nothing about this.

Could a soldier leaving his regiment—and I don't know how it works in the divisions—contact the division? In a case such as this, could I tell him to call the unit he is from? Let's take a specific example: if he is from the Royal 22nd Regiment, can he contact the regiment, receive medical services and explain what he would like to do?

[*English*]

Col A.G. Darch: I know that Veterans Affairs is working a lot more closely with us now. They are actually putting groups of people on the major army bases in Canada. That will facilitate this transition. Another possibility for somebody like the soldier you mentioned is what's called the regimental family. The Van Doos have a very strong regimental association, so there might be some services that he could access through them.

[*Translation*]

Capt(N) M.E.C. Courchesne: A number of procedures have been greatly improved since the Second World War. People are aware of the services they have access to on their release. There is obviously the Department of Veterans Affairs, but there is also the Centre—and this is outside of my area of responsibility—where the information is provided. This is an organization that is within the purview of the Chief of Military Personnel, the DCSA Centre. I believe you have already spoken to Lieutenant-Colonel Blais. Those services are available to people who have been released. There is also a 1-800 number, but I am unaware of it.

[*English*]

The Chair: Thank you.

The next spots are to government, official opposition, government, official opposition, and then the NDP.

Ms. Dawn Black: I have a very short question.

● (1720)

The Chair: That would be good.

Ms. Dawn Black: Captain, I want to ask you about Afghanistan and the air force, because obviously there's increased activity for the air force in Afghanistan as well as the other forces.

Those of us on the defence committee who went to KAF flew in on the Hercules and went through the manoeuvres and all that sort of stuff. I wondered at the time whether there is any kind of psychological conditioning before they start that helps the pilots who do that, and the pilots who do the other work in Afghanistan, with the stress of the job they're doing.

I'm also wondering whether you've seen an increase in these kinds of issues—post-traumatic stress disorder or occupational injuries—within the air force with pilots who are working in Afghanistan.

Capt(N) M.E.C. Courchesne: I'm not aware that there's any increase in the incidence of any occupational stress injury with respect to our pilot population. We don't do any specific psychological preparation other than what my colleague, Colonel Darch, mentioned. They're trained to do these specific types of missions, and they're prepared in that sense—well prepared for the missions they will be conducting.

Ms. Dawn Black: Thank you.

The Chair: Thank you, Ms. Black.

I thank you all very much for being here. I think your remarks and answers have certainly stimulated the committee to ask some pretty good questions. You were very useful in our study, and we appreciate your being here. I'll just say we appreciate what you do. Keep them all well.

Ms. Black, there was a notice of motion.

Ms. Dawn Black: Yes.

The Chair: Did you want to move that?

Ms. Dawn Black: Yes, I will move my motion.

It is that as part of the committee's study on health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder, this committee invite Ms. Cindy Smith-MacDonald and Ann le Clair to appear before the Standing Committee on National Defence at the next regularly scheduled meeting, to be held on February 28.

The Chair: Thanks for that. We're just passing out the motion. I think everybody was briefed on it.

Our next regularly scheduled meeting is February 28, and we've already indicated that at that time we will go in camera to deal with future witnesses. So I think it would be wise for us.... The 26th, the Tuesday we come back, has just recently been announced as having the budget at 4 p.m.

Ms. Dawn Black: Are we not meeting on the 26th?

The Chair: No, the budget is being released at 4 p.m.

I would like to advise the committee that we will deal with this motion on February 28, in camera, as we deal with future business.

Ms. Dawn Black: If we're not going to deal with it until after then.... The speculation is that the House is going dissolve before then. I hope this isn't a way around hearing from families who have very important contributions to make to this committee.

The Chair: No, it is not. As I indicated, the next scheduled meeting is the 28th, and that is when we're going to go in camera and deal with future business and future witnesses. So this is not a dodge from hearing from people. We'll deal with it and all the parameters around it at that time.

The meeting is adjourned.

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