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Chair

Mr. Gary Schellenberger

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● (1530)

[*English*]

The Chair (Mr. Gary Schellenberger (Perth—Wellington, CPC)): I call the meeting to order.

Welcome everyone, to the 30th meeting of the Standing Committee on Veterans Affairs. Pursuant to Standing Order 108 (2), we are conducting a study of combat stress and its consequences on the mental health of veterans and their families.

For the first hour, our witnesses are William Maguire, as an individual, as well as Dr. John Whelan and Steven Cann.

We have only an hour. If you can keep your opening remarks relatively short—within 10 minutes would be nice—then our questions will be five-minute questions and answers, and we'll see how many questions we can get in.

Again, welcome.

Mr. William Maguire, would you like to go first, please.

Mr. William Maguire (As an Individual): I was up here in March. I recognize some faces and see some new faces. As I think I stated in March, you're going to hear it in a soldier's language. I don't beat around the bush. I shoot from the gut. I have nothing to prove to anybody.

Ladies and gentlemen, you are looking at an individual who has suffered with the dreaded affliction known as PTSD, post-traumatic stress disorder. I have been suffering with this mental disorder for the past 36 years of my life of 62 years. For the past four years, I have been under the care of medical professionals after being diagnosed with the disease in April 2006.

PTSD is a dreaded disease that one can be suffering with while looking completely normal to anyone who does not know what the veteran is fighting with on a daily basis. In other words, we all look normal. You walk in and see me and think, "There's nothing wrong with that guy. He's normal." Well, I'm not normal, not mentally anyways.

One of the biggest factors that we constantly endure is the knowledge that once a veteran is diagnosed and the word gets out, then we are looked at as an enigma and are treated with distrust, not to be put into an area of responsibility. Basically we are treated like one with leprosy.

To try to cope and hide the fact that there was something wrong with me, I put on a phony act and tried my hardest to socialize, but in the end it all came crashing down, which damn near destroyed me. Many veterans cannot handle this daily battle with oneself and completely withdraw into a world of depression and what we refer to as "bunkering in". That is, a veteran goes into his basement or his little room, and he stays there and will not come out. He becomes completely reclusive, not wanting to socialize or be bothered by anyone. There is a complete social breakdown.

As for me, I have been suffering from massive headaches, nightmares on a regular basis, bouts of anger to the point that I have scared individuals, frustration in not knowing what was going on with me, anxiety over having to carry out the simplest tasks, and an unwillingness to fully trust anyone close to me—i.e., at work or at home. I was always on guard, keeping my shield up at all times, constantly vigilant as to what was going on around me. I had social misbehaviour and run-ins with authority. These things are common in men suffering from PTSD. I use the word men because I have never worked with women with PTSD.

These conditions manifested themselves directly when I returned from Cyprus in December 1974, after a United Nations tour with the Canadian Airborne Regiment. After my first marriage broke up in 1982—I had been married for 10 years—my parting wife stated to me that she still loved me but did not know me anymore. Another statement she made was, "You are not the same man I married since coming home from Cyprus in 1974, and at times you actually scare me, as I do not know what to expect from you." This is another one of the things that we have to face—the family support system, and loss of that system.

After returning from Somalia in 1993, I remarried, hoping beyond hope that I could find normalcy with the woman who I now love. This too fell to the wayside, leaving me in a daily battle with my conditions, which I call the roller-coaster ride of emotions: up one minute and down the next.

Presently, I am still suffering through many of these conditions, even though I am seeing a psychologist on a regular basis. Because of the constant struggle to find meaning in life while suffering from the black dog of depression—that is what I call it—my physical being has taken a beating faster than what I or the medical professionals predicted.

● (1535)

I may be wrong in making this assessment, but I blame the never-ending cycle of emotional ups and downs caused by PTSD for my failing health. To try to find some meaning in all of this, and to make a commitment to myself—in others words, for a get-out-of-the-house project—I volunteered to join the OSISS, occupational stress injury support service, as a peer helper. It is this experience with OSISS, of which I am no longer a member, plus taking on a workload of veterans on my own that I now draw upon.

I did my best, giving 100%-plus to help my fellow veterans until I went through what we call the burnout phase, something all peer helpers like me will go through, because you get too involved with the man that you're working with and you get burned out.

It was during these episodes of burnout that I suffered severe depression and a deep bunkering in period. As you can imagine, this took its toll not only on me but also on my relationship with my loving wife, which was already at the breaking point. It was during these black dog times that I completely cut myself off from the outside world, missing important medical appointments and basically cutting back on my duties to help my fellow veterans.

This part really upset me, as I consider it my duty to keep in contact with them. That's the old thing about soldiering. You help your buddies, and in return they help you. When you can't do that anymore, then it falls on your shoulders: you've let them down. We've all gone through it.

These episodes would last for weeks to months at a time. While I have suffered through these horrible times in my life, my loving wife has constantly stood by my side, even though I would spend days in my bunker, not washing, shaving, or changing my clothes, and only going upstairs to eat every now and again. She has endured quite a lot over my illness through the years, and has even threatened to leave me on a few occasions. I would not blame her in the least if she did, as I think she would be better off without me.

As time passed and my condition worsened, she kept cutting back on her hours at work so she could be with me more and more as she was concerned that I was going to kill myself. When she could not cope anymore at work, she decided to quit her job to be with me at all times. Even though this was a great boon to me, it cost us dearly financially, but we manage. This is more stress put upon us. Besides all this, I have not been able to sexually satisfy her for over 10 years. You can imagine what stress this has put on our relationship.

I see my life as one of constant pain and suffering. My life as I knew it is in ruins, and at times I feel that there is no sense in carrying on under these relentless circumstances. I have to admit and I say without malice that PTSD has taken a great toll on me and on hundreds of other veterans.

This is what I have experienced over the past four years.

First, PTSD will ruin the veteran's family and social life until they turn to addictions such as alcohol and prescribed or illicit drugs, gambling to the point where they are no longer in control of their finances, or dangerous sexual overactivity that may turn to prostitution. Or they might become workaholics. By carrying out these manifestations, they ruin any chance of getting self-respect or battling the effects of PTSD.

Also, I must state that when someone is suffering from one or more of these addictions, it makes the diagnosis of PTSD more difficult, as the person must first be treated for these addictions. This period of assessment is very stressful to the member, as it will more than likely ruin his marriage, if he is married, or any relationship that he is in. With the loss of family support, which is critical for the veteran's recovery process, he will more than likely end up as a recluse or come to the point of attempting suicide.

If he can maintain family support, which is hard and stressful not only to the veteran but to the family as well, then he has a much better chance of living with the effects of PTSD. On the other hand, if a member is single, then the battle is waged on a different scale—that is to say, it is harder on him to seek help and he will probably turn to other means such as addictions. If he is not fortunate enough to get medical help immediately, he will normally self-destruct.

● (1540)

Because of the constant mistrust by veterans towards authority and the banishment they feel by the system in place, they will rebuke any help and form themselves into splinter groups to seek advice and help from one another. This is what I refer to as a speeding car going down a one-way street—a very dangerous street at that. Instead of gaining help from one another, all they are doing is putting their lives in jeopardy by not seeking proper medical assistance. Meeting in one's basement or a garage does not solve anything, especially when they do most of their discussions over a couple of cases of beer or illegal tobacco. All they end up achieving is more anger, frustration, mistrust, and the threat of oncoming deep depression. I have personally witnessed these occasions twice, and must admit that it totally shocked the hell out of me.

I have personally attended two group sessions held by my psychologist, which have helped me considerably to further understand the effects and causes of PTSD. These, as well as one-on-one sessions, have taught me how to cope during times of undue stress and anxiety, and have taught me the triggers that set me off. These sessions have considerably helped numerous fellow veterans to try to live a normal life. I will not go as far as to state that they are a magic cure, because they are not designed as such, but they will further benefit the veteran in their daily battles with PTSD and help them put trust in one another. The veteran can only get out of the program what they are willing to put into it. In other words, what I've put into it is what I receive. If I don't want to meet the psychologist halfway, he will not meet me. Then it's a waste of time for both individuals.

Many veterans have been refused help from the medical system because many doctors and psychologists refuse to take us on as patients. They do not know how to treat us, nor do they understand the effects PTSD can cause on the human body. Training is also a big issue. By their refusal, veterans feel even more isolated and mistrustful toward the system. This is one of the main causes of mistrust. If I go looking for help and I can't find it, I don't trust anybody. Then we go to the splinter groups. It's like you're on a speeding car going down a fast hill with a brick wall in front of you. There's no way out of it.

One other major factor that we all suffer from is trying to be understood and properly cared for by a respectful system. That can have very serious effects on the veteran if not found in time. Without proper medical facilities and care, we are basically doomed.

Suicide is on the rise, and I again refer to my own personal experience in stating this. During the last group session I put forward a question to my fellow veterans in attendance. When I asked how many in the group had contemplated suicide, seven out of eight put up their hands. When I asked how many had plans to carry it through, four put up their hands. When I asked how many had tried, three put up their hands. I was one of the three. I have personally suffered through five suicides plus numerous attempts. This has taken its toll on me, as can be well imagined.

Before closing I would like to state that PTSD—and this is coming from a veteran—cannot be cured, but it can be controlled if caught in the early stages. I was not lucky enough to be properly treated at an early stage, even though I requested help back in 1985 and the early 1990s. I knew in 1985 that there was something wrong with me, and my biggest fear was that I was going crazy. That is the first thing a veteran will think when he starts misbehaving and becoming a social outcast. He thinks, “I'm going nuts. I'm the only one out there suffering.”

● (1545)

When I went to the base surgeon in CFB Shearwater in 1985 and explained my concerns about loss of control and nightmares, the medical doctor stated that it was all in my head and that over time I would heal myself.

Well, here I sit, and I am far from being healed.

Signed, Mr. William D. Maguire.

The Chair: Thank you, Mr. Maguire.

We now go to Mr. John Whelan, from Whelan Psychological Services Incorporated.

Dr. John Whelan (Director, Assessment-Treatment Services, Whelan Psychological Services Inc.): Thank you, Chair.

I'd like to thank the committee for the opportunity to be here today. Mr. Cann and I represent Whelan Psychological Services. We're a private practice of psychologists working primarily with military-related OSIs in Nova Scotia.

By way of background, I served in the Canadian Forces from 1977 to 1985. For the past 15 years I've worked as a clinical psychologist, first as director of addictions services for the navy in Halifax. For the past five years I've been in full-time private practice, working primarily with serving and retired military and RCMP.

My remarks today will focus not so much on departments but on the current system of care in effect for veterans.

Our clinic was established in 2005, as an eight-week intervention program in response to a joint RFP by DND and Veterans Affairs, an initiative that was never used. Our work began with referrals of veterans from other civilian providers and family physicians, and self-referrals through the OSISS network. Many of these crisis cases, unknown to the military or Veterans Affairs at the time, were referred by civilians because of addiction or depression problems, and were often assessed and diagnosed by us for the first time.

Recently the situation has improved, in that more referrals to the practice have been previously diagnosed with an OSI by the military. After leaving, they are often referred to us. We tend to have more complicated cases referred to us, which, as Mr. Maguire said, involve a variety of other conditions.

Of the 400 military and RCMP clients referred to our practice over the past five years, approximately 70% are experiencing chronic problems with addiction and post-traumatic stress, which is often further complicated by chronic pain from physical injury, suicidal preoccupation, or anger control problems. Some of these clients, particularly younger veterans and serving members, can do exceptionally well and end treatment successfully. However, in general, the prognosis for successful treatment is guarded, and relapse is the more frequent outcome.

Consistent with the research, veterans with PTSD, and particularly with chronic addiction problems, usually do not respond to treatment as usual for treatment of post-traumatic stress. They often have multiple chronic and comorbid conditions that are difficult to manage on an outpatient basis. They cycle between stability and crisis. Many do not have medical or psychiatric support in the civilian community after they leave their organizations. Suicidal risk is an ongoing concern.

Despite earlier identification and treatment of OSIs by the military, from a continuity of care perspective, there appear to be major gaps in the system. Veterans under medical care in the military often become deeply distressed upon leaving the military, and they go underground, sometimes for years. They're often unemployed, isolated, and pessimistic about any change or possibility of change. Some require hospitalization for attempts of suicide or psychosis; others require close clinical monitoring. In our records, four have died prematurely because of PTSD-related problems.

As outlined in Senator Kirby's 2006 report, “Out of the Shadows”, there are formidable challenges facing the delivery of mental health services across Canada, as we know. In particular, he said,

> The...“clash” between mental health services and addiction services has created substantial problems for clients, particularly those with concurrent disorders.

When it comes to managing mental health problems among veterans, then, the question is whether this Canadian average is the expected standard of care.

In our region, services for veterans rely heavily on a collection of approved mental health providers and public health services, when available, such as physicians or psychiatric support, and they may have limited or no expertise in managing veterans' concerns. Under this system there are no mechanisms in place to determine expertise beyond professional credentialling. As well, there are no opportunities for these providers to communicate or coordinate their efforts when a veteran has two or more independent providers.

In contrast, the Canadian Forces in Halifax seem to be working towards a collaborative model in treating military OSIs, including staff cross-pollination and efforts at interdisciplinary cooperation. This model could be considered for application in other jurisdictions. Our attempt to replicate this within a small private practice setting has been very challenging.

● (1550)

The problems faced by veterans are complex and multi-faceted. The solutions will likely require fundamental shifts in organizational cultures, systems of communication, and professional attitude, which must change from one of “experts know best” to one in which client and family needs are identified, valued, and actively managed.

In terms of established evidence in the trauma field, we know that the gold standard involves cognitive behavioural therapy, often in staged approaches that can last one to three years, on average.

In brief, prior to engaging in any treatment of a military-related or an RCMP-related traumatic stress reaction, stabilization is imperative. That includes problems with suicidality. This often means medication management, fostering a stable home environment, managing addiction problems, and reducing overall stressors.

For many of our clients, it is extremely challenging to move past this first stage of treatment. Loss of employment structure and military identity, family dissolution, unmanaged pain, active addiction, problems attaining medical supports, and a persistent preoccupation with pension application and appeal processes results in a perpetual state of instability. As a result, some of these clients may never get to a point of second-phase treatment, which is when they would actively address the specific OSI.

During this time, of course, these clients become even more disillusioned and angry and depressed, which can turn into a chronic state of traumatic reaction.

Mr. Cann is going to complete our remarks.

Mr. Steven Cann (Representative, Whelan Psychological Services Inc.): My name's Steve Cann. As well as working at Whelan Psychological, I'm also a contracted clinical supervisor at the addiction treatment program in Stadacona, Halifax. Prior to this, I was a district psychologist, and prior to that I was a case management officer for Correctional Service of Canada.

My comments pertain to two issues: case management and addiction interventions. Before addressing these points, I'll provide a snapshot of our experience as private providers working with these issues with veterans.

In our experience, there are approved services for veterans and there are many others that are necessary but not approved. Efforts to effectively help veterans often mean moving into multiple roles, to the point where our clinical roles become seriously distorted. For example, we are often asked by veterans to act in advocacy roles for them, such as helping them to complete pension applications or referring to civilian physicians or psychiatrists.

There have been instances where we have had to move into the case management role, which can be a source of confusion and conflict. While we are acutely aware of our roles as primary support for our veterans, we are not viewed as being part of any system. We are treated as a resource to be used in a very restricted manner.

There has been much discussion in the past several years about a client-centred approach to veteran treatment. In our experience, a client-centred model of care places the identified client and his family in the centre of a hub surrounded by a collaborative team, all of whom have shared an understanding of the complexity of the issues, have clearly defined roles, a shared commitment to client goals and to the team process, and, importantly, a strong oversight to ensure commitment to these goals. The client and the family form an integral component of this team and are continually involved.

However, what seems to exist can be best described as a “service eligibility” model where each service—psychotherapy, medications—represents a discrete hub with one provider and one veteran working in isolation from two or three other independent hubs involving the same veteran. In this model, there is no opportunity for interaction among the providers and there is no coordinating oversight. Case managers who coordinate client care and have the authority to refer directly to treatment providers are essential for a client-centred approach to function effectively.

As a provider, we find our responsibilities confused by the role adopted by the case managers of Veterans Affairs. In our experience, they do not manage the case. Case management through the department appears to be one of authorizing or denying funding for the recommended interventions based on an insurers list of approved services. Changing the role to one where the case manager is clearly identified as the case leader and coordinator, in consultation with providers in the community, a team approach, would be a big step toward a collaborative model.

Other federal organizations have case managers who act in this role—for example, parole officers through my old job with Correctional Service of Canada. However, a major obstacle to this change in role is that VAC case managers are not permitted to refer or to direct clients to services. These decisions are currently made by outside providers, who may have little or no expertise in the likely outcomes of combat trauma.

Our clinic deals primarily with veterans who are referred for PTSD and addiction. The model of treatment employed at the clinic is an integrative PTSD addiction model, which has shown in our preliminary research to have positive outcomes. Integrated treatment is treating multiple issues and problems simultaneously, such as PTSD, addiction, and depression.

Integrated treatment has been recommended for coexisting disorders for a number of years. Treated alone, the risk is that one disorder can exacerbate the other. For example, the veteran being treated for PTSD becomes overwhelmed emotionally, triggering a relapse to heavy alcohol use, which places him at high risk for self-harm.

In conclusion, as treatment providers we would offer the following suggestions under systems of care: a truly collaborative, client-centred approach be enacted where the veteran and the expert providers collaborate on a team to achieve client goals; teams have a qualified case manager with the knowledge base and the authority to act; and mechanisms be established to ensure continuity of care when serving members who have been treated for OSI are released, thereby helping them avoid treatment relapse.

● (1555)

Under treatment options, we make the following recommendations: first, adoption and implementation of integrative treatment models of care for veterans with coexisting mental health problems; second, decisions about treatment modalities, individual/group medications, or family therapy should not be based on whether it exists on an approved list, but rather it should be made by a collaborative team, based on the evidence and client outcomes; third, in-patient capacity should be sought in local regions for veterans with coexisting mental health disorders to reduce the financial costs and family disruption that occurs when veterans are required to travel to available centres in other areas of Canada, such as Ontario.

Thank you very much.

● (1600)

The Chair: Thank you.

We have only a half hour left for questions, so I will be stringent on the time. Members have five minutes for both questions and answers, so we'll try to keep both questions and answers as short as possible.

Ms. Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you.

Mr. Maguire, I will start by thanking you for your contribution on behalf of all of us as Canadians, and also for the courage you have shown today in coming to talk to us. This is an important issue for all of us, as it is for you, and it will be your comments, and others', that will help us to come forth with some recommendations that I hope will make a difference.

After the difficulties you've gone through, what do you think should be the first stop for someone coming home from theatre in order to start getting connected and to receive the necessary help?

I can only believe that everybody coming from theatre has to suffer from PTSD. I cannot imagine anyone not suffering in different degrees. I would think everybody would. If we use the analogy that everybody coming from theatre is going to suffer from PTSD to a degree or another—

Mr. William Maguire: No, ma'am, it doesn't work that way. I would say probably 60% of the soldiers who come home have no visible effects of PTSD. Of the 40% who are left, I would say probably 20% show visible signs, and after a couple of years the other 20% will kick in.

It took me roughly 10 to 15 years before I started seeing things from a different perspective, and then I thought I was the one at fault. I started having nightmares, which have never ceased: I'm on guard duty in the middle of the night, with nothing to guard, basically, just patrolling around the areas.

The first step for a soldier returning home to Canada is that they should be observed. You cannot take everybody in and say, “Are you suffering from PTSD?”

What is PTSD? Are you going to explain to the soldier what PTSD is? Are you going to say, “Are you having nightmares?” No. Are you going to say, “Are you having flashbacks?” No.

What do you do with him then? Do you pat him on the back and say, “Thank you, carry on—next, please”?

Hon. Judy Sgro: Very often the—

Mr. William Maguire: What I'm trying to explain, ma'am, is that when the soldiers come back, the medical staff have to be trained to recognize the visual effects of PTSD. You get a man who's loud and boisterous and all of a sudden he's quiet and withdrawn, that man is suffering from something. Or it could be just the opposite; it could be a man who's withdrawn and quiet who all of a sudden becomes outlandish, does stupid things for attention, gets adrenalin rushes, that shows that he's craving for something, that he's missing something in his life. Normally it's the adrenalin rush that coincides with battle.

Hon. Judy Sgro: Mr. Maguire, you said it was 10 years after you came home that you started having erratic behaviour. You are no longer in the forces, you're living your own life, and you're starting to have a variety of issues come out. You wouldn't necessarily think that maybe this is a result, would you?

Mr. William Maguire: Ma'am, I was suffering from these things well before I was out. Back in 1985 I knew there was something wrong with me. I knew I needed help. When I went looking for help, it was denied. It was refused. They told me to go to sleep, take some sleeping pills, get back to work the next morning.

Hon. Judy Sgro: And it will go away. That's just terrible.

Mr. William Maguire: They tell you to fill your load station—“load station” being an old army term—to which you might say you're “on the gun”.

Hon. Judy Sgro: What years would those have been, Mr. Maguire?

● (1605)

Mr. William Maguire: I started feeling the effects probably in the late seventies, early eighties, and thought it was just something I could deal with.

In 1985, when I was in Shearwater, I actually started scaring people. People on the detachment that I was sailing with refused to have me sleep in the mess. They wouldn't socialize with me. They were actually scared of me. I was very aggressive. I wouldn't think twice about striking out.

I said, "Okay, there is something wrong; this isn't the Billy Maguire I knew five or ten years ago." I knew then that there was something wrong. When I went to get help from the medical system in place at that time—I agree now the medical system has changed for the better—I was refused help. I was told to get my ass back up to work.

Hon. Judy Sgro: Thank you, Mr. Maguire.

Mr. William Maguire: And pardon for the slip of the tongue.

Hon. Judy Sgro: Not to worry.

The Chair: That's okay.

Monsieur André.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Mr. Chair, I would like to know if I actually have seven minutes.

[*English*]

The Chair: Five minutes.

[*Translation*]

Mr. Guy André: I will be sharing my time with Mr. Vincent.

My message is to everyone. I would like to address the issue of mental health problems Mr. Maguire talked about. I am sure that you, the psychologists, will agree with me. The situation has improved over the years. In the 60s, 70s and 80s, there were many taboos and prejudices around mental health. As you pointed out, Mr. Maguire, whatever the problem was, the tendency was to tell someone with a problem to go get some rest and take a sleeping pill. I feel our society has made progress. You have been following this issue very closely, just like Mr. Whelan and Mr. Cann. Could you tell me what improvements have been made to treat PTSD? Has there been an improvement? I can only imagine how things were in the 70s and 80s. My father was in World War II and retired in 1955. I always said that he had PTSD but he lived with it. That's the way it was: you would get out of war and leave. Have there been improvements?

What you are saying is important. The screening does not take place. But, over the years, we have still managed to develop tools for detecting PTSD in those at risk. Given the high percentage of people with PTSD, should we not invest more in the screening process and make it almost mandatory? As you said so well, Mr. Maguire, the sooner we treat people and establish they have PTSD, the sooner we will be able to reduce the future impacts of this problem. That's my question.

[*English*]

Mr. William Maguire: I'll give you a short answer. You are correct in stating that the sooner the individual is pegged as suffering from PTSD, the more chances there are of his being accepted into a social normalcy.

Also, care facilities should be placed in the areas where they can be utilized. The only one that we have available, I think, is up in Ontario, and the waiting list is a mile long. I mean, they only have so many they can deal with. I hear there is program now on the fifth floor at Stadacona, which is running a fabulous program, but that's geared toward addictions.

What we need is a centre where I can walk in after being diagnosed with PTSD and have men like this—psychologists and medical doctors like Heather McKinnon—who can say, "Now we are going to treat you, you are coming in here at this percentage of normalcy and we're going to increase that, if we can, to a point where you can be taken back into the social sphere of things."

The biggest thing is getting us to socialize again. We don't want to socialize. We want to be left alone. Again, it comes down to trust. It's such a teeter-totter. If you get me on a good day, I'll talk to you; if you get me on a bad day, I won't even look at you.

● (1610)

The Chair: We have four minutes left. If Mr. Whelan is going to answer, we do have to proceed.

Sorry for interrupting.

Dr. John Whelan: That's a wonderful question. Thank you.

Regarding improvements, that really comes back to the point that we really need to look at outcomes. With all our energy invested in our veterans and our people living in the military, with in-patients and out-patients, and various kinds of medications and interventions, I think we really need to look at outcomes.

Does something improve the veteran's quality of life and that of his or her family? I don't think we have good data on that.

As for improvements overall, I think we've come a very long way since 1993 when I first did my clinical rotation at the Stadacona psychiatric hospital and we saw our first folks come back from Bosnia. But we've come a long way since that time in terms of identifying.

I think we still have some problems in identifying reservists who leave our system, and then we can't track them. I think that's an issue.

In terms of programs, we have all worked pretty hard at trying to stay in line with evidence-based programming. The problem is trying to implement those in the community as we are civilian external providers to any system. There are many gaps and problems.

The Chair: Thank you.

Mr. Stoffer.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you very much, Mr. Chairman.

What Mr. Maguire doesn't tell the committee, because he's very modest, is that even though he is suffering himself, he has helped an awful lot of individuals in the Halifax area in their discussions. It would take too long for him to describe some of the cases, but I just want to thank Bill on behalf of the committee for the work he's done in helping other soldiers, airmen, and veterans recognize that they have a problem and that there is help out there if they seek it.

Dr. Whelan and Mr. Cann, I'm wondering about short-term facilities at which a person can stay, because one of the difficulties we hear about is the family. First, then, do you treat any family members? We heard evidence a couple of years ago that post-traumatic stress can actually be transferable from the veterans to the family and especially the children. Are you treating any of those families?

Second, do you have short-term facilities where someone like Bill, for example, whose wife feels threatened in some way or feels afraid, can go for a weekend or a couple of days in order to get out of the home environment just to have a breather, some discussion, and some time?

Those are my two questions for you. If you don't have those short-term facilities, what would you recommend in that regard?

Also, I'd like to ask about your interaction with the case manager at Veterans Affairs. I know they usually send out people who are under contract to them, such as the VON and so on, to give an assessment of a particular person. Do you feel the contractors who are contracted to DVA have enough knowledge of post-traumatic stress disorders to recognize it, understand it, and make the proper diagnosis or recommendation to DVA so that they in turn can make the recommendation to you?

I thank all three of you for coming.

Dr. John Whelan: I can start with part of that answer and then turn it over to Mr. Cann.

Do we see family members? We do very minimally, and it's usually the spouse of a veteran. I really don't understand ratios, but there's a formula that for any veteran who is being seen for psychotherapy or ongoing counselling, of every ten visits for the veteran, the spouse can come for two. That's the latest thing.

Mr. Peter Stoffer: Time out. Who made those ratios?

Dr. John Whelan: Veterans Affairs.

Mr. Peter Stoffer: Where do those requirements come from?

Dr. John Whelan: It's usually under our authorization as a provider, if we attempt to provide services to the family member of the veteran. We have not seen children or adult children, and that may be because of the particular kind of practice that we offer.

As for the second part of your question on whether we provide short-term facilities, no, we don't. In the past I've had some assistance from Stadacona. Usually if it's a requirement for safety, we call the police or our emergency line to try to have some intervention. That's the only option we have.

So we don't have those resources. We don't have those facilities.

● (1615)

Mr. Steven Cann: As for the case management, basically there is a knowledge gap, at least in the Atlantic region. There's a very broad knowledge gap about PTSD and especially anybody with a comorbid disorder of PTSD and addiction. Most of the people who would encounter these individuals would have no idea that they had PTSD or that there was some other issue going on. Some of the case managers even inside VAC would not have the expertise that I would say would be of sufficient content knowledge to know exactly what that is.

The Chair: Mr. Kerr.

Mr. Greg Kerr (West Nova, CPC): Thank you, Mr. Chair.

I'd like to thank all three of you for joining us today. As you're well aware, the committee puts this as a very important priority, by trying to help in some small way to bring about some changes.

Given the limited time, I'm going to go to the Whelan clinic folks.

When you said “referrals” very early in your remarks, Dr. Whelan, you said they come from outside. Are they coming from family? Or are they coming from others in the community? How does that happen?

Dr. John Whelan: I'll try to give you a straightforward answer. It's a bit of a complicated issue.

Often a veteran will arrive at our office—that was early on—at the suggestion of a family member, at the suggestion of an OSISS peer support person, a military comrade. It could be a formal referral by a civilian physician. But I guess the point is that they were outside the system at that point. They were not known to be a military person who had suffered a mental health injury because of their military service.

Mr. Greg Kerr: But the referrals do come from outside, so there's some connection there.

Dr. John Whelan: Yes.

Mr. Greg Kerr: Okay.

I guess being Nova Scotians, we understand some of the challenges we face. I worked as a volunteer and a board member in a hospital system and so on. Collaborative practices become a big focal point within the health system and for two reasons, which I understand from the 12 years I spent as a volunteer. One is the silo system that tends to exist in the delivery. Communication was abysmal, and that's a national problem. It's not located just in Nova Scotia.

In the collaborative practice, we've seen in Annapolis an example go ahead whereby the teams literally sign contracts so that they work together. You know what happens to the patients; they have to see the doctor, they won't want to see anybody else, and so on. Although there are glitches, the process and the principle seems to be a very valued one.

Not to make an absolute parallel, but is that the kind of context you're trying to push that forward in?

Mr. Steven Cann: Yes, that's exactly what it is. I worked a little bit with the valley hospital in some of those collaborative relationships, me as a federal employee with provincial counterparts, psychologists inside mental health, to gain access to services for, in that case, offenders, but it would be the same principle here.

When people are together and you destroy the boundaries, people can move from one system to the other without having this break. What happens now when you come out of the military is there's this break. We lose touch with them. They disappear into the ozone layer and by the time they resurface, their problems are much worse and have been there for a long time.

Mr. Greg Kerr: I know time is short, but I'd like to follow Mr. Maguire's story back into this—early diagnosis, early capture, early entry. One of the things that is seen in a statistical response to that on the civilian side is that it has been quite phenomenal because mental stress issues come up regularly in the conversation. As opposed to going immediately to your medication, it's going to how we are going to fix this and so on.

One of the things I know that is happening and will continue to happen is this, and you referenced the case worker. Part of the real priority within the department is recognizing—there's been enough said in the last year, particularly—that the case workers are going to be empowered to do a lot more, including referrals and being able to do it on the ground.

But I sense from all of you that one of the things that has to happen is the appropriate training, regardless of who it is, to understand what it is they're dealing with and to ask the right questions—to Mr. Maguire's point, I think the peer part is critical—to somehow couple those who have been there and done it with those who professionally are paid to help out.

Do any of you see that as a working possibility?

● (1620)

Mr. William Maguire: I tried that approach. I took my job very seriously and as I progressed with my job I met more and more veterans. Through what I was suffering and by observing other veterans, I knew these men were suffering. Again, I use the word “men”, because I refuse to work with women.

They and their families need help when they have PTSD. I have gone seeking help and was told to back off. It's not your job to bring that to our attention.

I said, well, during my peer helper course, that was one of the things they stressed. If I picked up something from a veteran, I was to report it. I am reporting it. What's the follow-up? This man needs help and he needs help now. Do you have a list of doctors, psychologists, and GPs who can look after him?

My answer was that I should open the phone book and pick out a name.

Mr. Greg Kerr: But just to—

Mr. William Maguire: Now, hang on.

Mr. Greg Kerr: I was going to ask Dr. Whelan to comment on the opportunity to connect the caseworker with the process.

Mr. William Maguire: Do you mean the caseworker himself, the case manager?

Mr. Greg Kerr: Yes.

Mr. William Maguire: The case managers I have met think that they're psychologists, but they're not.

Mr. Greg Kerr: They need training.

Mr. William Maguire: They need training.

Mr. Greg Kerr: Exactly. Yes.

The Chair: Mr. Whelan, did you have a quick response?

Dr. John Whelan: Really, it is the same issue. It is the shortage of trained personnel. We need training, training, training, and qualifications beyond just showing up with my degree and saying that I'm now a Blue Cross provider to veterans. I need expertise and training, overseen throughout the veterans system, for any provider coming into that system to provide care for veterans.

The Chair: Okay.

The next round will be a three-minute round.

We'll start with Ms. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair.

I'm going to be very quick.

Thank you to all. We appreciate this tremendously.

I am concerned, and I'm wondering what you think about screening for currently serving members of the forces. They could do their own screening, as they do at the U.S. Department of Defense health services during their time. When they leave the military, should they be offered self-screening as well? If they are going to be offered screening, this should be seen as only a first step to treatment, and it has to be linked to effective and timely treatment.

The other point is about the need for medical transitional services, set up across the country, that are designed to deal with both regular and reserve forces members.

I know that you have no time to address traumatic brain injury, PTSD, and dementia.

Mr. William Maguire: Who are you pointing this at?

Ms. Kirsty Duncan: I would like to ask Dr. Cann, if I may.

Mr. Steven Cann: Screening is an important issue. Knowing how to screen and when to screen is really an important issue.

“Adjustment disorder” is the catch-all phrase for people during the period when they first come out. The proper diagnosis for people when they first have a problem is “adjustment”. But if you check the DSM-IV, it's a six-month period, and that's it. A lot of people would say that almost everyone has some version of adjustment disorder. It's whether you return to your normal functioning.

So the testing and the screening should be periodic and should be done for people when other people in their lives are noticing a change in their personality and a change in their background. In those cases, those people should be targeted for screening at those points. You would not be screening every living soul but would target the screening so that it's more cost-effective.

Dr. John Whelan: To answer your second point about medical transitional services, I absolutely agree. The question becomes how we create a structure that follows a person as they transition "out of uniform", to use that phrase, into civilian life, while dealing with an operational stress injury. Also, adjusting to civilian life is another component that I think often gets lost. So I'd absolutely agree. Create those facilities, structures, and processes. That's the problem.

● (1625)

Ms. Kirsty Duncan: What would—

The Chair: We have to go on. I have to be fair.

We'll go to Mr. Lobb and then to Mr. Vincent.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you, Mr. Chair.

The first question is for Mr. Maguire.

I wonder if you could tell the committee when you first felt that you started to turn the corner in dealing with your post-traumatic stress disorder. What were the series of things that you thought started to get you to round the corner?

Mr. William Maguire: I don't follow the question. When did I start feeling the effects?

Mr. Ben Lobb: No, when did you start to feel that you were improving?

Mr. William Maguire: When did I start feeling improvement? It was after meeting these two gentlemen here, and Dr. Heather McKinnon.

At that point of the game, I was ready to blow my brains out.

Mr. Ben Lobb: Okay. That's a good answer.

Mr. William Maguire: Well, I'm telling you.

Mr. Ben Lobb: Thank you.

Mr. William Maguire: I can still taste the metal in my mouth.

Mr. Ben Lobb: This question is to all of our guests. At our last meeting, General Dallaire was here, and he made two points that I certainly took home. One was about his tremendous support for the OSISS networks, the peer support networks. The second was about the need for more psychologists who are specialized in dealing with this.

Do you have any comments on those two points that he made?

Dr. John Whelan: On the second issue, I agree. We need psychologists, psychiatrists, physicians who have training, and other mental health folks who have training. This is not part-time kind of moonlight work. Often people do, of course as part of their practice, take on and see some veterans as well. It needs to be dedicated.

Mr. Ben Lobb: Can I ask a quick question? Where do you get the knowledge to actually treat combat disorders? Where did you get your expertise in dealing with this?

Dr. John Whelan: Certainly it was through working within the military system and conferencing. Part of my own academic training would have provided it in a general way. It's ongoing education.

Mr. Steven Cann: Over the last three years, and we're about to go to the fourth year, we have gone to the annual conferences that are held here, mostly in the United States. But we try to stay up to date with what's going on with people in the research and the practice end as best we can. Every year we attend a conference associated with PTSD. And you have to do that. You have to stay on top of it.

Mr. Ben Lobb: Is there any place that you're aware of where certification is required to treat this disorder?

Mr. William Maguire: That's a million-dollar question.

Mr. Ben Lobb: I mean, you go to all the courses and conventions, and—

Dr. John Whelan: I am receiving an answer of "no", which I trust. So the answer is, no, there isn't.

It really comes back to vetting, really scrutinizing who the system takes on as providers for the care of veterans.

The Chair: The final question goes to Monsieur Vincent.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Thank you, Mr. Chair.

Mr. Whelan, Mr. Cann, are you able to diagnose PTSD? As psychologists, are you able to diagnose PTSD when you see a person, a client or someone who was referred to you by the Canadian Forces? Do you make the diagnosis? Or have the people already been diagnosed and then come to you for care?

[*English*]

Dr. John Whelan: In terms of referral, if people are referred, and they've already been diagnosed by a physician or another psychologist or psychiatrist, they can already have the pre-existing diagnosis of PTSD. As psychologists, we will also assess and we can diagnose them as PTSDs or some other related disorder.

There is a very structured interview, testing, all those sorts of things, that ask pertinent questions to come up with either a diagnosis of PTSD or other things. There are other things that happen under an OSI that is not only PTSD. It could be major depression. It could be panic disorder. It could be other issues as well. So yes, we can diagnose those.

[*Translation*]

Mr. Robert Vincent: From the people who were diagnosed with PTSD and were referred by the Canadian Forces, and from other veterans who took the phone book and decided to go see a psychologist, how many had National Defence reject their PTSD diagnosis? How many of them had to fight for years to have their diagnosis recognized? You made the diagnosis, you are treating those people. You said earlier that you are case managers because people don't know where to go anymore, since their diagnosis has been challenged.

In your opinion, how many of your clients had their diagnosis challenged by the Department of National Defence or by the Department of Veterans Affairs?

● (1630)

[*English*]

Mr. Steven Cann: We can't give you an exact number. We didn't know you were going to ask that question.

[*Translation*]

Mr. Robert Vincent: Do you have a percentage?

[*English*]

Dr. John Whelan: It would be that they were not identified—not so much that they were refused but that they were not identified. The system was not in place.

Back in 2005, we were still being referred people who had left the military and were just not identified. But for them to come forward and say, "I have a problem", and for the military to say, "No you don't"? I would say it would be none of those cases; it would be more the member not wanting to be treated or seen on a military base because they—

[*Translation*]

Mr. Robert Vincent: I don't think you understood my question. I will try to make it clearer. If someone comes to you with PTSD, you treat them for PTSD. But their status has not yet been recognized by the Department of National Defence or by the Department of Veterans Affairs. The diagnosis was established and the person wants to have it approved for compensation. Is it disputed for a number of those people? Are they told that they have to provide concrete evidence, although you yourself diagnosed them and established there was a cause and effect relationship? How many cases are disputed?

[*English*]

Dr. John Whelan: It's a low number, 10% to 15%. All the information is there, the assessment is there, and they're struggling to have it accepted.

Mr. William Maguire: I would go higher. I would say it's 20%.

As well, we have one case in Stadacona where the man has PTSD and is being refused help by DND. I'm not sure how it goes. I haven't got to the full extent of it yet. But I've been told so far that the man has been warned that if he goes for medical help, he'll be in caca. So that's a threat.

The Chair: I apologize, but I have to bring it to a close.

Mr. Vincent used up your minute, Peter.

We'll recess for a short time to get ready for our next witnesses.

● _____ (Pause) _____ ●

● (1635)

The Chair: We're back.

Everyone will have slide sheets in front of them. They are bilingual.

The visual on the wall is only in English.

Is that acceptable, sir?

Okay. Thank you.

I welcome for our next hour, or 55 minutes—time flies when there are short sessions like this—Lieutenant-Colonel Stéphane Grenier and Lieutenant-Colonel Rakesh Jetly.

Welcome, gentlemen. Please make your presentation.

LCol Rakesh Jetly (Advisor to Surgeon General, Psychiatry and Mental Health, Department of National Defence): Thanks very much, sir.

Basically, we have chosen to leave as much time as possible for questions, so we won't make opening remarks.

Steph and I started this journey about ten years ago as majors. I'm the clinical lead and he's been on the non-clinical side for all the changes that have occurred in DND.

My understanding was that this committee was particularly interested in suicide and suicide prevention, so what I'll try to do—cut me off whenever I've run out of time—is give you a brief overview of the Canadian Forces suicide prevention, including the expert panel we had last year, just in terms of the broad interdisciplinary approach we have within our own organization.

Veterans Affairs colleagues were at this meeting, and they have modified...and they have their own program as well, which is somewhat different. It will become evident, as I speak, that it's very difficult to compare both organizations. We're a large organization; we have 6,000 people in the Canadian Forces health services; we run large clinics; Stadacona has 50 mental health professionals working in this very model. It's a very different thing to try to compare.

The first slide looks at our suicide rates, which are male suicides that are tracked. Contrary to what the media says, we have been tracking very carefully since 1996. I'll speak at the end about how we're tracking them even more closely. We haven't had an increase of serving members since the Afghan conflict began. Nobody can predict the future, but those are the stats we have for now.

In September 2009, the Surgeon General convened, asked us to put together, an expert panel on suicide prevention. The goals were to review what the CF is doing now, evaluate our approach against the scientific literature and the practice of our allies, and recommend opportunities to strengthen the program.

The reason for this was not that we are having the crisis that the U. S. is experiencing with a very high rate, but that suicide and suicide prevention is a major public health issue in this country. It behooves us, as the CF, to have the best practices in place that we can. We're not "happy" that our rate is below civilian society—the loss of every soldier is a loss to us—and if we can do anything to reduce that number, to prevent it, that's our goal.

Very briefly, I'll give you the range of people. We have our CF folks. With our team we have deployment health and epidemiology folks. We have psychiatrists represented, and social workers, primary care physicians, mental health nurses, as well as some of our educators.

We have external consultants. We have our colleagues Dr. Thompson and Dr. Ross from Veterans Affairs. Professor Links is a very important person. He's probably the most renowned suicide expert in Canada, as the chair in suicide studies at St. Michael's Hospital in Toronto. Colonel Ritchie is the advisor to the Surgeon General, so a big player in the U.S.; Lieutenant Colonel Bell, likewise. Andrew Cohn travelled all the way from Australia. Australia does some very interesting things—similar force, similar history, and they don't have all the big hospitals that the U.S. has. It's the same idea of where do we put our high-risk patients; the Australians have a similar thing. We have colleagues from the U.K., Neil Greenberg and Nicola Fear.

The name of a Dutch colleague is not appearing on the slide. I apologize for that....

Oh, there she is: Lieutenant-Colonel Horstman.

A voice: We can't forget the Dutch.

LCol Rakesh Jetly: Yes, we can't forget the Dutch.

The key message from the panel, as I mentioned, is that it's an important public health problem. In terms of the three cornerstones for our suicide prevention program, really what we could put, for an effective mental health program, is excellence in mental health care. When people come, we have to have evidence-based practice. We have to have team-based practice. We have the professionals there.

Within our clinics across the country, we have close to 400 mental health professionals. We're funded up to 440. We're watching the wait-list, we're watching the times, so that when people get ready, they're available, as well as the contract professionals out there.

My colleague here is instrumental in the second of the two, which is effective leadership. Leadership needs to set the tone. Leadership funds mental health care and keeps it as a priority even when we stop the conflict in Afghanistan.

● (1640)

A leader is a gatekeeper. A tough job for a leader is whether I pat a guy on the back, kick him in the butt, or tell him to get help. I think the point was very well taken that being a good leader means knowing your people and knowing when they change. Many, many of the programs, which you can specifically ask Lieutenant-Colonel Grenier about, are aimed at that.

The other part, again, is about aware and engaged members. Members have responsibility. We are educating members to understand mental illness, to understand they're not going crazy and they have something that would benefit from help. They can understand, when they're 40-something years old and dragging ass, that it might be a depression, not just getting old.

These are the three pillars. All three need to be up and standing in order to have effective suicide prevention or an effective mental health program.

JAMA, the *Journal of the American Medical Association*, published a very comprehensive suicide prevention campaign. Dr. Mann is actually leading the U.S. DOD. I think they are probably going to spend $150 million studying what we did with $50,000, in our Canadian way.

I'll go to the next slide and expand on some of these points. I'll show you how we have actually adopted it, from a suicide point of view.

Up to 90% of those committing suicide—depending on the study you read, it will be from 75% to 95%—have mental health problems, especially depression. Now, PTSD does elevate the risk, and of all the anxiety disorders, PTSD is the highest risk factor.

Then there's usually a stressful life event. Stressful life events can trigger suicidal thoughts. I think this is really important. Quite often we'll see both things happening. As an organization, as a society, it's looking after both sides that's important.

The illness in most cases, plus the stressful life event—which to the rest of us may not seem stressful, but if you're ill, the financial stressors or family stressors can be quite big—lead to suicidal thoughts, intents, plans, and actions. Your last witness talked about putting his hand up, asking who has thought about it, who has actually tried it. These are all lumped into that ideation.

These are really important factors that I've highlighted in the next box: impulsivity, hopelessness, pessimism, and emotional dysregulation. Emotional dysregulation is part of an illness.

Steph and I quite often talk about hope. We champion a few different kinds of things, that outside-of-the-box thinking within our organization about occupational transfer or keeping people within the organization—this kind of thing. A lot of it is that we don't have the science but we've argued we should give them some hope.

These are really important. When we hear people talking about hopelessness, that's when we worry, and that's when we tell our clinicians and our leaders to worry.

With respect to access to lethal means, again, it's what's out there: gun control, different kinds of devices, looking at how pharmacies are packaging drugs. These kinds of things become an issue. It's not always something we can control, but certainly within our organization we do what we can in order to not give people lethal amounts of medication, for example. How we manage our weapons is certainly an issue as well.

Imitation is very controversial, considering we had a really sad suicide in Ottawa lately. There is literature that says talking about suicide too much in the media can be a bad thing, a contagion. We all know about Kurt Cobain and things like that.

People like me don't say hush it, drive it into the ground and don't talk about it, but responsible media reporting presents it in a responsible way. It's dangerous to romanticize it, which Shakespeare did very well, or to rationalize the suicide. “Well, what could the guy have done? He killed himself.” If it's reported in a balanced way, it says this unfortunate thing occurred and there was help available if only the person had gotten help.

So with respect to imitation, some of the suicides I've specifically looked into, where a colleague has killed himself shortly before by the same means.... We worry about the clusters of suicides that occur in universities, for example, for that reason.

The Canadian Forces has limited control over a lot of the access to lethal means. We can't get Home Hardware to stop selling rope, for example. These kinds of things are impractical. The imitation is also difficult because they occur elsewhere. We can certainly look at clusters, if they occur within our own organization, and we can engage media at a certain level, if that is one of our next steps.

● (1645)

We go from where do we get a suicidal ideation, a thought, to the act. All of these factors mediate between them. Basically, then, all of these are potential targets for suicide prevention. So we can look in the box. There are education and awareness programs for primary care providers, members, gatekeepers. Gatekeepers are leaders. One thing we've done is we've gone away from having the mental health professional, the doc, always standing in front of people telling them what they should do. We have people who are peers, who have been trained, who also deliver the message, saying, “I went for help; it helped me too.” The credibility of people who have the experience, who have the time in, the operators, and engaging them in our education programs have been very effective.

There was a question about screening and assessment. We do screen. Like all of our allies, we screen three to six months after deployment. We're asking specific questions about PTSD, depression. On our periodic health exams and your annual medical exam, when you have it—I just had mine recently and looked at the latest questions—we're asking about drinking behaviours. We're asking about that. Unlike our allies, with our screening it's not just the pen and paper. We actually sit and have a professional talk with the person for about 40 minutes as well. So we're screening for PTSD, depression, physical health issues, drinking behaviours, and we've added MTBI since about late 2008, since hours of expert panel on MTBI. So we're doing it, and we know it doesn't end there. You're catching a lot of people there, but there will be people afterwards, so the ongoing initiatives are going on there.

We've split from the Mann model to really realize the advantage that the Canadian Forces has, which Ford doesn't have and Chrysler doesn't have. We have a lot of control over the environment of people. We are the Canadian Forces. People work for us. We provide their health care. We set the tone within the environment. We can decide to work people hard, to rotate people, to rest them. So we've split the work-related stressful life events and other stressful life events. We can't always control what happens at home, but we can certainly have influence over the kind of work environment that we create for our soldiers.

That whole group, which is sort of added onto Dr. Mann's model, is the leadership and organizational factors, in which we have the luxury of actually training our leaders, stepping out in front of them. General Dallaire is certainly an example, as is our Chief of the Defence Staff, standing up talking about the “Be the Difference” campaign, where mental health, the health of folks, is everybody's business. Maybe with mental illness the Surgeon General and his people can do their part, but when it comes to the health of soldiers, leadership has a responsibility of knowing its people and getting them to health because they are our most valuable resource.

So leadership policies and programs can mitigate work stress.

There's also selection, resiliency training, risk factor modification: selecting the right people, enhancing their resilience, decreasing their risk factors. The idea here is let's make sure people are ready for their deployment. Let's train them well. Screen them ahead of time. If they're not, let's have a backup plan. We have had mental health professionals, including in psychiatry, in theatre since 2006.

So making sure people are well is there. We have our “Road to Mental Readiness” five-phase package that's going on throughout the deployment cycle, where people are getting trained a few months prior to going. They have consolidation training during their last exercise in Wainwright or in Fort Irwin.

They're learning the skills from sports psychology. They're learning the breathing, the self-talk, all of these skills. When they go into theatre and they're having trouble, their leaders are taught to ask, “What have you tried? Have you tried the skills?” If not, backup is there as mental health professionals. We're identifying the guys who are having difficulties in theatre, and they can have an appointment by the time they return home. So the continuity we have around the deployment cycle is there.

In terms of barriers to care, most suicide victims have mental illness, but less than half are in care. That's what we're finding as we're investigating our suicides. This is where the non-clinical side comes in. It has to be okay to go for mental care. Leadership has to encourage it. The courageous thing is to step forward and say you're having trouble.

● (1650)

That's a huge issue. We can have the best program in the world—remember our three pillars—but if we don't have leadership that's engaged and keeps the stigma down, then we're not going to get the members into care.

On the delivery of effective care, Dr. Whelan is absolutely right in the sense that we have been in such a hurry to set up phenomenal treatment programs that the actual quality assurance, making sure that what we're doing is working, has sometimes not been emphasized. The next step is to set up the outcome measures. We have little pockets of outcomes. We have satisfaction surveys; we have all that. But in developing a program, we need to look at reducing symptoms across the board. Our next step is to ensure that our programs are giving us effective mental health care for suicidal members.

I think part of the issue there is that we can focus on the person when he is on the bridge about to jump, or we can go back, and through effective leadership and education, and try to stop it before it gets to that point. That's what our targets are.

We talked about mass education, increased suicide awareness, and a mental health program. We have cradle-to-grave mental health education. We give people education at the recruit level. At the junior leader level, they're learning to look after not only themselves but also their subordinates. The officers are getting similar training. I just lectured about 50 or 60 captains in Kingston. People are getting it. It's a matter of training and education.

Psychotherapy and pharmacotherapy are team-based. They have access to clinicians, and there are no co-payments or limits, so members are getting access to evidence-based best practices.

I've just signed off on a new follow-up policy. If a patient doesn't show up, sometimes the CF tends to take a punitive approach. They will write a letter to the soldier's commanding officer, saying it costs this much money and he didn't show up. As soon as this policy gets published, it will be different. If you're a mental health professional and your patient doesn't show up, and you had an hour booked, before you do your paperwork, you call that patient up. You say you missed him, you ask if everything's okay, and you make another appointment. This will be standardized across the country. What the dentists do and the physiotherapists do may be different, but every mental health professional in our organization is going to take that approach.

With respect to media engagement, organizations like the CDC have guidelines for responsible and ethical reporting. One of our hopes is to meet with them at the higher level. CF members tend to be front-page news, even though there are 4,000 or 5,000 suicides in our country a year. We'd like for them not to bury it or hide it, but we'd like to point out that there's a balanced way of reporting. There are guidelines developed not by us but by organizations like the Centers for Disease Control.

Leadership has a great effect on the mitigation of work stress. A fellow is having trouble with finances. You can reprimand him and charge him, or you can give him Friday afternoon off to go see his bank manager to try to get things sorted out. That's the idea, the little things that leaders can do to keep things from becoming big.

Colonel Grenier can tell you all the initiatives we've done over the last ten years in terms of barriers to care.

Finally, you have to understand that not all suicides are preventable. We'll do our best. We'll do our absolute best. The way we've set this up is that the ancillary benefit of such a program will actually be improving the overall mental health of the Canadian Forces. That's our aim.

● (1655)

The last thing that we've been doing has been since April 1...and I just want to tell you the interest within our organization. In September last year we had our panel. Within a month we presented to the chief of military personnel. Two weeks after that, he sort of said, “Hey, this is good”, and he took us to the Chief of the Defence Staff. In his private office we presented it to him again. By February, Armed Forces Council was interested, and in February they endorsed the entire thing, all 61 recommendations.

As of April 1, the Surgeon General was directed, and now we're doing these investigations of every single suicide that occurs within the regular force where a team flies out. I've done two of them. A mental health professional and general duty medical officer will go into the unit, not wait for a board of inquiry of six to eight months, and speak to the members, speak to the treating people, review the person's medical files, speak to the MPs, speak to the chain of command, speak to the spouse, speak to the mother, and find out if we can learn something from this, if we could have done as an organization something different.

Within a month, a report is written, and the Surgeon General has the recommendations. Anything within health services that we can do to change, that we can modify, he can initiate that immediately. If it's something beyond health services then he will have to channel it to the chief of military personnel or the CDS, if necessary.

I'll stop there because I know we're running out of time. Let's get the questions going.

The Chair: I know we went a little over time, but it was a tremendous presentation.

The first questioner is Madame Zarac, for five minutes.

[*Translation*]

Mrs. Lise Zarac (LaSalle—Émard, Lib.): You mentioned that screening is done 36 months later and that it takes about 40 minutes. We just heard Mr. William Maguire say how important it is to establish trust between people. Then it is easy to talk.

Is it possible to build a relationship of trust in 40 minutes? Is it enough to detect that someone has problems?

● (1700)

[*English*]

LCol Rakesh Jetly: That's a great question.

Our organization is light years ahead of where it was years ago. In 2002 I actually walked down to Stadacona with a whole bunch of forms to do the very first screening on sailors. These are the guys who went out after 9/11, the 2,000 guys who went out. I'm sitting there I'm thinking, "Jeez, they're going to crucify us. Here I am in an army uniform and I'm going to walk on the ship and do this."

One of the crusty old petty officers that was on the ship said, "It's about fucking time. It's about time you're asking us how we're doing."

Many times over the years I've seen people who have come from the post-deployment screening, and I've asked, "You've been sick: so why now?", to which they've said, "It's the first time somebody has asked me."

Nothing is perfect, but you get education, you get training, you learn about these things, you have courageous people who are suffering illness stand up and say, "Hey, it happened to me, and I got help." In the context of—

[*Translation*]

Mrs. Lise Zarac: I am sorry to interrupt you, but here is my question.

Do you think 40 minutes with someone is enough? Shouldn't the meeting be longer?

[*English*]

LCol Rakesh Jetly: Yes. For a mental health professional to sit face-to-face, look somebody in the eye, and say, "How are you doing?", it's enough.

[*Translation*]

Mrs. Lise Zarac: Can a trust relationship be built in 40 minutes?

[*English*]

LCol Rakesh Jetly: Yes.

[*Translation*]

Mrs. Lise Zarac: All right, thank you.

I would like to talk about the first graph you showed us. Looking at a graph is all well and good, but I think we should go beyond that.

Could you tell me if you have studied something? You have the number of men and women. Have you compared them? Is the percentage of men identical?

That seems to be minimal, but I am sure there are many fewer women in the Canadian Forces than men. Is the percentage of female suicide proportionate to the percentage of male suicide?

[*English*]

LCol Rakesh Jetly: It's below.

Mrs. Lise Zarac: Much below?

LCol Rakesh Jetly: I don't know how much below, but the proportion is below.

This isn't done in my section. This is an epidemiology section. It's a statistic. For women, it is between zero and one, and in an organization of 70,000, statistically, it's very difficult to measure—

Mrs. Lise Zarac: Did you study why it is below? Do women have different duties than men and could that be it? Did you study the factors as to why?

LCol Rakesh Jetly: No, we haven't studied that. But since April 1, part of our new and more detailed investigation may result in some suggestion as we start tracking them.

Mrs. Lise Zarac: Okay, because I think you can get some answers if this is studied carefully.

Also, you see a decline and then it goes up again, up and down. Have you analyzed, in the years during which it goes up—

LCol Rakesh Jetly: That's not statistically significant.

Mrs. Lise Zarac: It's not?

LCol Rakesh Jetly: It's not. This is—

Mrs. Lise Zarac: The reason I'm asking is that General Dallaire's book just came out. In it there is a paragraph that talks about Vietnam; when a soldier lost hope of gaining anything—he went out into combat thinking, oh, this is going to be fast, and then in combat he lost hope—that was the beginning of the problems for him.

LCol Rakesh Jetly: That's very valid. Again, I think suicide is probably the worst way of gauging that. We should gauge that long before. We should look at mental illness, we should look at suffering, we should look at this.

Suicide—this is always the tricky part, because you need a degree in statistics to understand all of these, and I don't have that—has to do with the confidence bars there, similar to the polls before elections.

Mrs. Lise Zarac: How much is that done at the beginning, before somebody joins the army? Do you evaluate his mental health?

LCol Rakesh Jetly: No. Well, it's an overall health evaluation.

Mrs. Lise Zarac: But not specifically mental health.

LCol Rakesh Jetly: It's not specifically mental health, but you make sure that somebody is healthy; it's a recruit medical.

● (1705)

Mrs. Lise Zarac: Should we do it?

The Chair: Thank you.

Mr. Vincent.

[*Translation*]

Mr. Robert Vincent: Thank you, Mr. Chair.

I would like to talk about the patients referred to a doctor who diagnoses them with PTSD. In your experience, would you say that the Canadian Forces recognize the diagnosis at the outset and agree to compensate the applicant, or is the file challenged?

[*English*]

LCol Rakesh Jetly: The army doesn't have a choice. We have confidentiality. So the army will never—

[*Translation*]

Mr. Robert Vincent: What choice do the armed forces have?

[*English*]

LCol Rakesh Jetly: The choice to reject or to not accept the diagnosis...you know, the medical confidentiality.

If a soldier walks into my clinic in Petawawa and I give him a diagnosis of PTSD, I don't tell the head of the army that he has that diagnosis.

In terms of whether the culture accepts the diagnosis, yes, absolutely. Does the organization understand that when you send soldiers to war zones time and time again, some of them are going to come back ill? Absolutely. For the individual soldier, we will not divulge his diagnosis.

[*Translation*]

Mr. Robert Vincent: My question was more specific and I feel you were sort of trying to get around it.

If you ask a member of the Canadian Forces to go see a doctor and the doctor gives a diagnosis of PTSD, is the diagnosis made by the doctor—the doctor to whom the Canadian Forces sent the soldier—accepted by the Canadian Forces at face value? Will that person be compensated from that moment on? Or will there be a challenge instead? Will it take years to prove that it is a PTSD case even though we are talking about the doctor the Canadian Forces referred the person to?

[*English*]

LCol Rakesh Jetly: Compensated by Veterans Affairs or compensated by...?

[*Translation*]

Mr. Robert Vincent: I am talking about both.

[*English*]

LCol Rakesh Jetly: CF doesn't compensate. We treat our soldiers, so if somebody has a diagnosis of PTSD given by a professional who is able to give that diagnosis, our first approach is treatment. Basically with the patient, we determine what they desire—and most of our soldiers want to continue working and staying within the organization—so we provide them with timely evidence-based care for their illness. So yes—

[*Translation*]

Mr. Robert Vincent: Do you agree with that?

LCol Stéphane Grenier (Operational Stress Injury Special Advisor, Chief Military Personnel, Department of National Defence): I don't believe the diagnosis will be refuted. In the past, I have noticed that it could be rejected sometimes, following our recommendations on retaining a soldier in the Canadian Forces. I agree with Dr. Jetly in terms of the diagnosis not being refuted as such. But, at my level, it can happen that we try to convince the Canadian Forces to keep someone with a diagnosis like that.

I have often noticed in the past that the treating specialist's recommendations were not always accepted by the mental health bureaucratic system in the Canadian Forces. That's a fact. There are all kinds of reasons for that.

Personally, I am not a clinician. I try to get involved as much as I can, but, at some stage, the doctor's recommendations come into play.

I have actually noticed that in the past.

Mr. Robert Vincent: If I understand correctly, you are saying that, if a diagnosis has been made, it is recognized because it has been made, but it is not necessarily accepted for compensation since it can still be challenged.

LCol Stéphane Grenier: But, as Dr. Jetly said, the compensation does not come from the Canadian Forces. The compensation comes from the Department of Veterans Affairs. We often say that we should perhaps keep the soldier in the Canadian Forces, because that is a type of compensation in itself.

Mr. Robert Vincent: If the diagnosis is made, that means the member of the Canadian Forces can be told that he is done, he is laid off, he is no longer needed, and he becomes a veteran.

You don't keep someone diagnosed with PTSD. They are discharged, just like General Dallaire. You discharged him.

LCol Stéphane Grenier: I personally suffer from PTSD and major depression. I take my medication every morning. That's not necessarily the case anymore. That's what OSISS—the program we talked about earlier—does. We are really pushing the system to make sure the people who have received that diagnosis are not rejected right away. That is changing significantly. More and more soldiers are being retained. That's a fact. Is everyone being retained? No, they are not. I'm not better than anyone else, but I am still able to serve. I sometimes have bad days and sometimes things do not go well, but that's not the general rule. I believe it's just like any other medical condition. This has changed over the past 10 years. Would I like to be able to retain more soldiers? Yes, I would, but I am not going to tell you that they are all rejected. That is no longer the case.

● (1710)

[*English*]

The Chair: Mr. Stoffer, please.

Mr. Peter Stoffer: Thank you, Mr. Chairman.

Thank you, gentlemen, for coming.

In your first slide you talked about the number of suicides of CF members. Does this include reservists and any of those who have left the military?

LCol Rakesh Jetly: There are two initiatives going on. Actually, the statistics that we're showing are CF regular force.

Mr. Peter Stoffer: So that's reservists, veterans, their family members.

LCol Rakesh Jetly: Yes. I mean, veterans we wouldn't necessarily do anyway. I think the reservist is a good question. It's very hard to define reservists. Statistically speaking, there are people who parade one day a week, one day a month, and there are people who are on full-time contracts, those kinds of things.

Now, I don't know if you have heard about the CAMS study that we're just starting. From 1972 on, for anybody who served—veterans or whoever—we will have an idea of how they died, their mortality. So we'll have a good idea by looking at different illnesses, those kinds of things.

Mr. Peter Stoffer: Thank you.

On one of your slides it says that CF members have "excellent access" to pharmacotherapy and psychotherapy. Does that include reservists as well?

LCol Rakesh Jetly: For reservists, it depends on the type of contract you're on.

Mr. Peter Stoffer: It also depends on your location.

LCol Rakesh Jetly: Yes, all those factors.

Mr. Peter Stoffer: So not all CF members have access to this.

LCol Rakesh Jetly: No, they do.

Mr. Peter Stoffer: It says here they have "excellent access". I spoke to a couple in Thunder Bay who don't. They're having difficulty finding access. They have to travel from Thunder Bay to another area in order to get assistance.

LCol Rakesh Jetly: We are in a very large country. So you can't have a 50-person clinic on the west coast of Newfoundland—

Mr. Peter Stoffer: Understandable.

LCol Rakesh Jetly: —but you can fly the soldiers into Halifax to get their assessment. We have gone all over the Atlantic to try to train people. Somebody asked the question about training. We put on workshops to try to increase the level of knowledge within the professionals in the communities to help look after the soldiers.

Mr. Peter Stoffer: Okay.

A question was asked about screening prior to employment with the regular forces. Is there an extensive mental health screening process before a person is actually signed on with the CF?

LCol Rakesh Jetly: No.

Mr. Peter Stoffer: Okay. Later I will ask why, but I have a couple of other questions.

In terms of the families, we heard from Mr. Whelan that they're permitted two visits or something like that, according to what DVA may offer. Are any of these services allocated as well for the family members and/or their children, and are they just as extensive as for the veterans themselves?

And the last one is this. We still hear about a lot of guys who have been removed from the CF, and one of the biggest problems they have—Mr. Maguire talked about it—is the adjustment out of the military. You serve 20 or 30 years and it becomes a way of life—like that crusty petty officer you talked about. They have great difficulties in adjusting to the civilian life, and it causes a myriad of problems.

I know that transitional services are improving, but can you elaborate a touch more on what they're doing for mental health concerns, besides the pension in respect to this?

LCol Rakesh Jetly: Those are excellent questions. You might need to remind me of them, but I'll do the last one first.

Again, we've come way ahead. Nothing's perfect, but we have come way ahead in this area. It starts way back, but one thing we do have for members with chronic illness, physical or psychological, is the joint personnel support units that have been created on every base. So the people who need extra attention administratively, medically, and those kinds of things, belong to these units, which are on every base.

There will be a transition, so a person getting a release message will not be released from the Canadian Forces for at least six months. And "case manger" is the most badly defined term ever, because every clinic will have a different definition of case manager. But our CF case managers are all nurses, and one of their main jobs is absolutely to hook the person up with services after they leave. Again, it's a huge country and people have the right to move wherever they want. If I had my druthers, all of our members would release around large centres, for obvious reasons.

When they do know where they're to be released from the forces, we take care of details right down to telling them, "Make sure you apply for civilian health care." We don't have OHIP cards, right? We tell them to make sure they apply for a health card. We also ask them if they have a family doctor. If not, we try to set up the person with a family doctor. If we know where they're communicating from, our mental health professionals will try to hook them up with a professional in their region. If it happens to be in a region where there is a VAC OSI—and there are a number of them now—we will make arrangements for them to transition there. They might even be seen there while they're still serving.

So we make those connections with the professionals. Maybe we'll pay by Blue Cross or something like that prior to their release.

So it's now light years ahead of where it was. We're not tossing out people and hoping that VAC.... They can apply for their pensions early. One of the first things I do when I see a patient soon after diagnosing him, even if he is nowhere close to release, is to ask, “Have you put your paperwork in to VAC?” It's much easier to go through the process while they're still with us than somebody having to find them 10 years later.

So as much as possible, we have that transition. It's not rushed, but slow. And they can start their post-secondary education or college while still serving. Within the last six months of this September, they can start in school and still come to our clinic to get care.

As for the families of the members, we are governed by the Canada Health Act. My family doesn't get care on the base either. And when we move, we had to find pediatricians and doctors for our own kids, as well.

We are allowed to provide care in support of the member. Within mental health, we stretch that as far as we can stretch it. So it doesn't mean the member has to be in the room. The member could be overseas. If the spouse walks into our psychosocial services unit and says to our social worker, “I'm having a hard time”, we will help the spouse right there.

When we're treating people and talking about PTSD, part of our standardized assessment across the country is to have the spouse come in within the first or second session. Keep in mind, it's within the member's confidentiality. He or she has to allow the spouse to come in. So very early on, we'll engage the spouse in the process and the education we provide, telling them what's going on.

We run regular educational groups for the spouses. We run couples groups for a week in Halifax. We'll fly people in, for example, to get some education about the illness, coping, anger, stress, families, raising children, and those kinds of things.

So as much as possible, we do provide help. It's not going to be a U.S. TRICARE service. For example, if a spouse suffers from depression, I can't write a prescription for an anti-depressant. We're held back in that sort of way.

● (1715)

Mr. Peter Stoffer: And the screening?

LCol Rakesh Jetly: The screening—

The Chair: I know that Mr. Stoffer asked quite a few questions, and we have gone overboard here. I must say that a lot of it was very good, but Mr. Mayes has a question.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Chair.

Thank you to the witnesses for being here today.

Gentlemen, because we're talking about the context of the Canadian Forces, there's an assumption here, I think, that the suicides on this chart are directly related to combat or the vocation of being in the Canadian Forces.

I was wondering if you had really identified whether that was the case, that every one of these recorded suicides is a direct result of combat engagement, rather than living conditions, for instance. If you live on a base, there could be a lot of people around whom you're stuck with on a base and you might not get along with, or there are family or personal problems.

Have you broken that figure down to really identify how many of those suicides are directly related to being in combat?

LCol Rakesh Jetly: I can start.

Statistically, we've shown that it's not. There's a very interesting thing here. Statistically, there's a thing called association. I've deployed four times. Stéphane Grenier has deployed as well. We've both been in Rwanda. We've been in Afghanistan. We've been places. There's definitely an association with these places. If seven years, ten years, from now something were to happen to me, how would you causally link that to my tour?

Having said that, we have looked at it; it's different from our allies, but all of our allies are looking at this. Deployment, per se, is not associated with it. The numbers are too small. But the majority of the suicides that have occurred this year, for example, have never deployed. Causality aside, we're not going to have the association.

Clearly, OSIs, PTSD, and depression are illnesses that increase a person's risk. I think it's a very interesting area to look at. Longitudinally, if people, after they release, have their illnesses later on and lack the containment and the care system of the CF, what happens? I think that's an interesting area, and our colleagues at VA will be looking at that.

So far, the data from Stats Canada and various sources do not bear out that theory.

● (1720)

Mr. Colin Mayes: I feel that extreme stress and depression are... have some of the characteristics of an addiction, whether it be drugs or alcohol. There are some external pressures that are forcing this behaviour.

I'm not an expert here. I don't want to give you the impression that I really know a lot about this, but as a person who has had some stressful jobs, you find that the stress can become a habit.

Is part of the work to identify those external pressures, take action to get out of that cycle, and finally identify the symptoms so that you don't fall back into that same cycle?

LCol Rakesh Jetly: Absolutely.

That's a personal thing, but it's also a leadership thing. Sometimes you have a very keen member who keeps jumping up and keeps volunteering for tours. As a leader, sometimes you have to say, “That's enough. Take care of things at home.”

What we're trying to teach are individual coping skills, these big four. They're so basic. We should be teaching them to kids in school. Ideally, our next step is to sort of take some of this stuff and introduce it into society. These are such very basic skills. Learn how to look after yourself; then, as a leader, look after your people. I think that's the key.

As a health care professional, I have nothing to do with that. When it breaks or doesn't work, I'm happy to be there, but I think the culture needs to be such that we recognize that we can burn people out. We can use them too quickly. Sometimes they're their own worst enemies. In a competitive organization, in which results get success, every once in a while you need to sort of have that pause. When you look at a lot of the differences between our stats and U.S. stats, that's the difference: six-month tours versus 12- and 15-month tours. There's a huge discrepancy in terms of how much reserve a person has and how much energy they have.

Mr. Colin Mayes: Thank you.

Do I still have some time?

The Chair: No, you don't at this point. I'm sorry.

I'm going to ask for one question. We only have a few minutes. We'll have one short question, and hopefully we can get the answer.

Ms. Duncan, you can have one question.

Ms. Kirsty Duncan: Thank you.

How often are you screening, and who's doing it?

LCol Rakesh Jetly: The screening is called enhanced post-deployment screening. It's done three to six months after every deployment for anybody who's had a deployment of 120 days. Because we have it canned, we will decide to use it in certain situations, even if they're not that long.

For example, in the case of the *Chicoutimi* sailors, I was in Scotland with them, so we decided what they had gone through warranted this, and we screened them and followed them. So it's done three to six months afterwards.

There's a lot of evidence that shows that if you ask people right when they get home, it is too soon, because everybody's fine. So just like our allies, we use a three- to six-month window. Following every deployment, you'll have it multiple times. There is a series of evidence-based questionnaires on depression, PTSD, and all that. They're scored and computerized, and then the mental health nurse, usually the mental health professional who is actually doing the face-to-face interview, has those scores in front of them and can specifically target whether you're talking about sleep, anger, or drinking, but also, if there's really not much there, can say, “How are things going?” There are semi-structured, really broad questions in terms of personal function, life function, family function, and work function. There's a very holistic approach to these things.

I've been screened a couple of times myself. Just because I'm the boss or I'm the senior person...there are no exceptions; I still get tapped. It's a chain-of-command responsibility to make sure that people get screened. It's not the responsibility of health services. The reservists are actually more compliant than are the regular force members, so the reservists are being screened as well.

● (1725)

The Chair: Okay.

Mr. Kerr, and then Mr. André.

Mr. Greg Kerr: Thank you, Mr. Chair.

We don't have time, I realize, but I was going to point out that with the new clinic going up at Greenwood Air Base in the valley, everybody has been talking about the fact that mental health is being brought in as part of the team package and about how important it is. I was struck by that, because they were all talking about that team work and the collaborative part.

I have a question with regard to the stigma. We were at a conference recently in Montreal, a symposium in which Veterans Affairs and civilians were involved. I realize the comment about too much media attention has been made, but at the same time, how many professionals were pointing out that the stigma is still there in many mindsets, and that the public understanding that this is as serious as any physical...? I'm just wondering how you'd address that.

LCol Rakesh Jetly: Just to complement what my colleague here said, we are recognized, within NATO, within the armed forces, as the “stigma busters”. I will go to a NATO meeting and people will say, “Well, in Canada, you guys have that sorted out.”

It's not as perfect as that, but it asks the exact same questions of British soldiers, U.S. soldiers, and Australians. Our stigma—the perception of people being weak, this kind of thing—is about a third of the other nations'.

So the campaigns—OSISS, “Be the Difference”, all of these things—have been working. In fact, we asked 2,500 soldiers in one block, one year, “Would you think less of somebody else who was receiving mental health care?” and only seven percent of them said yes. So we've come way ahead. In my career, there was a stigma against mental health professionals when I started, never mind patients.

It's not done. We're not done. But I think we need to look at other barriers to care as well. There are structural barriers like geography. You can take down all the stigma in the world and you're not going to make the country smaller.

So I think we'll never lose sight of that stigma and that culture, because as soon as you look away, it's going to rear its ugly head again. People like Bill Wilkerson in the economic round table point and say, “If the Canadian Forces can do this, why can't Ford, or why can't these other large companies?”

The Chair: Thank you.

Mr. André, you can have one short question and answer, please.

[*Translation*]

Mr. Guy André: I have a quick question about your involvement in terms of suicide while in service. Let's take Private Couture for example. The soldiers in Afghanistan made a suicide pact. He attempted suicide while he was serving. He came back here, he was suffering from PTSD and killed himself. So I am wondering about your intervention protocol in terms of suicide while in act of service. Let's talk about health care. When professionals are trying to prevent suicide and they feel that a person is at risk, they can breach confidentiality, intervene and hospitalize that person. In the case I was talking about, the soldier was not hospitalized, at least I don't think so. There was a suicide pact and these people came back here. I only have one minute and I would like to hear what you have to say about that. I would have liked to have more time, but one minute is not that long.

LCol Stéphane Grenier: I have tried to kill myself three times. My wife found me during my last suicide attempt. I had a cable and I was in the middle of writing my suicide note when she found me. I am not trying to defend the armed forces, but no one saw that coming. In fact, according to Dr. Jetly, that is not even in my file.

I am not defending the system. We must still turn the corner. But the armed forces never saw that coming.

● (1730)

Mr. Guy André: I am talking about a suicide pact that was on TV. That was a known fact, even on the ground.

LCol Stéphane Grenier: That's right, but there is a difference between the suicide pact on the ground and what happened five or six months later, while the soldier was in rehabilitation. He was being assessed by the system that was trying to find out whether he was in good condition or not.

Personally, I have been under a psychiatrist's supervision for years and my doctor let me come home, when he knew I was really not doing well. Where do you draw the line? I don't want to defend the doctors either, but where is the line that allows us to know whether to commit Stéphane Grenier or to send him home? It is not always easy.

Mr. Guy André: I was asking the question about the professionals.

[*English*]

LCol Rakesh Jetly: I'll never speak about a specific case, and I don't know the details of the case you're speaking of, from a medical point of view.

In general, we have a robust Role 3 hospital in Kandahar. We have mental health professionals; the Americans have taken over. We absolutely train our leaders. If the leaders are concerned about members, they bring them in themselves, and that's so refreshing. It's music to the ears of a mental health professional if a sergeant or a warrant officer will say, “I'm worried about my guys, doctor. Can you see them?”

There's a suicide assessment. Nothing is perfect. You do your best training. You do your best to assess risk, to assess fatality. In a war zone, where people have weapons, the risk is higher. We will keep the person, restrain the person. We'll take his weapon away. We will put him on a C-17 and send him to Landstuhl if we have to, tied to a stretcher, medicated. Again, nothing is perfect.

I feel for every case and feel for every mother who goes to the media. We have a heightened awareness. These aren't the soldiers of the Canadian Forces; these are the people who wear the same uniforms as us. These are my comrades in arms, not my patients.

There are systems in place. If somebody is worried, we say, “Come for help.” They get briefings on mental health. The chain of command knows they can't ever stop somebody from going for care. The chain of command is told to get them to the doctor, and we have our policies and procedures in place. Despite all that, people are still going to die from their physical wounds, and there will be people who are going to have mental illness and attempt suicide.

The Chair: Is there any pre-screening before you join the forces for mental health problems?

LCol Rakesh Jetly: There's a health screening. There's all kinds of legislation, human rights and all that. There's a health questionnaire, and for now it's based on the honesty of the person—i.e., “I have a peanut allergy.”

In fact, next week we are briefing all of our physicians' assistants who do the medicals across the country. They've asked me and my colleague, the addictions expert, to help them in dealing with someone who says he had a problem with alcohol a few years ago but is fine now. If you go to your civilian doctor, the civilian doctor sends a note that says he had the problem but he's fine now. So how do we help our colleagues with that?

Yes, there's a health screening. Mental health is part of health. There's no separation there. But it is difficult to predict behaviour with these screenings. There are no perfect screenings.The special forces do it; some of these organizations do it. How predictive is it? We debate. Having a personality profile to predict whether a soldier is going to do well or going to do poorly would not stand the test of human rights. A disease or a diagnosed illness is different. A personality profile or an IQ test, I don't think that would be effective. We haven't come up with any such test, and none of our allies have either.

The Chair: Thank you for your presentation today.

The meeting is adjourned.

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