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Chair

Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): We'll call the meeting to order. Today we're carrying on with a topic that we investigated for many months in the previous Parliament. Pursuant to Standing Order 108(2) and the motion adopted Monday, February 23, 2009, we are continuing our study of the health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

We're having this session today to help us refocus on where we are and what has transpired.

Our meeting is split into two parts today. The first hour is going to be spent with Mary McFadyen, general counsel, who is probably better known as the former interim ombudsman.

We'd like to turn the floor over to you for your comments. Then we'll open it up to questions from the different members.

So the floor is yours.

Mrs. Mary McFadyen (General Counsel, Office of the Ombudsman for the Department of National Defence and the Canadian Forces): Thank you, Mr. Chair.

[*Translation*]

I would like to begin by thanking the committee for inviting me to testify this afternoon. I am pleased and honoured to be here today in my capacity as General Counsel for the Office of the Ombudsman for the Department of National Defence and the Canadian Forces to discuss our recent report on operational stress injuries.

[*English*]

The ombudsman's office has been helping to ensure the fair treatment of Canadian Forces members suffering from post-traumatic stress disorder and other operational stress injuries since 2002.

At that time, our office made 31 recommendations aimed at helping the Canadian Forces identify and treat operational stress injuries, while at the same time ensuring the fair treatment of all Canadian Forces members.

[*Translation*]

Over the next few minutes, I will highlight some of the key findings from our most recent report released in December 2008 and the areas where we have found progress has been made by the Department and the Canadian Forces.

I will also underscore some of the areas where we feel more work is required.

Finally, I will highlight some new and evolving issues and problems identified during our most recent investigation.

[*English*]

It is clear from our most recent review that the Canadian Forces has made progress over the past few years in the way it approaches individuals with operational stress injuries. We found evidence of improvements in the Canadian Forces' attempts to prevent, identify, and treat operational stress injuries. Unfortunately, it is also clear that there continue to be cases where injured soldiers, sailors, and airmen and airwomen who have served our country with courage and dedication are slipping through the cracks of an ad hoc system.

During our investigation we discovered that more than half of our original 31 recommendations had not been implemented, either in practice or intent. I believe this has hampered the consistency of care received by the military members across the country who are suffering from mental health injuries.

We also identified a number of areas where progress continues to be slow, particularly with respect to high-level direction and national coordination, the efforts to standardize care and treatment across the Canadian Forces, and the collection of national data and statistics.

Access to quality care still depends on a number of arbitrary factors, including where the military member lives, the distance of the member's base from the nearest large city, the availability of mental health care professionals, and the attitude of the member's superiors and peers.

We were also disappointed to learn that a national database has yet to be created. This database would accurately reflect the number of Canadian Forces personnel who are affected by operational stress injuries. A tool of this kind is critical to understanding the number of Canadian Forces personnel affected by mental health injuries, the extent of the problem, and what needs to be done. Without a national database, the Canadian Forces is unable to evaluate the impact of various clinical interventions and to target education and training initiatives where they are most needed.

[*Translation*]

Regardless of where they are located, what their duties are, or who they work and train with, all Canadian Forces members are entitled to quality, consistent and timely care when they are injured—whether the injury is physical or psychological.

Some of the problems identified by our office likely could have been prevented with the full implementation of our original 31 recommendations.

[*English*]

At the same time, when we conducted the latest investigation, it became clear to us that new areas of concern had emerged in the six years following our original report. The environment in which Canada's military has been operating in recent years has changed dramatically, particularly in light of the level and intensity of combat operations in Afghanistan. And it is evident that the Canadian Forces and its members are strained almost to the breaking point. This strain also significantly increases the demands on families, caregivers, and mental health care providers.

[*Translation*]

Taken into account these current realities and problems, we focused on three issues that we considered to be critical in insuring quality and timely care for military members suffering from operational stress injuries.

[*English*]

First, there is a need to strengthen national governance and leadership related to the identification, prevention, and treatment of post-traumatic stress disorder and other operational stress injuries.

Our original report in 2002 stressed the need to appoint a senior officer of significant rank reporting directly to the Chief of the Defence Staff. This officer's primary duty would be to act as a national coordinator for all issues related to operational stress injuries, including the quality and consistency of care, diagnosis and treatment, and training and education across the Canadian Forces. The position would also serve an important practical and symbolic role in helping to put an end to the ongoing stigma associated with operational stress injuries.

[*Translation*]

Second, it is now apparent that the challenges and difficulties associated with operational stress injuries are not restricted to military personnel alone. When a Canadian Forces member suffers from post-traumatic stress disorder or another mental health injury, the whole family suffers. It may also require support and assistance for each family member.

● (1540)

[*English*]

Our investigators found a number of quality programs offered by provincial and municipal governments, local military family resource centres, and local base chaplains to support military families. Unfortunately, we found no evidence of a coordinated national approach that would ensure that military families are able to consistently access the mental health care and support they may need.

Although the department and the Canadian Forces do not have a legal responsibility in this area, there are compelling reasons for them to ensure that military families have access to timely and appropriate services and support.

[*Translation*]

First, as mental health injuries are enough the result of military service, and the direct cause of family stress, the Canadian Forces have a moral responsibility to ensure that care and treatment are provided to families.

A second, more practical reason for ensuring the care of military family members is that it could reduce the level of stress on the operational stress injury sufferer and speed up recovery time.

[*English*]

Finally, as part of the broader investigation we also found that much more needs to be done to deal with stress and burnout among Canadian Forces caregivers. This stress is created by a lack of resources and high caseloads. The majority of caregivers interviewed by our office stated that personal stress or burnout was a pressing concern to them, to the point that it was leading some of them to quit the military.

The department and Canadian Forces had informed us, during our investigation, of their intention to hire an additional 218 mental health professionals by the end of March 2009. I understand now that the deadline has been extended to 2010.

Hiring more mental health care workers would be a positive step towards resolving the issue. However, we have concerns that it may be difficult for the Canadian Forces, as just one of the employers across the country vying for health care professionals, to fulfill this commitment, even with this extension to 2010. This makes it even more essential for the military to retain the mental health care professionals already working in the defence community.

Given the very dangerous and demanding nature of the current mission in Afghanistan, it is clear that post-traumatic stress disorder and other operational stress injuries will become an even greater challenge for the military for many years to come. In many respects, this will be a generational challenge for the department, the Canadian Forces, and the Government of Canada as a whole.

We acknowledge that the Canadian Forces has made some progress over the past six years in generally dealing with the issues and challenges related to post-traumatic stress disorder and other operational stress injuries. However, much more needs to be done to ensure that Canadian Forces members suffering from operational stress injuries are diagnosed and receive the care and treatment they need.

Addressing these outstanding issues and implementing the recommendations made in our report will help our Canadian Forces members in many years to come, whether in the Canadian Forces, if they stay, or in their lives as civilians.

At this time, Mr. Chair, I stand ready to take any questions you have. Thank you.

The Chair: Thank you very much.

Committee members, this is a seven-minute round. We'll start with Mr. Wilfert.

Hon. Bryon Wilfert (Richmond Hill, Lib.): Thank you very much, Mr. Chairman.

I thank the general counsel for coming here today. I want to congratulate you and your colleagues for the report, which I think is extremely important. Given the fact that there were 31 original recommendations and we have heard some comments from the government and the media, can you tell us whether you have received any formal response from the government on those 31 recommendations, of which over half have not been implemented, and on your new three areas of concern?

Mrs. Mary McFadyen: The process in our office when we've finished a systemic report like this, in order to be fair, open, and transparent, is we provide a copy of our draft report to the Canadian Forces in order that they have a chance to review what we're intending to provide to the minister so they can comment on it.

During that process we did receive some comments from the Canadian Forces and reviewed them, and we still determined that our recommendations were needed.

Hon. Bryon Wilfert: Through you, Mr. Chairman, there seems to be a disconnect in the fact that we have heard testimony that indicates that higher echelons within the military are acknowledging some people are falling through the system, but generally the system is working well. And yet from testimony from those who have come back, particularly from Afghanistan, it is not. There is also an issue of discrepancies between east and west in Canada. Could you comment on that?

● (1545)

Mrs. Mary McFadyen: Certainly during our investigation we interviewed 360 people throughout Canada in various bases, health caregivers and people suffering from post-traumatic stress disorder. It was certainly our finding that it is true, it depends on where you live sometimes if you're able to get the care you need. And it is a problem that we thought it was important that the Canadian Forces address.

Hon. Bryon Wilfert: Through you, Mr. Chairman, one of the issues that is of concern to me, and certainly to my colleagues, I know, is the issue of a national database and the inability, really, to be able to target education and the inability, as you say, to deal with clinical interventions.

Can you comment as to any feedback on that, and why up to this point there has been a failure to implement?

Mrs. Mary McFadyen: That will probably be a question that specifically should be asked of the Surgeon General. However, our understanding and what we were advised during our investigation was that they are planning to computerize the medical records within DND. However, unfortunately, my understanding is that it will take until 2011 until that will actually be implemented. It was supposed to be 2008—that's what we were told—but my understanding is that it's now 2011.

It was one of our original recommendations, and we stressed it again in this follow-up report, that it's hard to know how to deal with a problem unless you know the extent of the problem. And then once you know the extent, you can determine where you need to target resources, education, and training. We thought that was a very important recommendation worth stating again.

Hon. Bryon Wilfert: I do, too, and my concern is that the minister was here with supplementary estimates, and obviously in terms of the priorities and needs within the forces, and particularly with regard to this issue—which I think more Canadians are becoming aware of because of the number of people affected when returning from Afghanistan—this should in fact be a priority. I would certainly hope we'll follow that up with the minister and with the deputy minister in terms of really pushing this up, because obviously 2011 is still too far away, given the fact that you have indicated, quite rightly, that this recommendation has been around for a while now.

That's certainly, Mr. Chairman, something we should be pushing, because without that information it's pretty hard for us to do many of the other things that I think there's a broad consensus on this committee need to be done. You need to know what you're dealing with before you can actually move ahead. So again, I appreciate that recommendation and coming back to that as well.

One of the issues deals with the reserves and the regular forces, and obviously there seemed to be an inadequate response to reservists in particular not having the same kind of network that colleagues in the regular forces have. Again, you point out particularly the need to maintain a type of standards. Can you enlighten us a little more on that from your findings?

Mrs. Mary McFadyen: The issue with respect to health care that goes to regular force members and reserve members?

Hon. Bryon Wilfert: Versus those in the reserves.

Mrs. Mary McFadyen: Yes. In our report that we released in April 2008 we addressed that issue. We found that currently the system they have and the regulations they have are very muddled. We had health care workers telling us they didn't really understand who was entitled to what. And it was certainly true when we did our investigation.

Right now health care is tied to your contract as opposed to what you're doing. If you are hurt as a result of what you're required to do as a result of military duty, the Canadian Forces should be responsible for ensuring you get the proper health care and treatment you need. We have asked them to review all those regulations and policies and we have asked them to ensure they're treated fairly, no matter what. If they're working, if it's military duty related, the military should be responsible for their health care.

Hon. Bryon Wilfert: I think your comments on the medical and dental care provisions for reservists was in fact very timely. I think the issue of clear, user-friendly terms, as you say in your report, is important, because again, some people were not clear as to what they were really entitled to when they came back. So again, it's another area we need to really stress as we go forward with our own report.

The Chair: You still have a little time, Mr. Wilfert.

Hon. Bryon Wilfert: You're being very generous today, Mr. Chair.

The Chair: Well, no, the clock is.

Hon. Bryon Wilfert: You're very kind.

Also, through you, Mr. Chairman, on the issue you raised today, there are three new issues. A concern we certainly have is that the majority of recommendations have not been adhered to yet, and then we have three new ones, three very important areas, particularly in light of Afghanistan. In terms of your own timeframe, do you see a timeframe that could be developed to deal with these three areas in terms of their priority, given the other recommendations that are out there?

● (1550)

Mrs. Mary McFadyen: As for timeframe, I guess that's for the Canadian Forces to determine. We certainly intend to keep at them on this, because we feel they were very important issues that arose during our follow-up review of the original 31 recommendations.

Hon. Bryon Wilfert: Do you feel you are getting the kind of cooperation you need? I realize in some cases things haven't moved forward, but in general?

Mrs. Mary McFadyen: They have commenced a lot of new initiatives. Right now, from what I've seen on paper, these are just getting started. I think it's important that lots of times policies are made over here at 101 Colonel By, but they don't necessarily get down to the ground. I think it's really important that we make sure there is action taken on their words, their commitments to families and to health care givers, and that we actually see some action.

The Chair: Thank you.

To the Bloc, Monsieur Paillé.

[*Translation*]

Mr. Pascal-Pierre Paillé (Louis-Hébert, BQ): First, congratulations on your work. I am a new member on this committee, but if I understand correctly you have taken over on a temporary basis, yet done very effective work, which is greatly appreciated.

I read in the report that the clinic at St. Anne's Hospital can take in some ten patients for eight weeks. What is the current status of the clinic? Is the work completed? Can a maximum of patients be taken into the hospital?

Mrs. Mary McFadyen: Across the country, there are several hospital programs conducted by the Canadian Forces and the Department of Veteran Affairs. I believe that a new clinic was opened yesterday in Ottawa for people suffering from operational stress injuries. There is still a long way to go, but we are pleased to see the progress that the Canadian Forces has made in this area.

Mr. Pascal-Pierre Paillé: It would appear that the government, in the 2007 budget, planned to open a network of some ten clinics. Has any progress been made in this regard? Could you give us more details as far as clinics are concerned across Canada?

Mrs. Mary McFadyen: That is a good question, but I think it should be put to the Canadian Forces and not to our office.

Mr. Pascal-Pierre Paillé: Okay.

You may once again refer me to the Canadian Forces, but I would like to know if you can tell me how many places are available across Canada, by province, to help these people? It would appear that there are several hundreds and even thousands of people who require these services, but we can see that there are very few spaces available. The need is very great.

First, can you tell me how many spaces are available by province?

Secondly, what happens when there are not enough spaces? Is there some kind of procedure set up in the meantime?

Mrs. Mary McFadyen: Once again, that's an excellent question, but it should be put to the Canadian Forces.

Mr. Claude Bachand (Saint-Jean, BQ): You stated in your report—and I'm going to use the exact terms—that there is a problem with high-level direction. According to your most recent report presented in December 2008, can you tell me how many people in your office worked on this very exhaustive report? I know that there are many employees in your office, but how many of them actually worked on the substance of this report?

Mrs. Mary McFadyen: Our office has been working on this issue since 2002. According to the latest follow-up report, some five investigators worked on this. As General Counsel, I worked on the report as well.

Mr. Claude Bachand: Can you explain to us what research you and these five investigators did? Did you speak to the superior officers in the chain of command? Did you speak with soldiers who have come back and who do not suffer from post-traumatic stress disorder? Did you speak with soldiers who are victims of this disorder? Did you speak with their families? How big a sample did you use? Is it similar to what I have just described to you or does it go beyond that?

● (1555)

Mrs. Mary McFadyen: During the last investigation, we interviewed over 360 individuals, including Canadian Forces members, family members, members of the chain of command, the chaplains and health care workers. We feel that we did a good job collecting information from throughout the Canadian Forces.

Mr. Claude Bachand: Could you explain to me what you mean when you state on page 2 of your presentation:

> We also identified a number of areas where progress continues to be slow, particularly with respect to: high-level direction and national coordination [...]

Are you referring to the defence staff of the Canadian Forces? Are those people slow to respond?

Mrs. Mary McFadyen: In our first report, we made a recommendation, there is a lack of global leadership. What is needed is a special advisor who would report directly to the Chief of the Defence Staff to ensure that proper direction is provided across the country.

Mr. Claude Bachand: Very well.

[*English*]

The Chair: Thank you very much.

Ms. Black, you have seven minutes.

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

Thank you for coming, Ms. McFadyen. It's nice to have you back at our committee.

Your 2008 report found that of the 31 recommendations from your original 2002 study, only 7 had been partially implemented and 11 had not been implemented at all. This appears to be a rather astounding failure and a shocking lack of progress over six full years.

There was a piece in today's *Ottawa Citizen* that said "stubborn traditionalists inside Canada's military have still not fully accepted the reality that psychologically damaged soldiers urgently need treating for combat traumas." It quotes a support counsellor in the same article as saying the traditional military culture "is still alive and creating a big barrier".

Over the course of your investigation, is it your opinion that the failure to implement the recommendations is more the result of an unwillingness to recognize the seriousness of the problem? Was there an effort made to implement these recommendations that failed simply because of a lack of capacity and resources, or is it a combination of both?

Mrs. Mary McFadyen: During our investigation, our investigators found that at virtually every base they visited—they visited over 19 bases during their investigation—that stigma was still raised as being a real problem. There's a problem that people are still afraid to come forward. They're afraid that they'll be stereotyped or that people will think they're malingerers or they're lying.

Ms. Dawn Black: We've heard that from soldiers at this committee.

Mrs. Mary McFadyen: Yes, and we certainly found that when we were out visiting bases. That is why we made the recommendation strongly again in this report that there needs to be some high-level direction and leadership.

After the first report, there were CANFORGENs and other policy documents issued that said this is an important issue and it's a lack of leadership if we don't deal with this. But we're not necessarily sure from what we found when we were doing our investigation that those words have made it down to action, because when we spoke to people, there were still some problems with stigmatization. That's why, in our opinion after our investigation, we determined that it was still necessary to have someone at a level reporting to the CDS just to show that it is a very important issue and taken seriously.

Ms. Dawn Black: I agree with you. I think that's critical in terms of making real change along the way.

In your recent report you reiterated the 2002 recommendations and you called for a database to track the number of CF personnel in the system. You're also calling for another mental health survey to get an updated picture beyond this survey, because it's old data now, from 2002.

● (1600)

Mrs. Mary McFadyen: It was conducted in 2002 and it's now 2009.

Ms. Dawn Black: Could you tell the committee exactly how the information gathered from such a survey and a database would help the department better serve the Canadian Forces members who have post-traumatic stress disorder, or OSI?

Mrs. Mary McFadyen: When we made the recommendation initially, and reiterated it in 2009, we found that if you have the database, then you can determine how many people have the problem. There is a lot of money spent on Canadian Forces health care, about $500 million a year. So let's make sure that those resources are going to the right places and we know where training and education programs should go.

I believe when the Auditor General did her report last year on this issue, she also reiterated that there needs to be some way to make sure the money is being spent properly.

Ms. Dawn Black: Without data, it's pretty hard to determine that.

Mrs. Mary McFadyen: We thought it was very important to stress that again.

Ms. Dawn Black: Now, you first submitted this report to the minister in September 2008. Is that right?

Mrs. Mary McFadyen: Yes.

Ms. Dawn Black: It wasn't released until—

Mrs. Mary McFadyen: No, because of the election and everything, we waited until December.

Ms. Dawn Black: Since December, or even since September, when the minister had the report, have you observed any actions taken to address the report? What was the reception or response to your report? I really want to ask you, has the response to your report been adequate, or are you concerned that another six years could go by without many of these recommendations?

The last thing I would add is that in your comments to us you said the department had indicated it was their intention to hire an additional 218 mental health professionals by the end of March 2009, and they have now extended that deadline. Knowing that it's difficult to find all the personnel, I'd still like to know how many of those 218 were hired.

Mrs. Mary McFadyen: I don't know. That's a very good question to ask the Surgeon General when she comes.

Before we released our report, in order to be open and transparent we gave them a draft copy to comment on before it was provided to the minister. They indicated some initiatives they had intended to bring forward to try to meet the recommendations. I noticed last month and this month on the DND website there are some backgrounders on what steps they have taken towards dealing with the issue. That's where I got the information about the deadline changing to 2010.

So we applaud them for trying, but we'll see if these actually are enough to meet the intent of our recommendations to make sure that the necessary work is actually done.

Ms. Dawn Black: Yes, it seems to me that one of your most important recommendations is that position right at the top that reports directly to the CDS. I know there are many important ones.

The other question I have is about the regular forces and the reserve forces. We had information last year, I think, that a reserve member who was injured and lost a leg got less compensation than a member in the regular forces who had the identical injury. Have those kinds of issues of inequality between members of the regular Canadian Forces and members of the reserve forces—we're now having a higher percentage of reservists serving in Afghanistan than we've had in any other war—been resolved?

Mrs. Mary McFadyen: With respect to the one about insurance—your leg not being worth as much if you are a reserve forces member as opposed to being a regular forces member—when we released our report we made a recommendation for equal treatment. The minister, I believe, brought forward a proposal to Treasury Board. I'm not sure of the status of that proposal. That would also be a very good question for Canadian Forces personnel when they come.

Ms. Dawn Black: What about other inequities? Are you aware of any?

Mrs. Mary McFadyen: As to other inequities, I believe that in the report we gave them a year to make the changes to the regulations to ensure fair treatment. So in a year we will follow up to see what was done.

Ms. Dawn Black: Thanks very much.

Mrs. Mary McFadyen: Thank you.

The Chair: We'll go to Mr. Blaney.

[*Translation*]

Mr. Steven Blaney (Lévis—Bellechasse, CPC): Thank you, Mr. Chair.

Mrs. McFadyen, I would like to welcome you back to the Standing Committee on National Defence. This is our first meeting on the study that we began last spring in 2008. Sometimes, delays are good, because we will be able to incorporate the recommendations from your report published in December 2008 into our study. This will give new momentum to your recommendations, and I am sure that our researcher, Mr. Cox, will be very pleased.

Something new and exciting has happened over the past year: the number of operational stress injury treatment clinics set up by National Defence and Veterans Affairs will increase from five to ten this spring. So, as you indicated in your report, there have been improvements.

I would like to come back to your report. You said that 13 of the 31 recommendations made in your initial 2002 report were taken into account by DND. You also pointed out that the challenge of post-traumatic stress disorder is linked to intensive use of our Canadian Forces during various missions, in particular the Afghanistan mission, for which you state that our Forces are stretched to the breaking point.

Something else that I appreciated in your report: you mention that it is not only military personnel who are affected, but also their family members. You pointed out that there is no coordinated approach to help families living with someone suffering from PTSD. I am sure that we will be taking this into account in our study, because it has also been raised by witnesses who have appeared before the committee.

However, what surprised me in your presentation is this: you state that in many respects, the Canadian government, the Canadian Forces and DND are faced with what you call an generational challenge. Could you explain what you mean by this when you refer to the improvements to be made to assisting victims of post-traumatic stress disorder?

● (1605)

Mrs. Mary McFadyen: Our intention, by making this comment, was to underscore the fact that symptoms of operational stress injury do not necessarily appear immediately upon the victim's return from a mission in Afghanistan. They may appear up to one or two years later.

[*English*]

Right now we're not necessarily sure how big a problem this is going to be, and I think it's important that it be addressed so we can deal with it.

[*Translation*]

Mr. Steven Blaney: It would appear that approximately 20% of military members who return from missions experience mental health problems. Are you saying that because of the scope of the mission in Afghanistan, the challenge is that much greater? Is that what you mean when you talk about a generational challenge, or are there other aspects? For example, the fact that the military is losing health care professionals because of their age or because they are retiring.

[*English*]

Mrs. Mary McFadyen: What we mean is that this is the first time our Canadian Forces have seen active combat since the Korean War, and more than 8,500 people—for example, from Petawawa—have participated in this mission. I don't know necessarily if we know the extent yet of what they will be suffering. It is important that we will be able to assist them, to make sure as a country—they have served our country well—that they are taken care of properly.

[*Translation*]

Mr. Steven Blaney: One thing is for sure, as we have seen, the after-effects can last for some time.

We see that there number of challenges. A member of the military, Mr. Paul Franklin, appeared before our committee and told us that the way in which the Canadian Forces supports sufferers of PTSD could be improved. He had studied what is being done in other countries as part of similar programs. In his opinion, Canada leads the pack and provides services that are superior to those in other countries.

Do you agree with him?

● (1610)

Mrs. Mary McFadyen: Yes, we agree with Paul Franklin. In our report, we stated the following.

[*English*]

Canada is a world leader, but that doesn't mean there isn't more work to be done to ensure the fair treatment of our Canadian Forces members.

[*Translation*]

Mr. Steven Blaney: Absolutely. To meet a challenge, political commitment and material and financial resources are required. In your opinion, which of these three elements is the most important in helping us make progress or truly meet the challenge with regard to what you stated concerning greater involvement in Afghanistan? Which of these criteria, in your opinion, is the most important? You are aware of the situation. Would you say that political commitment, material resources or financial resources are the most important? Which of these appear to you to be the most essential at this time?

Mrs. Mary McFadyen: All the recommendations that we made in our report are very important, but I think the main problem is the overall lack of leadership.

[*English*]

There needs to be a high-level person determining where the money should go, where the training and education should be. I think that will trickle down and help with the cultural stigma that's been there, making sure the money, the resources, are spent properly.

[*Translation*]

Mr. Steven Blaney: So it is really leadership.

Mrs. Mary McFadyen: Yes.

Mr. Steven Blaney: Thank you very much.

[*English*]

The Chair: That ends the opening round. Now we will go into a five-minute round.

We'll start with Ms. Neville.

Hon. Anita Neville (Winnipeg South Centre, Lib.): Thank you very much, and thank you for your presentation.

I'm new to this process. I was going to ask you one line of questioning, but I want to pick up on something a colleague down the road asked.

You indicated that the release of the report was held up. Could you just clarify that again? You completed it when?

Mrs. Mary McFadyen: We provided it to the department in July 2008. What we do is make sure they have reviewed our recommendations and have had a chance to comment before we provide it to the minister. We provided it to the minister in September; however, there was an election call.

As an ombudsman's office, our role is to be neutral and impartial. We make observations on things, and we made a determination that it was appropriate to wait until after the election to release the report.

Hon. Anita Neville: That was your call.

Mrs. Mary McFadyen: It was totally our call.

Hon. Anita Neville: Okay, that's what I wanted to hear. Thank you.

I'm struck, when I'm reading your remarks today and just going through this, with one of the issues you identify. You say that access to quality care depends on a number of arbitrary factors, and one you identify is the attitude of the member's superiors and peers. Then I'm looking through the report here, and one of the things you say is, “one is left to question the lukewarm leadership and commitment at the national level”, obviously at a lower level. How serious an issue is this? What can be done? Post-traumatic stress disorder often carries a stigma, in the minds of some, and it is important to work around this.

Mrs. Mary McFadyen: That's a very good comment to make.

Again, we found during our investigation that stigma was still an issue that arose at every base we went to. We talked to caregivers and family members. I sound like a broken record, but that's why we do think leadership is needed at the highest level to make sure that the word that this is inappropriate behaviour trickles down to every base across Canada.

Hon. Anita Neville: What would you do in the first steps to make that recommendation happen? Is it training?

Mrs. Mary McFadyen: It's somebody appointed, a high-level officer reporting directly to the Chief of the Defence Staff. They would be responsible for all areas with respect to the treatment of operational stress injuries—education, training, treatment, and diagnosis—so that they have a good handle on all aspects and know where training should go. We think that's very important.

Hon. Anita Neville: As time passes, one would hope that this kind of attitude or stigma would be diminished. Have you experienced a difference in your two reports?

● (1615)

Mrs. Mary McFadyen: Certainly it was very profound in 2002, but it was still an issue that was raised at every base during the second investigation. It's still an issue that's raised. I've met with family members myself, and they still raise it as an issue, that it's still a problem. People are afraid to come forward.

Hon. Anita Neville: Thank you.

The Chair: Ms. Gallant. No?

Over to the government side and Mr. Boughen.

Mr. Ray Boughen (Palliser, CPC): Let me first of all add our congratulations to you, Mary, for your very succinct and well-written report.

I have a couple of questions that arose as I read the report. The first one would be this. What do you see as the requirements that are needed to deal with the shortfall in the report? There's the original recommendation and then another nine recommendations. It seems to me that some of the recommendations are being acted upon, for whatever reason, but we're not privy as to why or why not they're not being acted upon. What's your thought on that?

Mrs. Mary McFadyen: As to why the Canadian Forces haven't acted on all of them, that is a good question for the Canadian Forces.

Again, we would hope there would be leadership shown high up to make sure those programs work on the ground.

Mr. Ray Boughen: What do you see in terms of putting in checks and balances for the implementation of the report?

Like any report, the design of that report has to have something in terms of a timeframe. What we're looking at here this afternoon is what happens to the report. If there's no time attached to it, then time just moves on, a bit gets done, and other things maybe do not get done.

Mrs. Mary McFadyen: In the past with this issue we made a commitment to follow up on them, which we did. These recommendations are still very important, and something that we intend to keep raising with the Canadian Forces until we observe that they've correctly handled the issue and ensured fair treatment for all Canadian Forces members.

Mr. Ray Boughen: Do you now have a liaison person that you work with who is a member of the Canadian Forces?

Mrs. Mary McFadyen: When we ask for an update on recommendations we usually provide it to the Chief of the Defence Staff, for example. He's the leader of the Canadian Forces. He may assign it to somebody, but we expect him to respond to us on these matters.

Mr. Ray Boughen: Thank you.

The Chair: We still have some time.

Mr. Payne, go ahead.

Mr. LaVar Payne (Medicine Hat, CPC): Thank you, Mr. Chairman.

I'm interested in your opinion on the Canadian Forces reserves. There's an awful lot of reserve people entering into the regular forces to assist in Afghanistan.

My question is this. When these individuals return, do they have access to the health services that you refer to in your report? If so, do you have any kind of information around the numbers that might be there? Where would they be able to access that across the country?

Mrs. Mary McFadyen: Offhand, I don't have the number of how many people are reservists who are participating in Afghanistan. The Canadian Forces should have that number exactly.

When they serve in Afghanistan they will be on a class C contract as a reservist, which means they would be entitled to the same health care as a regular force member. If they're injured over there and if they come back to Canada, if their contract ends, they would no longer be entitled to health care as it stands now.

Usually what happens is, of course, when they come back, CF has renewed their contract if they still need medical care, but that's basically on the goodwill of their commander. That was one of the issues we raised in our report. It shouldn't matter if the contract ends. It shouldn't be based on your contract; it should be based on why you were hurt. It should be based on who is looking after you.

Mr. LaVar Payne: Do I still have some time?

The Chair: Yes, you still have a minute.

Mr. LaVar Payne: I have another question. I have Canadian Forces Base Suffield in my riding, and there are military people returning from Afghanistan. If they have been injured, where would these individuals be able to access the mental health care facilities?

Mrs. Mary McFadyen: That's again a very good question. One of the points we raised in this is that sometimes there aren't services available where the member lives, and that's something the Canadian Forces have to ensure, that there are services available. It shouldn't matter where you're living, what base you go back to. You should be entitled to the same health care wherever you're living in Canada. That was one thing we found was not the case when we did our investigation.

● (1620)

Mr. LaVar Payne: Do I have any time left?

The Chair: You have 21 seconds.

Mr. LaVar Payne: I have a really quick question. In terms of access, would the Canadian Forces then be able to outsource this to, say, local providers?

Mrs. Mary McFadyen: I believe they do use private contractors, yes.

Mr. LaVar Payne: Thank you.

The Chair: Very good. You got it in.

All right. We continue with this round. We go over to Mr. Bachand and then back to the government, and that will just about do it.

[*Translation*]

Mr. Claude Bachand: I read somewhere that the ombudsman is assisted by an advisory committee composed of several members. Is that true?

Mrs. Mary McFadyen: Yes, we have an advisory committee that meets twice a year to discuss broad issues affecting the office. However, this committee does not deal with individual complaints.

Mr. Claude Bachand: How many people sit on the advisory committee, and who are they? Are they former military personnel, public servants?

Mrs. Mary McFadyen: I believe there are eight members: One or two from the Canadian Forces, at the chief warrant officer or captain rank, as well as a former ombudsman from Ontario. The members are from different backgrounds and we meet to discuss the policy directions of the office.

Mr. Claude Bachand: Does this advisory committee know, for example, that you are undertaking a major study like the one you presented today? Does it issue opinions on how you should conduct this study?

Mrs. Mary McFadyen: Yes.

Mr. Claude Bachand: Yes?

Mrs. Mary McFadyen: It provides us with direction during the meeting. This committee was set up because when the office was created, none of the employees had any military experience. The minister thus thought that it would be a good idea and included in the ministerial directives the creation of an advisory committee.

Mr. Claude Bachand: So it's a ministerial directive.

I would like to ask you a question on your stint as acting ombudsman. Should the role of the ombudsman be set out in the statute on National Defence in order to give this position more teeth? You have made recommendations to the Department, but I am disappointed at its response. After seven years, almost nothing has changed. In the act respecting National Defence, if the ombudsman reported to Parliament rather to the Minister, or if certain provisions stipulated that the recommendations were biding, would that help us achieve our objectives more rapidly and effectively?

Mrs. Mary McFadyen: The two former ombudsmen, Mr. Côté and Mr. Marin,

[*English*]

were both of the opinion that we needed a statute. We should be in the National Defence Act.

During my time as interim ombudsman, we were able to conduct our abilities and do our work and our investigations under the ministerial directives. I think we did a pretty good job, so they do work.

Even if we were in a statute, an ombudsman's role is only

[*Translation*]

to make recommendations, not issue directives.

[*English*]

So we would still have the

[*Translation*]

Same role, even if there were a legislative provision to this effect.

Mr. Claude Bachand: Unless we change the title of ombudsman for something that is more prescriptive. We could do this if we decided to amend an act or incorporate a provision. We try to use terms that will achieve our objectives. If we chose that route, you suggest that we not use the term ombudsman, because that person only makes recommendations. We would have to find another term.

● (1625)

[*English*]

Mrs. Mary McFadyen: Our role, like every ombudsman that exists, is to review administrative actions and to use public pressure, by appearing before committees like this, to force the organization to do the right thing.

The Chair: Thank you very much.

Thanks, Claude.

[*Translation*]

Mr. Claude Bachand: Thank you very much.

[*English*]

The Chair: Over to the government.

[*Translation*]

Mr. Steven Blaney: Thank you Mr. Chair.

I have three short questions for our “ombudsman.”

I would like to come back to my colleague's question concerning the treatment of persons suffering from post-traumatic stress disorder. Have you seen a difference in the quality of the care giving to military members and their families, according to whether the victims are reservists or members of the regular forces?

[*English*]

Mrs. Mary McFadyen: What we observed when we did our reserve investigation was that reservists, depending on their contract—even though they had been hurt because of military duty—couldn't get the Canadian Forces to deal with them sometimes. They said they had to go to their provincial health care provider. We determined that was unfair, that if you were hurt with respect to your military duty, the Canadian Forces should be ensuring that you get proper health care.

[*Translation*]

Mr. Steven Blaney: I would like to come back to what you said concerning the importance of leadership.

In your initial report, you recommended the creation of a position of national coordinator for post-traumatic stress disorder. The Forces have a chief of military personnel and have created the position of special advisor. Is this sufficient, or do you still recommend that there will be someone who reports directly to the Chief of Staff?

[*English*]

Mrs. Mary McFadyen: The special adviser to the CMP is a new initiative. I think it was created in November 2008. My understanding of the role is that it is to deal with non-clinical issues only, such as education and training. They have done initiatives like this in the past. After our report in 2002, two special advisers were appointed and it went nowhere; nobody knew that they were around. They had an OSI steering committee, which didn't work; it fell through the cracks. I know they made that new initiative as well. So we'll see if this helps. Those are just my comments on those two initiatives right now, but we're hoping that they do reach the intent of our recommendation.

[*Translation*]

Mr. Steven Blaney: How do you ensure the follow-up of the recommendations in your report? How does this usually work?

[*English*]

Mrs. Mary McFadyen: We want to give them enough time to implement the recommendations, but after a sufficient amount of time has passed, we contact them and say we're going to do a follow-up in which they tell us what they've done. Then we get a response back from them and we investigate to see if what they've said is really what they have done and if it does meet the intent of the recommendation.

[*Translation*]

Mr. Steven Blaney: In such a case, in your opinion, how long would it take for the follow-up to be completed?

[*English*]

Mrs. Mary McFadyen: That's hard to tell. We did our report in 2002, then we did an initial follow-up nine months later. They had made progress, but probably it was a little bit too soon. We waited six years to do this one, but we would have to see how things were going to see when it was appropriate.

[*Translation*]

Mr. Steven Blaney: Thank you very much.

[*English*]

The Chair: We just have a minute or two left. Over to the official opposition.

Mr. Coderre, just a minute or two.

Hon. Denis Coderre (Bourassa, Lib.): It's a short question, and it's following up from my colleague Claude.

There's a way to protect quality of life and make sure that nothing falls through the cracks, and that's to provide status to the ombudsman.

Do you believe, as in some countries, in having an inspector general with some specific judicial power? We can talk about procurement, but there's also the angle of quality of life for the troops—like in the United States. I personally believe that we should appoint an inspector general. We can have all the recommendations we want, but when you don't even have the central data, recommendations are not sufficient. Do you believe that kind of position would add value to the system as a whole?

● (1630)

Mrs. Mary McFadyen: I don't know if I've fully analyzed the inspector general model. I know that was looked at in 1998 when they created our office. It was decided that an ombudsman would be the appropriate model as civilian oversight for the Canadian Forces.

Despite this report that only half the recommendations were made, I think in 10 years we have done a lot of work. We've held the Canadian Forces' feet to the ground to make sure they improve treatment. I do believe the progress they've made in the last six years—the next panel may disagree with me—is partially because of our office pushing them on the issue.

Thank you.

The Chair: We want to thank you very much for appearing. We wish you well as you go on to your next life; I guess that's how we like to put it.

We appreciate the input and the way you answered the questions.

We'll suspend for a couple of minutes while we change panels.

● (1630)

(Pause)

● (1635)

The Chair: Order, please.

We'd like to get started. I know there's lots of interest in the next panel, so we'd like to have as much time as possible.

We have General Jaeger back with us. Welcome.

You have with you Colonel Darch, Colonel Grenier, and Colonel Ethell.

Good to have you all here.

We'll turn it over to you. You know the drill. We'll give you some time to do your presentation, and then we'll open it up for questions.

Brigadier-General Hilary Jaeger (Commander of the Canadian Forces Health Services Group, Director General of Health Services, and Canadian Forces Surgeon General, Department of National Defence): Thank you, Mr. Chairman.

I may have forgotten the drill, but—

The Chair: It'll come back quickly.

BGen Hilary Jaeger: —you will remind me.

[*Translation*]

Mr. Chair, members of the committee, good afternoon. I am happy to have the opportunity to appear once more before you to provide some information that I believe will be of interest and value to you. I have assumed that the major focus remains on mental health care. It has been many months since I last appeared before this committee, and there is quite a bit of new information to pass along. Due to the unavoidable absence of Major General Semianiw, I would present some information about initiatives outside the health services, as well as inside, to try to provide as complete a picture as possible.

[*English*]

The first thing I thought worth presenting is our most recent data about the size of the CF's mental health challenge. We have continued to collate the results of the enhanced post-deployment screening, which you will remember is done three to six months after return from deployment.

We now have results from over 8,200 completed screening questionnaires, which show 4% responding in a manner consistent with PTSD; 4.2% consistent with depression; a total of 5.8% consistent with either or both of these conditions; and 13% consistent with any mental health diagnosis.

We do see a correlation between the intensity of the operational stresses and the rate of positive screenings for PTSD. If the results were broken down by smaller groups, it would be expected that some platoons and companies would have higher rates. It is also true that some people experienced problems later on, even though they appeared well at the time of the screening. But it is worth emphasizing that 87% of those screened reported doing well.

[*Translation*]

It is also worth remembering that the overall mental health problem in the Canadian Forces is not limited to PTSD or OSI. We have some recent information about the overall number of mental health patients currently being seen. The eight largest Canadian Forces clinics tracked new patients over the 5-month period from August to December 2008. This data shows an average monthly total of 530 new patients, of whom roughly 250 were seen by the psychosocial programs—which deal with less complex, more transient issues—about 210 by the general mental health programs and an average of 76 by the OTSSC programs. If you assume these numbers carry on year-round, you can forecast that roughly 6,000 new cases will present to these eight clinics in a year—and most of these will be unrelated to deployment.

● (1640)

[*English*]

The second type of new information I want to present to you involves measuring results. How do we know whether the care we offer is of high quality?

I'll admit we have not yet progressed to where we want to be with performance measurement, so we cannot yet report on direct clinical outcomes. But to provide one indicator of quality, we have conducted periodic patient satisfaction surveys.

Our most recent data were gathered anonymously from our five OTSSCs between January 12 and 23 of this year. Every patient being seen was invited to complete a survey containing 19 questions, plus an opportunity for free-text comments. One hundred and seventeen responses were received.

In summary, we found that overall, 96% agreed or strongly agreed with the statement, “Overall I am satisfied with the support and care I receive”, while only one person disagreed or strongly disagreed. Eighty-eight per cent agreed or strongly agreed that “The amount of support and care I receive is sufficient for my needs”, while 2% disagreed or strongly disagreed.

In a separate assessment of patient satisfaction, the general mental health program in Halifax has also been collecting feedback. When it came to whether they felt they were making progress, 88% of the 288 patients who responded said “some progress”, 27%; “moderate progress”, 23%; or “considerable progress”, 38%; while 12 stated they had gotten worse—that was 3%—or they were not getting anywhere, the other 9%. A higher percentage felt that their counsellor was “somewhat helpful”, at 18%; “pretty helpful”, at 34%; or “very helpful”, at 45%.

[*Translation*]

We also have evidence that our efforts to combat stigma seem to be paying off. Indeed, the Global Business and Economic Roundtable on Addiction and Mental Health recently cited the Canadian Forces as an example in this respect. While there is no task to directly measure stigma, we have been collecting survey data about certain beliefs linked to stigma from our returning personnel. Over 9,000 personnel have now responded to these questions and my analysts have been pleasantly surprised by the what they found.

[*English*]

Twenty-four percent admitted to being concerned that members of their unit might have less confidence in them if they were to develop a mental health disorder. This was the highest of any of the 10 questions asked. Only 14% admitted a concern that they might be seen as weak, 12% had concerns about harming their career, 10% expressed distrust of mental health professionals, and only 6% felt that mental health care doesn't work. Perhaps the most interesting result was the response to whether the respondent would think less of a colleague who was receiving counselling. Only 7% admitted they would do so.

In reality, the situation is probably not quite that rosy. But what this response tells us—and I want to emphasize that this was an anonymous survey of a large number of people—is that the vast majority of our personnel are unwilling to admit to this bias. It seems clear to me that the CF cultural norm is now to be supportive of those with mental health problems.

The third area I want to touch upon is what changes have been or are currently being put into place. The Rx 2000 mental health initiative has made substantial progress in hiring, and we now have a total of 361 mental health providers across the country. This is still short of our goal of 447, but represents a very real improvement on the 229 that existed at the outset. I know there has been particular interest in Petawawa, so I am happy to report that significant progress has been made there, and there's more to come.

In spring 2008 a senior CF social worker was posted to become the mental health manager and provide clear leadership. Additional clinical support has been and continues to be provided by Ottawa-based clinicians travelling to Petawawa at frequent intervals, and a tele-mental health connection is being installed that should become operational this spring. This coming summer we will post three additional CF social workers and a CF psychiatrist to Petawawa.

[*Translation*]

Thanks to the fact that Colonel Allan Darch—who is with us today—was appointed to be the Director of Mental Health of the Canadian armed forces, there will be a better coordination of efforts among all our mental health care providers. Since Colonel Darch's work will be entirely committed to mental health care, these services will be directed more attentively and there will be an improvement in the communication among the stakeholders. Lieutenant-Colonel Grenier, who is also at the table with us, is the Special Advisor regarding Operational Stress Injuries and he regularly and directly advises the Chief of Military Personnel about the non-clinical aspects of the care provided to members of our personnel who suffer from mental health disorders. Lieutenant-Colonel Grenier is focusing his efforts on education with the help of the DND Speakers Bureau, which reached out to 8,000 members of the Canadian Forces in 2008, and is intending to serve more than 12,000 this year. His upcoming project will deal with the social determinants of mental health. Together, Colonel Darch and Lieutenant-Colonel Grenier are actively trying to establish connections with their counterparts in the United States, especially with the Chief of the Centre of Excellence on Mental Health of the United States Defence Secretariat.

● (1645)

[*English*]

We have re-oriented the OSISS advisory committee and broadened its mandate. It has become the DND/VAC/RCMP mental health advisory committee, and it had its inaugural meeting last week. The chairman of that committee, Colonel (Retired) Don Ethell, is also here today. You can see that there are open channels of communication and means for various points of view to be brought forward. As an aside, I know that Colonel Ethell has a direct line to the chief of military personnel, and they have a long history of working together.

To better reflect the range of people affected by tragedies, the CF members assistance plan, which is the confidential 1-800 service that provides access to up to eight counseling sessions, has been extended to parents and siblings of those killed or injured while in service. Of note, there has been no detectable growth in demand for this service over the past decade. Regular force members are the most frequent users, followed closely by family members. The most common reason for accessing this service remains marital problems, followed by psychological concerns.

All in all, I believe the CF now enjoys an excellent capability linked to overlapping proactive approaches to detecting members in need, but I'm willing to guess that what I've described to you today may not be in line with testimony you have heard from others. The natural conclusion might be that someone has been less than forthcoming. I do not believe this is the case, and in the last part of my remarks I'll try to explain why this apparent gap can exist, when everybody is speaking the truth as they know it and when everybody has the best of intentions.

The first point I will make, and I think I've made it before, is that no matter how much we care about the well-being of our patients or how well we are organized, staffed, and equipped to care for them, the unfortunate fact is that not all of them will get better. This is not the system's fault, it's not the provider's fault, and it's certainly not the patient's fault; it's because these are tough disorders to treat. The state of medical science at the moment just doesn't allow for mental health treatments that are perfect.

When someone being treated for coronary artery disease goes on to have a heart attack, the assumption is not made that their care was inadequate or their cardiologist negligent. Some people just have more serious cases than others. Mental health care and mental illness should be viewed in much the same way.

I suspect that you have spoken to patients or to families of patients who are in the unfortunate position of continuing to struggle. Remember that our own data shows about 12% of patients at one clinic did not feel they were making any progress. I don't mean to belittle their difficulties, but concluding that there's a systemic problem on the basis of extrapolating from a few anecdotes, no matter how compelling, is erroneous, and in fact may put at risk that which you seek to improve.

There is a phenomenon known as the “availability heuristic”, which produces a powerful cognitive bias. Basically, it states that our perception of the extent of a problem is strongly influenced by how readily an example can be brought to mind. If everyone knows of one or two examples of people who feel their care did not meet their expectations, that fact leads us to conclude there's a systemic problem.

Given the widespread media reporting about some cases, it's evident that interested observers can all think of at least one patient whose situation has not yet improved. Objective data, however, may reveal a very different picture. Individual problems should be addressed on a case-by-case basis while care is taken to preserve the system as a whole. Systemic problems obviously demand systemic solutions.

I'm spending quite a bit of time on this point because I firmly believe the CF is served by an excellent system of mental health care. But it requires two things in order to, most importantly, continue to function, and secondly, to make the local or incremental changes that may be warranted: we need to retain the trust and confidence of the members of the CF so that they will readily come forward to seek our care, and we need to retain the commitment of our health care professionals. Continuing to portray the glass as mostly empty when in reality it's over 90% full places both of these critical things at risk.

I ask that the members of the committee weigh all of the objective data presented before reaching any conclusions.

Thank you for your attention. I now look forward to addressing your questions.

● (1650)

The Chair: Thank you very much.

We'll start an opening round of seven minutes with Mr. Coderre.

[*Translation*]

Hon. Denis Coderre: Thank you very much.

General, colonel, thank you for coming.

It is important that the 10% be taken care of and that this does not turn into a chronicle gap.

[*English*]

We were talking to the ombudsman in the interim before this, as you noticed, and they were talking a lot about issues falling into the cracks. We're not dealing with statistics, of course; we're dealing with human beings, and that's important to note.

There are several issues I'd like to talk about. I know we don't want to go into personal issues, but the first one is an incident that happened in Valcartier a few weeks ago. The thing we have to realize is that because there was an important rotation that started on February 20, up to March, there was one case, and then another case, and then a third case in a row. Once is an incident. Twice, it might be a coincidence. But as for three times, I don't want to say it's a trend, but it's a bit scary.

You spoke not only about the patient, but also about the sake of the family, and rightfully so. We have to take a look at that. How do you explain that? Is it from the stress? Is it because we might have forgotten some of the prevention tools? We can never know when it will blow up, of course. We already spoke about that the first time you came here. I think it may be important for the benefit of our colleagues here to address that question specifically regarding rotation and the impact on our troops.

BGen Hilary Jaeger: I'll start off and then perhaps people who have more specific information can jump in.

I admit that I am only aware of these cases through the media reporting, and I take everything I see in the media with a relatively large grain of salt. I'm pretty certain there were these police incidents and members were barricaded inside their homes, but I don't know anything specific about what was going on in their lives at the time, other than that they were on the list for rotation. There's a whole lot of unknown information in the background.

Hon. Denis Coderre: With your answer, are you just proving that it's falling into the cracks?

BGen Hilary Jaeger: I don't think so, because the reason we're organized the way we are is that there are local resources in place. Obviously, it's terrible that this happened, and everybody would rather prevent it, but it's not always possible, so you have to react to the situation when it occurs.

The first line of reacting to this kind of thing would be the police, but at the conclusion, after being taken into custody by the police, the next step would be to have a mental health assessment. Depending on the results of that, you would go from there.

A mental health expert would tell you that this constitutes a crisis. It's an easy word to say, but there's a threshold you have to reach in order to be in one. But that would be treated as an in-patient—

Hon. Denis Coderre: You and I agree that it's a serious matter.

BGen Hilary Jaeger: It's a serious matter.

Hon. Denis Coderre: So what's the chain of command? They were soldiers. It was a serious issue. Of course, I saw it on the media, too, but some of the entourage spoke about it, too, so it was serious.

Just for the benefit of our understanding, what are the steps? Is it under the Valcartier unit? How do you manage that? Since you were aware, you know what's happened since then, I guess.

BGen Hilary Jaeger: They would be assessed at a civilian facility, one that had a mental health in-patient capability. Depending on how disorganized they were or what their state was, you may need one of the locked facilities, and there are not many of those. The attending civilian psychiatrist would institute immediate treatment. At the point where they had settled down somewhat, then care would be transferred to the mental health clinic in Valcartier.

Now, as to the chain of command's role, they of course are keeping track of what's happening, and they are thinking about what adjustments they have to make to the immediate pre-deployment training plans. It's not a tough decision to say this person shouldn't go on the rotation. That's the easy part. And then what?

● (1655)

[*Translation*]

Hon. Denis Coderre: The problem as I see it in general, is that we are about to perform a rotation, if it has not already begun. Right from the start, you say that an event can bring about a certain amount of stress. They are leaving for Afghanistan for a second or a third turn, and just at that time, they could reach a breaking point.

I do not want to discuss these people specifically, but I want to understand what is going on. If there are problems with the follow-up of a file, if the left hand does not know what the right hand is doing... We must have adequate communication in order to improve the system and to help the people. We are dealing with individuals.

Colonel Grenier, have any preventive measures been taken? The cases that occur may be due to the fact that the measures are inadequate. What do you do when you face this kind of situation?

Lieutenant-Colonel S. Grenier (Special Advisor, Operational Stress Injuries, Post-Traumatic Stress Disorder, Department of National Defence): These situations are not isolated cases. In fact, in 2000-2001, we launched a social support program among peers. More communication was established since Colonel Darch and Lieutenant-Colonel Jetly, a psychiatrist, arrived. At my level, we now have very close communication between the non-clinical support program and the clinical mental health care programs. I would be lying if I told you that over the past 10 years there has been total harmony between our perception of the experiences we lived through as soldiers and peers and, on the other hand, the solutions proposed by the clinical workers.

Nevertheless, I think that the events, especially the fact that the right people were appointed to the right place at the right time, have led to closer communication. Personally, I am envisaging closer coordination between the non-clinical interventions for which I am responsible and the clinical interventions. This might offer a systemic solution.

Regarding the patients, we have been saying for many years that soldiers have private lives between their assignments. We do not want the doctors to infringe on the private lives of their patients. Besides, we favour an approach that takes the individual's life more into account. Benchmarks and supportive measures have been implemented to make sure that once a patient has left the clinic, he continues to follow the treatments and therapies properly.

[*English*]

The treatment compliance, I think, is a huge issue.

[*Translation*]

I do not mean to say that this closer communication is the solution. As you know, during these past years, I saw that as a glass that is half empty. Today, I see this more like a glass that is half full, not only by reason of the improved functioning of my therapy, but also due to this closer communication. We no longer seem to belong to adversarial camps, and I am proud of it. Finally, our coordinators on the ground can rely on somewhat more solid support. That will repair a big hole in this net that is, after all, rather broad. I am not saying that that is the solution, but from my point of view, it is a positive factor.

[*English*]

The Chair: Thank you. That's very good.

We'll go to Mr. Bachand.

[*Translation*]

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

I want to welcome the General and his aids.

On February 5, 2002, the ombudsman published a report entitled *Systemic Treatment of CF Members with PTSD*. Several months later, in December 2002, the Department of National Defence responded to each of the 31 recommendations. I have the document with me. This is a profile of the response to the recommendations. Amendments were suggested for only 3 of the 31 recommendations. As for the 28 remaining ones they received support, even full or entire support.

How do you explain the fact that seven years later, only 13 of the recommendations have been implemented? Moreover, 7 have been partially implemented and 11 have not been implemented at all.

It is important for me to say this right after your presentation. I do not think that this is a superficial problem. Instead, I think that it is a fundamental problem. I want to know what it can be attributed to. For example, could this be conceivably a cultural problem, with a predominating stereotype of the resilient man? I tried very hard to find a dictionary here. It says that resilience was at the outset a term that referred to the resistance of material to shock. It was first published in the field of psychology in 1939-1945, and Boris Cyrulnik developed the concept of psychological resilience based on his observations of concentration camp survivors. Thus, resilience could be the result of many processes that disrupt the negative trends.

At the Canadian Defence staff, they are so intent on developing resilience that they end up denying the real problem, which is present everywhere. Many witnesses have confirmed to us that these are not nearly small exceptions. What we heard is the contrary to what you are saying. It is false to say that 98% of the witnesses said that they had received adequate treatment. It was more like the contrary. Perhaps you were taking a preventive measure when you yourself said that this could sometimes seem to contradict what we have heard.

At the Canadian Defence staff there is so much emphasis on the resilience of the armed forces that there is an attempt to minimize the fundamental process and the reality of post-traumatic stress disorder. Do you agree with me?

● (1700)

BGen Hilary Jaeger: Sir, let me answer you in English, because it is important that I choose my words carefully.

[*English*]

I do not agree that the senior staff of the Canadian Forces, the leadership of the Canadian Forces, are focused on resilience or on the concept you're describing, for the reasons you attributed. The leadership of the Canadian Forces is very interested in having a Canadian Forces that's fundamentally ready to undertake operations in every sense of that word, and that means they have to be confident in what they're doing. They have to have a certain esprit de corps. They have to have confidence in their training, in their leadership, and yes, that could be construed as perhaps leading them into a bit of a sense of denial about what they might be facing. But I don't believe it goes that far, and it's certainly not because they want to deny the extent of problems when they occur.

You mention resilience. It's a wonderful concept. We would all like to prevent post-traumatic stress disorder. Unfortunately, if you read the scientific literature carefully, there is not even an accepted definition of resilience, much less anything you could measure in order to conduct a scientific study to say which interventions might promote resilience and which might not. As far as we know right now, the best we can do is to encourage tough realistic training with the same group of people they're going over with, to build confidence in the team.

I'm a bit sensitive to your point about not necessarily believing the rosy picture I've painted for you about the state of care in our clinics. You might be interested to know that Accreditation Canada, which is the national body that looks at the quality of care in hospitals and clinics across Canada, visited the Ottawa clinic over the past two and a half days. I was present at their debriefing this afternoon at which they praised the mental health clinic for outstanding work—one of the best mental health clinics they had ever visited.

[*Translation*]

Mr. Claude Bachand: I'll continue by—

[*English*]

BGen Hilary Jaeger: Everybody is searching for perfection, and part of my sad duty is to tell you that this is 2009 and perfection in the realm of detection, prevention, and treatment of mental illness is just not possible.

[*Translation*]

Mr. Claude Bachand: However, you should not use that as an excuse to distort the facts. We still have a major problem. Many people are telling us that they have to live with post-traumatic stress disorder.

It is important to look closely at the department's true intention. Let me give you another example. In 2002, you said that it was extremely important to have an information system and a data base for health. How come, seven years later, we still do not have that data base? Nonetheless, in 2002, the department said that it was entirely in support of this recommendation. Are there not some attempts, not to cover-up but to minimize what is happening to the Canadian armed forces? We, as members of Parliament and as legislators, have a right to investigate the department's true intentions.

I do not want to cast judgment on your intentions. However, I cannot help but note that there is no data bank in 2009 although seven years have gone by and even though the department said that it wanted one in 2002.

Now I will let you answer.

[*English*]

BGen Hilary Jaeger: Shall I respond, Mr. Chair?

● (1705)

The Chair: A short response, if you can.

BGen Hilary Jaeger: I would ask Mr. Bachand if he's ever been involved with the management or implementation of a large information technology project. The Canadian Forces health information system is now in phase three of its three-phase roll-out. The project concludes about a year and a month from now, and at that point we will have gone.... It's like building a sewer system and then we're going to turn the taps on in the next year. So we've spent all this time digging and laying the sewer pipes, and the amount of useful information is just going to explode, but we have about another year to the finish line.

The Chair: Thank you very much.

Ms. Black.

Ms. Dawn Black: I'll continue along these lines, because we had the past interim ombudsman here before you, and she, again, has given another report. It was given to the minister in September 2008 and was released publicly in December. The military ombudsman is calling again for the creation of a database to track the number of personnel who are affected by stress-related injuries. It was recommended in 2002 but was never implemented.

I have here a quote from a story by Helen Branswell of The Canadian Press. She quotes a senior official with public affairs at the Department of National Defence, Major André Berdais, who responded to her about that kind of data. It relates to a study that was done in the U.S. Berdais said that this kind of data is not tracked by the Department of National Defence and that it “isn't essential in supporting our primary responsibility of patient care”.

That would indicate a reluctance, in my view, contrary to some of what we've heard today, to implement this recommendation that's been waiting now for seven years to be implemented. I want to ask if what this gentleman articulated is still the position of the Department of National Defence. And how can that be justified when the ombudsman has clearly stated that this kind of tracking is absolutely essential to effectively deal with post-traumatic stress disorder and operational stress injury?

BGen Hilary Jaeger: I'll answer along two lines, Madam.

First of all, André Berdais is my public affairs officer. He works for me, and the words he releases have all been cleared by me.

It has been my leadership decision not to set out and create—stealing staff effort that I need in other places—a mini database separate from the health information systems project. The rationale behind that is that I need every smart person I can get my hands on to keep that major project moving forward. It's had its challenges with timelines and.... I'm not sufficiently geeky that I can go in and get that thing to work by myself. But we've flogged that horse about as hard as we can. So a decision was made to not divert any effort that we really need to get that big piece done.

The other side is that we don't track patients with the national database. The patients are tracked, monitored, and followed at the clinic level. Yes, I'd love to have great data so I could say on any given day of the week how many patients have depression and who was seen in the last week for depression. I'd love to have that. But as to the difference it would make to the care of the individual patient, I don't believe it would make a significant difference.

● (1710)

Ms. Dawn Black: So you stand by your public affairs officer's statement.

BGen Hilary Jaeger: I do.

Ms. Dawn Black: In your remarks to us earlier, you said that you're actively cultivating contact with U.S. counterparts on these issues. There was a report from the Institute of Medicine, a body in the U.S., commissioned by the U.S. Department of Veterans Affairs. It came out, I think, a few months ago, in mid-December of last year. It said that traumatic brain injuries have become the signature wound of the wars in Afghanistan and Iraq and that troops who sustain them face a daunting array of potential medical consequences later on.

This body, the Institute of Medicine, said that military personnel who sustained even moderate brain injuries may go on to develop Alzheimer's, dementia, symptoms similar to Parkinson's, a higher risk of seizure disorders, and psychosis. It said that people with even mild brain injuries are more likely to develop post-traumatic stress disorder.

In the 2002 study there was a mental health survey done, which was a follow-up. The ombudsman reports now that the information is very dated. Again, that information is seven years old. It was before we were in a combat situation in Afghanistan.

Will the department be conducting our own new study? The numbers you reported earlier were reflections of volunteer participation and were not from a medical, scientific study. So will there be a new study, as the ombudsman recommends, of the mental health situation of the Canadian Forces in light of what has now, I guess, been eight years of combat in Afghanistan?

BGen Hilary Jaeger: There are a lot of implicit questions in there. The short answer to the last part is, yes, in fact we're in the middle of collecting data on the health and lifestyle information survey at the moment. I have copies of this survey in English and French, which I can leave with the clerk.

It's a long period to collect data, but I believe 50 of those questions are related to mental health and they really focus on PTSD and depression because of the two most significant problems we found in the 2002 survey. That survey is going to be repeated at two-year intervals. It also includes questions pertaining to experiences while on operations and related traumatic brain injury.

On the subject of traumatic brain injury, first of all, if you've had a moderate traumatic brain injury or a severe traumatic brain injury, believe me, you know it because you are going to be hospitalized for that. These people are knocked out. They have significant neurological deficits from the outset of that injury, so they're not hard to find. Yes, recovering from brain injury is a very.... You only have to think of Captain Greene. That is a severe traumatic brain injury.

Ms. Dawn Black: You are talking here about mild—

BGen Hilary Jaeger: We're talking about mild. We had a national-level conference on the issue in April last year. Since then we have put decision support tools into Afghanistan, algorithms that help our people in the front line determine whether there is cause for concern.

You are right. I call it an association between traumatic brain injury and PTSD, and it's not hard to understand why that would be, because to have a mild traumatic brain injury, you've probably been pretty close to an explosion. That's the kind of significant stress that can also trigger PTSD, so it's really not surprising there is a close—

Ms. Dawn Black: Have you read the study?

BGen Hilary Jaeger: I have, yes.

The Chair: I'm sorry, we'll have to get back to that.

Over to the government, Mrs. Gallant.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Mr. Chairman, I'll be sharing my time with Mr. Hawn.

First, I'd like to commend Colonel Ethell for his work with OSIs and now his expanded duties with the full range of mental health issues for our soldiers.

I congratulate Colonel Grenier. For many years you were the lone voice in the wilderness when it came to PTSD, and through your tenacity in pursuit of helping your fellow soldier you have brought the issue right to the House of Commons Standing Committee on Defence.

On April 15 of last year the veterans affairs committee travelled to Base Petawawa, and among the different forums we had some soldiers who had suffered PTSD. They related their experiences to us in a private forum. One soldier had been injured over a year ago. He had been travelling in a troop carrier, and other people died. He lived. He had been asking for psychological/psychiatric help for over a year, and it wasn't until that day, when the veterans affairs committee just happened to be coming, that he got his first appointment with a specialist. It was too late for him because he'd already applied for medical release.

Last week we had General Semianiw who said:

> A decision was made, not in the last four years but before that, not to put an operational stress injury clinic in Petawawa. In hindsight, it was probably a bad decision. What we see here today is that having an OSI clinic in Petawawa would have been the right thing to do. It was not done, but we're dealing with that issue to ensure the men and women in uniform get the support they need in Petawawa.

The military ombudsman just related to us today that over 8,500 soldiers have deployed out of Base Petawawa to Afghanistan. How can you assure this committee, and, more importantly, the mothers, the fathers, the spouses, the children of our soldiers who are starting to return right now, that they will obtain the proper medical care they need, be that physical or psychological care?

● (1715)

BGen Hilary Jaeger: At some risk, I will disagree with General Semianiw. When you decide where you're going to put your major treatment centres for operational stress injuries, yes, proximity to the population at risk is very important, but you also have to be realistic about where the resources can be found.

Petawawa, I know, is two hours up the road from Ottawa, but we have been trying, unfortunately, for the last three or four years to hire people into that position. The reason we're posting military social workers and a military psychiatrist there this summer is that we cannot attract civilian providers to Petawawa. It's a beautiful place in the upper Ottawa Valley, but we have been unable to attract them there.

If we had decided back in 1999 to open the OTSSC in Petawawa, it would have half the staff it has now in Ottawa. The ideal would be to have all the providers you want where you want them, but it's better to have them close by than not to have them engaged in your organization at all. Of course, 8,500 people have rotated out of Petawawa, but the total base population is somewhat less than that. That accounts for the fact that people get posted and people get rotated.

We are continuing our efforts to build the clinic in Petawawa. When we achieve what we're going to get to this summer, they will have a full general mental health program. Of course, they have a full psycho-social program. The only thing they will be missing is the OTSSC label, but they will have all the components of an OTSSC.

I'll turn it over to the director if he wants to correct me on this, but I don't see any reason we could not institute the assessment protocols right in Petawawa.

Colonel A. Darch (Director, Mental Health, Department of National Defence): I agree.

With Petawawa, one of the problems, as General Jaeger said, is getting enough mental health care professionals there. Part of the problem is the number of mental health care professionals we depend on who are civilians. With Petawawa, we're dealing with the fact that there is a general shortage of mental health care professionals across Canada. There is a lot of competition for those mental health care professionals. Petawawa is a semi-isolated location, and the amount of money we can pay under Treasury Board guidelines is not competitive with what some civilian organizations can pay. We're just having a lot of difficulty getting civilian mental health care professionals to work there.

To improve that, our Ottawa OTSSC is operating satellite clinics in Petawawa, and the health care professionals go there. One of our senior Canadian Forces psychiatrists is spending a minimum of one day a week in Petawawa. We have a tele-medicine pilot project that will link Ottawa with Petawawa. Through high-definition medical cameras, soldiers will be able to have tele-medicine consults with mental health care professionals in Ottawa. While we wouldn't recommend that for initial assessments, it would be useful for ongoing care.

We posted a major social work officer to Petawawa this last summer who is taking the lead as a mental health care professional there and leading the clinic, and that has made a big difference by itself. This summer we'll post in three more social workers and a military psychiatrist, which will augment their capability significantly. Along with that, we've not been able to fill all the civilian positions, so we're going to transfer five of those to Ottawa: one psychiatrist, two psychologists, and two social worker positions that are not filled. We'll be able to fill them in Ottawa. Those people will then be used to run the tele-medicine capability that will link Ottawa and Petawawa. They will also do satellite clinics in Petawawa.

In addition to this, I have a lieutenant-colonel within the new mental health care directorate who is capable of spending up to two days a week in Petawawa as a psychiatrist.

As well, we still have the capability for patients to come to Ottawa to get help. It's not that far down the road. So where that works out for them, we can manage that.

● (1720)

The Chair: We're right on schedule.

We'll go to Mr. Wilfert, and then back to the government.

Hon. Bryon Wilfert: Thank you, Mr. Chairman.

In the December ombudsman report, “Battling Operational Stress Injuries”, of course she looks at what has and has not been attained by the department at this point.

Trying to prioritize 31 recommendations is a very daunting task, and no one expects that all 31 can be done instantly. Given our continued presence in Afghanistan and the fact that we are seeing more of these cases coming home, as a framework this would indicate that clearly we need to be better prepared in terms of dealing with the personnel who are coming home. In her report she clearly says there is a need...“so that they can continue to be contributing members of Canadian society”, within the forces or outside, that it is absolutely paramount, and that we still have very much what is considered an ad hoc system.

I want to go back, just for more clarification, to the data system, and then I want to go to recommendation 9. On the data system, maybe I didn't hear it correctly. To me that is the most important thing in terms of being able to understand what you have to deal with presently in terms of the information, in terms of the personnel affected by these injuries. Can you tell us when you see this completed? To me this would be one of the most paramount things given the fact that we're seeing increased casualties and certainly response from people coming home from Afghanistan in particular.

BGen Hilary Jaeger: In regard to the CFHIS project, sir, its authority to spend money expires in—I'm not sure which—April or May 2010. So we're about a year away from the end of the project. I think it will probably take us about six months after that to get really good at manipulating all of the ways to pull data from the system. That's as close to an accurate timeline as I can give you.

We have alternate sources of data. A lot of our understanding of workload...we do receive, as I've briefed, counts of new patients coming in from the clinics. We do the enhanced post-deployment screen, which is not a diagnostic tool, it's a screening method. But screening methods by their nature are supposed to produce more false positives than false negatives. They're supposed to err on the side of saying there's a problem rather than denying there's a problem. So we do have some measure of the size of the problem. What we can't do is go across the system on any given day and say how many patients were seen this week for PTSD.

Hon. Bryon Wilfert: In terms of these surveys that you initially talked about, what about six months or a year from now when these people may in fact be experiencing latent symptoms, or in fact circumstances develop because they're either still in the forces or now they're in civilian life and we see the kinds of problems that may have happened, some domestic issues, and that type of thing?

BGen Hilary Jaeger: We actually did give some thought to that because we know there are people who will present with problems after the six-month screening has been done. We did give some thought to whether there was a need to systematically go back across and re-screen. It is an enormous effort to do that screening. I would never say that the effort would not be worthwhile because that's a harsh kind of thing to say.

But I want to give you some encouraging information. I had occasion to review all of the files from the *Chicoutimi* fire, for all of the sailors who were on board *Chicoutimi*. Over time, since that fire, a little over 50% of them have in fact been diagnosed with PTSD. They underwent the enhanced post-deployment screening, and probably only about half that number screened positive at the time. I think the effect of that mandatory screening made approaching people for mental health care a whole lot less scary, so that maybe six months after they were screened, when they realized that things weren't going very well and they were having flashbacks or nightmares, it was not threatening to walk into the clinic or to pick up a phone. I think that's a very powerful effect of the enhanced post-deployment screening, and I'm hoping that applies to the problems the army finds.

● (1725)

Colonel (Retired) D. Ethell (Chair, Mental Health Advisory Committee, Veterans Affairs Canada and Department of National Defence, Department of National Defence): Sir, I've been around the forces a long time—and I don't work for DND or VAC; I'm a volunteer. I now chair the Mental Health Advisory Committee. In the past I had two legs; now I have to grow a third one, because the RCMP last week came on board.

The mental health OSI—let's just stay with OSI for the time being—has come light years from where we were 10 years ago when Grenier appeared before the Canadian Forces Advisory Council and explained what OSI and OSSIS were. And that was built into the Neary report , which led to the new Veterans Charter, which the Canadian Forces are reaping the benefits from.

The point I'm making, which you brought out and which General Jaeger brought out, is that it doesn't happen right away.

I'm not a clinician. I looked in the mirror five years after I got out and said, like many of them, “I have a problem”. I had seen some very horrendous things. The kids coming out of Afghanistan or coming back from Zaire, or wherever, six months or a year from now may look in the mirror or may talk to one of the OSSIS people and say, “Who can I talk to?” Then they'll be going to the professionals: the clinicians, the psychiatrists, the psychologists, and so forth.

There are not only the OTSSCs, but there are the OSI clinics from Veterans Affairs. It's a dual process. In fact, it's a crossover between the two, and that's being organized between the two departments, thank God, where a soldier can walk into either clinic, and the same with a veteran. There are veterans coming out of the woodwork, going back to Korea, who have said, “ I have a problem”. The reason for that is the publicity for PTSD and OSI.

I'm not saying this because these three people are in uniform, but the mental health thinking—the facilities and so forth that you've heard about today—has come a tremendously long way from where it was 8 or 10 years ago. There's not only a cultural change, but certainly a physical change to the benefit of the troops and their families, and I haven't heard that mentioned yet—the families—because that's also in the mandate of either DND or VAC, but it's certainly being considered.

The Chair: Thank you, sir.

We now go over to the government side, and it looks like it will be the wrap-up here.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair, and thank you all for being here.

I'll perhaps start by saying that I can't let Mr. Bachand throw out false numbers. The report the ombudsman came out with had 31 recommendations, 20 of which were fully or partially implemented and 11 of which were not implemented—that's the number. You can judge that. We've talked about glasses being half full and half empty. You can say that's half full or half empty, your choice.

You talked about the two intentions of DND. General Jaeger, is it the intention of DND, ideally, to fill that glass?

BGen Hilary Jaeger: It's always the intention of DND to meet the needs of all of our patients.

Mr. Laurie Hawn: Realistically, will we ever get a glass like that full?

BGen Hilary Jaeger: When my magic wand comes back from the third line.

Mr. Laurie Hawn: There you go. Will it be natural for media and those who are part of that glass that's not full, however legitimate their cases are—and they are legitimate—and for other people in government or the media to focus on whatever that number is? If it's the top 10%, 5%, will it be natural for them to focus on that and build cases, publicity, or whatever you want out of that?

BGen Hilary Jaeger: They are very compelling stories. It's natural to pay attention to them. In fact, actually we're quite glad when people bring people back to our attention, because then we can try again.

Mr. Laurie Hawn: So we will always focus on the part, naturally, that is not quite full.

Master Corporal Paul Franklin was one of the people who came before the committee, and I think everybody knows his story. He has a lot of experience, not just in the CF system, but he has a lot of exposure to other countries' systems of dealing with disabled, injured soldiers—severely disabled in his case. One of the things he said was that clearly more needs to be done. There will always be more that needs to be done. But one of the things he said was that, given that, the CF in Canada treats their injured soldiers far better than any other country that he had visited. Would you agree with that?

● (1730)

BGen Hilary Jaeger: Well, I'm very glad to hear that. I actually haven't gone down and compared benefits for benefits and care for care. We were very lucky to bring on board an experienced and senior physiatrist to head our rehabilitation program. His name is Lieutenant-Colonel Markus Besemann.

He has worked very hard to make links with all of the civilian rehabilitation programs and to talk to them about what the needs of our returning soldiers are like, to find out what they are good at and what they might need support at to get better. He's in the process of putting specialized teams at seven locations across the country. We're very happy with the work that he's doing. This fellow has a really good systems way of thinking and we're lucky to have him.

Mr. Laurie Hawn: As a professional medical person, you deal in medical things. As a professional military person, you deal in military things. The combination of those is unlike things that most organizations have to deal with.

In your professional judgment as a medical and military professional, what is our biggest obstacle to doing better, to filling the glass?

BGen Hilary Jaeger: Does the air force understand the concept of a centre of gravity, Mr. Hawn?

Mr. Laurie Hawn: Absolutely.

An hon. member: We all understand it.

BGen Hilary Jaeger: Oh, good. We've been in this committee a long time.

Mr. Laurie Hawn: Mine's getting lower.

BGen Hilary Jaeger: My centre of gravity is having the right mix of people with the right skills and experience in the right place at the right time. I'm talking about health human resources.

That's my biggest challenge. I have smart and really committed people. If I could just make sure I have enough of them in the right places.... They love the work they do because ethically it feels right to these folks. They love working in our system. We just need a few more in certain places.

Mr. Laurie Hawn: Colonel Ethell, from the professional soldier's point of view, how would you answer that?

Col D. Ethell: I would answer that by saying that the newly formed Mental Health Advisory Committee, on behalf of three departments, is looking afield—outside of those departments. They're looking at academic research and practitioners. We've brought aboard external experts, PhDs, from the University of Toronto, Simon Fraser University—Dean Cheryl Regher, Bill Wilkerson, Dr. Kates and so forth—to solicit their thoughts and recommendations as to how we can move forward with regard to not just OSI but mental health, the whole thing. It's significant experience and knowledge in the field of mental health and social support, strong national networks across the country, access to universities. OSI is not the purview of the military alone. There are all sorts of societies out there. Probably half of you in this room have had a touch of PTSD—a car crash or something, or riding in the back of a C-130 or a fighter.

It goes on and on. That's the challenge that has been given to us by the champions of mental health in the departments: General Semianiw; ADM Brian Ferguson, from VAC; and Deputy Commissioner Peter Martin from the RCMP. That's where we're going to go.

Mr. Laurie Hawn: Thank you.

The Chair: Thanks very much, and I want to thank all of you for being here today and answering the questions.

Colonel Ethell, it's always a pleasure to have our most decorated peacekeeper in front of us. Keep up your good work.

And to the rest of you, thank you very much.

The meeting is adjourned

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