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Chair

Mr. Rick Casson

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● (1530)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): We'll call the meeting to order.

We are meeting today on our study on health services in the Canadian Forces, with an emphasis on post-traumatic stress disorder.

We have bells, I believe, at 5:15 for a 5:30 vote, so we're not going to make it all the way to 5:30. We have two presentations today. I might try to make up a couple of minutes with our first witness to give to our second, but we'll see how that goes. We will certainly make sure everybody has an opportunity to ask a question or two.

We have Mr. Brunet, researcher at the Douglas Institute and associate professor in the Department of Psychiatry, McGill University, to start. Sir, we have you scheduled till 4:30 and we'll see how that goes.

The floor is yours for a presentation, and then we'll open it up to a round of questioning. Go ahead.

[*Translation*]

Mr. Alain Brunet (Researcher at the Douglas Institute , Associate Professor, Department of Psychiatry, McGill University, As an Individual): Mr. Chairman, ladies and gentlemen, thank you for the honour of appearing before this committee.

My name is Alain Brunet and I am a professor at the Department of Psychiatry at McGill University. I specialize in post-traumatic stress disorder. I have submitted a document that my group wrote recently. Over the past few years, the group has analyzed the results of the Canadian Forces Mental Health Survey, which is one of the largest surveys of the Canadian armed forces, or of an active army, ever conducted. Armies are usually quite reluctant to allow researchers to conduct surveys that are as in-depth as the one conducted in 2002. Beginning in 2004, researchers had access to the results, which had been made public. My team, which works in this field, began analyzing the data.

I am going to make a brief presentation on one of the documents that I submitted. I will then answer your questions.

There is very little data on mental health problems in armed forces. Armies are typically very reluctant to allow research of this kind. Therefore, the sample we had access to, which is representative of the Canadian Forces, is truly unique. However, bear in mind that this data was collected in 2002 and that all of the conclusions drawn were based on the premise that things have not changed since, which would be a harsh judgment of the army. I do not think we can make that judgment.

The survey involved 8,441 respondents. It was a large-scale survey, comparable to the best work that is done in the world. The survey was representative of the Canadian Forces.

What are the main findings from this research and, particularly, the data that we published recently? The first finding is that many so-called peacekeeping missions are as stressful, or as traumatizing, as combat missions. The concept of a peacekeeping mission has changed considerably over the past 10 to 20 years. We talk more often about peacebuilding rather than peacekeeping.

I would also like to draw your attention to the fact that, in the general population in the United States, the rate of post-traumatic stress, for example, is approximately 6.7%. It is important to compare the rates of the various disorders found in the army to those in the general population, to determine if they are higher or lower.

The document that I submitted examines behaviours linked to the seeking of care in cases where people had a diagnosable mental disorder within the past 12 months. Of a sample of 8,441 people, we found that 1,220 of them, or 15%, had suffered a diagnosable mental disorder within the 12 months preceding the survey. Of 1,200 people, 43% had contact with a mental health professional. On the other hand, 67% never sought help.

What disorders did these 1,200 people suffer from? Major depression affected 47% of them, alcoholism, 33%, social phobia, 22%, post-traumatic stress disorder, 16%, panic disorder, 12%, and generalized anxiety disorder, 12%.

● (1535)

So the most prevalent disorders were major depression, alcoholism, and a little farther down the list came disorders like post-traumatic stress disorder. Bear in mind that depression, alcohol abuse, phobias and panic disorders may also be triggered by a traumatic experience. If that factor is taken into account, the prevalence of mental disorders triggered by a traumatic event is higher than what this data would suggest.

We also looked at why people with a diagnosable mental disorder were not consulting anyone, particularly Canadian Forces members who have ready access to health care. What are the main obstacles to requesting a consultation? Three main factors came to light. The first is the lack of trust in authorities. The second is not acknowledging they have a mental health problem. The third factor is that while people may acknowledge having a mental problem, they believe that they can overcome it and want to try to deal with it themselves.

We also discovered that before asking for help, 73% of soldiers may have had up to five traumatic experiences, which means more than one deployment. They had been through many traumatic experiences before asking for help.

In light of these results, what can be done when people do not realize they are suffering from a diagnosable mental disorder? One of the things we should think about is more mental health education. People must be better educated so that they have a better idea of what they are suffering from. That is even more important because for most of the mental disorders I mentioned, effective treatment exists. The treatment is not 100% effective, but it is available. We believe that is an aspect that people do not understand. Not only are they not necessarily aware that they are suffering from a mental disorder, but even when they do know, they do not know that effective treatment is available.

Another consideration that emerged from the survey is the notion of confidentiality and the stigma surrounding mental health problems. As regards confidentiality, some participants in the survey felt that the contents of their medical file might come to the attention of their superior officer. Since Canada has an army of deployable people, you can see that if your superior officer were to learn that perhaps you were not as deployable as you should be, that might jeopardize your job. A kind of shame, a macho culture, that could fall under the umbrella of stigma, is also prevalent. It is as if becoming a hardened soldier who puts aside his emotions and everything else and recognizing at the same time that that soldier might be affected psychologically and emotionally by a very traumatizing experience were contradictory. It is as if expectations for soldiers were somewhat contradictory.

● (1540)

I think that committee members should look into the issue of confidentiality. Should confidentiality be improved? To what extent does confidentiality need to be breached? I think that question must be asked.

A final element emerged quite clearly. As regards psychological assessments, we should not wait for people to come and see us to say they may have a problem. Soldiers returning from a mission should undergo mandatory assessments.

Some of these recommendations have already been implemented or are already being tested on a trial basis in the Canadian Forces. However, perhaps some of these initiatives should be taken a little farther.

I will stop here and answer committee members' questions, in English or French.

[*English*]

The Chair: Thank you very much. We appreciate your input.

We'll start our round of questioning with Mr. Coderre.

[*Translation*]

Hon. Denis Coderre (Bourassa, Lib.): Thank you very much, Mr. Brunet. I read your study and I did not fall asleep. It was good. It contained an abundance of figures, statistics, and rules of three.

In short, you are telling us that there may be a link between not necessarily wanting to obtain treatment by the forces and refusing treatment. Not wanting anyone to know is one of the main reasons why someone may not want to be treated.

Mr. Alain Brunet: I don't know if it is the key reason, but it is one of the main reasons mentioned by the 8,441 participants in the survey conducted in 2002.

Hon. Denis Coderre: Basically, our questions are based on the study. It is a bit like a snapshot or a sociogram. You have rules of three, among other things. I will broach that subject with the next witness, when we examine the situation in the forces.

In light of what you have seen and studied, do you think that the psychological assessment process needs to be improved? This is not just about curing someone, prevention must also be involved. The mission has changed, and Afghanistan is not Rwanda or Bosnia, although any mission may be traumatizing. A change in mission may change the circumstances, and we have compiled figures for the period beginning in 2007-2008.

What do you think about recruitment? Did you see anything related to that? Should we perhaps also improve the way our soldiers are recruited? I imagine that an expert on this disorder is in a position to see who is more susceptible to that. The factors that predispose someone may also include past sexual traumas or everyday events. We could come up with a profile of people who are predisposed to the disorder.

● (1545)

Mr. Alain Brunet: There were two questions there. The first question was whether or not assessments need to be improved. Based on the discussions that I have had with Canadian Forces members and based on what I have been hearing, screening and assessments are now more systematic than they were in the past. According to what I have heard, people undergo systematic screening three to four months after they return. Should this screening be improved? I am not familiar enough with the way screenings are done, but I think that the idea of systematic screening is already a huge improvement.

The second question is whether or not we can recognize risk factors and whether they should guide us in the recruitment process. The answer is yes, but there is an ethical side to that. First of all, you must be absolutely certain of what you are saying when you identify something or other as a risk factor. In my view, not enrolling someone based on that consideration could cause ethical problems.

Hon. Denis Coderre: There could be repercussions.

Mr. Alain Brunet: If you refuse to enrol someone in the Canadian forces because he was a victim of abuse when he was young...

Hon. Denis Coderre: That is not what I was asking. I am asking if we are in a position to determine, based on a person's experiences, if he will be more predisposed to post-traumatic stress disorder than someone else.

You looked at sexual and non-sexual trauma, when considering factors for understanding the situation. We can understand what has happened after the fact, but we also need a prevention strategy. How could we do an assessment, in the same way as a physical examination is done?

Mr. Alain Brunet: With a good selection process and a good assessment based on the symptoms of post-traumatic stress, I am not sure that you need to know if the person was abused sexually as a child, whether that is a risk factor or not. In fact, what we would want to know, three or four months after the person has returned from a mission, is whether he is exhibiting the symptoms of post-traumatic stress, whether he is clinically depressed, whether he is currently abusing alcohol, and so on. In the end, that is all you need to know about that individual.

Hon. Denis Coderre: Religion was mentioned. After a visit to Afghanistan, it becomes clear that the chaplain plays an important role, for instance in cases of serious trauma, such as the death of fellow soldiers. Group sessions are arranged to help soldiers deal with the trauma they experience.

What can you tell us regarding religion? I imagine that having people attending to one's spiritual needs can be helpful. It is not merely a question of medicating people.

I'm repeating what you said, because I am not obsessed by religion.

Mr. Alain Brunet: It seems that it could be an element of protection for those who are religious. I imagine that it can be helpful for them to be able to speak to a person in whom they can confide.

Hon. Denis Coderre: I'd like to come back to this famous stigmatization issue.

At this time, do you believe that decompression after missions is adequate?

Mr. Alain Brunet: To my knowledge, decompression takes five days and it is done in Cyprus. Decompression seems to me to be a good idea in itself. I think that it could have a beneficial effect, because if you are back in your living room 24 hours after leaving Afghanistan, you might not be able to adjust that well.

Hon. Denis Coderre: Did you draw a distinction between reservists and regulars? There seems to be a difference between them.

Are there different approaches for reservists and regulars?

● (1550)

Mr. Alain Brunet: I think that decompression is a good thing for everyone, including reservists.

Hon. Denis Coderre: Thank you.

[*English*]

The Chair: Thank you, sir.

Mr. Bachand.

[*Translation*]

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

First I would like to congratulate you, Mr. Brunet, because we seldom see studies that are so advanced. I consider myself to be an experienced parliamentarian, because I have been an MP for 14 years, but I am sometimes stumped by certain specific elements of your studies. I would like to ask you some questions about this.

I imagine that you have the same concern as does the ombudsman of the Canadian Armed Forces, who says that the mental health trauma centres should not be located on bases, as is the case in Valcartier, for instance. When they are located on bases, there is less confidentiality, from the moment one is admitted to a mental health trauma treatment centre. Do you believe, as does the ombudsman, that these clinics should be located off base?

Mr. Alain Brunet: I agree with you: there is little confidentiality, and some people are uncomfortable with that. On the other hand, there might be some advantages to locating the clinic on the base, in terms of proximity and accessibility. I am somewhat divided over this issue.

Mr. Claude Bachand: We, the parliamentarians, study the characteristics of a sampling, and we ask, for instance, if there is any one age group more likely than another to experience post-traumatic stress disorder. Does a person's family situation or gender come into play at all?

Table 1 shows a characteristic of the sample on the demographic and military variable. I am a bit disappointed with this—

Mr. Alain Brunet: Which table do you mean?

Mr. Claude Bachand: I mean Table 1. There is a list of 1,220 cases out of 8,441 or, as you explained to me earlier, cases where persons received treatment during the previous year.

Mr. Alain Brunet: These are persons who suffered mental problems during the previous year.

Mr. Claude Bachand: Yes. I notice that in 349 of the 1,220 cases, the individuals concerned are between the ages of 17 and 25, but it does not say how many of them suffer from mental problems. This is the overall problem with your sample. Would we not have been interested in knowing that people in the 35- to 44-year-old age bracket, for instance, experience these symptoms most often, or in seeing data based on the gender and level of education of these individuals?

This list represents the 17- to 25-year-old age group that you interviewed during your study, but you do not tell us whether, given their profile, they are more likely to suffer from mental illness. Can we not find this information anywhere in the study?

Mr. Alain Brunet: In each document that we publish, we can only present a certain amount of data. Regarding this study, it includes all the persons who suffered from mental problems during the past year. The sample gives details of the characteristics of the 1,220 persons. Theoretically, we could cross-reference a certain amount of information, as you suggest. In any case, it is true that this information is not contained in this document.

Mr. Claude Bachand: Do you agree that the information would be of interest to us? Sometimes we wonder whether post-traumatic stress disorder is associated with a given profile. As we try to draw this profile, we are inclined to look at the divisions that you established, such as age, family, and so forth. Could a good statistician take your study and make the cross-references that you are talking about?

● (1555)

Mr. Alain Brunet: Studies have already been published on the basis of this survey. I would not be surprised if a part of the work is already done. For example, we know that women report more mental problems than men do but, this is probably also the case for younger individuals. A certain amount of the data that was published is not necessarily found in this study.

Mr. Claude Bachand: I noted that many of these studies involved the civilian population, but that the results could not be applied to military personnel. To your knowledge, have any studies been done on people whose jobs entail a high degree of risk, such as policemen and firemen?

I clearly remember that this question was put to professors in Great Britain who were studying the incidence of post-traumatic stress disorder in that country. I would like to know if, possibly, soldiers in a combat zone are under the highest level of stress, and consequently, experience mental problems more frequently.

Mr. Alain Brunet: I do not know how to answer your question. We tried to compare data obtained from the general population. Sometimes studies have been carried out on people in specific occupations, but it is always difficult to determine whether or not these studies are representative. Moreover, whether members of the target group have the same social and demographic profile also needs to be taken into consideration. For instance, if we compare an occupation that has more women than men, we have to adjust the ratios. A true comparison of studies side by side really involves a large number of statistical adjustments. Otherwise, we wind up comparing apples to oranges.

Mr. Claude Bachand: Is my time up?

[*English*]

The Chair: You have a minute.

[*Translation*]

Mr. Claude Bachand: Is it true that the criteria for diagnosis are now stricter and that it is therefore easier to diagnosis disorders? Could we have a clear idea of the grid used to evaluate the sampling? Is a universal measurement applied, or do the measurements vary from one study to the next?

Mr. Alain Brunet: We've become quite good at diagnosing mental problems. The diagnostic tools employed are fairly standard today.

[*English*]

The Chair: Thank you very much.

Ms. Black is next.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you for coming and giving us this information. I've read through two of the papers and found it very interesting.

My understanding is that the study was done on 8,841, and these were not Canadian Forces who had necessarily come back from combat; they were—for want of a better word—part of the general population of the Canadian Forces, not post-conflict. Out of that, you determined that 1,220 had a diagnosable disorder, and that 67% of them had no treatment or contact with mental health professionals. That's quite startling, I think.

You also made several observations in your article that I found quite interesting. One was in relation to comorbidity. I think other people on the street might call it dual diagnosis. I think it's clear that PTSD has been misdiagnosed as other disorders when there have been diagnoses in the past. So it brings to mind the question of which diagnosis most often comes first: is it depressive diagnosis, drug addiction, or alcohol dependency, and then you discover post-traumatic stress disorder, or does it most often come the other way around?

I also wondered what impact that has on treatment, because I assume, as a layperson, that treatments are different for severe depression than for post-traumatic stress disorder, and different for drug or alcohol dependence than for PTSD. So I'm curious about how that impacts on the treatment.

● (1600)

[*Translation*]

Mr. Alain Brunet: You want to know if there is a pattern to the disorders, for instance if post-traumatic stress disorder comes before depression. About 90% of those who suffer from chronic post-traumatic stress disorder also fall into deep depression.

Regarding the other disorders, I cannot answer your question. We observe various patterns. A person might begin by consuming large amounts of alcohol, and then fall into depression. We see all types of patterns.

Different treatments are applied, based on the most serious of the problems diagnosed. However, treatments can serve more than one purpose. For instance, anti-depressants are used to treat post-traumatic stress disorder as well as depression. In such cases, the treatment, if drugs are involved, is simplified.

[*English*]

Ms. Dawn Black: The treatment that I understand has the best end results, from what I've read in different studies, is the cognitive behaviour therapy, is that correct?

[*Translation*]

Mr. Alain Brunet: Currently, the most effective treatment for post-traumatic stress disorder and for most mental problems is psychotherapy, followed by drugs. Both treatments are more or less equally effective. We observe that among psychotherapy patients, positive results generally last longer. In many cases, in fact, the most widely used psychotherapeutic approach is the cognitive-behavioural approach.

[*English*]

Ms. Dawn Black: So in your experience then, when there is this difficulty in diagnosis, and when there is often more than one condition, does that present unique challenges in determining what kind of treatment to offer the person?

[*Translation*]

Mr. Alain Brunet: Yes. Those cases may be a bit more complicated. Nonetheless, health professionals often encounter cases of this kind, which they treat as well as the others.

[*English*]

Ms. Dawn Black: I have two more questions. One is—you outlined this in your paper, but it would be good to get it on the record—why do you think 67% of the people in your study with a diagnosed disorder had no contact with mental health professionals?

The second question is, if you had the power to make a recommendation to this committee or to the Canadian Forces, what recommendation would you make about steps that should be taken to improve the diagnosis and treatment of people in the Canadian Forces with PTSD or other disorders? What about acquired brain injuries? How do they fit in with the other ones you've identified here?

[*Translation*]

Mr. Alain Brunet: As I mentioned, the main obstacles to treatment were a lack of confidence in the authorities, the fact that mental health problems are not recognized by members of the Canadian Forces and the desire to solve the problem on one's own.

I spoke of the problem of confidentiality and the stigmatization of mental illness. We would recommend, among other things, offering more psychological education to members of the armed forces regarding mental problems and their symptoms. People should be aware of the fact that such problems can be treated quite effectively.

I also mentioned the need to protect the confidentiality of the relationship between the health professional and the patient. I also said that assessments should be mandatory.

● (1605)

[*English*]

The Chair: Thank you.

Mr. Lunney.

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

I have a few questions, Dr. Brunet.

First, I wonder if you'd clarify the statistics for us, because of the 1,200 I understand you studied, I heard figures saying that 43% of those sought contact with health services. I thought I heard originally that 67% did not. Those numbers don't add up.

[*Translation*]

Mr. Alain Brunet: It was 57%.

[*English*]

Mr. James Lunney: It was 57%, thank you.

Just for the record, let's get that right.

You also said even traditional peacekeeping missions are stressed, as opposed to combat missions. I'm wondering about the difference between PTSD and what the department calls operational stress injuries? Are you equating these, or are you saying there are clear criteria for diagnosing PTSD that are different from operational stress injuries?

[*Translation*]

Mr. Alain Brunet: Operational stress injury is not a diagnosis.

[*English*]

Mr. James Lunney: Thank you.

[*Translation*]

Mr. Alain Brunet: In psychiatric terms, operational stress injury is not a diagnosis. Operational stress injury is an umbrella term that refers to a set of psychiatric conditions including depression, post-traumatic stress disorder and other disorders that can be triggered by intense or extreme stress experienced during a mission. This is what we call operational stress injury. It is a way of saying that mental health problems are another form of injury. Physical injury is recognized. It is considered to be an injury, and not an illness. Thus, we are getting away from the more pathological aspect. Between you and me, this is a euphemism.

[*English*]

Mr. James Lunney: Thank you.

There's been some discussion already about which ages were more vulnerable to diagnosed injuries. We have a lot of female soldiers serving over there. Was the comment related to whether there was a difference by gender between the numbers of people reporting?

[*Translation*]

Mr. Alain Brunet: In our study, and in the other studies that were published, we typically find that women report more mental health problems than men do.

The question then is whether women are more vulnerable or whether they are more inclined to acknowledge and discuss their mental health problems. Regarding post-traumatic stress disorder, in the civilian population, it was demonstrated that the risk... Even when taking different kinds of trauma into account, even after weighing a host of factors, it was found that women were still more likely to develop post-traumatic stress disorder.

Regarding depression, there are those who say that women get depressed and that men get drunk. This has more to do with the different ways in which men and women deal with their problems.

[*English*]

Mr. James Lunney: Touché. I think most of us recognize some validity there.

Your study was back in 2002, and you'll be aware that the Canadian Forces have put a concerted effort into increasing the number of personnel available to counselling and psychological services, as well as pre- and post-counselling, and of course the decompression you mentioned, and so on.

Regarding the relevance of the incidence or severity, do you feel there has been any progress? Are you in a position to comment on that from the time you did your study?

● (1610)

[*Translation*]

Mr. Alain Brunet: As far as I know, considerable progress has been made. Many initiatives have been undertaken since 2002. Thus, we may have good reason to believe that things have gotten better since then. This would be an educated guess, but it is also the impression I have when I talk to colleagues from the armed forces, other researchers, and so forth. I feel that things have improved a great deal. At the outset, the Canadian Armed Forces had a long way to go. For instance, 12 years ago, practically nothing was being done. There has been a huge investment of resources and I believe our efforts are about to pay off.

[*English*]

Mr. James Lunney: There was some indication that not only is a certain percentage reluctant to seek help, but they certainly were resistant to receiving drug help, in particular, and didn't want to go on medications.

I noticed that you have written a bit about propranolol, and I think I saw a comment go by that you were aware that the drug reduced the intensity of memories, perhaps, but didn't actually solve the problem.

I think I heard a little bit of a discussion about cognitive behavioural approach. In your own experience, do you feel it's more a behavioural approach that's superior to a medical approach, or is that something that has to be judged individually, or is a combination of therapies better?

[*Translation*]

Mr. Alain Brunet: I think that both methods are useful and that they are a part of the package of intervention tools. Some people prefer medication, others prefer psychotherapy. In some cases, both are used together.

Regarding propranolol, this is an experimental treatment that my team is currently testing, and we are getting very interesting results. This kind of drug therapy aims at reviving the traumatic memories, and, as the brain encodes them again, at alleviating their emotional impact.

We are not trying to erase people's memories, but simply to reduce their emotional impact, because we believe that in cases of post-traumatic stress disorder, the problem is caused by the overly intense emotional impact of memories.

[*English*]

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

We're going to come back to you folks right away. We have time for about three spots.

Mr. McGuire.

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

The 8,000 people you tested, were they all front line troops or just troops who were deployed?

[*Translation*]

Mr. Alain Brunet: The 8,441 individuals in the sample were selected at random from the Canadian Forces. Thus, it is a representative sample.

[*English*]

Hon. Joe McGuire: So a lot of these people may not have been seeing any kind of action whatsoever?

[*Translation*]

Mr. Alain Brunet: Most of these people had been sent into the field several times. Very few of them had never been deployed before.

[*English*]

Hon. Joe McGuire: Okay. So if they were deployed, were they deployed on the front line, or as backup? In the Afghanistan case, most people who are on the base never leave the base. There are 600 to 800 actually who are out on the front line. There should be a big difference between the two groups. Do you filter out any of those differences?

[*Translation*]

Mr. Alain Brunet: We did not have access to that information.

[*English*]

Hon. Joe McGuire: No? So regarding the concerns about confidentiality, wouldn't supervisors make it their business to find out if their troops were fit or not mentally? Wouldn't that be information they'd automatically get?

[*Translation*]

Mr. Alain Brunet: Some people maintain or think that officers should have access to this data, this information, because it could be important, especially during a deployment. Once the soldiers are back on the base, is this information still as relevant? I can't say.

[*English*]

Hon. Joe McGuire: If they wanted to make a career and stay in the forces and be promoted, it probably would weigh heavily on somebody's mind whether or not their supervisors felt that they were mentally healthy or not.

[*Translation*]

Mr. Alain Brunet: The problem is that it has a negative effect. If supervisors have access to a person's medical and psychological files, this has a negative effect to the extent that people might prefer to keep their problems to themselves, and the more they do that, the more likely it is that they eventually become ticking time bombs. On the other hand, if they consulted someone a bit earlier and if they got some help, chances are they would get the help they need to recover and get on with their career. Some soldiers are apprehensive about these things. They are faced with some rather contradictory requirements, as it were. This is not an easy problem to solve.

● (1615)

[*English*]

Hon. Joe McGuire: Yes, it wouldn't be very easy.

Have you compared your numbers with representative cases in the U.S. or Great Britain, as far as your findings are concerned? Did you have any kind of comparative analysis with other armies?

[*Translation*]

Mr. Alain Brunet: As I said previously, this study is a first and the only one, to our knowledge, that is based on a representative sampling of the Canadian Armed Forces. Perhaps the Americans and the British have not yet dared to do such a study. All we have access to are sub-samples and subsections. We never know these are representative of the whole population. Therefore, it is difficult to make comparisons.

[*English*]

Hon. Joe McGuire: Are you saying the Americans and Brits have never done something like this?

[*Translation*]

Mr. Alain Brunet: The Americans and the British have not carried out any studies based on a representative sampling of their armed forces.

[*English*]

Hon. Joe McGuire: I see.

Have you done any follow-up since 2002?

[*Translation*]

Mr. Alain Brunet: No, we were not the ones who collected the data. It was compiled by Statistics Canada, which did not follow-up with these individuals.

[*English*]

The Chair: Thanks, Mr. McGuire.

We'll go over to Mr. Hawn, and then back to the Bloc.

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

Thank you, Mr. Brunet, for coming. There's some valuable input.

There's a lot more awareness of PTSD and other operational stress injuries and so on, and obviously it's getting a lot or reporting, as it should. It's something that obviously we care about, because we're here.

People perceive that there's a lot more of it out there, and I'm sure there probably is. I know you can't give a precise answer, but how much of that is due to just more awareness and more reporting, and how much is due to actual increase in frequency?

[*Translation*]

Mr. Alain Brunet: As you say, it is difficult to answer that question. In my opinion, post-traumatic stress disorder is not really more prevalent than it used to be, it is just that we are more aware of it. It is not necessarily more prevalent. I spent a great deal of time at the Hôpital Sainte-Anne. I have met with many patients who were over 80 and who had traumatic nightmares every night and yet, they had never been diagnosed with PTSD at any time during their lives.

[*English*]

Mr. Laurie Hawn: I was in a hospital many years ago with a World War I vet, and every night he woke up screaming that they were coming through the ceiling at him. So I've had some exposure to that. The stress of getting shot at, and so on, is obvious.

We had a lot of people in Bosnia and places like that who were constrained by the rules of engagement from actually engaging in proactive defence. They were forced to stand by and watch atrocities take place without taking action. I believe a lot of the stress injuries or the PTSD that came out of Bosnia or places like that were probably exacerbated by their helplessness at seeing things happen.

How would you assess that generation of PTSD versus that from pure combat, where they're involved face to face with the enemy?

● (1620)

[*Translation*]

Mr. Alain Brunet: Earlier, I was mentioning that peacekeeping missions caused as much PTSD as many combat missions. That is what I was referring to. In many cases, to watch helplessly while atrocities are being committed can be just as traumatic as going to the front and being involved in military combat.

The nature of the trauma typically varies from one war to another. There is no doubt about that. The types of trauma vary, but the main symptoms remain essentially the same.

[*English*]

Mr. Laurie Hawn: When we're talking about protecting troops, you don't design rules of engagement for that reason alone, obviously. Would you say a consideration in designing rules of engagement in any particular environment is the protection of the troops from their exposure to that kind of risk?

[*Translation*]

Mr. Alain Brunet: I am not sure I understood your question correctly.

[*English*]

Mr. Laurie Hawn: Should we take into consideration the risk to our troops from exposure to this kind of potential stress injury when we determine the rules of engagement in any operation we go on?

[*Translation*]

Mr. Alain Brunet: I think that would be difficult to do. Generally, when forces are deployed, things happen very quickly, and there is no time for this type of consideration. I think this might be desirable, but difficult to do.

[*English*]

The Chair: Please wrap up, Mr. Bouchard.

[*Translation*]

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

I would like to thank you for appearing before the committee today and I congratulate you on your recommendations, which seem very practical to me.

You say that there should be a systematic assessment process put in place, given that people are still embarrassed to turn to a professional for diagnosis.

Would it be costly to introduce a systematic procedure? Would we have to hire many more professionals, or could that be done with current resources?

Mr. Alain Brunet: This is not a costly operation. I think the cost-benefit analysis would show a heavy weighting for the benefits. I think the cost would be low compared to the benefits, in other words.

Assessments can be done very inexpensively using self-administered questionnaires. A great deal can be learned from a one-hour assessment, for example.

So I think the benefits would be great and the cost low.

Mr. Robert Bouchard: You also say that 57% of the members of the military do not consult professionals because they are afraid that this will appear in their file and that it could harm their advancement or be seen in a negative way by their superiors.

Do you have any recommendation to help increase the understanding of military superiors? You have an approach for the ordinary members, but would it be possible to work with the superiors to provide them with information or to get them to understand that soldiers with mental health problems can be rehabilitated and become functional once again, just as some physical ailments can be treated?

● (1625)

Mr. Alain Brunet: Rehabilitation is possible in the case of a number of mental health problems. One thing is rather disturbing, however. Unlike other armies, the Canadian army does not give people a desk job if they have had PTSD. It might take a number of years, but the army does not keep people it cannot deploy someday. Efforts are made to try to place these individuals in other positions, but ultimately, the Canadian army is composed of people who can be deployed. That is a choice that was made. I think that also explains why the military does a great deal of recruiting, but also why there tends to be a rather high turnover. In my opinion, there are advantages and disadvantages to this. I would say that one of the disadvantages is the loss of some military expertise.

Mr. Robert Bouchard: I have one last question. In the past 10 years, 132 members of the armed forces have committed suicide. Between 1997 and 2007, anywhere from 10 to 14 suicides were recorded annually. You did a study using 2002 data. I presume that was done before.

Have you looked at this aspect? Can you comment on it? Are suicides on the increase? It is difficult to determine whether the rate was higher in 1997 than in 2007.

Mr. Alain Brunet: I do not have any accurate figures, but I can tell you than in Quebec, the suicide rate is between 12 and 18 per 100,000 people. When a suicide rate of 130 is reported for a particular period, we have to take into account how many suicides occur each year and compare that to the total number of people in the armed forces. In other words, we have to look at the suicide rate and compare it with comparable people in the general population. The rate may be higher, or it may not be higher. That is the comparison that must be made in order to obtain this statistic or to come up with a meaningful number. To my knowledge, this has not been done.

[*English*]

The Chair: Thank you very much, sir, for coming in and offering us your expertise. We appreciate it.

Committee members, we'll quickly change witnesses and move on with our next presenter.

Thank you.

● _____ (Pause) _____ ●

● (1630)

The Chair: I call the meeting back to order, please.

We welcome our next presenter, Colonel Girvin, psychiatrist, mental health services, CFB Edmonton.

You've seen the process here. You have a few minutes to make a presentation, and then there'll be rounds of questions from the parties. The floor is yours.

Lieutenant-Colonel Theresa Girvin (Psychiatrist, Mental Health Services, CFB Edmonton, Department of National Defence): Good afternoon.

By way of introduction, my name is Dr. Theresa Girvin. I'm a lieutenant-colonel in the military. I've been in for 19 years now. I have specialist training in psychiatry. I joined the forces 19 years ago while attending the University of British Columbia. Following that, I did my two-year family medicine residency at McGill, and some time later I did the psychiatry residency at the University of Ottawa.

Over my career, I have served at bases as a general duty medical officer in Esquimalt—that's Victoria—then I served in Ottawa with psychiatry specialist training at the National Defence Medical Centre. In my work there, I also provided advice to senior Canadian Forces leadership on matters of psychiatry and mental health. I have also provided clinical care. In addition to Ottawa, I did clinics in Petawawa, Kingston, and Gagetown and I also traveled to other places, including the staff college in Toronto and to Trenton, to teach on mental health topics.

I was posted to Edmonton in 2002 and I now work at the mental health services clinic there. In addition to assessing and treating the CF patients, I provide clinical leadership in psychiatry at the regional level, and I have also participated in national working groups on mental health for the Canadian Forces.

In September 2005, I began advanced fellowship training in forensic psychiatry at the University of Alberta. The year-long course of study there was interrupted when I was deployed to Kandahar from August to November of 2006, and I was able to pick up the last three months of the fellowship and finish that just last November. Although I have the specialist training in forensic psychiatry, my main area of interest and my main area of clinical work is in providing care, assessing, and treating members of the Canadian Forces—my patients—who have difficulties of a psychiatric nature.

That concludes my opening remarks. I'll be pleased to answer any questions you may have.

The Chair: Thank you very much for that. We will have questions, I'm sure, and we'll start with Mr. Coderre.

Hon. Denis Coderre: Colonel Girvin, *bonjour*. Since we can now ask questions on clinical issues, let's start.

We spoke about the psychotherapy and we spoke about medication. As a psychiatrist, you have the capacity to provide some medication, so what kind do you give to the soldier who has post-traumatic stress syndrome?

LCol Theresa Girvin: Intimately connected with that is an assessment process. So I don't just prescribe; I make the diagnosis. I do the assessment of the patient first.

Hon. Denis Coderre: I believe that.

LCol Theresa Girvin: So if I do the assessment and I make the diagnosis of post-traumatic stress disorder, the diagnostic interview that I do doesn't just focus in on post-traumatic stress disorder. It covers a broad range of psychiatric difficulties. So very often—and you heard this from Dr. Brunet as well—a person will also have comorbid or coexisting major depressive disorder, and that will impact on what medication treatments I might recommend.

Right now in psychiatry, for medication treatment of post-traumatic stress disorder, we have some pretty good randomized double-blind controlled studies that look at the effectiveness of treatment of post-traumatic stress disorder with medications called SSRIs or serotonin reuptake inhibitors. There are pretty good studies on two of them. I don't know if you want the names of them.

● (1635)

Hon. Denis Coderre: Please give them.

LCol Theresa Girvin: We have studies on paroxetine and on sertraline. There's also a fair amount of evidence for fluoxetine.

Now, these medications are anti-depressants, so they're also very effective for depression. So generally speaking, from my own clinical practice, they would be medications of first choice for treatment of a person who meets the criteria for diagnosis, who is informed of the choices, and decides that this is something they want to try.

Hon. Denis Coderre: So that's pretty strong stuff too, I guess. Are those medications pretty strong?

I'll tell you why, because when we spoke with General Jaeger—

LCol Theresa Girvin: They're effective, yes.

Hon. Denis Coderre: —we were talking about reinsertion, and it seems that right now we have some soldiers whom we want to reinsert and send back into the field, and they're doing transportation or whatever.... Is it a different type of medication? And what's your say on that, sending a soldier back to the field while under medication?

LCol Theresa Girvin: The real advantage of these medications is that they're actually quite well tolerated. They actually don't have much in the way of side effects initially.

If you're going to prescribe a medication, whether it's in Canada or on Kandahar airfield, first of all you want to see that the person is tolerating the medication. So my practice is that if they're going to accept a prescription, they get some counselling on what side effects are most common, what they might expect, how to deal with the nuisance level of side effects. Then I get them back fairly shortly after they start the medication to see how it's sitting with them. If it's causing them problems, then we can look at alternatives.

Hon. Denis Coderre: What would be the ratio of people we're sending back? Do you have any percentage of soldiers we want to send back under medication to the field? What would be the percentage?

LCol Theresa Girvin: I want to clarify your question. You're asking me about the situation in Kandahar, when I was seeing patients who came in with difficulties—what percentage of them subsequently went back to work and may have been on medication?

Hon. Denis Coderre: Yes.

LCol Theresa Girvin: I don't have those figures for you, but they're pretty low. I don't have exact figures.

Hon. Denis Coderre: Then overall, do you have any figures? I know you're working on the base, but do you have any numbers in general? Of course, we have Mr. Brunet's study, but right now can you say there are a lot of those soldiers who are being sent back to the field under medication?

LCol Theresa Girvin: No, I would say there are not a lot.

Hon. Denis Coderre: There are not a lot.

LCol Theresa Girvin: I can't be more specific than that. I believe General Jaeger is trying to track down numbers for the committee.

Hon. Denis Coderre: I think it's important. Some people will have some doubts about sending them back to the field. I heard also that there are some soldiers who, because of the macho culture, will get rid of those medications when on the field. What's your say on that?

Would you please tell us, also, about the security of other members of the troops in the field when you have that kind of individual who is under medication?

LCol Theresa Girvin: It sounds to me as though you have three questions there. The first one—

Hon. Denis Coderre: Go for it.

LCol Theresa Girvin: —was something to the effect of what the others would think if their corporal came back and he was taking a medication. It's up to that corporal whether or not he wants to share with his co-workers that he's taking a medication, if in fact that happens. I would remind you again that I believe these numbers are quite small.

Also, probably the majority of these medications might be, for example, sleep aids. And in fact—and this is related to your second question, and I don't have any numbers to back this up—I believe probably a lot of them don't take their medication when they go out. In fact, they'll make that decision based on whether or not they think it'll impair them in any way in doing their job.

When I see patients in Kandahar, if I'm going to make any intervention, I don't want to put that person at any higher risk or put any of his colleagues at a higher risk in the operation. So any of my interventions are going to be geared to lowering that risk.

Hon. Denis Coderre: But do we agree, Colonel, that we don't know what the eventual reaction might be? Because we never know what kind of stress—and it might pop up and cause some flashbacks.... How do you do the follow-up to make sure there won't be, as we say in French, *une rechute*?

How do you say *rechute* in English? You're the wrong person to ask that of.

A voice: Relapse.

Hon. Denis Coderre: Thank you.

● (1640)

LCol Theresa Girvin: If I see a person and I'm very concerned about them, I'll arrange for a follow-up. Also, one of the really great things about being in the military is that you're part of a team. You don't work in isolation; you have colleagues and supervisors, and people all watch out for each other.

I suppose at any time—

Hon. Denis Coderre: That explains that, then. I'm just trying to put myself in their body. They're shy. Probably they don't like being different. They have to take those medications, and everybody is all together, so that's why sometimes for them it's stressful even to take a medication with the troops. You have that comorbidity, and they try to find some other auto-cure, whatever it may be.

That's why, if they're having that medication at a certain level, and if they get rid of it.... You provide that individual medication to help, and if he's not taking it, he's maybe becoming a problem for the troops themselves. How can we do that kind of follow-up to make sure those individuals are doing what they're supposed to do?

The Chair: A short response, if you have one, Theresa.

LCol Theresa Girvin: You're asking about the issue of compliance when medications are prescribed. Most of the time when the medications are prescribed, they're for symptom improvement. I suppose you could draw an analogy between this and giving someone a Tylenol for a headache. They are free not to take the Tylenol and have a headache. The question is whether that headache will impair their functioning, and that's what I look at.

The Chair: Mr. Bachand.

[*Translation*]

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

You mentioned in your presentation that you had gone to Kandahar. I would like you to tell us more about that. How many psychiatrists were there in Kandahar? Were you the only one? Were there other psychiatrists with you at the camp in Kandahar?

[*English*]

LCol Theresa Girvin: When I arrived, there was an American psychiatrist, and she left after a month and a half or two months. She was with the American military. They rotated their team, which included the psychiatrists, and they brought in a new team that was made up differently.

[*Translation*]

Mr. Claude Bachand: I understand that when Canadian psychiatrists go to Kandahar, they may have to treat Americans, Dutch or Estonian members of the military. What happens in the field?

[*English*]

LCol Theresa Girvin: Yes.

[*Translation*]

Mr. Claude Bachand: When the American psychiatrist left, you were the only one there. So there was only one psychiatrist for approximately 15,000 people at the camp in Kandahar. Is that correct?

[*English*]

LCol Theresa Girvin: I believe so. I think the population in the CAF is more like 10,000, but I might be wrong.

[*Translation*]

Mr. Claude Bachand: Right. I imagine that you were working full time. Was one psychiatrist enough? I'm surprised by what you're saying. I thought that the physicians and psychiatrists we sent there were supposed to work with Canadians only.

Is one psychiatrist enough for 10,000 or 12,000 people?

[*English*]

LCol Theresa Girvin: The medical facility there is multi-nationally staffed, so we work alongside our American colleagues, the Dutch, the Finns, and in some cases the Australians and the Brits. For the most part the Brits have their own medical people, and people would come in from the British military and see their own British clinic facility, so we didn't see a whole lot of the Brits.

We had regular clinic hours, Monday through Sunday, and we could be on call at any time. But there was also a doctor on call 24/7, so if someone needed to be seen at three in the morning there was a physician who could see them. It might not be a psychiatrist, but if they had concerns and needed to consult, they could always call me.

● (1645)

[*Translation*]

Mr. Claude Bachand: Based on your experience, would you say that people at the front who are involved in combat operations suffer greater psychological trauma than those who stay in the camp?

[*English*]

LCol Theresa Girvin: I'm not sure. Could you repeat the question?

Mr. Claude Bachand: People going into combat zones, are they more inclined to have PTSD than the ones left behind, the ordinary people who work in the camp?

LCol Theresa Girvin: I can give you some general answers. They come from past experience—work done during other conflicts in other militaries, and work done in civilian psychiatry.

You are more likely to develop post-traumatic stress disorder when you have traumatic stress that is more severe psychologically. Yes, being in combat on the front lines is generally more stressful. But balanced against that is the fact that these guys are well trained. This is their job, their career. I think this is protective for them, to a certain degree.

Someone on CAF who is not expecting to have a rocket fall in the camp might find the experience very psychologically traumatic in some ways. So although they might have fewer traumatic experiences, they can be just as at risk for PTSD.

[*Translation*]

Mr. Claude Bachand: We talked about confidentiality earlier. We heard that members of the military were afraid to go to a psychiatrist like yourself or go to a post-trauma centre such as the one in Valcartier because the information in their file may be passed on to their commanding officers.

Could that happen? To what extent is the treatment received by these soldiers kept confidential?

[*English*]

LCol Theresa Girvin: A person's medical information, their medical file, is confidential.

There are two pieces of information that go to commanders so they can command effectively. One is whether the person's employment should be limited. Two is the prognosis, or roughly how long their employment should be limited.

As for diagnosis or personal medical information, that does not get released. The information on a person's medical chart, the paper it is on, belongs to the CF, but the information contained on that chart actually belongs to the patient. If the person wants a copy of it and wants to give it to the commanding officer or wants to discuss it with the supervisor, that is up to him or her. That's not inhibited in any way. But as for whether anybody in the health profession hands information on a medical diagnosis or personal medical information to commanders, no.

[*Translation*]

Mr. Claude Bachand: What is the perception of PTSD in the Canadian Armed Forces? I remember the sad events that happened in Edmonton recently, where an allegorical tank was used to poke fun at PTSD. Is it really taken seriously in the Canadian Armed Forces? Do you think that soldiers who receive treatment for PTSD receive good treatment? Is every possible effort being made to rehabilitate them?

[*English*]

LCol Theresa Girvin: Sir, your question is about the general perception of post-traumatic stress disorder by the military. It's taken very seriously by health care providers, by mental health care providers, obviously.

Mr. Claude Bachand: Is it by the high brass?

LCol Theresa Girvin: Absolutely. There are ongoing seminars, there is ongoing teaching integrated into basic medical officer teaching at all levels. People are being educated about various mental health issues and the effects of stress. Information is being provided, but as you are probably aware, providing them with the right information doesn't always totally eliminate people's biases.

● (1650)

The Chair: Thank you.

We'll go to Ms. Black.

Ms. Dawn Black: Thank you very much.

Thank you very much for coming. I enjoyed your presentation. You've had a very interesting career for 19 years.

Some of the members of this committee visited Edmonton, and we met with some of the families there. I'm just wondering about your experience with PTSD and how it impacts on the family. Does the entire family need to be included in the treatment? If that is the case, what challenges does that pose for people without close family? Is treatment in any way different for people who don't have family members or close family?

I also wonder how that impacts on the issue of health care for the person in the Canadian Forces coming under the military responsibility, and yet health care for family members comes under the jurisdiction of the provincial government of the province in which they're residing.

LCol Theresa Girvin: I'm sure I've forgotten some of those questions. First is how the family is affected.

Ms. Dawn Black: Are they included in the treatment process?

LCol Theresa Girvin: Post-traumatic stress disorder oftentimes, in fact I'd say much more often than not, will include symptoms like irritability and anger. You can imagine how much that might affect an intimate relationship between a spouse and a member or between the children and the parent.

Ms. Dawn Black: That's my point.

LCol Theresa Girvin: So yes, it does affect them a great deal. Right from the start, they're invited to participate, for example, in the assessment process. If a person has a family, social work services are consulted.

What I also find is that a lot of times it's the spouse who actually urges the member to get help. It's sort of related to Dr. Brunet's studies. A lot of people don't recognize when they're having problems, but their spouses will recognize the change.

So how are they included? They're included in the assessment process. They are allowed a certain amount of support and treatment services from the social workers in the military. But they aren't allowed medical care. We don't have a mandate to provide medical treatment for non-CF members.

Ms. Dawn Black: So there was the issue in Petawawa with the children there who weren't able to access counselling services. Did that continue to be a problem in the Edmonton area as well, where you are?

LCol Theresa Girvin: Well, Edmonton is not as isolated, although psychiatric services for children are pretty rare across Canada, and that's true for Edmonton as well. So if a child needs psychiatric services, they would have the same access as other non-military civilians in the area, which is not always the best.

Ms. Dawn Black: What have been your experiences in the 19 years you've been involved in the military? Have you seen a change in the way that PTSD is viewed? Obviously we now have this post-deployment screening that happens when soldiers come back from Afghanistan. Have you had experience with the post-deployment screening and the follow-up to that?

LCol Theresa Girvin: Yes.

Ms. Dawn Black: I wonder if you could tell us about that.

Also, are the challenges any greater for soldiers returning from Afghanistan than they were from other deployments, in your view?

LCol Theresa Girvin: First, on the perception of post-traumatic stress disorder, my perception of changes over about 19 years is that there's a lot more awareness, there's a lot of emphasis on it. If you look at the CF survey, there are more prevalent conditions, but the focus is on post-traumatic stress disorder, it seems, right now. I think probably that's an artifact of it being very easily linked to traumatic stress and to combat.

So there's a lot more awareness. I would say it's almost impossible for a CF member not to have some exposure to information about post-traumatic stress disorder.

Yes, I've actually participated in, I believe, three rounds, anyway, of the post-deployment screening. Most of the patients referred to me come in because the screening has identified that they're having difficulties and they need a further assessment—because it's a screening, it's not a diagnostic assessment.

I'm sorry, I don't remember what else you asked.

● (1655)

Ms. Dawn Black: I wonder if you see a difference in the soldiers who are returning from Afghanistan from the ones who return from other deployments, in terms of this post-traumatic stress disorder.

LCol Theresa Girvin: What I would give is just general impressions. There are lots of people going through Afghanistan, so you see more of it.

On the screening that we do post-deployment, we get more coming in, whereas before, as Dr. Brunet's study in 2002 showed, a lot of people wouldn't even recognize they had a problem, so how could they go for help? This way they're recommended for a follow-up, and it's written down. They have to see their MO, they have to go in, they have to get told. So we're seeing a lot more people.

The more we know about the mission, the more people know what to expect. For missions like Rwanda, like Somali, for different tours in the Balkans, I think maybe people weren't expecting those things, and so in some ways it was more difficult for them. The popular perception of what a deployment is like is different now here in Canada, I think, with Afghanistan from what it was on those previous deployments. So a person is probably feeling better supported here in Canada now than perhaps on one of those previous deployments.

Ms. Dawn Black: Another question I had was on that whole issue of, as they call it, traumatic brain injury or acquired brain injury. There have been studies from the States indicating that soldiers who were experiencing explosions over and over again are coming back with various kinds of brain injuries. Someone likened it, to me, to shaken baby syndrome. I wonder if you're seeing that as well in the post-deployment treatment you're doing.

LCol Theresa Girvin: The study that I read from *The New England Journal of Medicine* actually captures a population of people who are injured, and then it separates out from those the people who had some kind of head injury with sequelae—so concussion, if you want. Then it looks at that population and says, okay, what's the incidence or prevalence of post-traumatic stress disorder in that group? And lo and behold, I think it was around 40% of the people with significant concussion had post-traumatic stress disorder.

I wondered when I was reading that study if that was a proxy to being close to combat and close to danger, which is the risk for post-traumatic stress disorder, right? So if you have an explosion significant enough to knock you out and your life is in danger, you pretty well have criteria A of post-traumatic stress disorder, a psychological trauma, down there. So I think that might be what it's predicting.

The Chair: Thank you very much, Ms. Black.

Over to the government and Ms. Gallant.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): I'll be sharing my time with Dr. Lunney, if there's time left over.

Dr. Girvin, I'd like to read you a letter from a constituent, and then I'll ask my question. My riding encompasses Canadian Forces Base Petawawa.

> Dear MP:
>
> I write to you today to bring to your attention the matter of your soldiers that are returning from Afghanistan with PTSD or other mental health issues. My fiancé returned from his tour in August 2007 and has been seeking help through the military for his mental health issues. We've been attending the doctors' appointments, going to the mental health clinic, and talking to whoever will listen. All the military has done is give him time off work and grief over having to deal with this.
>
> As of late last week, he was sent to Ottawa to see a doctor on base there, and was told he has PTSD and that there's a very good chance that he will be medically released from the army because of this mental health issue. The army is my fiancé's life, and the last thing he wants is to be released. He wants the proper care required to help overcome this issue.
>
> It's very upsetting to me to hear that our government, that is supposed to be helping and supporting our troops, is so quick to wash their hands of the men and women that come back from their tours overseas with mental health issues. I do realize that there are hundreds of women and men that require help with their mental issues after returning to Canada and that we're not equipped to deal with all of this, since we've not seen numbers this high since World Wars I and II. I do, however, think that this issue needs to be brought to the attention of our government and that someone needs to step up and help our young men and women, because they are not disposable, and this does not only affect them, but their families, as well as our country as a whole.

Thank you very much for your time. I look forward to hearing back from you.

My question to you is this. How do I respond to this constituent?

● (1700)

LCol Theresa Girvin: If I had the letter in front of me, I could suggest an approach for you, but I don't think you really want me to respond to—

Mrs. Cheryl Gallant: Not to this specific person, but as a whole, because this letter is representative of many people who have not written to me.

LCol Theresa Girvin: Some things stand out: that this government doesn't care, and that nobody's doing anything. I think this committee's hearing is evidence that it is.

I guess part of the next step, before sending the letter back, would be to get more facts. For example...you see, I'm coming at you from a physician's point of view. You're getting the fiancée's perspective, and I don't know if that is the perspective shared by her fiancé, the person who's affected. So I guess I would want more information before I would respond to that.

Mrs. Cheryl Gallant: The heart of the matter seems to be that this person has been told by the doctor in Ottawa that he's likely to be medically released because he has PTSD. That is the challenge we have to overcome, because we're being told from the top echelons down that this is not necessarily going to mean they're to be kicked out of the military.

So what do we do to ensure that they're going to get care instead of the release?

LCol Theresa Girvin: The way the process works now is that the person presents, as this lady's fiancé did, for help. He is seen in the clinic and assessed and then offered treatment. I don't want to give the impression that a person is seen, assessed, and released. That isn't what happens. They're afforded a course of treatment, but because the military requires a person to be deployable, the expectation is that with treatment they're going to return to health within a period of time. In returning to health, then, they return to their full functioning and their full deployability, and then they are not released.

Not having been in the office with that patient or the doctor, I don't know what was said, but to predict from the beginning that a person is going to be released from the military seems premature.

Mrs. Cheryl Gallant: Thank you.

The Chair: Two minutes, Mr. Hawn.

Mr. Laurie Hawn: I'd like to follow up on that, Dr. Girvin.

In your view, after 19 years and after seeing some of these so-called peacekeeping deployments in Bosnia and so on, and now in Afghanistan, what's your assessment from your professional point of view of the progress we've made within the military and government in terms of the sensitivity of the system—and I mean the whole system—in terms of treating this seriously and giving people access to the care and attention they deserve?

LCol Theresa Girvin: I think it's light years ahead. There's been a huge change, and not just in the last year or two either. It's been ongoing since 1997.

Mr. Laurie Hawn: And is it fair to say you're always going to find somebody who finds the system inadequate, no matter how good any system is?

LCol Theresa Girvin: I suppose, yes.

Mr. Laurie Hawn: Is that human nature?

LCol Theresa Girvin: It goes with the adage that you can't please all the people all the time. I think so.

Mr. Laurie Hawn: Yes, something like that. Okay.

I'd like to pass to Mr. Lunney.

The Chair: One minute.

Mr. James Lunney: Okay, I'll try to make it quick.

I think you mentioned that SSRIs are still the preferred treatment for people with certain post-traumatic symptoms. Haven't SSRIs recently been in the media?

All over the world they're discussing major studies that are showing them to be hardly better than a placebo in addressing this. I was watching *Westminster*, where questions were being asked of the Prime Minister of Great Britain at the time. Is that not the same class of drugs that are under discussion right now?

Are you aware of a non-drug approach, EMDR, that is approved by the American Psychiatric Association? Israel uses it, and Australia.

● (1705)

LCol Theresa Girvin: Yes, I have training in EMDR, and for select patients that is a very good approach. It's not for everybody, just as medications aren't for everybody.

I haven't seen that meta-analysis looking at SSRIs in treatment of depression, but I would say it's in treatment of depression in moderate and mild cases, not severe. So I don't know that it's appropriate to generalize that lay media coverage of the study results to PTSD patients with whatever degree of symptoms.

The Chair: Thank you.

Okay, that ends the first round. We're going to run out of time, but we'll get as deeply into this as we can.

Mr. Coderre, for the second round for five minutes.

[*Translation*]

Hon. Denis Coderre: First of all, thank you very much for appearing before the committee. I particularly like your frankness, it is like a breath of fresh air today. We like getting this type of answer.

I'd like to talk to you about decompression. We see in today's newspapers a report that Canadian soldiers administered a beating to someone living in Cyprus. Of course, this is an isolated incident. If appropriate, justice will take its course.

There was a time when people were sent home immediately after their mission. There were some rather pathetic cases. Does decompression really work? What actually happens? We hear that PTSD does not appear overnight. During the decompression period following a mission, it is impossible to tell whether a person will suffer from PTSD.

How do assess what is done during the decompression period? Is it possible to determine whether there will be more cases? It is true what there are some stressful situations in any mission. However, the mission in Afghanistan is a new situation for our troops—they are experiencing a different kind of stress.

During the decompression period, can you determine the number of cases of PTSD that will emerge?

[*English*]

LCol Theresa Girvin: First of all, I'm not an expert on decompression, but I do know that it is decompression. It's not assessment and it's not treatment. It's a chance for a person who's been in desert...some place austere or a combat environment to shift gears to come back to Canada.

And historically the roots of this go back to World War II. One of the things the Brits did was have health halfway houses for their veterans coming back from the front. They found it was prohibitively expensive but quite effective.

So that's what decompression is. It's a transition and it's an opportunity to provide them with information. People are going to misbehave, given the opportunity, and I'm glad to hear you recognize it's a rare incident. I believe there was—

Hon. Denis Coderre: It is isolated.

LCol Theresa Girvin: Yes, it's isolated, and that's a good thing, because it's an embarrassment, and I wouldn't want it to affect this opportunity, which is very well received by the troops. I wouldn't want to see this taken away from them.

Hon. Denis Coderre: One of the issues that I have felt from the beginning.... Of course, everybody will find out there has been some improvement, but it seems that it's more at the cure level and in evaluation after the fact. I don't feel we're putting enough emphasis on prevention; specifically, I think we should do better regarding recruitment. We never know what will happen with major stress, but I guess there is a grid or a check and balance that we should use.

What would be your recommendation?

LCol Theresa Girvin: I'm really glad you asked that question, because in my reading of history, back in World War II the American military—

● (1710)

Hon. Denis Coderre: I was much too young at that time.

LCol Theresa Girvin: The American military made efforts to recruit people who would be less likely to drop out from combat stress. There's probably an equivalent there: combat stress, then stress reaction, and later, PTSD. Toward the end of the war, they were screening out up to 70% of their recruits, saying, no, you're too high a risk. Yet this had no significant impact on the numbers of soldiers with CSR.

Other than a few people, those actively distressed and suffering from symptoms of a mental disorder at the time, or who are perhaps mentally retarded and untrainable, there aren't many others you can screen out. If your expectation is that we're maybe going to be able to find a configuration of factors that would say no, that person can't be recruited because their risk is too high, I don't think we're there yet, or able to identify that.

Hon. Denis Coderre: Is there any simulation where we can, after the fact, maybe have some results from a potential case?

LCol Theresa Girvin: No, there aren't laboratory simulations, but there is basic training and ongoing training. Before a person ever gets to the point of being deployed on a mission, they have gone through their basic training, they have gone through the mission training, they have gone through their trades training. All of that is like a screen or series of hoops that a person has to go through and prove their mettle before they're fit for deployment. So that's how it can function, in that way.

Is that exactly why it's constructed? No, the training is provided, and it's provided in a stressful and realistic way to prepare people, because there is some evidence that very realistic and very tough mission-specific training helps decrease the incidence of stress on deployments. So that's one of the pieces, I guess, in which leadership has a very important role in reducing stress casualties, taking care of the basics, for example.

Leadership, in taking care of the basics for the troops, will decrease stress. Stresses on deployment include things like not having enough water early on in roto zero, and physical stresses like that, such as not being able to shower, or these very basic needs that are stressful. These can be addressed, and they are addressed. You were there and would have seen that there are a lot of amenities. I remember that I did one of the first rounds of post-deployment screenings, and one of the best things that a lot of the soldiers described was getting the gym. Then, instead of using whatever they were working out with before—rocks, or whatever—they could go to the gym and work out.

So providing amenities, taking care of the basics, and providing tough and realistic training all go a long way to help reduce stress casualties in the field.

The Chair: Thank you.

We're just about out of time, but the next spot is for the government.

Mr. James Lunney: To follow up then, I was glad to hear you mention that you're familiar with EMDR. I know it is approved by the American Psychiatric Association in its practice guidelines as effective for PTSD; and it's also approved as one of three approaches in Israel; and it's approved in Ireland, England, Holland, France, and in a number of countries.

I wonder if you would briefly define EMDR for committee members and give a brief description of this approach and the role of the EMDR in the CF.

LCol Theresa Girvin: Eye movement desensitization and reprocessing was developed by Francine Shapiro. She observed in her treatment of people who were dealing with traumatic memories that they would have saccadic eye movements. There were other observations she made that made her wonder whether, if she duplicated these for her patients while working with them on their trauma memories, they might be helped with their symptoms of post-traumatic stress disorder. She then developed a process, manualized it, and studied it to see whether or not it was effective for treatment of PTSD.

You do an assessment, obviously. You want to know what you're treating; you make the diagnosis. Then you have to identify in the patient that they are able to recall certain memories associated with images or imagery that symbolize for them their most distressing memories. You then have to help guide them through a way of describing in words what it is that's distressing about that. Basically, you have them hold that image and those thoughts in mind. You ask them to think about those things, and then you have them go through a series of rapid alternating eye movements while they sit with that. You would have them do a certain amount of that, and then you'd check in with them and ask where they are.

That's a very brief description. But I believe it draws on a component of exposure. We know exposure therapy helps with PTSD, having people face their demons, if you want, or confront their most distressing memories. It draws on cognitive behavioural therapy in encouraging a person to look at alternative thoughts in response to those, and it draws on suggestion. It gives them something to do. I think there's a component of suggestion in there.

● (1715)

Mr. James Lunney: Could you comment on how commonly you or others in the CF health team are applying this?

LCol Theresa Girvin: I believe that every base, every OTSSC base, has people trained in doing EMDR. They certainly do in Edmonton. I know they do in Halifax.

Mr. James Lunney: Can you comment on how commonly it's being used and what results you're seeing compared to other approaches?

LCol Theresa Girvin: No, I can't give you numbers, but I can tell you that some patients reject it as a possibility right out of hand, just like some reject the possibility of trying a medication to reduce their symptoms. There are some people right from the start who aren't interested. Using Dr. Brunet's analogy, you have to have a number of tools in the tool box, and that's one of them.

The Chair: Thank you.

We are being summoned to the House for a vote.

I want to thank you very much for your contribution today and thank you for doing what you do for our men and women in uniform. If there is anything you feel we didn't get to in the short time we had with you, you can submit it to us in writing. One of your responses was that you were glad that question was asked. If there was a question that wasn't asked that you would have been glad to hear, please submit it to us.

Thank you.

This meeting is adjourned.

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