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Chair

Mr. Rick Casson

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● (1530)

[*Translation*]

The Vice-Chair (Mr. Claude Bachand (Saint-Jean, BQ)): This meeting is now in session.

Today, during the first hour of our meeting, We have the pleasure of welcoming Senator Roméo Dallaire. I have crossed paths with Senator Roméo Dallaire on several occasions, particularly when he was the commander of the Royal Military College in Saint-Jean, which, for the benefit of everyone, reopened last week. I think that the general, who has come before us today, will play a preponderant role in Canadian history. I think that, in several generations, Canadian history books will chronicle his heroic exploits.

General, welcome to our committee. You have the floor. We are all ears.

Senator Roméo Dallaire (Senator, As an Individual): Mr. Chair, I want to thank you for that eloquent introduction. I hope that I will not disappoint you.

[*English*]

Ladies and gentlemen, I have a prepared text and I have also distributed two charts to which I will refer later on. Certainly they're for public knowledge. They are not scientific; they are a soldier's view of a situation.

Mr. Chairman, ladies and gentlemen, thank you for the invitation to speak to you about a significant threat to the long-term well-being of the Canadian Forces, its members and veterans, as well as the operational effectiveness of the Canadian Forces. Losses of experienced serving veterans are a serious deficiency to the Canadian Forces' operational capabilities. The committee's excellent sixth report already covers much of what I wish to speak of today, and I hope to provide some updating and also some insight, as well as a few recommendations.

You have had witnesses testify to the failings of the Canadian Forces health services, and more particularly the mental health services, and you have had the commander of the Canadian Forces Health Services Group, Brigadier-General Hilary Jaeger, also testify to the tremendous hard work and the achievements of exceptional clinical results, particularly overseas. How can the same organization succeed and fail at the same time?

Let me begin with a bit of background based on my observations as the assistant deputy minister of military personnel in the late 1990s, as a soldier who was injured by operational stress and diagnosed with post-traumatic stress disorder, leading to subsequent medical release, as a veteran convalescing under continual treatment, and as a senator receiving e-mails and requests for support from Canadian Forces members, veterans, and families of both groups.

[*Translation*]

At the end of World War Two and on into the Korean War, the performance of the Royal Canadian Army Medical Corps and the Royal Canadian Dental Corps were the envy of our allies. At that time medical and dental schools were directed by former medical and dental officers and the armed forces were getting graduates who were the cream of crop. Over time, the prospect of administering a peacetime force composed of healthy young persons whose only problems were generally the odd cold or sports injury held less and less appeal to top graduates and while they still enrolled, recruitment became increasingly difficult.

With the end of the cold war and demands for a peace dividend, the structure of the medical services began to tumble with ever-increasing cutbacks. When I was the Assistant Deputy Minister of Human Resources, a band-aid solution called Operation Phoenix was applied which did nothing. We then launched RX 2000, a catchy name. Fortunately, it is still ongoing and is producing the results we find in Kandahar, in the theatre of operations.

[*English*]

In 1997, when I was under medical treatment, I made a painful but conscious decision to go public within the forces, and subsequently it was picked up by the general public about my injury of PTSD. Some referred to me as the poster boy of PTSD, a disparaging and hurtful appellation. However, the countless letters and e-mails I have received from families who declare that their spouses' lives and their marriages have been saved by my openness more than compensates for the lack of compassion shown by former colleagues and less than friendly editorialists.

When my book was published in the United States, the back-cover blurb indicated that I had been medically released with PTSD. When I inquired why this information had been added without my knowledge, I was told I was the only general officer to date who had acknowledged being affected by PTSD.

I bring this to your attention because one of the aspects of this injury is the compulsion to hide, to withdraw as if you have contracted some terribly devastating contagious disease such as HIV/AIDS or leprosy, and you believe you have failed and have let everyone down.

As a soldier you have recurring nightmares of placing your colleagues in situations where you actually become a burden, a hazard to their security. At first I thought I was the only one possessed with these nightmares, but others have told me they also have these terrible nights. Subsequently in my mission, I asked to be relieved because of the impact of that injury at that time.

Dr. James Obinski, who is head of Médecins sans frontières, operating out out of the King Faisal Hospital in Kigali during the height of the Rwandan genocide in 1994 describes his PTSD and the impact that it has even on an excellent and also professional medical practitioner:

> I was driving along Highway 401 in Toronto as a blue Mazda Miata passed me. It was the same colour as the plastic tarp that I had been dreaming about for months without knowing why. Instantly, my car filled with the sweet semll of freshly killed flesh and blood. I saw sausages and then children's fingers in the red soil around the tarp. I veered as I tried to open the windows. The bumper scraped the guardrail as the car came to a full stop. I sat in the car, the smell and sausages gone. It was snowing outside. The wipers kept rhythm but I had fallen out of time. The worlds had not changed—I had. I sat there, counting pieces of roadside garbage and debris, and then I just drove for a while. I arrived at my parents' house three hours late.

In 1997 I was travelling with my family in Prince Edward Island. We were driving down a road where they had clearcut the sides of the road where there had been principally spruce trees. The large branches had been piled along the roads with the ends facing the road and the leaves or the quills had all rusted and turned brown.

As I drove down that I immediately fell into a trance in which it seemed to me like I was right back in Rwanda and what was piled beside the roads were the bodies of dead and decaying Rwandans. It was so overwhelming that I in fact had to stop and for a considerable amount of time took a lot of support from the family to be able to re-establish myself in my state.

PTSD is an injury. It is recurring. Whether you miss your medication or your therapy or at times even when you think you are fully taking the medication and therapy, you are continuously vulnerable to fall back into those states of shock, those states of horror, and you lose completely a sense of reality of where you are and ultimately you panic. If in a state of depression as you fall into that state, you are susceptible to suicide.

● (1535)

[*Translation*]

When the CF clinics were being established, two errors were committed. They insisted on calling them mental health clinics although they are now called operational trauma and stress support centres, which is a much preferred location to visit if you are a soldier with psychological problems, because of the stigma attached to mental health issues. PTSD is not an illness, it's an injury.

The second, and perhaps the most serious barrier, is the location of these clinics. The soldiers, as with anyone with a personal health issue, wish to maintain their anonymity. Being forced to report to a base location clearly identified for the treatment of psychiatric or psychological problems causes members to decline self-identification of poor psychological health or treatment. Some request release rather than undergoing the feeling of embarrassment of reporting to these locations and the perceived jeers of fellow soldiers. They are even willing to leave the Canadian Forces.

Early detection and treatment of operational stress injuries are absolutely essential to any recovery or state of “rationality”. The Canadian Forces have responded to this requirement very well and have established procedures to attempt to detect injuries. However you have read and have been told of cases falling through the cracks and this is a fact. This happens because the individual may want to fall through the cracks; some injured personnel wish to totally disappear from any sort of tracking system and contact with their former colleagues who remind them of the problems they are experiencing. This is the existing stigma of the injury taking over their thinking as they feel highly stigmatized even today.

The others are reservists who live far away from urban centres or military bases. There is no formal way to compel these individuals to continue to report or to provide funds for them to do so unless they are released and have come under the care of Veterans Affairs Canada. When it comes to care, they suffer from lethargy that could lead to serious behavioural problems and sometimes even cause them to be a danger to society.

I believe that the Canadian Forces Health Services are geared, in practice and thought, to a philosophy of repair and convalescence leading to rapid return to duty and this is how things should be to remain operational. But, operational stress injury repair is not a knee replacement followed by physiotherapy. This injury requires long-term and essential support before a reasonable amount of convalescence can be achieved, but it may also require specific assistance in order to allow individuals to survive on a daily basis without returning to a state of shock and stress.

I do not believe we have achieved the same level of excellence in this area of medical care that surgeons and dentists are demonstrating. This is a whole new dimension of military health care and something they are not, and may never be prepared to cope with, since wars continue to significantly change over time.

● (1540)

[*English*]

There are discussions about failure to attract the required specialists to the Canadian Forces because of low pay compared with their civilian counterparts. This is not entirely the case, because joining the Canadian Forces and serving Canada is a vocation, and remuneration has always been secondary for specialists, as well as for the general military population. However, responsible remuneration is required.

In any case, the large numbers of psychiatrists and psychologists required to treat the volume of soldiers returning with operational stress injury requires specialists in the civilian sector to pitch in significantly. There are civilian specialists working in some multi-disciplinary Canadian Forces clinics, but I am told the turnover is high because the civilian specialists are not all geared to the Canadian Forces working environment, its rules and regulations, and a command hierarchy that from time to time overrules their expert opinion.

The matter of the various civilian pay scales has been mentioned to me. Apparently, a civilian specialist working for the Canadian Forces earns considerably less than one at a community clinic funded by provincial health plans in many parts of the country. Of interest from statistics provided, a psychiatrist in Alberta can earn as much as $195,000 a year, while the top salary in Quebec is $97,000 a year. The national average is $159,000, with Treasury Board topping out at $128,469. From this you can see that someone working full-time for the Canadian Forces will earn almost $29,000 less than the national average. Yet the Canadian Forces don't seem to have a problem in Quebec, seemingly.

Turning the problem over to external health care providers is not an ideal solution, because the Canadian Forces lose control of the service, and it is invariably more expensive than an in-house program.

● (1545)

[*Translation*]

I am not sure if the committee has been told of the spectrum of operational stress injuries. Not everyone has PTSD. I am told that, of the vast number of OSI cases, less than 8% are classified as PTSD.

However, I am told that a benign case of minor depression can become acute, then chronic, leading to addictions such as alcoholism, drug abuse, inappropriate compulsive behaviour and eventually PTSD, if not detected and treated as a matter or urgency. Treatments that cost a few thousands dollars in the early stages end up costing small fortunes and the individuals may well lose their family, employment and ultimately life as a result of a system's failure to act with the same urgency as for physical injuries. Regrettably, there are inherent delays in getting treatment because of scheduling delays with specialists' appointments. The multidisciplinary approach to treating stress trauma seems to be the most appropriate as it is used in the most successful clinics.

When the Canadian Forces introduced the requirement for a patient to have psychological analysis before being referred to a psychiatrist, some saw this as a method of determining if a soldier was faking the symptoms in order to claim PTSD benefits. Fortunately, specialists are very capable of determining who is genuinely ill or not; they rarely ever need a second opinion. However, the requirement to see a psychologist before a psychiatrist doubles or even triples the time required for treatment to begin because psychologists are in equally short supply, so in seeking the preferred solution we have exacerbated a serious situation by further delaying timely care to the injured.

[*English*]

I shall bring just a few rapid recommendations, if I may, to this committee. I take full note of the House of Commons veterans affairs committee's report and some excellent recommendations therein in regard to closer joint work between Veterans Affairs Canada and the Canadian Forces health services.

I believe it is absolutely essential that the Canadian Forces clinics be moved off the bases and that, if necessary, they even be co-located with either Veterans Affairs Canada clinics or other civilian clinics within the communities. The bottleneck of having patients only begin treatment after seeing a psychologist, to undergo a very lengthy evaluation before a psychiatrist can be seen, needs to be broken. There needs to be a more rapid way of treatment, of identifying those who need the support.

The health of reservists must be tracked for an extended period of time, even up to five years after returning from a special duty area. Of the twelve officers who joined me in Rwanda at the start of the genocide, nine of them have fallen to this injury, the last one nine years after the fact.

We should reduce the number of tours or give more time to family support.

Please look at the charts I have given you. These are not scientific; these are based on my tour when I was the assistant deputy minister of personnel and the results we were looking at then. One chart is sort of a normal chart of stress, which would be a simple curve with the families evolving over the normal period of careers. That was certainly during the Cold War, and you add a bit more stress when you have spousal employment or kids who don't want to move because they're in high school. However, in the 1990s we entered a completely different scenario that is continuing to be exacerbated today.

We are not bringing people down from the exponential curve of stress after these very complex and dangerous missions, with enough time and enough support for them to be able to evolve to the next mission, with this backdrop of saying it was tough, but we lived it, we have gained experience, and we're ready for the next one. What we are seeing, because of the rotations going so fast and the smallness of our forces and the tempo, is that one set of stresses simply leaps onto the other and ultimately it creates a scenario where families and individuals literally crash. And in fact we have even seen cases of suicide.

The Canadian Forces has instituted an excellent decompression program for groups returning from special duty areas such as Afghanistan, but it has no structured program for the large number of individual augmentees who deploy and reinforce these formed units and subsequently return. My son is due back in a couple of weeks from six months in Sierra Leone in Africa, and there is no such program established to bring them back into a level where we can assess them and also provide a level of normalcy.

It is recommended that the Canadian Forces be tasked to address this issue of the large number of individuals who are far more vulnerable than those within formed groups to actually feel the ultimate contagion of post-traumatic stress disorder. The issue is that they are not identified and subsequently not treated or treated too late, by which time they have probably self-destructed, destroyed themselves and their families.

DND and Veterans Affairs Canada should jointly build a national research training development centre in Ste. Anne. I would like to recommend that the institution at Sainte-Anne-de-Bellevue Hospital be a place that is the repository of the experience and the knowledge so that we don't fall into the same problem we did the last time, which is to take over ten years to be able to rebuild a system in order to take care of those injured by the psychological impacts of conflict. We have to maintain an expertise throughout.

My last point is there has to be a way of introducing the families in a formal way into the treatment process. Treating only the member, and not the families, is not going to achieve the operational levels we are hoping to achieve by bringing those members who have been injured to a level where we can reuse them.

I leave you with the following comment as my ending. When I came back in 1994 from Rwanda, my mother-in-law told me she would not have survived World War II if she had had to go through what my wife and children did.

● (1550)

In World War II my father-in-law commanded a regiment and was in the field throughout. On occasion they got a bit of information, and that little bit of information was often censored.

However, today our families live the missions with us. They are continually watching the TV, listening to the radio, and clicking to find out when it will be announced that their son, daughter, husband, or spouse has been killed, injured, abducted, or whatever. When we come back from those missions, they are not the same as they were before. Nor are we. A system that cannot absorb the responsibility of sending the individual into these mission areas, taking care of that individual when he comes back, and taking care of the family that we put through the wringer is a system that has a major deficiency.

I realize fully the problematics between federal and provincial, but that should not prevent us from maintaining operational effectiveness of our Canadian Forces by providing support not only to the members but also to their families. This makes our forces that much more effective.

Thank you.

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Thank you, General, for your presentation.

We will begin the first round with Mr. Wilfert.

[*English*]

Hon. Bryon Wilfert (Richmond Hill, Lib.): Thank you, Mr. Chair.

Thank you, General Dallaire, for coming. I appreciate the recommendations that you put forward to this committee.

I am struck by your comment that this is an injury and needs to be treated as such, as well as your comment about people being continually vulnerable. You mentioned an officer's experiences nine years after the fact.

Some of us just came back from theatre yesterday. There's no question that our soldiers are doing an outstanding job on the front lines in Afghanistan, and we saw the medical facilities. There was one psychiatrist and one psychologist at the base in Kandahar. They do the pre-screening and the screening for return. There are a number of people I met, and I am sure other colleagues met them too. The need is to follow up. Some of them were there for their third duty, and some of them indicated that they had some concerns with regard to their colleagues and how they've been treated.

With regard to Canadian Forces clinics being moved off the base, can you elaborate on how that would work in conjunction with civilian or Department of Veterans Affairs centres?

Also, we've heard testimony about rapid response. There's sometimes a discrepancy between those at the higher echelon level and individuals who would say that they were told to just suck it up, that it wasn't manly to come out and talk about this. Yet you came out eleven years ago, and you were very clear about your situation. I know you didn't like to be referred to as a poster boy, but you had the courage to come out and tell your story.

It does not seem from what we have heard that a lot has happened to allow us to deal with people who are still falling through the cracks. I would like you to respond to some of those comments and the fact that we only have those two in the field in Afghanistan with respect to the support level. I would like to know whether we should be looking at more resources of this kind for our soldiers in theatre.

● (1555)

Senator Roméo Dallaire: I fear brevity is not my strength. However, when I participated in the committee that advised the Deputy Minister of Veterans Affairs for nearly four years and which led to, ultimately, the creation of a report that led to the charter—and Admiral Murray was the DM at the time—we debated at length the co-location even of the Veterans Affairs Canada clinics on bases to make it maybe easier administratively and so on.

However, there are still frictions within the forces between those who are veterans and recognize that this is an injury and those who are not veterans and say “It won't happen to me”. That friction was there in the fifties, after World War II and Korea. So that friction is underlying some of the stigma that is brought to those who come forward with the injury. There have been occasions on which the place where the psychiatrists and psychologists work on base is well identified, and on which people watch who go there and the word is passed around and so on.

At senior levels and as you go down there is an attitude of recognizing that post-traumatic stress disorder is an injury—it's not a disease, it's an injury, because our brains are physically affected; there are circuits that are burnt, but also it has physical impacts on us. It's an injury that is to be recognized with the same level of urgency and concern as the guy with his arm dangling. However, in a very Darwinian organization that bases its criteria on the overt expression of courage and determination and commitment, there are still those who have a problem with things they can't see. We are very visual people, so it's hard to see the injury between the ears until you start looking into the eyes of the people and raise a few things, and then you see the impact.

I don't believe the forces have sorted out the culture side yet. They've been fiddling with it and so on, but I really don't think they've cracked that code. Battalion commanders are put through an extensive program before they do go into the battalions. They try to pass it on, but you still get the odd jerk running around who can influence 800 or 900 people. So I think formalizing a culture change in regard to this injury is still not completed.

Also, how the veterans are able to influence the non-veterans is of enormous significance, particularly when you notice that veterans are fighting with those inside the wire and those outside the wire. But we had that in Korea and we had that in World War II.

Off base, you have none of that. No one knows the unit commander is going for a medical review, or wants to go. Off base, it is not within a realm that can permit a stigma or an identification. When I was ADM Personnel at the time, three stars and responsible for the medical system, I kept telling the specialists, “Of course you want the person to come to you to speak about his problem, but you're not allowed to sit there and wait until they hit your door”.

One thing the specialists don't do is go out and sell their product. They have to go into the company levels, down to the platoons. They have to go sniff out what's happening and with their expertise be able to identify some of that stuff. They have to go around to the units and pass on information and bring people to them that way. One psychiatrist and one psychologist in that nature of theatre is not enough. There is a lot of training being done to recognize it at the unit level and so on, but you need a couple of pros there. If you really had a bad scenario, like we did in Medusa when we had a bunch of casualities, one of each simply are overwhelmed. And then you start evacuating maybe people for PTSD or symptoms of PTSD and then you get the whole stigma going.

So you need more there off base and support for them.

● (1600)

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): There is another speaker, Mr. Dallaire.

Mr. Bouchard, it is your turn. You have seven minutes.

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

Welcome to our committee, General Dallaire.

We heard that soldiers suffering from post-traumatic stress disorder avoided consulting with medical health care professionals out of fear, apparently, that their superiors would be advised of their situation.

Does that fear really exist, and if so, why?

Senator Roméo Dallaire: Mr. Bouchard, you can imagine the stigmatization amongst civilians with regard to mental health issues. We have already made up our minds. Each of us has our own prejudices in this regard. So, imagine someone belonging to an organization in which every day you have to show your courage, your determination, your ability to endure stress and be a positive force in situations and who, suddenly, is no longer able to deal with that, not because that individual has lost his arm or has a bad back, but because something between his ears is not working properly. The worse thing is that it's already hard to try to make the injured person understand that things are no longer working properly. If we fail to encourage people to be aware of the fact that they suffer from this injury, they will automatically fear having to ask for help.

Furthermore, there is no doubt that such injuries create uncertainty within the chain of command. As you saw, soldiers arrive in theatre and start to shoot. So we can wonder whether an individual will do his job or panic and run away. This is an operational factor. In fact, we are at war, and it's not like during the Cold War, a period where troops went to train in Germany while waiting for the Russians to arrive. Today, we have a field army that sometimes returns to the garrison to try to heal its injuries.

In that context, commanders have a greater tendency to ask themselves whether regarding an individual, they will take risks or not. This puts pressure on individuals, who then feel an even greater need to control themselves. Those who are injured will not necessarily identify themselves. It's not because they fear that their boss knows or because they're afraid of being seen as a coward: it's because, as individuals, they feel a responsibility to the group. They know that the commander is counting on them and they don't want to be seen as not giving 100%. Maybe they could give 90%, that would be enough, but that's not the maximum.

In light of those two factors together, it is absolutely essential that professionals spend a lot of time seeing those individuals upon their return. The most vulnerable people are, for example, radar technicians from small towns who are sent over there for a certain amount of time but then who go back to their own bases and are alone. These people don't have any experience in theatre. There are also the reservists.

My regiment is the 6th Field Artillery Regiment of Lévis. Two weeks ago, 18 members of that group came back: one seriously wounded and 17 others in good shape. Their families came to the parade and the dinner. Simply by looking at an individual's ability to communicate, you can determine in two minutes if they have a problem. The proactive method is not yet sufficiently developed to save some of these people.

● (1605)

Mr. Robert Bouchard: Apparently, a significant percentage of military personnel identified as having post-traumatic stress disorder claim that they're able to recover on their own. What makes them think that?

Senator Roméo Dallaire: The proportion of individuals truly suffering from post-traumatic stress disorder is 8%. However, 20% of the population is affected at various levels, depending on their experiences. If they receive proper support from their family and their workplace, and if they are allowed a period of readjustment, these individuals can be successful in returning to some normalcy.

However, those suffering from post-traumatic stress disorder have been denied an honourable injury. Getting shot in the behind is considered an honourable injury, but not when the injury is between your ears. We are operating in an organization that has built its team spirit on honour, conviction and the gift of self. Individuals cannot accept suffering from this kind of injury. Many would prefer by far losing an arm rather than suffering from a psychological injury. When it's an arm, you can do something, get a prosthesis, but when it's a psychological injury, a noise, sound, or odour can completely destabilize that individual and even make them a danger to themselves.

The Vice-Chair (Mr. Claude Bachand): Very good.

Ms. Black, it is your turn.

[*English*]

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you very much for coming, Senator Dallaire. We're very pleased to hear your testimony. It's great to get recommendations too. I appreciate that.

You mentioned about your own personal experience and that you received some negative feedback from colleagues. I think your courage in going public has made it possible for other people to seek help. I hope you take a great deal of personal gratification and satisfaction from that. Until people do that, it stays behind closed doors, and I think you have done something that's made it somewhat easier for others to come forward and to seek help.

I was intrigued with your accounting of the experiences of having these flashbacks. I've talked to a number of soldiers who are currently going through this. We've had testimony here at committee in camera from young soldiers who described it in almost exactly the same terms. The striking similarities of what people have told me and told this committee when they've gone through PTSD has just amazed me. Clearly there's a way to diagnose this, and clearly we could be doing better, I think, in the Canadian Forces.

One of your recommendations was that the rotations are too frequent now because of the limited number of soldiers. At this point we're into Afghanistan now until 2011, and I think people are going back three times and perhaps even more than that, when I've looked at all the rotations going ahead. What is the solution to that?

● (1610)

Senator Roméo Dallaire: In 1997, when I was chief of staff of personnel and then went public because we were misguiding our own people, let alone outside, I went to the U.S. Veterans Center for Post-traumatic Stress Clinics, which is in White River Junction, Vermont, to ask them whether all treatment should be the same, such as commanders with their stresses and training, versus soldiers. I also asked them how to help us mature our program rapidly, because they had the experience of Vietnam.

The answer was “We don't want you to go through what we lived in Vietnam, and we'll help you”, because in 1997 they had on the books a number of suicides directly related to Vietnam. They had lost 58,000 troops in Vietnam. By 1997 they had over 102,000 suicides directly related to Vietnam.

This is an injury that never leaves. You cannot get out of it, as Monsieur Bachand asked me, without professional therapy and medication and a bosom buddy. The OSISS program on operational stress with peers is absolutely critical. You need someone who is going to sit there for four hours and not ask you one question, and let you talk and talk. You need that at all times.

Your vulnerability is never guaranteed. It's like they take away your prosthesis all of a sudden. I will give you an example, if I may. I was in Sierra Leone doing work on demobilizing child soldiers—in fact, working for Madam Minna at the time—and I had come back from the rebel area and was crossing the street in Freetown. Out of the corner of my eye I see a coconut vendor who has a machete and he's setting up shop. I keep crossing the road, and all of a sudden he took the machete and lopped the top off a coconut. There was white liquid and brown, and between the sound and the sight, I went totally and completely berserk.

The three people with me sat on me to hold me down for at least five minutes, then slowly I was able to rebuild. About 20 minutes later, I actually gave a briefing. So you have no knowledge of the noise, the smell, the comment that will trigger these reactions.

We have troops in my old regiment, 5th Regiment Artillery, and when I went back last year to a golf game, there were sergeants there who had been ten years in the army. Now, you need at least a year to get them up to minimum strength and then other training, so let's say they had about nine years' operational use. They had been on seven missions!

We have soldiers in the Canadian Forces who have more combat time than veterans of World War II. In so doing, we will continue to see an attrition of them and their families, unless you get the numbers up. It is not about reducing the missions, because we should also be in Darfur and a couple of other places; it is getting the numbers up.

Rebuilding an army is a long-term exercise, so I fear there will be more casualties, simply by burning them out.

My last point is we will probably have people going overseas who are suffering from that injury. God knows, a noise or an event might trigger them back in, and how effective they will be, we don't know.

Ms. Dawn Black: The other issue you raised was that of reservists. It has been an issue that's been at this table as well. I'm pleased to see you have some recommendations on that as well. It's something we certainly need to move on.

Other testimony from witnesses has indicated that there's a problem in having information filter up the chain of command around PTSD. Clearly, there's a lot of information that needs to go up the chain of command. Why is it that information about operational stress injuries or mental health issues seems to have such difficulty going up that chain of command?

● (1615)

Senator Roméo Dallaire: I would say that the situation is significantly different from what it was in the nineties, and we have leaped ahead. Also, it is not a money problem. Never, in one occasion of anything, have I heard that there's not enough cash to do the job. It's often the expertise, and so on, that's there.

However, with this problem of getting information up, it is my opinion that the senior leadership—and you're going down to brigade level, one star, and so on, colonels—know what's going on. I also believe that the troops down below know what's going on. It's the middle gang. And a lot of the middle gang are caught up in headquarters and in processes that don't necessarily reflect the fact that you have troops in harm's way in the war.

You have a middle gang that has a sort of process of bureaucracy to it that doesn't necessarily have that same sense of urgency, nor the ability to move on some of these requirements with the same speed one would expect. We accuse the health system of having disconnected with the operational. Well, I think they've reconnected significantly with the physical side; it's the mental urgency, the urgency of those injured from stress that is still not at that same peak as the other one, and that's because we haven't punched through that middle gang yet.

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Thank you.

Mr. Hawn.

[*English*]

Mr. Laurie Hawn (Edmonton Centre, CPC): Merci.

Welcome, General. It's good to see you again.

I have a couple of comments and a couple of questions.

We've heard a lot of testimony here, and a lot of it has been critical and in camera. No matter how good the system might be, those are the kinds of folks that are going to come and speak. We also heard some balanced testimony from a soldier and his wife, and the soldier had suffered very significant injuries.

Your point about reservists and tracking them is obviously very valid. The reservists need to cooperate with that as well.

Talking about sorting out the culture and so on, obviously that's important. The pre-deployment training has changed a lot. Are you familiar with the pre-deployment training that's going on now, and can you comment on its effectiveness?

Senator Roméo Dallaire: Yes. It is a hundred million times better than what we had. To give you an example, my militia regiment, where I'm the honorary colonel, has 25 chaps right now in training for leaving in 2009, and they have already been nearly five months in training. So some of them are getting over a year of pre-training to get into the operational theatre.

That is not an insignificant dimension, if I may say, because the more training, the more instinctive reaction and professional reactions they have to the circumstances they find themselves in, the less the surprise will cause trauma. There is a correlation between very well professionally trained, motivated, supported, focused troops and those who don't have that capability.

This brings me to the augmentees, the "one of"s here and there, and so on, who don't have that time and that cohesion. Some of them only have the minimum of three months, which is a lot more than they used to have, but even that doesn't provide enough for them. They're the ones who fall through the cracks.

There is a way, I am sure, through the contracting arrangements we have with the reservists when they're committed to these missions, that we have an obligation of following them up. Those kids are time bombs out there, and there has to be a way of creating —if not imposing—a continuing link with them.

Mr. Laurie Hawn: It's my understanding that the reserves are getting essentially the same training as the regular force guys when they're going on a rotation.

Senator Roméo Dallaire: They're in fact getting more.

Mr. Laurie Hawn: Yes.

You mentioned suicide rates, and obviously that's an issue. Suicide rates have not increased in the CF. In fact they're lower than the national average of the civilian population. But the critical shortage is of mental health professionals, and that's acknowledged. There are attempts to raise that number. You touched on some of the problems with attracting specialists, and it's not just pay, it's probably a bunch of things. What can we do to attract more?

We're trying to double the number of mental health professionals, and whether those people actually exist out there or not may be questionable. What do we do to attract more specialists and mental health professionals into the CF, either as CF members or civilian specialists?

Senator Roméo Dallaire: If I may, with respect to the point on the suicides, I went public in 1997 exactly because of a report that said we weren't really getting more suicides than anybody else, and it wasn't because of the missions in Bosnia; it was because they were already predisposed to this.

I think if you take a look at a very specialized group of people who have gone through a whole bunch of training and all their rigours and you've eliminated those who can't sustain that, and then you look at the figures, you might say those figures are troubling. I would caution how you look at the numbers of a specialized group with a lot of training and who have already undergone the attrition of those who would be in the norm of the civilian population.

In regard to the specialists, when I commanded the Quebec area there were not even enough for the civilian population, so how would we meet our requirement? How do you argue that our requirement is more important than the other requirements? How do you argue that the families of these people are more important than the families of others?

I would contend that the only solution in this regard is a continuity of programs. That is, between the Canadian Forces and Veterans Affairs, guaranteeing that both the therapist and the injured person have a continuum for treatment. That builds trust with therapists that they're not going to get shuffled every couple of months to different patients, that they'll only have ten visits. These artificial limitations are absolutely stupid and preposterous. You treat a person until the person is well or can reasonably function, not by a limited number of visits.

I think you create that continuum between Veterans Affairs Canada and the Canadian Forces in regard to the therapists. And secondly, get into the universities and recruit like mad. If you have to pay a prime for that, fine. Be competitive with civvy street, and go get them.

The money we invest in attempting to bring back those who have been injured—and we do bring a large number of them back through accommodation and so on—is peanuts compared to the investment we're putting into training them and the loss of the experience of that veteran to be able to help others. It's like a business plan: you pay the price up front.

● (1620)

Mr. Laurie Hawn: Unfortunately, it's a very long process. We've come a long way, as you said, but there's an awful long way to go.

You mentioned that we haven't achieved the same level of care with physicians and surgeons. Is it the complexity of the mind—it's easier to fix a broken arm than a broken mind? And do you think we'll ever get there?

Senator Roméo Dallaire: When we started to really shift gears on mental health after Operation Phoenix in the late nineties, we said we had to fast-track operational injuries to meet the sense of urgency. There was an argument that the injuries of the mind had to be as fast-tracked as the physical ones. We were having problems with just the physical injuries.

There was an attitude that you had to demonstrate the same sense of urgency to identifying the injury and bringing support to it, particularly in the first three to six months of post-deployment, where your greatest return is. I'm not sure whether that's been achieved. When you have a battalion of 800 coming back, you're overwhelmed. There's not enough surge capacity for these big deployments within the first three to nine months. If you don't hit them then, all of a sudden five or six years later there's a sound, and bingo, the person literally crashes.

It took me four years. You become a non-entity. You are a vegetable for months and months, until therapy and medication are able to bring you back.

The Vice-Chair (Mr. Claude Bachand): It looks like Mrs. Brown will be our last questioner today. It's a five-minute period, so go ahead, please.

Ms. Bonnie Brown (Oakville, Lib.): Thank you, Mr. Chair.

Thank you, General Dallaire.

I want to pick up on this professional help, because obviously this is the answer to getting people back on their feet and functioning well. You say that it's not the remuneration that is the problem with getting psychologists and psychiatrists. It seemed to me that in your list of things, the one that struck me was this business that the diagnosis or the treatment plan of such a professional might be overruled by the command structure, and you referred to that again in your most recent comments.

It would seem to me that if we could get rid of that, I think we'd get a lot more psychiatrists from the general community as well as within the armed forces, because these professionals don't necessarily have this vocation to serve in the Canadian Forces. They have a vocation that is elsewhere. It is to heal the mind and spirit of the patients who come to them, and to restore them to a state of responsible self-determination and health and ability to move forward.

So what we have here is a conflict between the vocation of a mental health professional and the culture of the armed forces, which tends towards conformity, obedience, brotherhood, and honour defined in a certain way. My guess is that a mental health professional might define “honour” quite differently from a military professional.

So how you bridge that gap, to me, would only be if we could get these external people to have freedom of treatment, not interfered with by the command structure. What do you think of that?

● (1625)

Senator Roméo Dallaire: In fact there has been CANFORGENs —I suppose you're familiar with the term—that have been issued by the Chief of the Defence Staff over the years, where the chain of command has no authority at all into the medical support that an individual gets. However, when we use chain of command, it's often used in the informal way; that is to say, it's not necessarily by order and directive, but it's by the boss: he's a warrant officer and I'm a corporal, and the warrant officer doesn't like anybody talking about PTSD or anything problematic of that nature. So the chain of command is not something that turns on and off, but a lot of the informal authority that still remains is a significant influence.

That's why I argued that there has to be a deliberate culture exercise, an attitudinal exercise change within the forces in order to ensure that both veterans and non-veterans are on line in regard to that injury and its honour as an injury, just like a physical one. That's on the in-house side. So there's a continuum of culture shift that absolutely has to be implemented and responded to, and not be ad hoc, which too often happens, and the supervision thereof.

In regard to the therapist, when I was working with the VAC side of the house, one of the first things we realized was that some of the therapists had enormous problems with the patients they were seeing because they didn't know how to talk to them. So there is an *apprentissage* that the therapist has to go through in learning the jargon. One of the things we insisted on is that in every one of the clinics they have a retired warrant officer or sergeant to explain the culture of the military, what its background is, the ranks, the acronyms, and so on, so that the therapist is able to move into that milieu with more comfort and not look foolish.

One of the first things we realized was we needed to sell the forces patient, this unusual patient, to therapists who are used to civilians. One of the answers we did look at was looking at those therapists who work with police, firemen, paramedics, people like that, and trying to bridge the gap on how they work with those specialists and how they could work with the forces. But the overriding factor is some of them just don't want to find themselves in a complexity that is not within the norm of patients. And that then falls on us to sell the product much more effectively.

● (1630)

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Thank you, General for your critical testimony. The committee encourages you to continue your excellent work. You have an exceptional presence, and you use it to help those the most in need. Thank you for appearing before our committee today. We want to say good luck, and until the next time.

Senator Roméo Dallaire: Mr. Chairman, thank you. I simply want to remind you of one thing, namely that families are absolutely crucial. My family had to receive care. We are still experiencing this situation today. So please, don't forget how important the family is.

The Vice-Chair (Mr. Claude Bachand): We will take that into consideration.

We will now suspend our proceedings for a few minutes.

● _____ (Pause) _____ ●

The Vice-Chair (Mr. Claude Bachand): We will now continue our deliberations.

Welcome to the Standing Committee on National Defence. As you know, we have an hour together. I don't know how much time you need for your presentation, but the shorter it is, the more time you will have to answer members' questions.

● (1635)

[*English*]

Mr. Fred Doucette (As an Individual): I don't think we're actually here as a group.

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Will each one of you make a presentation? If so, can you please limit yourselves to five minutes each?

Go ahead, Mr. Doucette.

[*English*]

Mr. Fred Doucette: My name is Fred Doucette. To start with, I'm here as Fred Doucette, former soldier, not as a DND employee. As the questions go along, I guess we can segue into the work that I do.

I joined the army in 1968 and served until medically released in 2002 with PTSD. I did not meet the universality of service, in that I could no longer deploy outside Canada. By 1999 I had served on six overseas missions: Cypress in 1973, 1974, and again in 1986; 1995 with UNPROFOR; 1996 with IFOR; 1999 with SFOR; and a year as a military observer in Sarajevo, where I was wounded in July 1995.

I served on domestic operations such as the federal prison strikes in the 1970s, the 1976 Olympics, Oka, the Swissair Flight 111 recovery, and the ice storm, to mention a few.

I began my recovery when I was diagnosed with severe chronic PTSD in 2000. At that time, I requested that I not receive any therapy from a military practitioner. My reason was based on my visit with the base social worker to sign my referral to the OTSSC in Halifax.

I was a proud, well-trained infantry officer who had made a very difficult decision to admit to a mental illness. The base social worker began by asking me my symptoms. When I got down to the one that was concerned with my emotions, I said that they were all over the place. And his response as a trained professional was that I was just getting old.

If it weren't for the coffee table between me and him, I would have probably hit him. I told him to sign the—expletive—paper and left. And I never went back inside the base social work office again.

My therapy began in July 2000 with a civilian practitioner in Fredericton. By the time of my release in October of 2002, I was 100% healthier, and I've never looked back.

Since 2002 I've been employed as the operational stress injury social support coordinator for New Brunswick and P.E.I. I've dealt with approximately 500 soldiers and veterans and currently have about 120 active peers on my phone list.

The Vice-Chair (Mr. Claude Bachand): Mr. Passey.

Dr. Greg Passey (As an Individual): I'm Dr. Greg Passey. I served for 22 years in the Canadian Forces until September 2000, first as a general duty medical officer, then, in the last nine years, in psychiatry, with particular expertise in post-traumatic stress disorder and associated operational stress injuries.

I did the first large-scale research project in the world to investigate PTSD and major depressive disorders associated with peacekeeping deployments. This was conducted on Canadian military personnel in 1993-94 deployed for Operation Harmony and Operation Cavalier in the former Yugoslavia.

Prior to that, there was a general awareness that there were psychological injuries and costs associated with conduct in combat operations. In 1990, in their book *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945*, Copp and McAndrew detailed how about 25% of all Canadian military casualties during the Italian campaign in World War II were neuropsychiatric, or what we would now call operational stress injuries.

My research in 1993-94 for the Surgeon General and the Canadian Forces Medical Service revealed a depression rate of 12% and a PTSD rate of 15.5%, or an overall 20% rate of either or both of those disorders in one combat engineer regiment, the 2nd Battalion, Princess Patricia's Canadian Light Infantry, and the 2nd Battalion, Royal Canadian Regiment, upon their return home from peacekeeping duties. This established that there was a cost beyond the expenditure of money, equipment, and physical injuries when conducting peacekeeping or peacemaking military operations.

These figures shocked the military, and its upper echelon was very resistant to addressing these new findings initially. The immediate response seemed to be to try to find ways to ignore or question the validity of the numbers rather than starting to initiate a plan to acquire and reallocate medical resources to address a looming health care issue within the military.

Recommendations by me and other health specialists in regard to the acquisition and placement of multidisciplinary medical teams with the brigades and on deployments were largely ignored until the Croatia board of inquiry results were released and General Dallaire, in 1997, publicly disclosed his diagnosis of PTSD and became a strong advocate for mental health assessment and treatment within the CF. Even so, it was not until 1999 that the operational stress injury clinics were finally initiated, although CFB Petawawa did not receive one.

Recent research indicates that the PTSD rate in Canadian personnel returning from Afghanistan is about 5%. This would potentially generate 250 new PTSD cases per year. American casualty rates in Iraq indicate that their regular forces have a PTSD rate of 17%, and for the National Guard it's 25%. This duplicates my finding that reservists are more at risk of developing PTSD. In Canada we utilize a high proportion of reservists on our deployments, yet the medical system and follow-up for them is lacking compared with the regular forces.

Failure to provide access to military specialists who can diagnose and treat PTSD has significant cost to the units, individual soldiers, and their families, and potentially can result in lawsuits. In 1994 it was reported in *The Medical Post* that the Ministry of Defence for Britain agreed to pay 100,000 pounds to Corporal Alexander Findlay for not diagnosing and properly treating PTSD.

In 2002, in the *National Post*, it was reported that Sergeant Peter Duplessis launched a lawsuit against the Canadian Department of National Defence, and in particular Dr. Boddam, for failing to diagnose and treat his PTSD. This was particularly important because from 1995 until 2008, Colonel Boddam was the practice leader for psychiatry and mental health in the Canadian Forces. As such, he advised the CFMS on the size, placement, focus, and direction of mental health resources within the military.

Colonel Boddam admitted in the examination for discovery in 2003 that he did not ask questions that would enable him to diagnose PTSD. This case subsequently settled out of court for a sizeable amount, but Colonel Boddam retained his clinical and advisory positions. There were other individuals with similar circumstances who would have also launched lawsuits, but they were precluded from doing so because of the statute of limitations. At the present time, there are other lawsuits against the CF that are either proceeding through the courts or are in negotiations for settlement toward PTSD.

Competency remains an issue in the delivery of care to our injured soldiers. For example, Corporal A was recently assessed four months ago at an OSI clinic and diagnosed with PTSD. During the assessment he admitted to drinking alcohol a lot, but the specialist did not quantify how much, nor did he ask about the corporal's suicidal ideation. This is important, because excessive alcohol intake often precedes a suicide attempt.

● (1640)

Corporal A was quite suicidal and is fortunate to still be alive today, only because of the intervention by another experienced clinician. About 49% of individuals with PTSD have suicidal ideation, and about 19% will actually attempt suicide.

The CF has made significant progress with the establishment of the OTSSCs and the OSISS network screening procedures, and certainly General Hillier's recent CANFORGEN is spotlighting mental health before he leaves.

Nonetheless, there is evidence that the clinical resources are swamped. This was confirmed in my conversation two days ago with a doctor deploying to Afghanistan from CFB Valcartier, where there are wait lists for treatment. I educate all the medical staff who deploy to Afghanistan and who attend the Vancouver General Hospital traumatic treatment centre.

In addition, most of the assessment and treatment of OSI is now done by civilian specialists contracted to the CF or VAC. Acquisition of these resources is in direct competition with civilian health organizations, and as such many of the hired specialists do not necessarily have the clinical experience or military environment knowledge to provide optimal care.

There are a number of issues that I wanted to address. One is the stigma associated with mental health and OSI diagnosis. One recommendation is that the Canadian Forces should adopt a zero tolerance policy in regard to discrimination with OSI diagnoses in the same way they have instituted zero tolerance for either religious or gender discrimination. We need to change the terminology from “mental health”, which has a high stigma attached to it, to “neurological health”. We also need to develop a specific program to retain individuals within the CF when appropriate, such as reclassification to other military jobs.

In regard to experienced clinicians, I think it's important that the CF and VAC both sponsor a yearly national conference wherein all clinicians providing mental health care can attend and receive continuing education credits addressing assessment and treatment issues, military culture, deployment stressors, continuity of care, and transition to civilian life, with a forum for clinician feedback. There needs to be special orientation for civilians who are hired, and there needs to be ongoing recruitment of clinicians who have at least two to three years of experience. But beyond that, there needs to be a mentor program to help the less experienced clinicians.

There also needs to be the development of a quality assurance program in both the CF and VAC in regard to health care delivery that has input from the members, their families, and other clinicians.

In regard to reservist care, I would recommend that a health care specialist be appointed to specifically oversee the delivery of health care to reservists, and further, that there be the development of a tracking system and policy to ensure at least two years' follow-up, especially for those who leave the reserves.

Then there are ongoing issues in regard to continuity of care during transition, which we heard about from General Dallaire. There needs to be further development of resources for family members.

Thank you for your time.

● (1645)

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Reverend Studd.

[*English*]

Rev. Allan Studd (As an Individual): Mr. Chair, I am the Reverend Captain (Retired) Allan Studd. I'm an Anglican priest and a retired Canadian Forces chaplain and a marriage and family therapist.

I am the son and grandson of career members of the Canadian Forces. I grew up on base at Wainwright, Borden, and Oakville.

I was ordained to the ministry in 1979. There were attempts at that point to get me into the military chaplaincy, but it was not until 1994 that I began to work as a chaplain at CFB Petawawa. I was commissioned as an officer and a chaplain on August 4, 1995, with the 1st Air Defence Regiment, which was a reserve unit in Pembroke, Ontario, and an asset of 2 Combat Mechanized Brigade Group at Petawawa at that time.

I served on continuous class B contracts as garrison chaplain and then chaplain to 2nd Combat Engineer Regiment and 1st Air Defence Regiment. Later I was posted to base chaplain and chapel life coordinator. I was medically released on October 30, 2002. I have PTSD comorbid with major depression and migraine headaches.

I concur with everything that General Delaire told us in his presentation. Very quickly, remember that between the years1994 and 2000, CFB Petawawa was returning from Somalia and saw the shutdown of the Airborne Regiment. They were just returning from mop-up operations in Rwanda. We were deployed in Croatia. Later on we deployed to Bosnia and did that twice. We deployed as well as aid to civil power, to Winnipeg during the Red River flood, and the ice storm in eastern Canada. We took the DART team to an earthquake in Turkey and Hurricane Mitch in Honduras. Finally, we deployed to Kosovo and managed another refugee crisis there. Somewhere in there, I was seconded as well to the American forces and I served as chaplain to Fort Sherman, the Panama Canal Zone, for a jungle operations training course.

I go through this because this is only a list of the extraordinary deployments. It says nothing of the regular training cycle of the Canadian Forces that takes soldiers away for extended periods of time. And through all of this, the military families suffered, and as chaplain I daily dealt with, counselled, and provided therapy to members, their spouses, and their families, as those families splintered under the strain.

Alcoholism, Internet chat rooms, infidelity, domestic violence, financial difficulties, brushes with the law, injuries as a result of automobile accidents, depression, mental illness, eating disorders, home sickness, illness of immediate family members, death of immediate family members, Gulf War syndrome, PTSD, suicide and the death of my own engineers while serving in Bosnia, all of these I dealt with daily, any time of the day or night.

In March 2000 I left the base exhausted, an exhaustion that after eight years I still have not fully recovered from, and I returned to a family that no longer knew me. The frenetic pace of operations, the breakdown of the day-to-day operation of the chaplain team in Petawawa, the constant stress of trying to be a caregiver, a 24/7 on-call work style, and a well-documented case of harassment left me a mere shell of who I had been in 1994.

This is a snapshot of the military family and what General Delaire was trying to impress upon us. When asked by SISIP what I would like to participate in for vocational retraining, I elected to attend a 24-month post-masters clinical training program in marriage and family therapy. I understood that I hadn't had the skills and training needed for the task of providing counselling therapy to the military families of CFB Petawawa.

I also knew from personal experience of the toll taken on the military family by members returning with post-traumatic stress disorder. So at my own expense I participated in a clinical week at the Veterans Administration National Center for PTSD in Palo Alto, California. Both my military and civilian training to this point had led me to become deeply concerned about this particular disorder. I was not yet ready, however, to admit that I was affected myself. That came later.

Today I sit before you as a marriage and family therapist. Family therapists are core mental health clinicians trained to treat disorders commonly faced by returning service members and veterans.

● (1650)

In my training I received 500 hours of supervised training in a clinical setting. In fact, as a discipline we received more supervision of our clinical work than any other discipline, including psychologists, psychiatrists, and social workers. Our supervision ratio is one hour for every five completed and it is not matched in any other profession. I have the professional equivalent of a PhD. I have completed almost another 500 hours of supervised counselling therapy since leaving there.

I had hoped I would be doing this so that I could get back to the military family. The Canadian military, however, views mental health care for our soldiers through a 1950s lens. It's a lens that says the only professional able to provide mental health care is a social worker, a clinical psychologist, or of course a psychiatrist, and there is a disturbing vacancy rate.

I want you to know that my colleagues are ready to offer professional mental health care to our CF members and their families. Marriage and family therapy has been recognized as a discipline since 1942. We have the only training where the focus is relational. It recognizes that all mental health problems exist within a system of relationships and what affects the individual affects the whole.

Marriage and family therapists are highly trained mental health professionals. We use evidence-based methods of therapy. That means that a method has been thoroughly studied and peer-reviewed before it goes into practice. We are able to work with a whole range of mental health problems, from depression, PTSD, and occupational stress injuries to relationship breakdown and mental illnesses such as schizophrenia. All of us have a master's degree and many of us have much more than that. We are collaborative as well, meaning that we work closely with all other health professionals. MFTs can be found in private practice, hospital settings, family health teams, and community based agencies. You name it, we're there. We're also inter-professional. Our initial training and experience can come from any of the helping professions. Mine came from the ministry. We are closely regulated through the American Association for Marriage and Family Therapy and we are required to have exhaustive core competencies.

It's deeply frustrating for me that after another five years of post-graduate training I have not been recognized as properly trained to do all the things I was expected to do as a chaplin. I have found it impossible to get myself hired to help in the mental health clinics for our soldiers.

The Americans have recognized us. We are recognized by both the Department of Defense and the Veterans Administration. The DOD has just recently opened 44 MFT positions across that country to work with its members. In fact, I myself have been asked during the past week to consider joining the mental health clinic at Fort Drum, New York, just a few hours south of this city, in order to fill one of those positions. I can tell you, I would much rather travel the 45 minutes to CFB Petawawa than the four hours to Fort Drum to do the same job.

I am here today as a person who grew up in PMQs. I'm here as an army brat and I'm also here as a chaplin who has agonized over how best to help our military members, veterans, and their families, and I am here as a person who himself is affected by post-traumatic stress.

The way I chose and the way I think would help solve a lot of the things we've heard spoken about today was the way of marriage and family therapists. We are extensively trained professionals who are the best of what the mental health profession has to offer.

My presence here today is endorsed by the Registry of Marriage and Family Therapists in Canada. I want you to know that there are 1,000 registered members in Canada. I know that many of them would want to work with the Canadian military.

I would like to recommend that the Department of National Defence institute as a policy the hiring of registered marriage and family therapists to work as psychotherapists in the mental health, PTSD, and occupational stress injury clinics. I would recommend as well that DND develop a relationship with the Canadian registry of MFTs and its training centres, so that military health providers can receive training in marriage and family therapy to better help the military members and families. As well, mental health positions could be filled with graduates from those centres.

● (1655)

l want only the best treatment for our soldiers who suffer from PTSD and OSI. This was my motivation in seeking out what l knew to be the best training. I want to assist our soldiers, veterans, and their families. l am so convinced of this that l would be happy to make some introductions between the National Defence staff, Veteran Affairs, and key voices in my profession.

Ultimately, I would like to pursue the goal of ensuring that there are registered marriage and family therapists on staff at every base and every regional veterans centre to fill the void that exists in most places today.

Thank you for your attention, and thank you for inviting me to be here today.

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Thank you.

[*English*]

Mr. Regan.

Hon. Geoff Regan: Thank you.

[*Translation*]

Thank you for having given the witnesses the opportunity to make their statements. It was very beneficial for everyone.

[*English*]

I would like to thank all three witnesses for excellent presentations and for coming today. Along with General Dallaire, all of you have given us much food for thought. I hope that this will have a positive impact on the future.

I want to start with Dr. Passey. First of all, what do you think is the answer is to the situation you described where the upper echelons were very resistant to the findings you had? This could be asked about perhaps any department when it is resistant to change. We see this often in government. Do you have a prescription for ensuring that departments examine things that may cause them to realize it's time to change something?

Second, I don't know if you talked at all about marriage and family therapists in your comments, but would you agree with what we heard from Reverend Studd? I thought that was excellent.

● (1700)

Dr. Greg Passey: In response to your first question, you need to realize that all people resist change. Organizations such as the Canadian Forces and the RCMP are steeped in tradition. It's very difficult to implement new types of programs, particularly if it goes against a belief system. The belief used to be that only weak people would develop PTSD. I deal with torture victims, immigrants, etc., and I can say that there's no person on earth for whom we cannot devise a situation that will cause him to develop PTSD.

The issue of change is difficult in the military. One of the things that's necessary—and I have to congratulate the military on the job they're doing here—is education. Education is occurring at the basic training level, at leadership levels, and at the higher levels. At this point, I believe they're embracing it. Certainly General Hillier's recent CANFORGEN would support this. He's actually pushing it.

When I came out with my study, there was huge denial going on, and it was very difficult to present the findings, let alone change anyone's mind. So I think the military has come a long way, but anytime you attempt to change a belief system and an organization steeped in tradition, it becomes very difficult. It's all about education. People are quick to judge. It takes a lot of energy to understand and become educated about something.

In regard to Reverend Studd's comments, I agree with him. In regard to a PTSD, like alcohol, it does not just affect the individual, it affects the supervisors, the co-workers, and the family members. We're talking about relationship issues. There are just not enough psychiatrists and psychologists around. I would certainly embrace any other profession with credible credentials that can do this type of work. Way back in 1993 I recommended that we have multi-disciplinary teams approach this disorder and the evolution of it.

I would certainly agree with what he had to say. On the civilian side, we typically work with multidisciplinary teams. That is the best way to address this problem, which is affecting both the professional and personal sides of the individual.

Hon. Geoff Regan: It's good to hear that obviously your research, while it took a long time, led to these kinds of changes in attitude, and undoubtedly there's still change to be had. I think you've all referred to that, but thank you for your work in that regard.

Mr. Doucette, you talked about this, and maybe this falls within that question. You talked about the fact that when you talked to your base social worker, you mentioned that there were emotional issues and he said you were just getting old. Is it your sense now that if a soldier, sailor, or airman went to the base social officer or social worker today, they'd get a different kind of reaction? Are you satisfied that this is the case?

Mr. Fred Doucette: Yes. Things have changed radically. One of the biggest changes is that the people who are in those desks now have served in those places. The fellow I saw was a sailor, a navy guy, and he had done all those clinical things, so he had no idea what I was talking about as far as I was concerned. But you see it all through the chain of command. The people who are in the positions now have served in the Bosnias, the Rwandas, the Somalias, the Haitis, and the Afghanistans. So you have that knowledge, and they've been exposed to what the soldiers are exposed to.

It was a learning curve, but it's nice to see that General Hillier.... He and I were in IFOR together. He saw what I saw. So guess what? He appreciates it. So that's where a lot of the learning has come from. I think the fact is that they're coming to realize now that it's the cost of doing business. If a paramedic or a fireman walked up to you and said “Yes, I'm trashed, I have post-traumatic stress disorder”, you could understand that. Well, why not a soldier?

It has changed. In the six years that I have been involved with the OSIs program, I've seen amazing things happen.

● (1705)

Hon. Geoff Regan: So for the foreseeable future, you're satisfied that those kinds of positions will very often be filled by people who understand because they've been there. The question that occurred to my mind was that we've had all this experience in the last decade or so, and if there were a period when we didn't have that experience, then you would not have people like that. But I guess that's not today's problem, in a sense. I think it's important to be sensitized to this, but you and I can't ensure that the people running the military in twenty or thirty years are sensitized. I don't know how you do that exactly.

Mr. Fred Doucette: The thing is, one of the key things about this injury is the first word in it, “post-”. The numbers probably ramped up radically after Dr. Passey put his study out. It would be great if it were “pre-”, because then we could screen them so they wouldn't get this illness, but it's “post-”, and the post can come six months, four months, ten months, four years, five years after. I spoke to a veteran who was 82 years old, who was having the symptoms of PTSD because he was now retired, sitting on his front porch, and his memories were coming back. He told me, “Fred, the shadows are starting to have faces”. That's 65 years after the war. So this is the gift that keeps on giving.

So however we maintain that knowledge, hopefully as the operational trend may die down that expertise doesn't drift off or we start saying let's not pay attention to it because it's not the flavour of the day. That's what we've always been afraid of: once we get out of an operational tempo that's not as heavy as it is now, the concern and the focus over mental health within the military will drift off. So it has to be maintained, I would say.

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Thank you, Mr. Regan.

Mr. Bouchard, you have eight minutes.

Mr. Robert Bouchard: Thank you, Mr. Chairman.

I would also like to thank our witnesses for being here today.

Dr Passey, I have an article here written by Mr. Stéphane Guay and which was published on February 18, 2008. It is entitled "*Les militaires consultent peu les ressources en santé mentale*" [military personnel rarely turn to mental health experts]. The article states, among other things, that the suicide rate within the military is double that of the general population.

Should we be concerned about this statement? In your opinion, do military authorities care? Based on what you have observed within your practice, if the suicide rate is not twice as high, is it nevertheless higher than in the general population?

[*English*]

Dr. Greg Passey: It's a very good question, and it's something I've revisited on a number of occasions with the military.

First off, should we be concerned? Absolutely. A suicide death is a preventable death. If there are adequate resources available and they're accessible without stigma, and they're also experienced and competent, then a lot of these suicides could be prevented.

The military should have a much lower rate of suicide than the normal population. We don't have the very elderly. We don't have the people with cancers, the very ill, the alcoholics, the drug addicts. There's a whole host of people who typically have high suicide rates, and in the military we don't have that. We've done screening out, we've been looking for people who can handle stress. For the most part I feel that our troops are well trained.

We have to have a look at what is actually causing these things. Is it the deployments? Is it the tempo? Sometimes the stressor is not necessarily the deployment. It may be the stress that is affecting the family and is then transferred back to the individual. Again, we need to be looking at more than just the individual. We need to be looking at the family as a whole and the support system in that regard.

I think, compared to where we were.... I keep saying "we". I'm out of the military, but you can't get the military out of me. I think we've come a long way in regard to mental health. I think we can go further.

Again, I think the regular force members have much better support than they used to, but my big concern right now is with the reservists. These people come back and they may leave their unit. They become civilians, and then they're lost for follow-up and they're lost in the statistics.

How many times have you read about a young individual who crashes their vehicle or motorcycle at high speed? That's never classified as a suicide, yet I can tell you right now, a significant number of the individuals I see, military and ex-military, engage in very high-risk behaviour, and they do not care if they die or not.

So the reservist issue is a huge one that I think we need to address much more than we have to date.

● (1710)

[*Translation*]

Mr. Robert Bouchard: Dr Passey, some time ago, during the mission in Afghanistan, soldiers were sent into combat for a six-month rotation, and then they came home. However, I have heard that the rotation period is longer today. It is nine months or even longer. So there are two approaches. I think this is because it is difficult to recruit new military personnel and because the mission has been extended until 2011.

In your opinion, is it better to have six-month rotations, and to repeat them more often, rather than having nine-month rotations? What do you think would be the better approach to reduce cases of post-traumatic stress disorder?

[*English*]

Dr. Greg Passey: It's difficult. On the one hand, if you have shorter tours of duty, given the small size of our army it means that people are going to have to rotate back into theatre much sooner. The advantage of a longer tour of duty, nine months or a year, is it allows other people back here in Canada a little bit of extended time before they have to start gearing up for training, so they have perhaps a little more time with their families and stuff.

The flip side of that, though, is that the longer you're in theatre, the more you're exposed to traumatic events. And we know that it doesn't have to be just one traumatic event. We know that the cumulative effect of stress can actually cause PTSD or other sorts of OSI.

The ideal—and it's what I had recommended way back in the nineties—is that the individuals have a minimum of two years, but preferably three years, in between the tours. The problem is that often there are certain MOCs or occupations for which there are just not a lot of trained people. When I was still in the military in Edmonton, I heard of people getting off the airplane and being approached to actually go back on the next tour.

So I agree with General Dallaire on recruitment. The military needs more numbers in order to better space out and spread out the stress exposures for its troops.

Mr. Fred Doucette: Could I just add to that?

One of my tours was a year long. I was a military observer in Sarajevo during the war. To be honest with you, if you're on any tour of more than six months, as the doctor said, you're going to start having symptoms. I actually started having symptoms of PTSD, but I didn't realize it, nine months into my tour. So I was already ill and was still in theatre. So it just compounds the injury, I think, by lengthening the tours.

[*Translation*]

Mr. Robert Bouchard: One of the experts who testified before the committee said that each soldier returning from combat should be systematically assessed to see whether there is post-traumatic stress. The witness said this would not be very expensive.

Would you be willing to make such a recommendation?

[*English*]

Dr. Greg Passey: Well, there are two parts to this thing.

It is very difficult to screen and predict who is going to get PTSD. They attempted to do that in World War II, and basically you could flip a coin and be as effective as our screening procedures. So it's difficult to predict. Even if you say this person is vulnerable to developing PTSD, it does not mean that he or she necessarily will, and they may actually perform quite well in theatre. So the issue of screening is difficult.

The other thing is that we don't have a whole lot of stupid people in the military. They are actually very bright and well educated nowadays, and if they decide they want to go, for the most part they know how to answer the questionnaires.

The question was asked earlier, but what I found in my research is that 50% of the people I identified as having PTSD rated their emotional and psychological health as good or excellent, which tells me that they really didn't have a whole lot of insight. The problem, they said, was I'm fine, but you guys are all messed up.

So in an ideal world, it would be great if we could actually screen and pick these people out and therefore be proactive and protect them. But I'm not aware of anything that we have at our disposal at this point in time that can actually do that. If a person has severe PTSD and you're observing them, yes, you could probably pick them out. But you have 800 people in a battalion, and you just don't have the time to be doing that, so you'd be doing it by questionnaires, and questionnaires are fallible.

● (1715)

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): Thank you very much.

We will now go to the Conservative Party.

Ms. Gallant.

[*English*]

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

Reverend Studd, in your opening presentation you observed that the Canadian military views the mental health of our soldiers through a 1950s lens. Would you please elaborate on that statement?

Rev. Allan Studd: My experience in trying to come back into the military as a civilian to help in the area of mental health is that I have been told outright, including by lots of people in the social work department at Base Petawawa—by the base surgeon, and by Calian, which does the contract hiring—that there are only certain professionals they recognize as being able to provide the care that is needed. Those professionals are clinical psychologists with a PhD, or a social worker. The social worker, I presume, would have to have a masters-level degree.

That's a 1950s view of who do you go to if you need help, and who do you go to if your marriage is falling apart and you want to get some marriage counselling? Well, you go to a social worker or maybe you go to a psychologist.

What I want you to understand is that there are other mental health professionals out there who are probably better trained and have the training and the depth of experience to be able to work in almost any field of mental health. So that's what I was trying to get at.

I've been very frustrated. SISIP paid for my vocational retraining, and actually paid out quite a bit of money for me to do this two-year course. I had the understanding that I would be welcome to come back into the civil service, and I haven't been able to do that. I haven't been able to make any headway anywhere.

I watch with a little bit of frustration as my colleagues in the States are recognized and are hired to do the work with OSI and PTSD that I'm very capable of doing here, and which I do in my civilian practice.

Mrs. Cheryl Gallant: That's interesting. So one of the agencies of our federal government paid your tuition to take this course. Then the federal government, or a branch of it, won't recognize it.

Mr. Chairman, I'll be sharing my time with Dr. Lunney, if time permits.

One thing that jumped out at me during your opening presentation was the amount of first-hand experience you had with the military in the time you served as a Canadian Forces chaplain. Based on what you know now, how would training in marriage and family therapy have helped you cope in your previous role as a military chaplain?

Rev. Allan Studd: Chaplains are front-line people. We are the people who are contacted when there is a problem that has anything to do with personnel or family, so much so that when social workers in Petawawa hung up their telephones at four o'clock and went home they in fact left a message on their telephones that said to contact the duty chaplain.

What I was dealing with almost always had family relevance. If there was a problem, it involved the wife and the children, and often grandparents and parents somewhere else, because all these things happen within a relational context.

There are many skills I wish I had had in sitting and helping a couple work through their problems. Their problem might simply be that the member has been away for probably a year, because there's six months of training and then six months actually on tour. He has come back and discovered that his wife, or spouse, I should say, is suddenly taking care of the finances, taking care of the kids, and coping very well, thank you. And he or she—the member—feels left out of the family.

I didn't know how to help with that when I was a chaplain, yet I was expected to. There was a great deal of time spent sitting with couples and sitting with families and trying to help them work through their problems. But I didn't really have those kinds of skills or that kind of training at that point.

● (1720)

Mrs. Cheryl Gallant: In speaking to this committee, Commander Dean Milner said that CFB Petawawa is severely understaffed in all categories of medical personnel. With the next rotation to Afghanistan coming from Petawawa, it's critical that we address the shortage of medical professionals now. In your mind, what would it take to get the job done?

Rev. Allan Studd: From what I'm hearing, because I also live in the Petawawa area, and from what I'm seeing in my own private practice, it unfortunately is going to take quite a bit. There needs to be an increase in staff in terms of what I believe is called the mental health clinic, although General Dallaire said that they're not using that name any more. A great number of people need to be hired to fill the positions so that the therapy can take place to help all the families that are hurting.

I told you about Petawawa in the 1990s. Petawawa right now is a much more tense place, because you have family members who sort of live daily with the understanding that they might get a phone call saying that their loved one who is serving in Afghanistan has died. There is a lot of stress because of that. It has increased the work for therapists in terms of families and in terms of workplace stress.

The Vice-Chair (Mr. Claude Bachand): I will have to interrupt you there, Mr. Studd.

I would like to give the last two questions to the other colleagues for one or two minutes each. Then it will be over for this session.

Would you like to go, Mr. Lunney?

Mr. James Lunney (Nanaimo—Alberni, CPC): Yes. Thanks.

The time is short, so I'll rush right in here.

With respect to a comment that was made earlier about what has changed in terms of how we're approaching this, we're doubling the number of health professionals, or at least DND is trying to respond to the needs. The pre-deployment training is much better than it was. We had some discussion about that. Now we also have peer counsellors that greet and meet the soldiers on the way back. There's debriefing time and decompression time on the way back. It's a time to talk, as I think you mentioned earlier, and a time to unload, to talk to people before they're released or find themselves back here alone. I'm just wondering, first of all, if you think that's going to help.

Second, really quickly, the mission has changed since we took over, particularly if we're talking about Afghanistan. It was a very tough combat mission when we took over. Now there's less combat. There are cleanup operations and patrols. The biggest problem now, really, is IEDs.

Do you feel that now that the range or the exposure or the difficulty and the nature of the mission has changed, with less direct combat, that the high numbers are likely to drop off?

● (1725)

Mr. Fred Doucette: Just on the first one, I have two things on the fact that we can't find professionals out there. An OSI clinic opened in Fredericton two weeks ago. Psychiatrists, psychologists times three, social workers times two—found, hired, and in that clinic. VAC found them. Why can't DND find them?

As for the training, there is next to no training psychologically for the soldiers on their pre-deployment training. It's focused on the mission. They don't sit down and say “Okay guys, if we have an IED and one of us is turned into a pink mist, we're going to be able to handle it this way”. They don't do that. I was told by a commanding officer that when I want to brief them on OSIs, brief these young officers leaving the infantry school to go to units, we don't want to teach them to surrender. That was his view of what I was going to teach them.

But when I went through all my therapy as a serving soldier, I wished I had some of those skills they taught me in therapy, how to de-stress, how to focus, how to ground, how to deal with boredom, how to deal with loneliness. There's nothing voodoo about it. I'm better armed now to deal with things like that than I ever was.

So the pre-deployment training is fighting and dying stuff. That's what it is. As for the threats, be it IED, be it somebody with a rocket-propelled grenade, be it somebody with a rifle, it's the threat to life, regardless of which way it comes. It doesn't matter. That's one of the prime things of PTSD—it's the threat of losing your life. You could be sitting in a camp and hear booms miles away. That will trigger the fear that this boom may get closer some day. If you sit there for six months dwelling on that fear, guess what? It's going to manifest, and you're going to end up with a sick soldier.

That's why we have cooks with PTSD. They never leave the camp. How does a cook get PTSD? He's not outside the wire. He listens to things. He gets little snippets of conversations in the meal line, “Boy, we were lucky to get through that today”. So they're getting all these little bits. He goes back after his shift and sits in his bed space at two in the afternoon because he's got to get sleep because he's on at four in the morning and the little wheels start turning. The fear is there; it manifests. That's how a cook gets PTSD.

As the doctor said, there's no way to train a soldier on what a dead body looks like. We can't do it. It's impossible. There's no way to explain what it's like to have one of your friends killed. There's no way to train to see what it's like to come under artillery fire, to hear bullets really coming, to see those puffs of smoke beside you, because we don't want to kill our soldiers in training. Therefore, the learning curve is when they hit there.

[*Translation*]

The Vice-Chair (Mr. Claude Bachand): We have some time left for a very brief question.

[*English*]

Mr. Brian Jean (Fort McMurray—Athabasca, CPC): Merci, Mr. Chair.

Congratulations to you all for your work.

I have a few questions. And if you can't answer the questions today, I'd appreciate it if you would send answers to the chair in writing.

First of all, on post-traumatic stress disorder, I've known that it leads to depression and suicide, but I'm wondering, does it lead to other diagnoses, such as chronic pain syndrome and chronic fatigue syndrome, which I dealt with as a personal injury solicitor in Alberta? It does in personal injury cases. I saw many other diagnoses come from this, and I have to say that the effects are absolutely terrible. The people who have this don't even realize it. They think they're not sane. It comes down to that in part, and I understand that it shows up two to three, even four or five years later.

Mr. Passey, I'm interested in your comments on this in particular. In 2003 you were critical of the then Liberal government in relation to their ability to deal with post-traumatic stress disorder. Are you seeing a change in government as far as a movement toward at least addressing and recognizing the disease? Of course you know the government moves slowly because it's so big, much like the military does sometimes, but are we moving in the right direction with this?

And finally, do we have the proper assessment or measurement tools in place to be able to diagnose it? Are they sufficient now?

Dr. Greg Passey: I don't think I actually criticized the Liberal government. I was criticizing the Canadian Forces and its inability to move in a direction I thought was necessay.

Certainly things are going in the right direction. It's much better than it was. There's still an issue around reservists and families that needs to be addressed. We could spend a whole afternoon on this, and I've sat on a VAC committee doing just those sorts of things.

To go back quickly to the comorbid diagnosis, we know that with PTSD about 50% of men will actually abuse or become dependent on alcohol. About a third will also either abuse or become dependent on other drugs. Almost 50% of men and women will also develop a major depression. We know that a person who has PTSD is 90 times more likely to develop physical symptoms than a person who does not have PTSD. We also know that for a peacekeeper with PTSD, the expense to the health services is 37 times more than for a peacekeeper without PTSD. So there is a mind-body link. There is a problem in regard to sensitivity to pain, etc. Fibromyalgia and chronic fatigue are absolutely associated. There is a much higher risk of developing those if you have post-traumatic stress disorder. The comorbid stuff is absolutely there.

You've given me an hour, but I've spent 16 years of my life on PTSD. You've asked the impossible from someone who is improbable at the best of times. PTSD, the assessment, the treatment—we're going in the right direction. Both Veterans Affairs and the Canadian Forces are going in the right direction. I still think that a lot needs to be done. There are still gaps in the number of resources, the competency of the resources, training, acquisition, etc.

We need to think outside the box in recruiting professionals. It may be something like the rural family physicians, where you go in early with training and funding while people are still students. With psychology, psychiatry, you have a real lag time of more than eight years. I think that we need to look at bringing other sorts of professionals onto the team, so that we have a surge capacity, which we don't have right now.

● (1730)

The Vice-Chair (Mr. Claude Bachand): Thank you.

Your presentations were really interesting. There was a nice chemistry among you three, even though you were making individual presentations. We really appreciate it. It was very useful.

Be careful on your way back. Thank you.

The meeting is adjourned.

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