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Chair

Mr. Rick Casson

Standing Committee on National Defence

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● (1535)

[*English*]

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

I welcome past and new members to the committee.

Today we have the continuation of our study on health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

We have Major West with us, who is base surgeon at the Canadian Forces Health Services Centre, Ottawa. We have Commander Wilcox, regional surgeon with Joint Task Force Atlantic. You guys move around so fast we have trouble sometimes keeping up with you. We also have Colonel Flaman, a surgeon at Land Force Western Area, CFB Edmonton.

I welcome all of you.

I understand each of you has a short opening statement. If you'd like to do that, we'll get into a round of questioning afterward.

Commander D.R. Wilcox (Regional Surgeon, Joint Task Force Atlantic, Department of National Defence): Thank you.

My name is Commander Wilcox. I am the Joint Task Force Atlantic regional surgeon. In other words, I'm the senior physician for Atlantic Canada. I'm responsible for clinical oversight of all of the clinics in Atlantic Canada, and I'm also responsible for being the eyes and ears of the commander for Canadian Forces Health Services Group.

I'd like to clarify three items from previous testimony, if I may.

The first is in regard to staff qualifications. I want to assure you that all of our staff are qualified. Our psychiatrists are duly licensed; they are also in good standing with their respective colleges. Our psychologists either have a master's or a PhD. In fact, in my area of responsibility, two-thirds of the psychologists have PhDs. The social workers have either a BSc or a master's, and again, in Atlantic Canada, my area of responsibility, 100% of them have a master's. The mental health nurses have a BSc, and they're also certified in mental health from either a university or the Canadian Nurses Association.

In addition to those qualifications, during the hiring process we utilize terms of reference and merit criteria and conditions of employment to select people who have the skill sets we're looking for. For instance, a skill set would be a proficiency in cognitive behavioural therapy. A skill set would be the eye movement desensitization and reprocessing, and psychodiagnostic skills. We use the selection process to further select people who meet our needs.

In addition, we have ongoing in-services in CME. In Gagetown this past year they had a four-day session on cognitive behavioural therapy. They have a similar session planned in EMDR. In fact, 1% of their salary goes to continuing medical education.

In addition to that, we practice collaborative medicine. That means no one person has to be an expert in all aspects of the treatment of post-traumatic stress disorder. We can utilize mental health nurses to provide portions of the treatment and social workers to provide portions of the treatment. For instance, part of the treatment is psychoeducation, and a mental health nurse could easily perform that. A social worker could do the stabilization, such as relaxation techniques. The advantage of having a collaborative practice is that we can do concurrent activities, rather than have one person do all the treatment sequentially.

The second thing is that we do practice evidence-based medicine. We did have a standardization committee that standardized the assessment of our patients, and we have an ongoing standardization treatment committee that will standardize the treatment.

While that committee has been meeting, we have been using best practices. We use the VA and Department of Defense from the U.S. We use their guidelines for the management of post-traumatic stress. We use guidelines from the American Academy of Family Physicians. While we are in the process of standardizing a treatment, we are using approved guidelines. We do use a multi-phase, multi-modal cognitive behavioural therapy protocol, and we do not use the brief therapy model.

The last thing I wanted to clarify is that management never determines how many clinical sessions a patient will receive. It's always done by clinicians. We never limit the number of sessions to 20. They get how many sessions they require. We do ask that after every 10 sessions we get progress notes. Related to that, we would never refuse a patient to be seen off-site if they had legitimate reasons.

Thank you for letting me clarify some of the previous testimony.

I'll hand it over to Henry.

Lieutenant-Colonel H. Flaman (Surgeon, Land Force Western Area, CFB Edmonton, Department of National Defence): My name is Henry Flaman. Some people know me as Hank. I've been in the Canadian Forces as a medical officer for 30 years. After 30 years, I transferred over to the primary reserve list. I've been on the primary reserve list and have continued to provide continuity of care. They have requested that I remain, and I am remaining for one more year, which will give me 32 years of service in the Canadian Forces.

For the last eight years, since 2000, I've been the area surgeon in Land Force Western Area, which is a large area. It goes from the Manitoba border, including Thunder Bay and the Lakehead, all the way to Vancouver Island and Yellowknife. It basically covers all those. I'm the regional medical advisor to the base surgeons in Shilo, Edmonton, Winnipeg, and Cold Lake, in that western region. In western area we started the Roto 1, or Roto 0, actually, into Afghanistan, so we have taken our fair share of.... The mounting units were force-generated from the western area. We started to take the casualties first, in Canada, out of the rotations, and I guess we had to then develop the processes, which were not necessarily all the best. We had to create our linkages, mainly with Capital Health, but we also had Winnipeg Health Sciences Centre as our main reception area for casualties. We had to work with the chain of command to make sure the processes for reception of casualties were done in a manner with due regard for the needs of the casualties, the families, the chain of command, and all that sort of stuff.

There is the command net, and then there is the professional technical net, meaning the clinicians, psychiatrists, and all the linkages there. We have a very robust professional technical network that in fact keeps everyone informed and anticipates what information needs to be fed to others that may be receiving somebody, so the task force surgeon receiving a casualty in Afghanistan will be able to call his counterpart in a part of Canada, knowing that is where the casualty is coming from, to give them a heads-up to say “be aware”. This is still not out in the command network, but we already have our informal network to be able to prepare people for what they need to do. We work behind the scenes to be able to facilitate the command elements.

I'll give you an example: notification of next of kin is something very delicate. It has to be done in a manner that is empathetic and compassionate. The AOs, those young officers or commanding officers, have to go up to the house and tell somebody that their son or daughter is injured or dead or whatever. We, in fact, will have the ability to nuance that and give information by having a clinician there who can provide that information to add more context to the case. I have had feedback from that, saying people were very thankful they had somebody who could provide that information to them.

Those are things we've now codified since moving from the mounting area in western area to central area to Atlantic area. Each one of us now is well versed in taking the lessons learned, moving them, improving on the process, and then, as it comes back, getting better at it. Getting better at it just means we've had casualties and stuff, and we just get better the more we do it.

That's all I need to do for the interim.

● (1540)

The Chair: Thank you very much.

I'm sure there will be some questions.

Major West.

Major S. West (Base Surgeon, Canadian Forces Health Services Centre Ottawa, Department of National Defence): I'm Major Sandra West. I first joined the forces as a medical student in 1985. I actually left the forces in 1992, at the end of my period of service, in order to go into civilian practice. I did that for seven years. In 1999 I moved back to the clinic in Ottawa as a civilian, and I was a civilian practitioner within the clinic for several years. In 2005 I transferred from the primary reserve list to the regular force and put my uniform back on. Since then I've been the base surgeon in Ottawa—other than a 10-month period in the past year, seven months of which I was in Afghanistan, in our Role 3 hospital.

As base surgeon in Ottawa, I am the clinical oversight for the clinicians who work in the clinic on a day-to-day basis. That is essentially the primary care clinic. Ottawa is structured a little differently from most clinics in that mental health does not fall directly under me, essentially because our mental health program is too large for that. They have their own oversight. However, I work closely with them. I also maintain a small clinical practice of my own.

In terms of the role of the clinic in Ottawa, we provide primary care and specialist care services where possible to all members serving in the Ottawa area. We do provide some backup to some of the bases nearby—Trenton, Kingston, Petawawa.

In terms of casualty repatriation, Ottawa of course has no large operational unit but some small ones, so we don't see units deployed out of Ottawa. However, given the special circumstances in Petawawa, it being a rural community with strains on their own medical system there, when Petawawa deploys, we back them up for their casualty care. Most of their casualties end up coming through Ottawa and, with our coordination, are cared for in the appropriate Ottawa hospital, which is usually the Civic campus.

● (1545)

The Chair: Thank you.

What were the dates you were at Role 3 in CAF?

Maj S. West: It was from August of last year to the end of February this year, sir.

The Chair: Okay. The first time we were there it was January of 2007, so we weren't there at the same time.

I understand you were part of a TV documentary or something.

Maj S. West: Yes, sir.

The Chair: We haven't seen that yet, but we will.

We've heard about some issues concerning possible regional problems. I'm sure you'll get some questions on those issues.

We'll start with Mr. McGuire, who will open up the round.

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

You've seen quite a few soldiers coming and going over the last number of years. We were out to Wainwright, and some there are being trained for their second and third rotation. Maybe you've come to some conclusion on just how much psychologically a soldier can actually take in a situation like Afghanistan.

How many rotations do you think a human being can take in Afghanistan, particularly on the front lines in Afghanistan, and still have a reasonable expectation of having his health in his remaining days?

LCol H. Flaman: Is that directed to me?

Hon. Joe McGuire: It's to anybody. You can all answer it.

LCol H. Flaman: That is a very difficult question to answer, because it varies with each individual. It varies with each individual's ability to deal with stress and the balance of life and their family life and everything else. There are times in a person's life when they're juggling too many stressors and even one rotation may be difficult for them. For others, depending on what the job is and what the requirements are....

The biggest thing is being prepared for the job and knowing exactly what has to be done, what it entails. Appearing here helped us; we went through some previous notes and so on. There's an educational process in preparing people to go.

So it varies with each person. You can't really say, or I personally can't say; one person sees it as a valued experience and another person sees it as a stress.

As to how we determine whether people can go, we basically have said that people should be 18 months back after a rotation. You shouldn't have any deployment after...or you should be back after 18 months. But that's unless you say that you really want to go and you have no problems. Then we do a further evaluation of your life circumstances and determine whether in fact you want to go. But by and large, the individual himself determines whether they're ready to go or not. And that's in all medicine; it's really up to the individual.

So if they want to go and everything seems to be good—the evidence shows that they have no other complaints going on or that no other background things may not be right—then the member is able to go.

Hon. Joe McGuire: But they're in a profession where not going has other connotations. There are other pressures associated with their decision to go or not. There could be a price to pay for voluntarily staying home while others are gone.

As you say, there should be 18 months separating a rotation. But when we were in Valcartier, the wives there told us the members were gone 12 to 18 months—on rotation, in training, or training somebody else—which really puts a heavy stress on them. They don't see their families for an extended length of time. It also puts a heavy stress on the families. The children are missing their father or their mother for extended periods of time.

I don't think there's a healthy period here that you can....

LCol H. Flaman: It's one of those occupations where if in fact you're in combat arms—it all depends, but mainly it's in combat arms—your job is training. That's your job: training, training others, and being prepared to deploy when you're ready to go. That is basically how the team goes.

There are—I'll take that exactly—stressors on families, just as there are in the oil patch in Alberta, where guys have to go work up in the oil fields and so on.

So it happens to be an occupation that puts stress on families and family support networks.

● (1550)

Hon. Joe McGuire: There's nobody shooting at them in the oil patch, though.

LCol H. Flaman: No.

Cdr D.R. Wilcox: To a certain extent, people self-select for these different types of occupations. For instance, we don't have any screening criteria for submariners. The people who end up in that field have self-selected to be comfortable in that close, confined environment. The Americans do a screening process.

I think in our military, most people self-select to the different fields, knowing that they are going to be away from home and knowing that they're going to be employed in that fashion.

Hon. Joe McGuire: We're hearing in the American experience that the rotations are so long, going on for such a long period of time, that the stresses and the casualties, not only out in the field but in their minds psychologically, particularly in the families, are utterly destroying most relationships.

Maj S. West: Mr. Chair, perhaps I could put it in a little bit of perspective.

When I was in the military the first time, I spent three years posted in 1 Brigade at a time when we didn't deploy frequently and were not involved in much conflict. There was the Gulf War, which happened so fast we all missed it. At the end of my three years there, I calculated how much time I'd been in Calgary, and it averaged six months a year.

We've always spent a lot of time training. We've always had risks associated. It's part of what the military does. People do self-select. If this is not the life for you, or if it becomes something other than the life for you, there are ways of moving on—with the skill sets that you've picked up in the military.

Hon. Joe McGuire: But you know, six months in a non-combat period is quite different from eighteen months in a combat period.

Maj S. West: From six months in a combat period.

Hon. Joe McGuire: It's the health of these people and the services that are available to them that we're trying to get at here. Is there anybody to advise them when maybe they want to go but they shouldn't go?

LCol H. Flaman: We have programs that try to teach them how to recognize stress in themselves and in others who happen to be there and how to understand what to do with those stressors. We have educational programs that are provided to them. We don't force people to take on any treatment or anything unless it's obvious that they require it, but in most cases the individuals themselves choose to take it on or not.

In an economy like Alberta's, even now recruiting seems to be up. So people generally are staying, or they're staying for reasons.... In fact, some people were looking for combat. They were maybe not fully cognizant of what that would mean to them and their families, but they actually sought out that type of employment.

Cdr D.R. Wilcox: If they were undergoing treatment, if they were being actively treated for an operational stress injury, we wouldn't send them, even if they volunteered.

Hon. Joe McGuire: You wouldn't.

Cdr D.R. Wilcox: No, we wouldn't.

Maj S. West: There's an extensive screening process for anyone who's about to go over. Every single soldier goes through a screening process.

If you were under any treatment, you wouldn't go. If you were not under treatment, there's a good chance the screening process would pick up the need for it.

The Chair: Thank you.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): I want to welcome you and thank you for your presentation.

I will start with you, Mr. Wilcox. You talked about a standardized treatment. Would this treatment apply only to the Joint Task Force (Atlantic), or is it possible to extend it to the Canadian Forces generally? In other words, within the Canadian Forces, would a person being treated for post-traumatic stress syndrome in Vancouver receive the same treatment as another person being treated for the same problem in Halifax?

● (1555)

[*English*]

Cdr D.R. Wilcox: They certainly do. There is a lot of leeway. These are only guidelines, but most of the clinics have access to these guidelines.

I want to clarify. The committee is meeting right now to Canadianize the treatment protocols. They're using some of the American protocols or guidelines as the current guidelines, but if you read them, you see that there is a lot of leeway on when you would introduce EMDR or cognitive behaviour therapy. They give you a number of tools in your tool belt to treat post-traumatic stress disorder or operational stress injuries.

To get a more concise answer, I'd recommend that you talk to some of the psychiatrists that we have in uniform, and they can give you a detailed answer. But I do know that there is a committee that is trying to standardize the treatment as we speak.

[*Translation*]

Mr. Claude Bachand: They are trying to standardize the treatments by canadianizing them, as you are saying. When I went to Halifax, I was surprised. I asked the admiral how we were canadianizing these submarines, and in answer, he told me that we had to equip them with American torpedoes. You seem to be saying the same thing about Canadian treatments. I have nothing against it, because I believe that we have a lot to learn from Americans.

You said that a committee is studying the clinical aspect. Is it possible to standardize the treatments? Are each clinician, psychologist or psychiatrist completely free to treat their patients in the way that they see fit? How can we standardize the treatments while at the same time respecting the practice of clinicians? Can it be done through an assessment grid? Will a psychoanalyst, for example, have to follow a number of steps? How does this work, generally speaking? Is it really a standardization, or are we leaving it up to each attending physician to give appropriate care to his or her patients?

[*English*]

Cdr D.R. Wilcox: When we say “evidence-based”, we are looking at randomized control trials that would prove one medication works better than another or one psychotherapy works better than another. Then you'd bring a working group together, and they would look at all of these randomized control trials to determine which is the best. That's what they're trying to do.

There will be one study that perhaps is performed by a pharmaceutical company and may show one result, but what we're looking for is a meta-analysis in which you take a look at all of the studies related to that one therapy and see if on balance it's effective or not. That's what these committees do. They try to look at all of the randomized control trials, and that helps.

They do work by algorithms. They give different options.

Mr. Claude Bachand: Can we have this? Are they classified documents?

Cdr D.R. Wilcox: No, you can get it off the Internet.

Mr. Claude Bachand: We're lucky today.

LCol H. Flaman: I'd like to add a little bit to that answer. Prior to this, everyone had post-traumatic stress disorder, and they never even made the diagnosis based on an appropriate standard diagnosis. So a lot of times there was a written diagnosis, but in fact it did not meet the criteria that were set.

So in order to add rigour to this, they basically said that first of all they wanted to standardize the criteria. When you say that someone is suffering from post-traumatic stress disorder, let's make sure they meet all the criteria of that, so if we're talking about oranges, we all understand what oranges means. Then there are other symptoms that go along with that diagnosis.

Trying to put some definition to that was the job of the mental health services, and they did an excellent job by coming together, deciding how they were going to work together, deciding what the criteria were, and trying to define those. In the past there was very little rigour applied to how diagnoses were made, etc.

● (1600)

[*Translation*]

Mr. Claude Bachand: Mr. Flaman, you said that you were improving in this area. Are you saying that on the basis of the situation that you have described to me? You said that you are trying to offer the best treatment and to improve your approach thanks to numerous exchanges between clinicians. Is this mutual consultation the reason why you are saying that the situation is improving?

[*English*]

LCol H. Flaman: We're getting better in the sense that they've defined how many clinicians they need, how many psychologists in a mental health clinic they require, how many social workers they require, how many mental health people they need. That has been defined.

There has been funding available to hire those individuals, and in various OSI clinics they have put those people together, and they are now working with clear definitions of requirements and deliverables, etc., so that has been improving as we go along.

[*Translation*]

Mr. Claude Bachand: Ms. West, you are the base surgeon. You said that you are monitoring all treatments, but you also stated that you have your own small clinic. I would not be very comfortable with the idea of you seeing patients and then referring them to your private clinic.

Are your colleagues or yourself able to tell me whether physicians or clinicians within the Canadian Forces are governed by a code of ethics?

[*English*]

Maj S. West: I'm afraid you misunderstood, sir. I have a clinical practice. I am still practising clinically. Some of the patients in our clinic are patients of mine. I do not refer out. I am busy enough on a day-to-day basis in my day job, which turns into a night job and a weekend job as well. I don't have time to practise outside.

Yes, there are ethical guidelines. There are regulations in place, both from our medical governing bodies and within the military, to govern situations such as that. We won't normally take a patient who is being seen by a clinician in our clinic and refer that patient to their private clinic downtown unless there is a legitimate reason for it. All referrals are reviewed, and anything like that would be very closely reviewed.

Mr. Claude Bachand: There would be a red light.

Maj S. West: Well, there would be a yellow light.

Mr. Claude Bachand: A yellow light—or an orange light would be even better.

Maj S. West: It depends on where in the country you are.

The Chair: Your red light is about to go off. You're out of time.

Thank you very much.

Ms. Black.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you very much, Mr. Chair.

Thanks to all three of you for coming today to appear at the committee.

I think you know our study has been going on for some time, so we've had a fair number of witnesses here giving testimony. I think it would be fair to say that some of the most compelling or dramatic testimony has come out in camera, so you wouldn't have had access to that testimony. But what we've heard over the months of these hearings has been that on a systemic basis people in the Canadian Forces are still not receiving the mental health services as quickly as perhaps they should and that the services they may need are not always available to them. We've heard that some of the health services, particularly in the mental health field, have been under-funded or understaffed, and that there are no clear guidelines for post-traumatic stress disorder, which you're saying is being rectified now, so I'm pleased to hear that. I hope you'll share that with the committee. Perhaps we could have a look at that.

Also, we've been told—again, in camera—particularly about the stigmatization of mental health or brain injury, and that the soldiers, themselves, have felt the stigmatization of that, and that it has made them perhaps less able to access treatment.

In the current situation with the war in Afghanistan, it's pretty clear I think to all of us, that a lot of the injuries that Canadian Forces members are suffering, whether they're physical or mental, are more complex perhaps than those we've dealt with over the years. We've had some information about something that in the States they're calling acquired brain injury. As a layperson, I understand that that is perhaps caused by exposure to explosions. I'm wondering whether you have been looking into that separately from post-traumatic stress disorder. I wonder if either of you could address those concerns.

● (1605)

Cdr D.R. Wilcox: The one thing I can address is wait times. The Canadian Medical Association, in partnership with the Canadian Psychiatric Association, established a Wait Time Alliance, and that was to benchmark what they felt were appropriate wait times. They said for urgent cases, on referral from a family physician, one to two weeks would be a reasonable wait time, and for elective or scheduled cases, the wait time would be two to four weeks. So that's the benchmark from the Canadian Medical Association.

The Fraser Institute, from January to April of 2007, looked at the wait times for psychiatric care in all the provinces, and I'll just speak of New Brunswick and Nova Scotia, of which I'm more knowledgeable. For urgent care in New Brunswick, the wait time to be seen by a psychiatrist was two weeks, and for elective cases it was eleven weeks. In Nova Scotia it was one week for urgent and eight weeks for elective. In our clinics we provide an initial intake assessment within five days, and in both Gagetown and Halifax, someone will be seen by a psychiatrist within three weeks if it's elective or non-urgent, and if it's urgent, they get the intake assessment the same day, and most times they're seen by psychiatrists the same day. So not only are we beating the present provincial wait times, but we've already met the Wait Time Alliance benchmarks. I think that speaks to the wait times.

I don't know if anyone else wanted to comment.

Maj S. West: I can say it's about the same in Ottawa for wait times. I think we've made a lot of progress, but I don't think it was ever really as bad as it was perceived to be. There are often patients who have needed help for a long time who haven't identified themselves to the medical system, and there may be a perception that that's a wait time. But from the time they are identified by our clinic, I can have someone seen within 24 hours, generally, if they need to be, and intake assessment takes place usually within about a week, I think.

Ms. Dawn Black: This is in almost direct contradiction of some of what we were told particularly in our in camera hearing. In fact, one family from the Atlantic region was very clear that their son still has not—many months after returning from Afghanistan—received a complete diagnosis. He's still dealing with his injuries from Afghanistan. They were very clear with us that they understand the Canadian military well but are very disappointed with the kind of care and attention their son has seen.

My point is that there seems to be this gap between what we're hearing sometimes from individual families and soldiers around post-traumatic stress disorder and acquired brain injury or brain injuries and what we're hearing from people in your position.

● (1610)

Cdr D.R. Wilcox: I could speak to that. We do know of cases in which there's been denial on the patient's part. Part of that denial is perhaps misrepresenting the situation to their families, because the wife will want them to seek treatment and they will tell the wife they can't get in.

Ms. Dawn Black: That's clearly not the case in what I'm referring to.

Maj S. West: You did say something interesting, though, in that he doesn't have a complete diagnosis yet, which suggests to me that he is getting medical care. With a brain injury, with mental health problems, diagnosis is quite complex and may take months. Patients frequently go through several diagnoses.

Ms. Dawn Black: I don't want to centre in on one case, because we've heard from more than one person.

Maj S. West: This is a common problem. Patients regularly come back and say, “I don't know what's wrong with these psychiatrists you're sending me to. They can't come up with a diagnosis. They aren't doing anything.” In fact, they are working very hard towards a diagnosis. It's extremely frustrating for the patient.

Ms. Dawn Black: I'm sure they are. I'm just pointing out that between what we're hearing at your level and at an individual level, there is a gap. It's important to acknowledge that.

Maj S. West: The gap is in perception.

Ms. Dawn Black: Maybe, maybe not.

LCol H. Flaman: I'll just add something, because you did mention the traumatic brain injury. *USA Today* said it was the signature illness or injury from Iraq and Afghanistan.

We do see brain injury. We obviously see the clear-cut severe brain injuries from rollovers and from explosions and stuff, and those are managed the way they normally are in ICUs. They monitor brain activity, and they do whatever. There are conditions now that they have found, when someone has been involved, for instance, in an explosion of an IED and they haven't identified that there was a concussion, or the person may have been dazed and confused or suffered a loss of consciousness.

Everybody coming through LRMC at Landstuhl now is being assessed. We do get follow-up for anybody who goes through Landstuhl. In fact, for anybody coming back who has been in proximity of an IED or whatever, we are doing the psychometric sort of testing to see whether there are any cognitive effects. Some people think of something like PTSD, which affects your memory and thinking and stuff, as being a mild brain injury when in fact it's something that affects your thought processes and is not an actual injury. But, you see, soldiers don't like to hear that they have a thought process problem. They like to have a physical kind of problem. So a lot of times when we talk about these things, what we mean by traumatic brain injury has to be clearly defined.

At this point, I'm out of my lane. There are experts in fact looking at that to define exactly what we need to do to evaluate it and then treat it.

Ms. Dawn Black: And are they two different things?

The Chair: Sorry. We have to move on. We'll hopefully get back to that.

Mr. Hawn.

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

Thank you both for coming.... [*Technical Difficulty—Editor*]

Just to go back to what Ms. Black was talking about, there's a lot of difference in perception involved in treatment, depending on whether you're the care deliverer or the care receiver. I think it's safe to say that a committee like this will attract the people who have the perception, right or wrong, that the care is not what they would like it to be. Does that follow human nature?

LCol H. Flaman: Perhaps I can explain how a person gets involved with medical services in the first place.

Obviously we have to recruit people, so they go through a recruiting process. Somebody in fact asks them if they've had any problems. They get a medical done to determine whether they're fit—their knees or whatever—to come into the forces. I always ask the doctors, when I'm talking to them there, "What picture did they paint on the Thursday afternoon when they had their medical done? Did they want to paint a positive picture or a negative picture?" If a person goes in there and says they're fine, they can do this, they can do the whole job, they're good to go and everything else, the doctor has nothing more to go on. We don't have a little gizmo—like on the starship *Enterprise* or whatever—that can tell you whether or not someone's good to go. It's all to do with the experience of the clinician. It's all to do with how you gather the information. The most vital part is doing a good history, with enough time to talk to the patient and establish a doctor-patient relationship.

Now, all the doctors in uniform are understandably company doctors. When people come to see us, they understand that we work for their benefit but we're working on behalf of the Canadian Forces. So we're sort of company doctors. When a person comes to see us and says, "I have this back problem that's bothering me", there's usually an expectation that they may not have to go to the field to train today or tomorrow. And this is anybody, not just in the military; anybody who goes expects they'll get an antibiotic for something or a consultation or something else.

If you get what you expect, you say "I had great service that exceeded my expectations." If you don't get what you want, you say "That doctor, I'm not sure he really knows what he's doing."

I'll give you an example. A doctor sees you and you expect antibiotics. But antibiotics may be the last thing you should get. You don't have a condition that requires an antibiotic. If you go there expecting one and you don't get one, you'll sit there and say, "Geez, he wasn't a very good doctor. He didn't even give me an antibiotic. He took an hour to tell me why I shouldn't have one."

That doctor probably did the most appropriate thing for you. But doctors, as you know, don't have time to spend an hour explaining why they're not giving you an antibiotic when it's much easier to say, "Here you go, you have your antibiotic." But in two days, when it's not working, you rush back and say, "That doctor wasn't very good. I need another antibiotic."

Therein lies the difficulty. You have to understand that care is complex. When people say they didn't like their care provider, it's just like what happens to mothers when things don't work out for kids: they get blamed. The one person with probably the most aspects to try to help them gets blamed. And this is the case with the complexity of care delivery.

● (1615)

Cdr D.R. Wilcox: Perhaps I can add one thing. It supports our statement that those wait times are accurate.

I looked at the data from the Canadian Medical Association on the number of mental health care providers and our population. I was able to determine the number of psychiatrists, psychologists, social workers, and mental health nurses per 100,000. I compared that with our patient populations on different bases. We far exceed the national average in mental health care providers on our bases. For instance, in Halifax they have five times as many psychiatrists as the national average: psychologists, double; social workers, double; mental health nurses, four times.

This does help support the case that we are able to meet these benchmark wait times: we do have the staff required.

Mr. Laurie Hawn: Is it safe to say that we'll always be in a learning environment with something like this?

Maj S. West: Well, we practise medicine, and one of these days we'll figure out how to do it.

Voices: Oh, oh!

Mr. Laurie Hawn: This goes for any kind of medicine. It's more dramatic, of course, when it's the kind of medicine practised in the Canadian Forces these days, with the physical injuries and mental injuries and so on.

Experience is the great teacher. Edmonton perhaps has an advantage over other areas because it has more experience. Other countries may have an advantage over Canada because they have more experience. Is the important part the sharing of that experience, helping out the Petawawas, the Gagetowns, or wherever else with what Edmonton has learned?

LCol H. Flaman: Yes, but it has to be applied differently. We had some discussions about the army, navy, and air force having different approaches to providing care. There are unique requirements in each environment. Applying an army-centric view to a navy base doesn't work. They have a different relationship with the chain of command. They're totally different environments.

We basically have to apply the general principles—namely, good medicine and enough time for clinicians to establish a relationship. Those are just good principles you should apply no matter what environment. You also have to be credible. The people who are providing the care should have some credibility in terms of knowing the unique demands of soldiers, airmen, and sailors.

Mr. Laurie Hawn: We are looking to expand the number of mental health professionals from 229 to 447 in the next couple of years. That's a great goal, and the money is there, but do you think it's a realistic expectation given the educational environment and the work environment out there?

LCol H. Flaman: Well, that is going to be a challenge, because I'll tell you what: there's only a certain limited pool of health care professionals. I'm talking about psychiatrists, doctors, whatever. If we manage to attract them to our clinics, we're going to be taking them away from some other part of society. If we put on a good ability to get psychiatrists, where is that psychiatrist going to come from? He's going to come from someplace where he's already providing care.

So we have to be careful there. We can have all the money we want, but the problem in the health care sector is that we may not have enough of the specialties we require for the whole of society. We are just one part of that whole society.

● (1620)

Mr. Laurie Hawn: There's a military medical training plan, which has been going on forever, to take people from other MOCs and turn them into doctors and so on. I think that was expanded a number of years ago as a special incentive or initiative program for NCMs and reservists who would not have been eligible under the older programs.

How successful has that been? Do we have any kind of numbers there?

Cdr D.R. Wilcox: It's been absolutely successful.

LCol H. Flaman: By 2011 we'll have enough people in the training pipeline—that is, those people in programs—to in fact meet our PML, or manning list, that's required for physicians.

Cdr D.R. Wilcox: There will always be a requirement to have civilian health care providers. The theory is that we want to have enough civilians in the clinics so that we can extract all of the uniformed doctors but the clinics can still run. That's why we're so useful during domestic operations. We can pull out those clinicians and nurses and support a domestic operation, whereas in Ontario, with its HERT system, they have to take them from emergency departments.

So there will always be a need for civilian health care providers even if we attract enough uniformed physicians.

The Chair: Thank you.

That ends the opening round. We'll now move to five minutes each.

Mr. Rota, and then Mr. Lunney, for five minutes.

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

I wasn't going to go on this track, but I find it interesting that there's screening in the U.S. and self-selection here in Canada. When I think of that, I think of young people trying to fit in and saying, "I think this is where I'd like to be." But it's kind of hard to say, "Yes, this is where I *am* going to fit."

I'll ask you a couple of questions on that, and then I'll let you answer them.

First, do they have a choice of being screened or being given an aptitude test on where they would fit in based on their mental aptitude? If you want to go into, say, artillery, or into flying a plane, those are two completely different fields. I would imagine there's a certain amount of skill and aptitude required, for one, and a tolerance for the type of stress you'll be under. Is that something that is considered or that is available to the individuals?

Many of the people we've seen to date have said they didn't realize they were sick until later. People would ask them what was wrong: "Nothing. Nothing is wrong." They went for a year or two until suddenly it hit them that this was not the way they were supposed to be, this was not the way they were supposed to feel. Then they realized they had post-traumatic stress disorder.

So does any kind of screening take place on a regular basis? I hear, yes, there are programs in there for them to identify each other or to see what's going on, and the commanding officer is supposed to check it out, but it's very difficult. Is there any one-on-one program where they go in once every six months, say, and go through things? I'm not talking about when you get out of theatre and you go for post-deployment debriefing or cooling down. Is there anything on-site that can be done to screen people as they're going through? I know they're saying the commanding officer might notice something a little bit different, but is there any kind of test or any screening done to detect that?

Cdr D.R. Wilcox: I can speak to the first part.

They do have aptitude testing for certain military occupations. Pilots in particular have to show manual dexterity, and they do go through a number of aptitude tests. For the majority, though, it's self-selection. We have an obligation to try to explain what an occupation would entail. However, if they don't like it after they've been involved in that trade, they can ask for an occupational transfer. In that sense they're self-selecting to something else.

We see that a lot in our medical profession. A lot of our health care administrators have transferred from the artillery. So we do allow that.

● (1625)

Mr. Anthony Rota: I know one of the biggest things is someone thinking that they don't want to show weakness. It's a mentality that's existed probably since Roman times, or even before that, in military psyches. I'm just wondering, if there is some kind of a—

A witness: A particular transfer usually is not a problem.

A witness: There's no stigma there.

Mr. Anthony Rota: There is no stigma with a transfer to another area.

Cdr D.R. Wilcox: It happens all the time.

LCol H. Flaman: But in the army, as soon as somebody says, “I don't want to stay with this group here, I'd like to just transfer into another one”—because they have to do it officially through the chain, sometimes they'll be told, “Then I'm not giving you a course now. If you're not going to be with us, I'm going to give the course to the next guy, because you've already told me you don't want to be with this group.” You're sort of saying that you want to move on, and you're not part of the group. So a little bit of that goes on.

Mr. Anthony Rota: Would screening enable the person to get around that?

LCol H. Flaman: Well, there is screening. You have to go to a PSO in order to get a vocational transfer into another occupation. That PSO will in fact have all the psychometric kinds of testing things they do to see what your aptitude is and whether in fact you should go into that trade. They do that.

In the recruiting centres, when you go, you actually do aptitude tests. But a lot of times in the recruiting centres they need so many infanteers, so you may say, “I'd like to go here”, and they'll sort of push you in one direction or another. As with any system, you really have to be willing to fight the bureaucracy a little bit, because that's the way it works.

Cdr D.R. Wilcox: Just on the screening, every two years there's a periodic health exam. It's carried out by a family physician. We're taught to screen within that for mental health, alcohol-related problems, or mental health-related problems. They get that every two years.

LCol H. Flaman: But the member himself has to check the box that says “I drink more than I should” or “I have problems”. They ask the questions. How the members answer those questions determines how this information is going to be used.

Mr. Anthony Rota: I would think that denial is probably one of the biggest problems.

A witness: It's a coping mechanism.

Mr. Anthony Rota: We can call it whatever we want. We can call it one of the greatest coping mechanisms with post-traumatic disorder. I was wondering if there's any way of getting around that.

LCol H. Flaman: Here's the thing, and I'm sorry if I sound kind of preachy. I always say everybody is coping. We are all coping with kids, interpersonal relationships, financial stuff, career stuff, everything. We're going along and we're coping. Some are coping better; some are not coping so well.

How do you know if a person is coping well or not? They either have to declare that they're not coping well or they get into trouble—driving while impaired, spousal violence, or legal stuff that occurs, and then the chain of command becomes aware that somebody is there. Or a member says, “Gee, I went home last night and yelled at my kids, and my wife pointed it out to me. Can I get some help here?” So he shows up at the medical side. Now if he shows up on the medical side, we don't tell the commanding officers and everybody else that this guy is here for help, because we see that as a positive. We then apply the appropriate diagnostic sort of criteria, tests, to see what the problem is, and then we determine if it's an addiction or whatever.

That's how things happen. That's why I said it's the individual who determines when they need some sort of support. We don't go around and try to find people. We have general screening processes. The pilots always had pilot sort of stuff because the Aeronautics Act says we're supposed to check a pilot on a regular basis. That was never applied to the army guys.

Now we are applying a two-year periodic health evaluation that is tied and focused on whatever stage in life you happen to be at. So if you're a young guy, we focus on those things that young people do. If you're a 40-year-old, we're going into cholesterol and your cardiac risk factors and stuff. The periodic health evaluation is sort of focused now on that—

● (1630)

Mr. Anthony Rota: The post-traumatic stress disorder is not part of that?

LCol H. Flaman: There's a mental health aspect in all of those. We focus on post-traumatic stress disorder, but that's a small portion of total mental health. We sort of single it out as being the targeted thing. It is one component of depression, anxiety disorders, all those other things.

The Chair: Thank you. At some point we'll want you to give us a very detailed example of how you examine pilots, just for Mr. Hawn's benefit.

Mr. Lunney.

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

We know that the pilots are used to having their fluid levels checked regularly. It's certainly a culture of safety when we're dealing with aeronautics.

I'll ask my question; I'm getting some encouragement here.

When you're talking about self-reporting abnormalities, this is the challenge with any form of mental illness, that the person who's not thinking straight is the last one to recognize it, or the last one to report on it, usually. Post-deployment, family members will notice changes, but is there any screening? Do we ask family members to participate in the screening process to pick up on some of those clues, such as not sleeping or substance issues?

LCol H. Flaman: I can tell you this. The MFRCs, the military family resource centres, are in fact holding educational sessions to talk about the battle mind, and I know it's been mentioned in some other groups. This is the program that was developed by the Americans to say that you have a battle mind that you need when you're hypervigilant and all that sort of stuff and then the ability, when you come back, to apply a different mindset. I pushed that educational program down to the MFRCs in western Canada when the redeployment was going on, to educate the spouses and the next of kin on what things to look out for.

Let's face it, the member may not self-declare, and the unit may not even see it, because they have a culture that says your business is your business as long as it doesn't affect me. But the spouses definitely see it. So we're trying to encourage people to talk to their spouses, and if their spouse or the kids see it, guess what, you should come in. This is part of the education.

So the one thing that should be done is an educational program about what to see, what to look for.

Cdr D.R. Wilcox: I'll just follow up on that. The combat-related first aid course that every soldier needs to take describes how to recognize operational stress injuries. In the tactical combat care course, a course that two members per section get, they're taught how to recognize OSI in their fellow soldiers. Then on the bases you have PSP courses, and they have anger management, suicide prevention, relationship enhancement, and so on.

So there are all kinds of courses all over the place provided by different agencies, and they may not specifically be mentioning OSI, but it's always in the mix.

Maj S. West: I could add something from the clinical perspective, as someone who has worked in the civilian system as well.

It's commonly quoted that approximately 40% of family practice visits are for overt mental health problems. Mental health problems are the bread and butter of what family practitioners do. It is the family practitioner, the general duty medical officer, who does the periodic health assessment every two years. We are very sensitive to it. We both actively and passively will pick up on most mental health problems in that situation.

Mr. James Lunney: That's in an operational sense, and I appreciate what you said about the complexity of picking up these things ahead of time. People are different. How they cope is different. Their family support levels at home are all very individual, I'm sure.

We heard when we were over there—and I can see how this would happen—that soldiers often go with minimal sleep. They're young, and of course now that we're into electronic gadgets I guess sometimes they pack them along with them, and when they should be sleeping they're sometimes occupied with games, computer stuff, and so on. And we all know we need to sleep to replenish neurotransmitters. So here's an operational stress that they're under when they're over there in the sense that they're not getting sleep, first of all. Then if you combine that with any alcohol or substance issues that a subset of soldiers may be caught in, now you're really complicating the neurological components.

So my question here really is, what comes out of the molecular world? Even if you took the group here and you stuck us with too little sleep...which does happen here, by the way; you probably should do a study on members of Parliament. But regarding your soldiers who are going through too little sleep and extraordinary stresses, is anybody looking at the nutritional requirements of these guys in terms of giving them some extra nutritional support? I can hear “evidence-based” coming back at me. But you have a subset that might be worth studying in terms of giving them some additional nutritional support for their neurological system, like Phosphadityl Serine or Acetyl-L-Carnitine or neurological components that are known to support the nervous system, B vitamins and so on. Is anybody looking at that? And are we doing any primary research? And if not, why not?

● (1635)

LCol H. Flaman: That's out of my field.

Cdr D.R. Wilcox: I can talk to you about sleep deprivation, because DRDC Toronto has an ongoing research project to assess sleep deprivation. They used a software package called SPSS. They can model the amount of sleep deprivation and relate it to cognitive functioning.

They did a study on long-haul transport pilots, and they finished that study. Right now they're working on submariners. The submariners work six on and six off. They found that was a highly inefficient way of scheduling the submariners' work. They have huge amounts of cognitive impairment because of sleep deprivation.

That's a long explanation to say that there are research projects ongoing right now to assess the effects of sleep deprivation, but they're doing it by MOC or by occupation, and they're picking the high-risk ones, like the long-haul pilots and submariners, and then they're going to go on and delve into the other MOCs.

The Chair: We have Mr. Bachand, and then we go back to the official opposition and over to the government.

[*Translation*]

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

I read recently an American report about the rather considerable amount of antidepressants drugs being prescribed in the theatre of operations. Some Canadian newspapers also published stories saying that Canadian soldiers were overmedicated.

Could you share with me your opinion about antidepressants and the fact that it is being alleged in some media that Canadian soldiers are overmedicated? Do you share that point of view?

[*English*]

Cdr D.R. Wilcox: I'll just say two things. One, the only medication the FDA has approved for the treatment of PTSD is selective serotonin reuptake inhibitors. That's the only kind of drug that has been approved for the treatment of PTSD. Everything else is off-label. The only kind of drug that's been approved is an antidepressant.

I've just actually come from Gagetown. I spent two days there talking to their psychiatrists. There is a perception out there that benzodiazepines are abused, and there are too many people.... I looked at all the printouts from all of the psychiatrists, and there's just a very small number, like 1% to 2% who are on long-term benzodiazepines. The use of benzodiazepines—I know you didn't specifically ask that—is primarily for short-term intervention when there's an acute anxiety reaction or there's an acute bout of sleep deprivation. I can assure you that there are just a very small number that are on long-term benzodiazepines.

With respect to the antidepressants, the two modes of therapy that do have randomized control trials that support them are serotonin reuptake inhibitors and cognitive behavioural therapy.

LCol H. Flaman: I can just add something to that.

When I deployed, which was in 2004 for six months, I was taking blood pressure pills, which I take because I have hypertension. Some soldiers who are going over require medication for chronic conditions they have. That's presumably to make them function better when they go. There may be some who require antidepressants, but by and large, if they were on antidepressants, they would be getting those medications based on a clinical diagnosis that was already there. In the screening process, somebody would look at that very closely to see what medication they were on, for what condition, why they were taking it, and whether or not it was in their best interest to deploy. The decision as to whether or not somebody is there will have gone through about three levels of review before someone says, "You know what"—and everything is kind of risk-based—"we're going to take the risk on sending you without whatever". And if you don't send them, the member will say, "Why can't I go? All I have is this condition. I take this medication. I function as well as any other group there." This is the argument we have.

We're nowhere near the place where the Americans are. Again I'm not even sure of the validity of the press that was reported on that American study. Was someone trying to overstate a condition? Certainly that's not the case from my perspective with western soldiers deploying, because I see all of the screening and I get asked the questions.

Perhaps Major West can comment.

● (1640)

Maj S. West: If I were giving a quick answer to your question as to whether or not Canadian soldiers are overmedicated, I'd say no, they're undermedicated. It is extremely difficult to get patients to accept SSRIs; it doesn't matter whether they're military or civilian.

I don't know what the statistics are. My suspicion would be that if you looked at the use of psychoactive medication in military personnel versus civilians, it would be higher in military personnel, and not because military personnel need them more but because we are able to pick up on them more often and are able to offer them treatment. In the civilian world, many people just never go to a doctor, particularly now when it's so difficult to find a doctor. It's much easier to detect the need in military personnel, and even then it's difficult to get them to take it.

If they are severely disabled from their illness, whether it is a mental illness or hypertension or cardiac disease, we have systems in place to ensure that they will not be deployed until the problem is fixed.

[*Translation*]

Mr. Claude Bachand: My question also dealt with soldiers who are deployed on the theatre of operations. A physician would not go so far as calling in Canada to ask whether he or she can prescribe medication. It is up to him to decide.

When they are on the theatre of operations, they are submitted to a level of stress that they don't have here. The stress level is different over there. Here, you can shoot someone with blanks and you know the person will not die. Over there, it is quite another story.

I am talking about medication and antidepressant prescriptions. Are physicians more inclined to prescribe antidepressants when they are on the theatre of operations, as compared with what they prescribe when they are in Canada?

[*English*]

Maj S. West: No. We prescribe in theatre where it's medically indicated, and part of the prescription is going to be not just medication but removing the soldier from a situation where he is in undue danger or where he is placing the mission or his comrades in undue danger because of his mental illness or physical illness.

The Chair: Thank you. We're going to have to move on.

Mr. McGuire, then Ms. Gallant, then back to the official opposition, and then back to the government.

Mr. McGuire, for five minutes.

Hon. Joe McGuire: Thank you.

Needless to say, we don't envy you your jobs. They're pretty important at any time, but particularly now.

We're looking for recommendations from you, given your experience and your positions, about how to improve things for our soldiers. For example, it's been suggested that maybe Cyprus is not the best place for decompression; maybe it should be closer to home, where they don't have to go through seven time zones after they finish the decompression before they see their families. In fact, we were told there's more PTSD inside the wire than outside, and maybe they should be given more attention and decompression than people who are outside the wire.

Do you have any comment on this, or is there anything else you might suggest that might improve the health of our people over there and the health of their families back here?

● (1645)

Cdr D.R. Wilcox: Inside the wire and outside the wire, they get the exact same decompression. There is no differentiation. They get the exact same debriefings and they're treated exactly the same.

Now, you make a good point about the time zones, and there is ongoing research to see the validity of the decompression. That is a legitimate point about the location, because they will suffer jet lag coming home.

Hon. Joe McGuire: We're picking these things up from our visits to Wainwright and Valcartier and so on. These things are brought up to us.

LCol H. Flaman: Even though we're now two and a half or three years out from when we actually started the deployments—and, again, those first complex injuries are just coming to the point where they're being released—we don't know how to allocate whether they were predominantly inside the wire or predominantly outside the wire and what kind of conditions they were presented with. The numbers we have are so small, and we never captured them by inside the wire or outside the wire so much. We wish we had better numbers and the ability to capture all that information.

But the decompression side of things is interesting. People can actually leave theatre and go to Australia for three weeks or go to Europe for three weeks and not have any decompression requirements at all, and then after the tour is over, before they come home, they have the decompression time. Now, a lot of that decompression time, I think—and this is just me saying it—is spent blowing off a lot of steam. They go there and they are freed from the constraints that are imposed by that operational theatre. They go there, and sometimes they overdo things that we tell them they shouldn't be overdoing, like alcohol and activities that are going on. A lot of times one has to say that having them do decompression there might be better than bringing them all home to Edmonton, to Whyte Avenue, or whatever, and then allowing that sort of activity to go on in kind of a party mode.

Again, you identify people who might be at high risk for drinking, and the studies all show that they're all young. So if you take that preponderance of young individuals, they generally have a higher rate of drinking to excess. And those are certainly risk factors we have identified. They're no different from any cohort of that age group, probably, that you'd be able to measure, but that is a problem.

The biggest problem we have, really, is alcohol use, the use of normal drugs, and young guys doing that sort of stuff as part of their post-deployment.

Cdr D.R. Wilcox: But in the surveys on decompression, the majority of people said they felt it was of benefit.

Major West could probably comment, because she would have gone through it herself.

Maj S. West: Yes.

The inside-the-wire/outside-the-wire dichotomy is an artificial one. You can be outside the wire and in a fairly safe environment for your entire time, and you can be inside the wire in a position where you are seeing and doing things that human beings were never meant to see and do.

I refer to the support staff in the Role 3 Hospital. When we have casualties coming in, you may be a clerk, but you're going to be carrying stretchers. Those stretchers are pretty messy, and if you are not prepared for that, that can be quite a shock. On our rotation, we were very lucky. We had extremely good people with us, who were very quick to jump in wherever they could and who were not particularly bothered by it. But I could certainly see that being an area in which you would be particularly prone to PTSD. Medical personnel should be prepared for this. It should not be a problem for us, but our support personnel are probably exposed to more than are many people outside the wire.

Everybody does go through exactly the same decompression. To be perfectly honest, when I went through it, it wasn't listening to the lectures—because I could have taught all of that stuff, and in fact most of my corporals could have taught it—but just having a few days in a safe environment, surrounded by my army buddies, who I had just gone through a war zone with for seven months, that allowed me time to transition back to my family.

● (1650)

Hon. Joe McGuire: [*Inaudible—Editor*]

The Chair: Yes, I realize that.

Maj S. West: Sorry, I missed that.

The Chair: Ms. Gallant, and then Mr. Rota.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you. I'll share my time with Dr. Lunney, if there is time left over.

A number of professions in which a high level of stress is inherent have set up special hotlines for the professionals and for their family members, so that if somebody's kicking in a wall or behaving abnormally, instead of calling the police, so that there are major consequences after, they are given some direction on how to properly react.

Is there such a hotline—and not necessarily for OSI, because somebody has to make the link that this is potentially an OSI situation—that the soldiers themselves or their families can call without fear of a record being kept on the soldier or any legal action being taken? Is something like that in place?

Cdr D.R. Wilcox: We all have Blue Cross cards. That gives you a 1-800 number to access care after hours, and it is a nurse you talk to. That person will give you some advice on where you should go, if you describe your symptoms somewhat.

The other thing we have is CFMAP, which is the Canadian Forces member assistance program. That will allow you up to 10 sessions of psychotherapy that is at an arm's distance from us. So if you are afraid there are going to be some negative consequences to your self-declaring a mental health problem, you can go to CFMAP and be seen.

But we don't have a 1-800 number for mental health problems. We have those other two.

LCol H. Flaman: In Edmonton there is a program I think where they're looking at spousal abuse, violence, that sort of thing. If someone wants to call and they don't want to bring in the MPs and the police, they're looking at some sort of a process that keeps the MP side out of it, which means there's a record and then a police call and so on. By and large, if someone is living off base—this is off base sort of stuff—and feels in danger of spousal abuse or that sort of thing, then the recourse is usually to the police and it becomes a public record. The MP and the base commander then know that somebody is there.

I think people are looking at an informal network or an ability to defuse a problem in the appropriate manner, especially on the spousal side, for spousal abuse.

Mrs. Cheryl Gallant: Yes. Right now, specifically, we don't have a crisis hotline, because the person involved may not be making the link that it's a mental issue and there may not be spousal abuse involved; certainly it would not fit into that category.

Is somebody looking at this right now, or what it would take to ensure such a crisis hotline that's not related or doesn't have the mental illness aspect to it or the spousal abuse aspect to it...?

LCol H. Flaman: Do you mean some sort of official process set up by the military or the base, or whatever, in question?

Mrs. Cheryl Gallant: Yes.

LCol H. Flaman: The problem with anything official is that it then becomes official. If you're talking about an unofficial blog that people sort of link into for their own self-help groups.... If you set it up as the base commander saying, “This will be the official line and here's how we're going to action it”, there are people talking about... we have a caring professionals kind of committee that talks about having mainly a social worker in that psychosocial setting wanting to help the commander deal with things so they don't have to elevate it to a charge and that kind of thing. They are looking at trying to do that.

How far along is it? I can't say right now.

Mrs. Cheryl Gallant: Would there be records attached to that—a record of calls—or would it be completely...?

LCol H. Flaman: Again, it's out of my lane. I don't know.

Maj S. West: But the MFRCs do offer some support. I don't think it's 24 hours in most cases, but they do offer some support, and that is definitely at arm's length from the military.

Cdr D.R. Wilcox: And OSISS does the same thing. If you get a counsellor, often those counsellors make themselves available, but you have to have declared yourself to OSISS.

I just read a CANFORGEN from Hillier, and they were talking about having a special advisor to the CMP on OSI issues that are non-clinical and the re-establishing of the Canadian Forces OSI steering committee. They're going to create another committee, the DND-Veterans Affairs mental health services advisory committee, so they're going to revisit a lot of these things under the venues of these three different committees.

Mrs. Cheryl Gallant: Thank you.

● (1655)

The Chair: Mr. Rota, and then back over to the government.

Mr. Anthony Rota: I have a quick question on wait times. You mentioned you've just done a benchmark study, and you have your stats and what not, I would imagine.

Is there any kind of a graph showing what the wait times are and demonstrating where the outliers are? Is that available?

Cdr D.R. Wilcox: I can only speak of Stadacona.

Almost every base now has a quality improvement person, and one of the things they do look at is wait times. I know the Canadian Forces Health Services Centre Atlantic, or the Stadacona clinic, in Halifax, do publish a wait time, and they compare it to these benchmarks that are set by the Canadian Medical Association.

I can't speak of....

Mr. Anthony Rota: Let me rephrase it. Could I get a copy sent to us?

I am interested. If there's any kind of a graphic representation, I'd like to see that as well. Sometimes it just makes it a little bit more understandable.

Cdr D.R. Wilcox: It is graphic. It's all bar graphs.

Mr. Anthony Rota: Bar graphs or dots are usually what I'm looking for, so you can see where the core is and where the outliers are, and you can see how many exceptions there actually are as opposed to the norm. What we hear in this room is often the exception. It's not the norm, I hope. I was looking for something along that line.

On that same line, as far as the feedback mechanism goes, again, we're getting the impression that at the ground level it is not the same as what you're bringing to us, and there seems to be a disparity. I'm hoping those are the outliers and not the norm; otherwise we'll be here for the next 10 years.

Regarding the feedback mechanism, to get back to how your programs are working, what do you have in place, and what is the structure that brings back the information on what's happening on the ground level with the patients or the individuals who are being treated?

Maj S. West: Sir, I am essentially ground level at this point. As a base surgeon, I am responsible for ensuring primary care gets delivered to members in the Ottawa area.

We are in the process of instituting throughout the system the Canadian Forces health information system, which will eventually include electronic medical records. In the early rollout periods, it allows us easier access to statistics so that we can follow things like wait times, look for problems, and try to address them before they get out of hand.

It's not completely instituted in our base yet, and I don't think it's completely instituted in any base yet, but we are working towards it.

Cdr D.R. Wilcox: To that end, as an interim solution, we routinely do patient surveys and clinician surveys to establish their percentage of satisfaction. We'll pick a day, and everybody that comes into the hospital or clinic on that day gets a survey. The quality improvement personnel then tabulate those and publish the results.

Mr. Anthony Rota: Very good.

The Chair: Thank you.

That wraps up the second round, and we'll start with the third one.

Mr. Lunney.

Mr. James Lunney: Thank you very much.

I'd like to just go back to the sleep issue for the soldiers. I'm aware of studies in which they interrupted normal subjects during the REM phase of sleep, or the rapid eye movement phase, and there was a definite decline in cognitive ability, problem solving, and the ability to learn new tasks.

It seems as though the military would be well aware of that. I suppose when you talk about something like Desert Storm, before they went into Iraq, in these pre-dawn raids, they pounded these poor guys—interrupting their sleep—before they went in on a ground assault.

Coming back to our soldiers, when we were in Valcartier we had a very interesting discussion with the base surgeon there, Chantale Descôteaux. She was remarking on some of the work they're doing there on group therapy for sleep for the soldiers. They not only identified but found resolution for some of the OSIs and PTSD and what might have been described in that realm, and they found great improvement in clinical practice just by doing group sleep therapy, which is much more palatable for the soldiers, of course.

I just wondered if you were aware of that.

● (1700)

Cdr D.R. Wilcox: There is a lot of research going on, on go/no go pills, mild amphetamines, caffeine replacement, and caffeine gum. There is a lot of research, primarily out of DRDC Toronto.

Maj S. West: There is also in the American system, of course.

In Ottawa, of course, with us being such a large base, we actually have our own sleep labs still in the clinic. We don't know whether we're going to be able to keep that long term. But for civilians, if there's a concern that someone has sleep apnea, at this point in Ottawa I think the wait time to get into a sleep clinic is somewhere approaching a year. For our sleep clinic it's a month or two, and we are sending an awful lot of our suspected PTSD and suspected mental health problems for sleep studies almost routinely, because obviously if there is a sleep disruption that you can address, the mental health problem tends to get better.

Cdr D.R. Wilcox: We participate in a lot of NATO standing committees, and there's a free exchange of research, so we freely share our research and the other NATO countries reciprocate.

LCol H. Flaman: My role, like Dave's, is to approve extensions of sick leave, which I say is absence from structured supervised activity. Basically, you allow people to stay home to get better. The trouble is that when people stay home to do whatever they want to do, their sleep patterns are definitely interrupted. They don't in fact have a really good structured sleep pattern.

So part of my role is to kind of diminish the amount of time you prescribe this sick leave and get people back to an activity level that imposes a better sleep, rest, and work structure. In the morning, you get up—show up at work or show up somewhere, just prove that you're up—and then you stay up. Go to sleep at the normal time and get that structure back.

With the new casualty support units that they're going to set up, I think we're going to have a better way to be able to provide a better ability to do that stuff. And some studies, of course, have shown that a 20-minute nap in the afternoon helps with cognitive functioning for everybody.

Mr. James Lunney: Yes, exactly.

I certainly support those observations. As I certainly found in my former career, when you treat people with back problems, if they're instructed to just stay home and rest and then they sit watching TV all day, that is the worst thing they can do for their backs.

LCol H. Flaman: Exactly.

Cdr D.R. Wilcox: I'll add one little bit about nutrition. I know there's a movement afoot now—this is not necessarily under the auspices of mental health, but under fitness—to get a dietician who's at a certain level, maybe even at a master's level, to act as a consultant when selecting the diet. It's under the auspices of a new weight wellness program. Other groups will benefit from it, but again, the emphasis is on an evidence-based approach to nutrition as well.

Maj S. West: We also have food services officers within the Canadian Forces. They're involved in continuous quality improvement of things like our IMPs, our hard rations. Of course, one problem is that no matter how palatable you think you've made the rations, there'll be some soldier who would rather carry 50 pounds of beef jerky than eat the balanced meal that's in his IMP.

A voice: Salt.

Maj S. West: Lots and lots of salt, which you need in Afghanistan.

The Chair: Thank you, Mr. Lunney.

That ends the second round. We'll start the third round.

The official opposition: you're good?

The government, the Bloc...?

Mr. Bouchard, do you have a question?

[*Translation*]

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

Welcome. Thank you for being with us.

In Afghanistan, I met with soldiers who told me about their deployment. For some of them, the duration of that rotation was six months, seven months and even nine months. In Valcartier, I met with spouses who told me that the decompression week should be included in these six months. They have a 15-day break between the first month and the fifth month. Often, when the soldier comes back home for this 15-day break, he seems to be elsewhere and keeps watching the news.

Do you believe that we should shorten the rotation in Afghanistan? Would it be better not to change anything? I would like to hear you on this issue.

● (1705)

[*English*]

Maj S. West: I've just been there, dealing with many other nations in the Role 3 hospital. It's Canadian-led, but we have the Dutch and the Danes and the Americans. I can tell you that every single country has a different approach. The approaches range from four-month tours with no break to fifteen-month tours with a three-week break in the middle. Ours is six months with a three-week break. We do have some people on nine-month tours, but the norm is a six-month tour.

When I talked with my colleagues over there, I found that everybody had a different opinion on what would be an appropriate thing. Personally, I always advise my patients when they are going over that they do not come home for their three-week break, if at all possible; they should meet their family somewhere else. That's not always possible. Children are in school, or you can't afford to move everybody that far. You can reverse your funding and give it to your spouse instead, but if you have a spouse and four kids, that can become quite an expensive proposition.

Personally, I don't think they should come home. However, for a lot of people that's what works out best. And for a lot of people, that break is wonderful. It's a chance for them to meet their spouse in an exotic third location and have a break.

Again, the time zones become a problem. When you come home from Afghanistan, you have to adapt to a nine-and-a-half-hour change. You get almost three weeks as a break, but you spend the first week adapting. So I question the value of it.

One way or another, you do keep connected. I went to Disney World for a week with my family. I spent my time trying to avoid young men with missing limbs in wheelchairs, which was exactly what I'd been dealing with for the previous three months in Afghanistan. It was not a shock for me, so I was okay with it, but for some people that would be a bit of a problem, I would think.

So yes, it's something the forces needs to examine.

LCol H. Flaman: All I can add is that I think the forces are looking at...and this isn't a medical thing. Whether or not they keep it or whether or not they lengthen tours will be based on how many soldiers they have to meet the requirements.

Again, it's positive and it's negative. I've heard spouses say, “I'd rather he didn't come home; it traumatizes the kids when they have to say goodbye again.” But it is seen as a benefit. The soldiers see it as a benefit.

When you start taking anything away, it will always be met with some resistance.

[*Translation*]

Mr. Robert Bouchard: Thank you.

[*English*]

The Chair: Thank you.

Mr. Lunney.

Mr. James Lunney: I have a short one, and it picks up on Monsieur Bouchard's comment.

That certainly was my observation as well about coming home; the time lag is a week, and it really hits you both ways. You have to deal with that coming back again. But I certainly support it for those who are able to do it.

I appreciate the advice you're giving, Major West, to your clients, encouraging them to try to find a way to meet in a third country. That might be a bonus for the spouse as well. They might both come out a winner in that regard, because the spouse absorbs that travel time.

I also appreciate the remarks that were made earlier about learning. I appreciate, in the time that I've been on this committee and working with our military family here, that the military is a learning organization, or organism, if you will. You're learning from experiences. Unfortunately, when you're talking about notifying family members, difficult assignments like that, you're learning through those difficult experiences, starting with the west and the east, coming forward as rotations move.

Our military is taking on a task that we haven't asked them to do for some time in this capacity. It's great to see the way learning is taking place. We just want to make sure that we use all of the best tools available and make sure we maximize the learning experience. Maybe Canada could lead the world in some regard. And I appreciate that we're exchanging data and experiences with those various other countries.

At any rate, I just want to say that I appreciate the way in which that sharing is going on, the multi-modal component that you described earlier, and that we are doing our best to meet the needs of the soldiers. I thank you in that regard.

● (1710)

Cdr D.R. Wilcox: I would just echo that. What I found amazing was how responsive the system was to body armour improvements. The turnaround time to enact an improvement was amazing. Again, it was collecting the data, analyzing the data, making a recommendation, and then trialing it—all evidence-based. It was amazing.

The Chair: Thank you very much.

Ms. Black, your patience has been rewarded. You're going to get the last word here.

Ms. Dawn Black: Thank you very much.

I just want to refer back to some statements that I think you made, Major West, around Canadian Forces members being screened before deployment for any mental health issues—maybe for other things as well, but including—

Maj S. West: They are extensively screened for many, many things, including their weapons preparedness.

Ms. Dawn Black: But you don't do that as a doctor?

Maj S. West: I'm lucky they actually let me have a weapon.

A large portion of that is medical, including a psychosocial screening, where the spouse has to come in to the base social worker and sit down and say, “No, there really are no problems at home with my spouse deploying”.

Ms. Dawn Black: Someone else said there are systems in place that prevent someone from being deployed if they do have a problem.

I wanted to contrast that with what you said earlier about when you're trying to make a diagnosis or understanding if a person has post-traumatic stress disorder or a brain injury, that you depend on self-disclosure. How do you weigh both of those?

You're saying there's a screening in place. I'm wondering how that screening works before deployment. Why wouldn't you use a similar kind of screening...? We've been informed that screening takes place two months after deployment, again when they return, and then six months later. What's the difference between the two?

Maj S. West: If you understand how physicians operate, you go to see your doctor for your medical—and you're a woman, so I know you actually will show up, as opposed to most of your colleagues here. You tell your doctor the issues that are important for you to put forward. Your doctor is still going to screen you for cardiac disease if you're at the right age. If you're a female, he or she is still going to say to you, "When was your last pap? Should we do that while you're here? Are you due for a mammogram?"

There are a number of things we're going to screen for. That includes mental health. However, people are very good at presenting the picture they want to present. No screening system is completely infallible. Mental health, due to the nature of it, is particularly difficult to screen, but we do actively screen for it.

However, if someone has identified themselves—or we have identified them or their chain of command has identified them—and is undergoing treatment, we have a system within the military to label that person as unfit for deployment until they have completed treatment. Our goal always, whether it's a physical injury or a mental injury, is to return the soldier to full duty. Failing that, it's to make him function as well as he can before he moves on to a civilian position.

We are constantly screening in our offices when we do our periodic health assessments, or when the patient shows up with back pain that in fact is a manifestation of severe mental distress. No, it's not infallible. We do miss people. It is easier if they self-report.

Cdr D.R. Wilcox: But we react whatever way they come in. It's brought to our attention by spouses, by co-workers. Any time there's an alcohol-related incident, the MPs will inform us. We rely on a lot of sources, not just self-referral.

The screening is one. Every second year they have a questionnaire they have to fill out that has mental health questions on it. We do as much as we can.

LCol H. Flaman: And we are company docs; we work for the company, but.... Therefore, at my level, I review the medicals done, because we don't want to send someone over who should not be over in Afghanistan—

Maj S. West: For a number of reasons.

LCol H. Flaman: —and then have to be sent back and use resources that are there, which are our own resources, medical resources, and cause the mission to have to find a replacement and whatever. So we're not going to send somebody over there who is not....

● (1715)

Cdr D.R. Wilcox: I wouldn't say that we're company docs; we're occupational medicine specialists.

Our business is to put them in harm's way, so we're trying to make sure we don't exacerbate that. I like to call us occupational specialists.

LCol H. Flaman: We're here to preserve the manpower, which is really what the old mantra was.

Ms. Dawn Black: I understand that. It just seemed to me that during your testimony you said many times that self-disclosure was the sharpest tool in your toolbox, or whatever.

Cdr D.R. Wilcox: It is a good history.

Ms. Dawn Black: When you talk about screening, I wondered how that screening worked without self-identification. I'm sure there are some soldiers who want to go on deployment in Afghanistan and there are indicators that would indicate they should not.

Maj S. West: We set up our screening in such a way as to encourage you to report. We can't force you to report.

LCol H. Flaman: The other thing is that people will, as I say, determine what picture they want to paint. If they want to paint the picture that says they're ready to go and they have no problems here, they'll check that. We used to do the enhanced post-deployment screening before, because we wanted to know how much of the stuff they reported after was really present before. We threw out the before, because everybody who is ready and actively training to go is not going to fill out the thing that says they don't want to go. They just go right down the list and check everything off as negative. Then they don't have any hook to say to you, "Well, you said here", or "What's your problem there?" There's nothing there.

Ms. Dawn Black: By percentage, how many who want to go to Afghanistan are screened and not permitted to go due to the screening process when they go in? Can you give us some idea of that?

LCol H. Flaman: Just off the top, I would say between 2% and 5%. There are those we screen out, and we tell them it's not in their best interest to go, for whatever reasons, such as a bad knee, for example.

Maj S. West: As far as the mental health issues go, again bringing the spouse in is a really good check. Even then I can assure you that my husband was very well briefed before he showed up at the social worker's, and we didn't have a lot of issues. So a family that did have issues....

The Chair: Thank you very much.

That concludes the questioning. We want to thank you. As a panel, is there anything you want to add? Very good, thank you.

I just want to remind the committee members that we're coming to the end of our hearing, so if you have recommendations, please move them forward. We'll see you next time.

The meeting is adjourned.

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