House of Commons
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 041 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Wednesday, March 2, 2011

Chair

Mr. Gary Schellenberger

Standing Committee on Veterans Affairs

Wednesday, March 2, 2011

● (1530)

[*English*]

The Chair (Mr. Gary Schellenberger (Perth—Wellington, CPC)): Good afternoon, everyone. Welcome to the 41st meeting of the Standing Committee on Veterans Affairs and, pursuant to Standing Order 108(2), a study of combat stress and its consequences on the mental health of veterans and their families.

Our witness today, from 3:30 to 4:30 via video conference from Vancouver, British Columbia, as an individual, is Marvin J. Westwood, founder of the Veterans Transition Program.

Welcome, Mr. Westwood.

I am Gary Schellenberger, the chair of the standing committee.

If you would like to, please make your address, and then hopefully we can keep our questions short and to the point. We look forward to a very informative hour, sir.

Dr. Marvin Westwood (Founder, Veterans Transition Program, As an Individual): Thank you, Mr. Chairman.

I will give an address, but just before I begin, can I clarify something? I have been invited to be a witness today. Just for my understanding, I'd like to know how my input will be helpful to your committee. Could you just help me? You do work in a different sphere than I do and I don't want to go on false assumptions. I understand we're talking about the topic—I know that—but how does this help inform your committee and where might this go?

The Chair: We are doing a study on suicide and mental problems within the military, particularly in our military veterans; a lot of it is that our veterans are coming back from Afghanistan and various other deployments with PTSD. So this, we feel...again, in the transition from the forces to veterans, is there a gap there? How can we handle that? Can we affect the mental condition of our veterans better by a better transition from the military life, which they're probably used to, to civilian life?

Dr. Marvin Westwood: Thank you very much. I appreciate that reminder.

First off, Mr. Chair, did you receive a copy of my presentation notes? Did the committee receive that today? Maybe they weren't ready for translation.

The Chair: We have translation, sir.

● (1535)

Dr. Marvin Westwood: Do you have the documents translated as well?

The Chair: Yes.

Dr. Marvin Westwood: Thank you very much.

Let me begin by saying that I really appreciate being invited to make a presentation to this committee, because the issue of soldiers and veterans returning to Canada is, in my perspective, one of the priorities in Canada at the moment.

Why do I say that? I say that because so much of the attention in the media is on, quote, PTSD and suicide and that kind of highly recognized injury, but there are whole other areas of costs to Canada that I think are not addressed. I'll address those in my presentation today.

I want to start with us recognizing that for every soldier who returns, if they have received an injury—and we call them war-related injuries, psychological injuries—not only does the trauma affect them, as you know, but it affects them, their families, and also the communities they return to. If these injuries are left untreated and unassisted, it's my perception from my work of the past 30 years that what happens is that not only do we lose this particular person's contributions to society, but there is a very serious impact on spouses, children, and the workplace.

One of the things I want to remind the committee of, to maybe put this into a term that they use in the health sector, in medicine, and so on, is that they talk about potential years of life lost. We can do cost estimates in our society. When people have injuries, whether physical or psychological, and are no longer able to contribute and function, not only do they lose, but society loses, and it has a tremendous cost to us.

So of course I am very interested in talking today about a program we're working with out here at UBC. It's sponsored by the Legion. It's called the Veterans Transition Program. You will notice the focus: it's the Veterans Transition Program. What I'm saying there is that it's about how we get these men and these women back into being productive, successful citizens of Canada. If they are injured, especially if it's a psychological injury, which the soldiers themselves refer to as an invisible injury, it's not often picked up, they don't access services for a whole lot of reasons that I'll address in a moment, and we are observing an enormous cost in our society. There's a moral issue and there's the economic issue. That's why I'm involved in this.

On the other hand, when in my work I see these same people have successful recoveries from their traumas, be reunited with their families and their children, get back to the workplace, go on to university, college, or technical school, and be productive citizens again, it is really very inspirational to me. So I am actually quite optimistic about what we can do in Canada with assisting veterans back into transitioning into Canadian society. Why do I say that? Because we do have the expertise. We have the medical expertise and we have the psychological expertise to achieve that.

Now, where did I get my training? I learned it in the trenches from the 85- and 90-year-old World War II veterans that I worked with 25 years ago in a project sponsored by Veterans Affairs Canada. I met with them in groups to find out their life stories and to find out how the war affected their lives and their transition back to Canada. There was no doubt in their minds when we finished the project....

In one of their biggest recommendations to me, they said, “Westwood”—they called me Westwood—“the problem with your program is that there's only one problem”. I asked, “What's that?” They said, “It's 50 years too late”. They said they needed to tell their stories and they needed assistance with transition 50 years ago. They said, “We wouldn't be where we are today, carrying the same baggage”.

And they refer to it as baggage, Mr. Chair. We don't use psychological terms too much today because soldiers don't use them. They call it “dropping the baggage”.

Some of these older veterans that both Dr. Kuhl and I.... Dr. Kuhl is a colleague of mine. He's from the Faculty of Medicine and was the director of the palliative care unit at St. Paul's Hospital. A lot of the patients on that unit were these 85-year-old men and women who had served in World War II and the Korean War. He observed—and it's well documented and researched—that if people don't deal with their war injuries, and I'm talking about the psychological injuries, their deaths are very difficult. The injuries are unresolved.

● (1540)

What we're doing now in working with the younger soldiers, based on the recommendations of the senior soldiers, is offering a place in the transition program where they start to drop the baggage by first telling their own stories about how the war has impacted them and their functioning.

I think I need to say that what's unique about the program compared with some programs we offer is that the program is really run by or supported, if you like, by other soldiers. In the team that works together with these modern-day soldiers coming back, we have physicians, psychologists, and therapists, but we have another important part of the team, and that's paraprofessionally trained soldiers. These are soldiers who have had deployments, have returned to Canada, have been through the transition program, and want to give back and be helpful. We train them to work with us. Hence, the soldiers coming into the program feel very confident that other soldiers are there on the helping team, and they have confidence and trust in that.

I've learned the hard way, as I'm sure some of you have who work with veterans, that by and large a lot of them do not trust us as civilians. There are two reasons they don't trust us. Number one is that they say to us as professional helpers, “You guys have not been there, and you haven't served, so how do you understand my story?” That's number one. Number two is that if these services are delivered through the Canadian Forces or through Veterans Affairs, many of the soldiers I meet won't go there, because they don't trust that the information will be kept confidential. So what do they do? They avoid. That's helping no one. It's not helping us and it's not helping them.

Now, some, of course, with the OSISS program...they have developed programs and ways to facilitate, and I really support that, but I have learned two points. Number one is that if you're going to be helping soldiers with war-related traumas, you need to involve returning soldiers. Why? It's because soldiers like helping soldiers. These men and women are highly experienced by the time they come back. They've been there. They have experienced what has occurred, and, with training, they're a tremendous support to any transition team like the one we have operating in this part of Canada.

It was humbling for me as a professional to find out that their respect for me came a great deal from my proving that I understood their lives. I understood their lives by listening to their stories. A veteran who goes to a VAC office sometimes will say to me, “I don't want to go there, because how do I know that the person who greets me at the door understands anything that happened to me?” I started learning very early from them what they need in order to have confidence and what they need to proceed, to feel like entering into some kind of treatment program.

That's the background.

So what have we done? Mostly, we are now serving veterans who are being released from the services. They have had deployments overseas and then they come into the Veterans Transition Program, which occurs over a three-month period, as you can see. It's residential. For the most part, they come into this program with the idea that they want to move away from their service in the military back into civilian life.

But if they have trauma-related injuries, it's almost impossible for them to move back into civilian life. Why? Because if you understand trauma, you will understand that what trauma does to people is alter their thinking. It leads to disorganized thought. They carry all the symptoms where they can be easily triggered and they don't feel safe. What we notice in many soldiers is that they want to isolate and retreat. I'm not telling you anything new, and I know that. You as a committee would be astute enough to know that a typical symptom of someone with a psychological trauma is that they want to go away, hide, and avoid. Why? It's because there is shame involved, especially for a soldier.

Now, we have to understand that soldiers come from a particular culture, and what is that culture? It is a culture that—and I like to think of it this way—values things such as being strong, self-sufficient, and not needing help. If they imbibe that culture and return to this country with an injury, we can all imagine how difficult it is to say, “I need assistance”. That violates everything they have been trained to do. So what my soldiers often would do is avoid getting help.

Well, but they're still suffering. What do they do? You know as well as I do. They avoid, they medicate, and in the worst-case scenarios, the pain is so enormous that they kill themselves.

● (1545)

Right away I think we have to recognize that we can build bridges with these people, these men and women, in different ways. We can also offer services. We have the PTSD clinics across Canada, and they certainly provide a service—symptom reduction—using their conventional methods. VAC's OSISS office helps, but when we look at the statistics of how many people visit those offices, it tends to be a low number.

Why? Because many of them are avoiding our services. We could stand on our heads and do cartwheels, and I still think that certain soldiers would never trust us to give service if they see us as representing a government agency. That's what we're dealing with.

That's by the way of background.

The program that I think I've been invited to talk about has been running now...close to 200 soldiers have been through it. To date, a majority of them are now reconnected with their families. They're showing progress, with many of them going back to school or upgrading employment. Why is that? Well, it works because—notice—the program we're talking about is a transition program rather than a PTSD program. Yes, we treat PTSD, but the latter part of the program is focusing on how you set new life goals and how you get the resources that are out there to get your life back on track.

It's my observation that the best way to help soldiers isn't to feel sorry for them and to give only our medical and psychological services to them, but to remind them that they are contributing citizens, that they can be productive again, and to give them the resources and skills to do that. I'm not pretending for a moment that the program I'm working with is something I'm recommending for everybody, but I think it began as a good pilot project, and it has promise.

Therefore, most recently, we received a lot of financial resources from the Royal Canadian Legion to begin to capacity-build and to train professionals as well as paraprofessional soldiers to create some other teams that could go to other parts of Canada—if invited—to deliver such a program with the soldiers.

It's a group-based program. Why is it a group program? It's because, as I said, soldiers help soldiers. Soldiers know very well how to help one another. They live in groups and they work in groups, so I find this modality highly effective. As the professional team, we set the guidance and the direction for them to move forward.

More recently, we have had follow-up groups for the soldiers. Soldiers are very keen to stay in touch with their unit. They would refer to our program here as a unit, a new unit, and they like to stay in touch with their units when they get home, so what we try to do is have monthly meetings. We're getting that going now.

That's by way of an introduction. There is more that I could say. I think I've said a lot.

I look forward to questions of clarification or more information as needed at this point.

The Chair: Thank you, sir. That was a great presentation.

Our first question is from Ms. Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you very much, Mr. Chair.

Professor Westwood, it's real pleasure to listen to you this morning—sorry, I mean this afternoon. It has been a long day already.

Many of the things you say are similar to the things we have heard from some of the soldiers themselves. You've talked about the World War II vets and the fact that it's 50 years too late. Often as we're doing this work, we think of all of what we're trying to do for the veterans today, and we think back to what was being done for those folks 50 years ago. Clearly, very little was being done in those days. I think that now we're trying to avoid as many of those past mistakes as possible and to look forward to how we can help many of these young vets who are coming home now.

You talked about the invisible injuries and the men's and women's unwillingness to address them. You were saying that they will do everything they can to avoid that. Clearly, you can't force people to get assistance, so isn't it a case of recognizing psychological problems early on in order to get them into the right veterans transition program—we can call it whatever we want to call it—and to get them into a mindset in which they recognize that as a result of what they have seen and experienced, they are clearly going to have some sort of trauma, whether it's today or tomorrow? Then we could head things off rather than have somebody commit suicide and then realize that overall as a community we failed that individual by not recognizing it earlier.

● (1550)

Dr. Marvin Westwood: Judy, I'm agreeing with what you're saying here. I want to just say that we have found that one of the best ways to invite young men and women in earlier for help is not for us to invite them in, but for other soldiers to do it. They look out for other soldiers. Our soldiers, who are the paraprofessionally trained soldiers, will go out into the community and will invite other soldiers and say, “This happens, it happened to me, and I've been successful, so why don't you come to a meeting?” It's an outreach by the soldiers. I think that's the only thing I have observed that really is effective: because they trust other soldiers more than they trust me as a professional, as a doctor of psychology.

Hon. Judy Sgro: I would agree with you. It sounded a little like an AA program. They're more apt to listen to somebody who has been through something than to listen to some professional. Are programs like your Veterans Transition Program available and operating in other countries?

Dr. Marvin Westwood: No. They aren't at the moment, because this is a Canadian initiative.

I just came back last week from the United States. They have a battalion program in Hawaii and they invited me to come down there. I did a presentation to them and today I received a request: could the Canadian approach to this kind of work be brought down as a presentation to them? So there's interest in other sectors. Israel and the United States are two places that I've presented in, for example.

What's unique about the program, which I don't think is anything that special—I think anybody could do it—is the fact that most professional groups don't use soldiers helping soldiers.

Hon. Judy Sgro: Maybe they should.

Dr. Marvin Westwood: Yes. Maybe they should.

Hon. Judy Sgro: Is most of the funding that you have received from the Royal Canadian Legion? Am I accurate in that statement?

Dr. Marvin Westwood: Yes. Currently all the funding comes from the legion.

Hon. Judy Sgro: Have you applied to Veterans Affairs Canada for funding?

Dr. Marvin Westwood: I have in the past and was not supported in that endeavour. About 20 years ago, Veterans Affairs supported a study I did with life stories of World War II veterans. I was appreciative of that and was kind of surprised when they didn't seem to want to support this initiative. I think it's because they see that they have their own services.

Hon. Judy Sgro: Well, part of the study we're doing today is to look at how we can improve those services.

What is the age range of the men and women that you have had an opportunity to work with? What are the ages?

Dr. Marvin Westwood: On ages, what I've learned, Judy, is that a soldier is a soldier is a soldier, whether they're 25 or 75. The age range of the current program now is maybe 27 to 40 or so, but every now and again.... A few years ago, we were having people from the former Yugoslavia, soldiers that had been back as peacekeepers, so we had people in their 50s and 60s. So the whole range I think would be from 27 to 60 years old. It's never too late.

Hon. Judy Sgro: Of course it's not.

Have you been able to figure out how to assess a success rate with many of the men and women you've worked with?

Dr. Marvin Westwood: Yes, we evaluate success in two ways.

We have psychological outcome measures. There are two studies we have going. We look at rates of depression and self-esteem and then at other factors like anxiety and depressive thoughts. These are outcome measures.

But to me the most important measure is the part of the study in which we follow them for up six months later and, in some cases, two years later. We look at their active employment and family reunification. If they are actively employed, getting a new career, and back with their families, we see that as progress.

But this doesn't lend itself to the same kind of psychometric measures that you often see in these studies. We follow up with many of them because they want to stay in touch with us. Once they've been through the program, they will often call back or call some of their buddies in the program. We currently have a new research project focused on long-term effects. We'll go back 10 years to assess some of the graduates of the program.

Hon. Judy Sgro: Congratulations, Professor Westwood. It sounds quite fascinating. I wish you much success. Thank you for caring so much about these men and women.

● (1555)

The Chair: Next question, Mr. André.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good afternoon, Mr. Westwood. Are you able to hear the simultaneous interpretation?

Dr. Marvin Westwood: Yes, it's working.

Mr. Guy André: I am glad we have the chance to discuss your PTSD transition program. You talked about services becoming more decentralized so that veterans can have access to self-help groups. People who go through similar situations can share these traumatic events and help each other. This helps them with their therapy and the healing process.

But I have been noticing a common problem in Quebec. I guess it also applies to the rest of Canada. Veterans who live in remote rural areas have a hard time getting to PTSD support services in cities, because the distances are often quite considerable.

I am going to talk about Quebec, but I am sure the situation is similar in the rest of Canada. Could we develop local services in the various areas of Quebec, in CLSCs? Could we train professionals to provide these services to veterans? What do you think about that? I think the system is highly centralized and it is not accessible to the entire target population.

Dr. Marvin Westwood: Thank you for your question, Mr. André.

[*English*]

I think it's a very good question.

There are two things I want to say. The answer is yes. We could train professionals accompanied by paraprofessional soldiers helping people in rural parts of Canada and Quebec. Why do I say that? I say that because soldiers know where other soldiers live. They seem to have their own network through the Internet. They seem to know where people are.

I think it would be a very good suggestion to have rural teams go out to where they are living, because many times they don't live near the large cities. We're facing that same issue here. I totally support the idea of going out into rural Canada and Quebec as long as we include other soldiers who are part of that team, because other soldiers being a part of the team gives confidence to potential newcomers.

[*Translation*]

Mr. Guy André: I do think the idea should be developed. This is about the link between the public sector and veterans. I think there are things we can work on.

I would also like to hear what you have to say on the issue of screening. We see that many veterans develop PTSD after a military mission, two, three, four or ten years after the traumatic event. Sometimes, they realize relatively late that they have been living with PTSD.

Through your research, have you developed tools to help you be more successful in screening people who could later develop PTSD? There does not seem to be any follow-up as such. It seems that people leave the army, go home, and, only later, it is usually their families that notice a change in behaviour.

[*English*]

Dr. Marvin Westwood: You've just identified one of the conditions of PTSD, which is that it doesn't present or become obvious until months later, so many people are not diagnosed.

No, we haven't developed any measures. What we have done is contact other soldiers who have been through our program in order for them to go out and make contact with newly deployed soldiers coming back, to let them know that this kind of program might be available if they wish to take it later. I think we could do a lot better job in this country at the point of deployment.

When they do the decompression program in Cyprus, we could perhaps do a better job of giving them information at that time by saying, “Look, when you return home, maybe up to 30% of you—you may feel fine now—will develop symptoms later, and these are normal, this is a normal part of a re-entry program, and this is how to make contact”. But the hard thing about working with PTSD and the military is that most military people at the end of their service just want to get home and want to avoid any contact with organizations. That has been my experience, so I don't think we've been very successful at identifying potential candidates.

But in reference to your notion of screening, when people apply to come into our program, we do screen them, because some of them are so severely injured with PTSD that they need more medically focused treatment, with psychotropic drugs or individual work. That is done in the PTSD clinics. Then they become stabilized and are ready for the group. All of our work takes place in a group.

● (1600)

The Chair: Mr. André, just a short one, please.

[*Translation*]

Mr. Guy André: In my opinion, when we are working with people struggling with PTSD, it is important to build on information from the families. There seems to be a lack of information from families living with soldiers who are likely to develop PTSD.

Don't you think we should put more emphasis on information from the spouses and families of those soldiers? I think they are in a better position to identify the symptoms.

[*English*]

Dr. Marvin Westwood: You're absolutely correct. I think the families are the best early warning systems of when returning members are showing signs of symptoms, so absolutely, we should work with families in a preventive way to inform them of what to notice, what to expect.

One thing I do need to say to you in the committee is that it's been my experience as a psychologist that there's a certain amount of social stigma and shame around having PTSD, so sometimes a family under-reports, as well as the serving member himself. So we have to normalize it and get this information out that the best way to help a loved one in your family is that if you see these symptoms, go with them and help them make contact with the service.

The Chair: Thank you very much for that.

We'll move on now.

Mr. Stoffer, five minutes, please.

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

Dr. Westwood, thank you very much for appearing today, and thank you for the work that you're doing.

My first question for you, sir, is this. You said that 20 years ago the federal government assisted you financially in a project you had done with war veterans—of World War II, I suspect. Have you or your organization in the last five or 10 years made a formal application for funding to the federal government—to the military, to Health Canada, or to Veterans Affairs—to assist you in your project? If you have, what was the response? If you haven't, why not?

Dr. Marvin Westwood: That's a good question. You said in the last five years...? No, I have not attempted that in the last five years. In the last five years, when I didn't meet with success in my early request for funding from Veterans Affairs, I met with the Legion, and they were very eager to support it. They provided us with all the resources that we needed here at UBC. I have not applied since that time because, frankly, I felt defeated.

Mr. Peter Stoffer: Say that again, sir: you didn't need it...?

Dr. Marvin Westwood: I felt defeated.

I felt defeated. From the response to my request and my suggestions to VAC a few years ago, I didn't feel very much support or reinforcement. I was using an approach that was unconventional and not in line with the protocol that VAC was using at the time. They focused primarily on individual treatment at that time. I was proposing group-based work.

Mr. Peter Stoffer: Well, Dr. Westwood, I would just make a slight recommendation to you that you consider making an application to DVA just to see what their response would be in 2011. I can't answer for the government or the minister, but hopefully you might get a different response. one that would assist you in what you do.

Here in our papers it says that since 1997 approximately 200 soldiers and veterans have come looking to you for assistance. Yet we know there are thousands more out there who need help, there's no question about it, and for a variety of reasons they're not getting that help. So my other question for you is this: do you assist any RCMP veterans at all?

● (1605)

Dr. Marvin Westwood: Yes. In my program we've had two RCMP veterans request to come to our program. The rest of them are soldiers, but we've assisted the RCMP with two, most recently within the last two years.

Mr. Peter Stoffer: Do you assist anyone else, such as municipal police, firefighters, or anyone of that nature at all outside of the federal responsibility of veterans and RCMP?

Dr. Marvin Westwood: No, just the returning veterans and the RCMP.

Mr. Peter Stoffer: In your discussions with the soldiers, veterans, and RCMP members, do you invite or do you ask to invite certain family members to come in with the individual at the time?

Dr. Marvin Westwood: Yes, we do. We have what's called a spousal program.We invite the spouses to attend a separate program that occurs at the same time that we offer ours. Ours is a 10-day program spread over three months. On one of those particular days, we bring the spouses in, to wherever we're meeting, and we give them a program and provide them information, support, ongoing future direction, and referrals if needed.

Mr. Peter Stoffer: Sir, my last question for you is on the comparison between regular force individuals who you assist and those who are reservists. I was wondering if you could break that down for us. In your work that you've been doing for the last 14 years in this regard, is it difficult for reservists to come forward or is it difficult to try to find them in order for them to seek out the assistance they may require?

Because along with that, here's what my question is leading to. Obviously when these soldiers are integrated into civilian society, they're working in other jobs and they feel like productive citizens. Do you work at all with any prospective employers out there who hire these soldiers and veterans to let them know certain things to watch out for in the event that their symptoms resurface in their new place of employment, in order to assist the new employer in what they may or may not encounter in the future?

Dr. Marvin Westwood: I wish I could say yes to that, but the answer is no. I haven't done that with employers.

I'll tell you who I have done that with, though. My team is working with the B.C. Institute of Technology here in Vancouver because they have a program for new veterans coming in. We work with the instructors, the staff at the school, the faculty and so on, to help them be alert and anticipate the special needs of this population.

But I think your suggestion of doing this with employers is excellent. We just haven't done that. We've just been focusing on working with the soldiers themselves.

Mr. Peter Stoffer: Thank you, sir.

The Chair: Thank you.

Next question, Mr. Mayes, please.

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

Thank you, Dr. Westwood, for being with us today.

I do have a question, but first I'll give you a little background. I was with Veterans Affairs here five years ago when I was first elected and, of course, the plan was to move Veterans Affairs away from being just a benefit plan to a life support plan or a caring plan where we were following the veteran and making sure that all their needs during their full life after service were cared for. That is why there was the inception of the Veterans Charter and then the further review that we've been doing to carry that out and to improve that system. This study is just a furtherance of that.

One of the things we've heard in previous testimony was about the importance of family—and you've mentioned colleagues—as far as helping those veterans who are suffering from PTSD and those who might be suicidal is concerned. What about...? You've stressed colleagues. Previously there were a lot of witnesses who said that it's important for family to be involved in that support, and I would even suggest the community, whether it be the local Legion or even church groups or organizations that are there to support those veterans. I was wondering if you have any of that as far as your transition program goes in looking for support for those veterans you're dealing with.

● (1610)

Dr. Marvin Westwood: So far, we've focused primarily on support coming from the other soldiers who've been to the program. The community groups have shown interest and want to support this, but it's mostly in terms of contributing money. I haven't done an outreach program in the community like that, except through community awareness. I'm often speaking in the local community or being invited to speak about this, but not in a formal way.

Mr. Colin Mayes: We've been dealing with the transition from active duty with the Canadian Forces to Veterans Affairs in regard to how they fit into the department and all the different programs they have to support the veterans. Would you say you're focusing more on that transition from active duty to civilian life and how they fit into society?

Dr. Marvin Westwood: Yes, I think you're right. There are folks in the transition program...it does include symptom reduction, but there's a need for assistance in transition to get them connected with their families and headed toward being re-employed or getting a new job and so on.

But we do process the trauma first. I need to say that. Our program has a little broader spectrum than just symptom treatment. Let me try to explain it this way. When people have psychological injuries from trauma, they cannot do anything until that's repaired. They come to our group and have symptoms such as flashbacks, intrusive thoughts, depressive reactions, inattention, and so on. Their families are fed up with them and they are going to get fired from their jobs, so we have to say, "Okay, let's get this symptoms management reduced first". They call it dropping the baggage, and that often means telling stories of what happened to them, of what they witnessed, what they saw, and of what they have to let go.

Then they have relief from the intensity of the symptoms and they can concentrate on getting their families back. They can say: "I want a life. I don't want to live out in the bush country in a cabin by myself with an ammunition store. I want to come back into the community".

That's what I really want to convey to the people today: that the psychological injury from war-related traumas is so serious around disorganizing people's ability to function. They can't do anything, so it's not helpful to offer courses or training until they drop the baggage and engage in trauma repair. Then they can move on. I know that's a long answer to your question, but that's exactly how the transition program works over the three months.

Mr. Colin Mayes: There was one comment we had from our witness from the forces in Australia who deals with PTSD, and especially suicide amongst veterans. The statement was made that a lot of the stress...or that of those who committed suicide, only one-third of them actually saw active combat duty, and that a lot of the issues around suicidal tendencies were more about things like marriage breakdown, financial issues, and tragedies in their lives that sort of manifested themselves in their lives. They weren't necessarily connected to their combat duties.

Dr. Marvin Westwood: No.

Mr. Colin Mayes: Do you find that at all?

Dr. Marvin Westwood: Yes, we absolutely do. Drug addiction is one of the symptoms of people who are traumatized. It's a cascading or domino effect. They cope by trying to self-medicate; that's one thing. But if depression sets in and they're not treated.... They may not have seen active duty; they could have been traumatized by what's called "vicarious traumatization", or secondary traumatization, by what they witnessed. That's a whole group that we don't really understand, but if you serve overseas...if you're in Afghanistan as a soldier, you may not be involved in direct face-to-face combat, but you can also pick up a certain amount of trauma just by the exposure of what you experience.

When they come back to Canada, I think you're absolutely right that we take very seriously that they...we look for acute depression that leads to isolation and that leads to giving up. People commit suicide in a number of ways, it has been my experience. They may commit suicide in an aggressive and active way, but some people just get really sick. I'm speaking now as a psychologist. They just give up, they get illnesses, and they die—and they die because of that.

I think that it's quite complicated, too. When you talk about suicide, I'm more concerned about all of the stresses our soldiers have before we have suicide ideation. I'm concerned about the risk of addiction, acute depression, isolation, becoming unproductive, and losing all the supports around them.

● (1615)

Mr. Colin Mayes: Would there be any possibility—

The Chair: Excuse me, Mr. Mayes. your time is up.

Mr. Colin Mayes: Okay. Thank you.

Thank you very much.

The Chair: We should have a little time later.

Ms. Coady, please.

Ms. Siobhan Coady (St. John's South—Mount Pearl, Lib.): Thank you very much.

You had a good line of questioning from my honourable colleagues. One of the things that I thought was interesting, which the previous speaker talked about, was lifelong care for the veterans and how that's what we're trying to achieve. We're trying to get to that point.

Mr. Westwood, this has been a very interesting topic this afternoon. You're bringing up the idea of this lifelong care and the fact that we have to do some trauma repair. I want to tell you about a case from St. John's, Newfoundland that I was dealing with. His name was Joe Hawco. He was a peacekeeper and, during his tour of duty, he had a number of peacekeepers die in his arms. He was in a fight and, unfortunately, there was loss of life.

The man went through his life. He had some issues, but he did make it through his life. When he turned about 70, the family started to notice a change. It was noticed that he was having more dementia, if I can say that, and eventually they thought it was Alzheimer's. So because modern-day veterans do not have access to pavilions, he ended up in a mental hospital in St. John's. He couldn't be held in an Alzheimer's unit because he regressed to when he was in the military serving as a peacekeeper, and he could actually pick the locks of the Alzheimer's unit.

I have two questions here. First of all, could you could talk about some of this trauma? When you've been tracking the success over the 14 years, are you finding that those later in life are not having as many challenges? Would it have any effect on the possible later onset of dementia? Two, could you answer that question of whether you're seeing any relationship?

The second question is about the veterans pavilions. Right now, we're housing modern-day veterans who are now growing older. As I said, Mr. Hawco was in his seventies when he passed. He died in the mental hospital, actually. I wonder if you could address where you think the best care is. Do you think there is some other mechanism or means to treat people in later stages of life who don't have access to the veterans pavilions? I'm concerned about that, because they are regressing to when they were soldiers.

I'll leave you with those two questions, if you could answer them, please.

Dr. Marvin Westwood: Okay. You've said something that we have observed, which is that if you don't get trauma treated when you're younger, you will have symptoms later in life, and it increases near the end of your life. They are troubled by that. They start getting flashbacks. As you've said, it can be confused with dementia, and so on. I think it's the evidence of untreated trauma. That's why we want to—on the advice of our World War II veterans—offer a chance for them to drop this baggage when they're younger.

So how do I see going forward with this? I would say one of the best treatments for older vets is to be in the company of other veterans who have some paraprofessional training. Where do veterans feel most at home? They feel most at home among those they have served with. Going forward, what I'd like to see is the government agencies working with community agencies or public programs like ours in the community to support these people. It isn't a one-shot treatment.

Your suggestion has interested me in coming back to that as a focus that we might consider out here: how do you ensure the support of older veterans who've had trauma? My answer? Keep them connected with other soldiers. That's what they appreciate. Whether it's pavilions, or if VAC does that, or colleges and universities set out to help create these groups, I think that's one of our best bets. Because that's where they feel at home.

● (1620)

Ms. Siobhan Coady: Well, thank you for that, because I think you're absolutely right. What ended up happening with this particular soldier.... As I said, it was very traumatizing for him and very traumatizing for his family. He was in a place where he could not relate to those around him. When soldiers would go to visit him, he could absolutely relate.

So I would suggest that even those who have passed the 65-year mark, let's say, still may need to have that trauma addressed.

Dr. Marvin Westwood: Absolutely.

Ms. Siobhan Coady: Now, on one of the things you talked about, is it possible to roll out a program like yours across the country?

Dr. Marvin Westwood: Let me just say that we've been quite careful in doing our program, studying it, and evaluating it over the last 10 years, and we're now in a position where we have received money to develop increased capacity by training more people to deliver this program. My answer is, yes, it could be, but it has to be the kind of program where people would be trained. I think that personally I would feel some responsibility in training them, supervising them, and being very careful that they are the right people.

Then they could go to Nova Scotia in teams—we've had requests from Nova Scotia and from Ontario—and they would be funded to go, because this requires high expertise. This program can never be "manualized". Some programs and treatment can be: there's a manual and you can give it to workers in another city to do it. This requires a lot of sensitivity to the existing symptoms of trauma. We are trained in that and I train my people to do that.

So the answer is yes. We could send teams out to the various regions of Canada, and then link to the locals to join in at that time, and they would carry on with the support following the delivery of the program. That would be one of my goals. I'd like to see that happen so I really appreciate the suggestion.

One of the things I wanted to say is that I think people were critical of our program at first, and I think...[*Technical Difficulty—Editor*]...guys would say, "This is great, it's been three months, I'm okay now". Then they would disappear. No, we don't do that any longer. They need to be followed up. I think it can be delivered, but we have to be responsible for training the workers in this profession. Running groups of traumatized men and women—and in our case, it's mostly men—is very complex work. You need to have a lot of skills and I'd feel more confident knowing they were well supervised.

The Chair: Thank you.

Mr. Storseth, please.

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you very much, Mr. Chair.

Thank you, Mr. Westwood, for your presentation, and thank you for the dedication you have to our men and women in the Canadian Forces, our veterans, and our police officers that you help out.

You hit a whole bunch of things that I think were very good. One thing I would like to follow up on is the culture our military has. Have you noticed a change? Obviously, Veterans Affairs and DND have tried to change to address this culture a little and make mental health awareness something that's more top of mind and more accessible. Have you noticed a change in the culture?

Dr. Marvin Westwood: I've noticed that there have been attempts within VAC, and I think the Canadian Forces and a number of people have attempted to change the culture by bringing up these issues earlier. I find soldiers resist listening to that because, when they come back, one of the characteristics of trauma is denial: that doesn't apply to them, or they don't need that, or that belongs to somebody else, or someone else has that weakness.

But here's what I have noticed. You may know Stéphane Grenier. I've met with him a couple of times. He's a former service person and is working I believe in VAC. He's having some success in introducing to the younger soldiers the information and psycho-education: If you go overseas and serve, you could take and sustain an injury called an occupational stress injury. So they are e attempting to do that, but what I find with the young guys is that don't take it up because soldiers in the military strongly believe "I'm all right, mate". They believe they're invincible, they're strong, and they don't need that. There's a psychological resistance there.

Well, as I said before, the people they will listen to will be other soldiers who come back who meet them and spend some time with them. These are sometimes what I call "alpha soldiers". Alpha soldiers are soldiers who have been through our program and who are highly respected in the community because they had an honourable firefight in Bosnia or they were heroic in Afghanistan. Their status is very high in the regiments. But some of them are a part of our program and soldiers will listen to them. That's what I see. There is some movement, but not as much as I would like.

● (1625)

Mr. Brian Storseth: I represent a rural riding with a couple of military bases in it. One of the concerns in my area is access to treatment. Sometimes your treatment meetings can be 15 to 20 minutes long, but it's a three-hour drive to a place to access them. Is this a concern you share as well?

Dr. Marvin Westwood: I absolutely do, and I would never actually offer that kind of service, because notice that I said that ours are 10 days or residential; you really can't effect much change at all in such a brief meeting. People need support. One of the healthiest kinds of support we have is groups. Groups are the best place to get support from other people such as your peers. When soldiers are with other soldiers, and the soldiers have been somewhat trained, they respect and trust them totally. They go to them for support more than they go to us. I think that there are possibilities for developing groups that are sustained and ongoing that soldiers could go to.

At the beginning today, one of the people said that it's kind of like AA. AA is well known in our society. Who helps people with alcohol addictions? AA has been a very strong force. I'm not proposing that model. I'm proposing a model that joins the best expertise we see in VAC, the universities, and the medical clinics with the soldiers who are being trained so that they can offer something outside.

Why? Because if they don't get treatment, they avoid getting the services they're entitled to, and they won't even go near the VAC offices when they feel that way.

Mr. Brian Storseth: Thank you.

I have just one more quick question for you. There has been a tremendous number of changes to programs. The government is trying to address some of the issues we've been talking about. In your mind, how knowledgeable are the soldiers you're talking to about the changes that have been made to programs or about additional programs that are available?

Dr. Marvin Westwood: Well, I'll tell you, I don't think they're really very aware, because so many of them report having not positive experiences with VAC, unfortunately. Even if they are, I think they're a bit suspicious. But OSISS workers—volunteer counsellors who are former serving soldiers—I think are making a good attempt to reach out to the soldiers and explain. I notice that some of the soldiers we work with will trust an OSISS worker if they know that he has served before in the military. I think that's progress.

Mr. Brian Storseth: Thank you.

The Chair: Thank you very much, Mr. Westwood, for your very candid answers and great answers today to our many questions. Again, I can only say that I wish you much success in your program.

I am not a veteran, but I do belong to the Legion, so I'm glad to see that the Legion is a great sponsor of your program.

Thank you very much for attending today.

We're just going to have a short recess.

● _____ (Pause) _____

●

● (1630)

The Chair: We'll start the second half of our meeting by welcoming our next witness, Dr. Alain Beaudet, president of the Canadian Institutes of Health Research.

Welcome, sir.

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): Thank you, Mr. Chair.

I would first like to thank the Standing Committee on Veterans Affairs for this opportunity to discuss the issue of combat stress and its consequences on the mental health of veterans and their families.

As in all matters of health, research is critical for achieving the quality of health and health care that we wish for Canada's military veterans. In the preamble to the act that established CIHR in 2000, Parliament recognized that investment in health and the health care system is part of the Canadian vision of being a caring society.

The act went on to establish CIHR's objective: to excel according to internationally accepted standards of scientific excellence in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system.

I have believed since I became president of CIHR in 2008 that this vision means little if it does not include a responsibility for the health of those federal employees who put themselves in harm's way in defence of our country and in fulfillment of national security objectives.

[*Translation*]

Reducing the burdens of mental illness is one of the five research priorities in CIHR's latest five-year strategic plan. In order to address this priority, CIHR is relying on one of its 13 institutes, the Institute of Neurosciences, Mental Health and Addiction. The institute's mission is to promote and support research in order to improve mental health by developing new strategies for prevention, screening, diagnosis, treatment and service delivery. We often forget that Canada has excelled in this area of research. It is in fact ahead of the pack compared to the rest of OECD countries in terms of quantity, quality and the impact of its scientific publications in this field of research.

[*English*]

CIHR investments in mental health research have totalled more than $234.4 million since 2006—$65.2 million in 2009-10 alone. As to post-traumatic stress disorder, CIHR has invested $7.6 million in research since 2006, including $1.7 million in 2009-10. However, this figure can be deceptive, since operational stress injuries can include PTSD as well as a variety of other disorders ranging from depression to hormonal imbalance, for which CIHR is also providing research funding.

For example, new brain imaging techniques have been put to use in looking at the effects of post-traumatic stress disorder on the brain. Neuroendocrinology studies, which look at the relationships between the brain and the endocrine system, have demonstrated significantly lower levels of the stress hormone cortisol in individuals with PTSD. Finally, it is likely that genetics and epigenetics will be key in helping us better understand the factors underlying the susceptibility of certain individuals to post-traumatic stress reaction.

I would now like to turn to some of CIHR's efforts to advance research into the issues affecting military veterans and their families, as well as research in operational stress injuries. You will appreciate that while I am not a research expert on this subject matter, I am pleased to speak to CIHR's efforts to accelerate research in this area.

● (1635)

[*Translation*]

As the other witnesses mentioned, the mandate of a number of departments is to promote research on the health of soldiers and veterans. These departments have formed specific partnerships with CIHR in this area. The Department of Veterans Affairs and the Department of National Defence have joined us in funding various research initiatives. I think we should build on these first successes to expand and strengthen our framework for action, increase consistency and maximize impact.

To this end, CIHR has started discussions with the office of the surgeon general of the Department of National Defence in order to identify areas of possible cooperation as part of their research initiative on the health of soldiers and veterans.

More recently, I met with the associate deputy minister of Veterans Affairs Canada, and we agreed to get our staff members together as soon as possible in order to set joint research priorities on the health of soldiers and veterans, and to develop a long-term cooperation plan.

Although there is a significant body of American research on combat stress and its effects, the military culture and community in Canada are different, and so are the types of operations in which Canadian troops participate. It is therefore important that we develop a research program of our own to fit the Canadian context.

[*English*]

A particularly noteworthy development for Canadian research has arisen from the November 2010 Canadian military and veteran health research forum in Kingston, which is the creation of the Canadian Military and Veteran Health Research Network, a network dedicated to building a better understanding of the health and well-being of military personnel, veterans, and their families.

Together, CIHR and the network announced in the fall of 2010 a request for applications for knowledge synthesis grants to summarize existing research in this area and determine gaps within the knowledge base.

This call for applications recognizes that military personnel and veterans have unique experiences in the service of their country, which can impact their physical, mental, and social health in a manner not experienced by the rest of the population. It also recognizes the increased need for research on the health and well-being of military personnel, veterans, and their families. We anticipate announcing the results of this competition later this month and subsequently using the data to identify research priority areas.

[*Translation*]

One of Canada's leading researchers in veterans' health is Dr. Jitender Sareen. He receives funding from CIHR and he testified before you in November.

Dr. Sareen is leading a CIHR-funded team on the study of trauma and post-traumatic stress disorder among soldiers involved in peacekeeping operations. He is also examining soldiers' need to access mental health care and the obstacles they have to overcome in order to obtain care; one obstacle is the fear of stigma in the workplace. The findings of his research have helped the Canadian Forces to create programs for those who need treatment and also to develop strategies to improve the mental health of military personnel.

[*English*]

Also, at the University of Manitoba, Dr. Darren Campbell is using functional magnetic resonance imaging in conjunction with psychotherapy to look at the emotional responses of military personnel with post-traumatic stress syndrome.

Similarly, Dr. Alain Brunet at McGill has led a Montreal-based research team on mental health disorders, including PTSD and related problems resulting from traumatic events in high-risk workplaces, and has been funded to examine treatment available to military veterans with operational stress injuries.

Dr. Gordon Asmundson of the University of Regina led a multidisciplinary team of researchers from Regina and UBC who examined whether exposure therapy—where patients are exposed to prolonged and repeated images of trauma until the images no longer cause anxiety—may be more effective than other methods for treating the disorder. Dr. Asmundson and his team have also looked at delivery of treatment over the Internet.

In 2009-10, Dr. David Pedlar, the Director of Research at Veterans Affairs Canada and a professor at the University of Prince Edward Island, along with a team of experts, received CIHR funding to study the reintegration into the workplace of veterans with mental health conditions.

CIHR-funded researchers are also doing important neural investigation into the brain activity of individuals with post-traumatic stress disorder writ large. For example, Dr. Ruth Lanius is the director of the post-traumatic stress disorder research unit at the University of Western Ontario. Her research focus has been the neurobiology of post-traumatic stress disorder and treatment-outcome research examining various pharmacological and psychotherapeutic methods, including in patients with post-traumatic stress disorder or major depression following motor vehicle crashes.

I could cite other examples of funded research dating back to CIHR's inception to demonstrate our history of funding those with research interests in issues specific to military veterans. I would like, however, to conclude by looking forward and acknowledging that more research is needed.

Canada is approaching the completion of one of its longest and most intense military missions in recent history. The care of these young men and women who served our country in Afghanistan makes even more pressing the need to thoroughly understand the physical and mental demands of military operations. We need to better understand through research what sorts of unmet mental health needs there are for veterans so that we can meet them with outreach and treatment.

We need to recognize that Canadian health research in this area is growing but needs to move beyond its infancy. The old military saying that “no one should be left behind” should guide us in ensuring that we understand and are ready to help veterans with health issues when they have completed their service.

Your work in this study will help us to understand where the gaps are and to set directions for future health research, and I would like to thank the committee for its work. I am pleased to take your questions.

● (1640)

The Chair: Thank you, sir.

We'll have the first question from Mr. Lamoureux, please.

Mr. Kevin Lamoureux (Winnipeg North, Lib.): Thank you, Mr. Chair.

I do have a couple of questions I'd like to ask the witness, and I appreciate his comments. It's encouraging when we hear about the breadth of research that seems to be in place.

Do you feel that there is a great value in terms of being able to benefit from this research so that we can develop programs such that, when a member leaves the Canadian Forces, we would have a better assessment of how serious an issue there is? Do you see any value to having assessments done when a member leaves the Forces or do you see how that could be done?

Dr. Alain Beaudet: That's certainly a valid area for research. I do not think there is, or at least I'm not familiar with, any research on this transition period and the difficulties linked to this transition period. But I know for a fact that we've discussed with the assistant deputy minister of Veterans Affairs Canada that this is an area in which we could collaborate on increasing support for research.

Mr. Kevin Lamoureux: One of the things I'm thinking of is that we have a great number of people who retire from the forces every year. The ones we hear about are the ones who come to us with issues.

Other individuals, even those from Veterans Affairs, have commented that we don't really have good tracking of information or any sense of the actual numbers. Can you comment on that, particularly with regard to the percentage that we really don't know about and any sense of what that might be?

Dr. Alain Beaudet: Quite frankly, I could certainly get you some information on that. I can't really comment on it because it's always difficult to get information on those who don't come to us for treatment.

What we do know, however, is that there are some areas, particularly the mental health area, in which, as you know, there are significantly higher percentages of disorders than there are in the normal population. For instance, the rate of depression for people coming out of the military is about twice that in the normal population. But again, these are indeed the people we look at.

● (1645)

Mr. Kevin Lamoureux: I guess that would be just it: how do we know which members leaving the forces are enduring some form of depression or other mental illness if we don't do some sort of an exit evaluation? Is that a fair comment?

Dr. Alain Beaudet: We don't. Clearly the ones we're aware of are the ones who come for help.

Mr. Kevin Lamoureux: When you think in terms of pre-deployment, there are all sorts of horrors in the different types of war zones and in civilian unrest. Do you feel there are things we could do to put our soldiers in a better frame of mind when going into these conflicts?

Dr. Alain Beaudet: Again, that's a difficult question, and it's outside my realm of expertise.

What is clear, however, is that if we look specifically at post-traumatic stress disorder, we know that certain individuals are susceptible to this disorder and others are not. That susceptibility is actually a biologically anchored event. In other words, we know that about 20% to 25% of people who will be exposed to combat stress will develop some form of post-traumatic stress disorder. As you know, for some it will be fairly short-lived and for others it will be for a very long period of time.

It is clear that certain individuals are more susceptible than others to developing this. My own belief, and it's really my own belief—again, I am not an expert on this topic—is that epigenetics and genetics studies will help us screen and identify the individuals who have an increased susceptibility to developing this type of disorder. As you know, it's a biological disorder. It's a truly anchored biological disorder. It's a link between the brain and the hormonal system and its imbalance in extinguishing the fear.

The first important thing to do is to explain to people who experience this that it is a biological phenomenon, probably a protective phenomenon, and that they don't have to be ashamed of it. You have to listen to them. You have to explain that it actually is a biological mechanism. Their hormonal system isn't balanced and their neurotransmitter system in the brain isn't balanced.

We need to better understand what type of imbalance we're facing and how it is and why it is that in certain individuals the mechanisms that normally extinguish the fear once it has appeared, which is a purely biological phenomenon, don't work. Hopefully, we'll eventually be able to screen these individuals, and either have a mechanism to protect them from that or just not send them into combat.

Mr. Kevin Lamoureux: Finally, given what you just said, do you believe it is possible that a psychological assessment examination could be developed to give to people when they exit the forces that would give an indication of this?

Dr. Alain Beaudet: Frankly, I believe that eventually it's going to be more than psychological testing. I think it's going to be biological testing. I think we're going to have biomarkers that could be genetic, epigenetic or hormonal markers. I believe that we need to develop true biological markers.

I think when people see that these biological markers exist, they will lose the stigma that they're doing something wrong or that they're not up to it, which is a real issue.

The Chair: Mr. Vincent, please.

[*Translation*]

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

Good afternoon, Mr. Beaudet. How are you?

Dr. Alain Beaudet: Very well.

Mr. Robert Vincent: At the start of your remarks, you talked about genetic evolution, and then you talked about biological evolution.

Do you think there is a difference between genetic evolution and biological evolution?

● (1650)

Dr. Alain Beaudet: There is no difference. Genetics is the basis of biology, it is most certainly rooted in it. I don't see a difference. As for this syndrome, we are really talking about an interface—which is probably genetic and epigenetic—of predispositions to an abnormal reaction to stress and, particularly—this is what I explained—to the ability to turn off the fear and stress mechanisms.

Normally, when an individual is subjected to intense stress or fear, there are biological mechanisms that engage. This fear is protective. It allows us to flee or fight, the "fight-or-flight" principle. It is entirely biological, but what is normally needed once the danger has passed is to be able to switch off this phenomenon. There are biological mechanisms that shut it down.

But, as you know, when it comes to post-traumatic stress syndrome, the fear extinguishing phenomena are dysfunctional, probably because the individuals have genetic predispositions to react to external phenomena or environments that mean that the individual is unable to extinguish this fear. So, everything replays constantly on a loop in their brain, and their stress response in their current life is totally maladjusted because a hypothalamo-hypophyseal system is functioning very poorly.

Mr. Robert Vincent: In your studies…

Dr. Alain Beaudet: They aren't my studies. They are studies we are supporting, funding and want to provide more funding to, because this is extremely important to understand.

Mr. Robert Vincent: In the context of these studies that you are funding to try to understand post-traumatic tress, genetic or biological, what link are you making between post-traumatic stress and suicide? Can a study tell us at what stage post-traumatic stress can lead to suicide?

Dr. Alain Beaudet: Well, with that, it becomes extremely difficult to determine. Once again, I am underscoring that I am not an expert, and I think that you have asked experts about this. So, I am speaking for myself.

It is clear that post-traumatic stress phenomena are linked to depression and, as you know, there is a relationship between suicide and depression.

That said, it is clear that the exact links between post-traumatic stress, depression and suicide are not at all clear. There are a lot of individuals who can suffer from acute post-traumatic stress syndrome and don't necessarily commit suicide.

Mr. Robert Vincent: Okay. You also said that there was a difference between members of the Canadian Forces and members of the American armed forces. Can you explain this difference to me? When two soldiers, a Canadian and an American, are in the same theatre of operations, how can they be different?

Dr. Alain Beaudet: First, overall, the Canadian Forces are more involved in peacekeeping missions, much more than the American armed forces. That is one of the factors. Also, there is no doubt that the environment is not the same within the Canadian Forces as in the American armed forces.

To go back to what we were just talking about, I would say that we also know that the suicide rates are much higher in the American army than they are in the Canadian army.

Mr. Robert Vincent: That's because there are more people serving in the American army.

Dr. Alain Beaudet: No, I'm talking about rates.

Mr. Robert Vincent: Oh! Rates.

Dr. Alain Beaudet: Absolutely.

Mr. Robert Vincent: You said that there is more post-traumatic stress among individuals who are sent to a theatre of operations than among individuals who take part in peacekeeping missions, like the people in the Canadian army. But we have heard from a number of witnesses who have participated in these missions, and I can tell you that a lot of them have experienced post-traumatic stress. They were not allowed to use their weapons, and they saw things that they shouldn't have seen.

Dr. Alain Beaudet: I didn't say that they experienced more or less of it. I said that it was different.

Mr. Robert Vincent: That doesn't change the diagnosis. Whether a person is in a theatre of operations or on a peacekeeping mission, the diagnosis of post-traumatic stress is the same. The phenomena are the same. So, whether a person is in one situation or another, if a person experiences post-traumatic stress, they experience it, I suppose.

Dr. Alain Beaudet: Yes, that's right.

Mr. Robert Vincent: Based on all these studies, what recommendations would you make to the committee so that members of the Canadian Forces can get training, or something else, to lessen or reduce post-traumatic stress, to control it or manage it better?

● (1655)

Dr. Alain Beaudet: My recommendation will not surprise you. I think that we need to step up research. We have an opportunity in Canada. We have a strength, an extremely large research capacity, in mental health neurosciences, compared with our population. As I said, the quality of the research in this area, in Canada, is remarkable. What I find unfortunate is that there isn't enough research focusing on this particular area.

Mr. Robert Vincent: If a lot of studies have been done, how is it that people at National Defence are telling us that soldiers are being given barely half a day of training before being sent into a theatre of operations? If there are so many studies, how is it that there isn't adequate training?

Dr. Alain Beaudet: I am not talking about training soldiers; it isn't really my department or my specialty. What I am saying is that, as the president of a research agency, I must work very closely with the Department of Veterans Affairs and the Department of National Defence to determine more specific strategic research objectives and to invest more and in a more targeted way in these areas. We are now taking part in new types of combats and we have young veterans that we didn't have in the past. I don't think that we have been made well enough aware of the importance of the development of this illness and the number of young Canadians who suffer from it. I think that we need to step up research in this area to understand the biological bases of the illness and develop treatments and, afterwards, of course, ensure that the soldiers are seen by doctors and treated.

[*English*]

The Chair: Thank you.

Mr. Stoffer.

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

Sir, thank you very much for coming today.

Do you also have allocations of research for members of the RCMP who have retired?

Dr. Alain Beaudet: Our allocations for research are to researchers, so the researchers choose their subjects and the type of research they're going to do. We haven't done any work with the RCMP, and I think that's an excellent suggestion, actually.

We haven't done much with National Defence, but we're starting to work with them. We've done a few things with Veterans Affairs to try to jointly support research teams that will work on topics of immediate interest to the members of the armed forces or the veterans. Clearly, it will always be based on the excellence of the projects that are proposed to us.

Mr. Peter Stoffer: In previous testimony, we heard that post-traumatic stress disorder can be transferred inadvertently to members of the family, either the spouse or the children. In the research allocations that are offered, do any of these researchers work with family members to perform some of the scopes and scannings of family members? Are you aware of that?

Dr. Alain Beaudet: I'm not aware of it, but I could certainly have someone look at it and send you the information. I don't want to go out on a limb; I don't know. It's possible that some of them do. I would have to look at the research projects specifically.

Mr. Peter Stoffer: Yes, because one of the concerns that we've had—

Dr. Alain Beaudet: I've heard the same thing, and I know that there are some research reports, for instance, of increased incidence of depression in the families of military persons.

Mr. Peter Stoffer: One of the concerns I hear consistently in regard to post-traumatic stress disorder, or operational stress injury, has to do with the efforts of those suffering from PTSD to get assistance. Someone will go to a department for assistance, either a federal or provincial department, and they'll get the bureaucratic delay. They're told to get in line and that someone will get back to them.

This aggravates their condition, from what they tell me. When their spouses or their kids go off the rails because this person has dropped the baggage, it affects them all. When you left for your deployment, your family was quiet and routine, and everyone had a place. You come back and suddenly everything is helter-skelter.

You don't know what you're doing. Your family members don't recognize you anymore. We hear the saying, “This is not my husband anymore—he's not the same man who left”. Everything's in a topsy-turvy sort of turmoil. That compounds the situation even more. For people trying to assist the individual, it must be a real challenge to try to put everything in balance and in place again.

Dr. Westwood indicated that for the last five years he hasn't applied to DVA for funding. Are you aware of him? Would he be eligible to apply to CIHR for some type of funding?

● (1700)

Dr. Alain Beaudet: I don't know the man, but if he has research credentials and he's affiliated with a hospital or university, he would certainly be eligible. We have two types of programs.

We have targeted programs. For instance, we could decide with Veterans Affairs or National Defence to pool some money on a targeted program to answer specific questions. Then, once we determine what the question is, it's an open call for competition. Everyone who has the credentials and the research training is allowed to apply to CIHR.

In addition to that, we have a fully open program so that anyone, any researcher in the land with the right credentials and proper affiliation, can apply to CIHR through our open grants competition with any good idea that he or she may have.

So there are two parallel mechanisms. In each case, you have to go through a competition. It's reviewed by experts, and only the very best proposals, and the ones that are methodologically sound, that have sound hypotheses, that are anchored in reality, will get funded.

Mr. Peter Stoffer: We know that other countries are doing research similar to this. Are there any cross-references between researchers here and researchers in the United States, Europe, and Australia? If so, it could constitute a cost saving.

Moreover, you don't want to keep spending money reinventing the wheel. And you want to develop best practices. We've heard that a soldier is a soldier is a soldier. Regardless of the uniform, their experiences may be equal. Is there any linkage from your organization to assist researchers in coordinating these efforts?

Dr. Alain Beaudet: Certainly.

First of all, there's a huge amount of collaboration between Canadian investigators and American investigators. The U.S. is our major collaborator in science and all areas, but particularly in the area of mental health. The second one is the U.K. and the third one is France. These are major countries we collaborate with and we do encourage collaboration with other countries, putting together experiences.

In addition to that, and I may have been misunderstood by Mr. Vincent before, it's clear that we always take into consideration the scientific literature that comes from other countries, and certainly the experience that comes from research that's been done in the United States. We don't reinvent the wheel.

What I was just trying to say is that, in addition, I think it's important that we don't let all the research be done by others. I think we may have some specificity here in Canada with the Canadian armed forces, and I gave some examples of what some of these specificities could be that make it worthwhile to also do our own research and to compare our data with the data in other countries.

We certainly do that systematically in that area, I would say, like in all others. It's an area where, because Canada is held in such high esteem in neuroscience and mental health studies, we have absolutely no difficulty collaborating with other countries. Other countries are actually willing to collaborate with us because of the quality of our researchers.

The Chair: Thank you.

Mr. Lobb, please.

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

My first question is around any research that you've done on what actually triggers the PTSD. We had General Dallaire testify before the committee in the fall. He talked about a trigger that he encountered after he had done his service. If he was at a market, the aroma of fresh fruit or vegetables brought him back to a time when he was in Africa. I'm just wondering what the research is on triggers or predicting triggers or trying to identify this.

● (1705)

Dr. Alain Beaudet: It's a difficult question and, again, I'm not an expert. Yes, we are actually funding research in that area. What you're describing is typical of post-traumatic stress disorder. Again, you have to understand it as the brain circuits that are involved in fear. These brain circuits also involve the hormonal axis that will release noradrenalin, adrenalin, and corticosterone in the blood-stream when you face anxiety and any stressful situation.

Normally, there are mechanisms whereby the fear circuit will be stopped; the hormonal imbalance will be stopped and will revert to normal. Everything reverts to normal, and you're okay. In the case of post-traumatic stress disorder, it's as if the mechanism to extinguish the fear reaction and the mechanisms to bring the hormonal levels—particularly the cortisol level—back to normal are no longer operational.

Lots of studies are trying to understand what is going awry in the brain circuitry. Not only are the normal mechanisms that extinguish the signal not operational, but also, you will have triggers exactly as you described. It could be sound. It could be smell. Very often there are spontaneous images—often dreaming.

As you know, it's like a state of hyper-vigilance, right? These people have huge problems sleeping, and they have a very strong dream content that always brings back the memories. The hippocampus is very much involved. All the circuits that are involved in recalling the memories are recalled and are put into action in an appropriate way.

You're asking me how we can understand it. We're talking about the next frontier, which is understanding the brain. Yes, there are several studies that we're supporting currently that are trying to examine just that through imaging techniques: what the relationships between the brain and the hormonal system are and what circuits of the brain are involved. But I would say that it's still early days.

It's critical in my sense, too, that we understand this, because it's only when we understand it that we'll be able to develop treatments that are not empirical. Right now, the treatments we're using are, as you know, the same types of treatments that we are using in depression. It's very difficult to treat.

Mr. Ben Lobb: Another question I have has to do with some of the research you're doing on MRIs and the cutaneous tissue and all these things you're doing post-service for our servicemen. Do those studies look at what the brain looks like before and after? Are you doing a lot of the “after” now? If you are, what are you seeing?

Dr. Alain Beaudet: It's always very difficult to.... Actually, they could exist, but I'm not aware of longitudinal studies that are looking at before and after, but there's a lot of comparison between the normal population and the population that has been exposed to stress, and comparisons between people who have been exposed to combat stress versus other types of stress. As you may imagine, it's more difficult to do the longitudinal study, the before and after, but there might be some studies that I'm unaware of, quite frankly, I think it would actually be an excellent thing to look at.

Because again, I'm really convinced, from what I've read, that there must be some neurobiological basis for the susceptibility of some individuals but not others to develop distress disorders. If we could develop either bar markers or imaging that would allow us to screen these people beforehand, it would be great. I'm sure there must be interventions in that area. I'm just not aware of them.

Mr. Ben Lobb: Is the research...? Obviously PTSD can be many different things to different people, with the triggers and all of that, but—

Dr. Alain Beaudet: But the syndrome is pretty well defined, though.

Mr. Ben Lobb: That's fair enough.

The question I want to get to now is whether you, through your research, are able to narrow it down to say that there are actually different types of PTSD. Or is it still globally accepted within the research community that PTSD is PTSD? Are you able to now narrow it down exactly?

● (1710)

Dr. Alain Beaudet: My understanding, from what I know of the literature, is that it's still a big syndrome, but there could be a narrowing down that has occurred that I'm not aware of. You have to remember that I'm funding research; I'm not a researcher working in the field.

Mr. Ben Lobb: Yes, I understand that.

I'll close with an experience that I've encountered. At one time, I was a competitive baseball player. You've talked about freezing once the adrenalin starts flowing. I always found relief pitchers interesting. You could warm up in the bullpen and throw strike after strike, but as soon as you crossed that line, you couldn't throw a strike to save your life. I know that's not PTSD, but it's to do with the adrenalin flow and all the—

Dr. Alain Beaudet: It's the same thing. But it's because what you're describing is an extinguishing mechanism that works. That's the normal mechanism.

First of all, I find it very interesting—it's not fun, but it's very interesting—that such a high proportion of the population develops post-traumatic stress disorder. It makes us wonder why they have it and why there's a susceptibility. I believe there's a genetic buildup. There might have been a protective role at a certain point in developing that. It may have been protective to ensure avoidance of certain stresses by human beings—and I'm talking about millions of years ago—but it stayed in parts of our genes. It's clearly no longer very useful.

The Chair: Thank you.

Ms. Coady, please.

Ms. Siobhan Coady: Thank you very much.

I certainly appreciate you being here today. I have a great deal of respect for the Canadian Institutes of Health Research. I hope you continue to do great work.

I have a couple of questions.

I was in biotechnology. I had a company that looked at how genes affect human health and disease; that's why I'm so familiar with CIHR. Here's one of my questions, though. You talked earlier about a lot of the research that you were doing. I'm wondering how that research is being translated? Do you know of programs that have been developed and where we are in the cycle of the research?

Because it's great to do the research, and I applaud you for it and I think it's important, but how is that being translated to help today?

Dr. Alain Beaudet: Actually, you know, it's very interesting, because you're putting your finger right on the tender spot.

We have a dual mandate at CIHR: to create knowledge, and to ensure that this knowledge, as I read earlier, is translated into better health outcomes and a better health care system. That's a huge challenge. It's a huge challenge for several reasons. I won't go through all of them, but we've identified that as a key and critical objective.

We're dealing in an area, however, which is right at the juncture of federal and provincial jurisdictions, because health care, as you know, is provincial jurisdiction and research is a mixed jurisdiction. So I'm convinced that the only way we're going to be able to very efficiently translate the results of the research is working more closely with the provinces to ensure that research is fully integrated in care, first of all.

Second, we've developed a patient-oriented research strategy at CIHR, which has one very clear, specific aim: to improve health outcomes through research. To do that, one of the things we want to do is create research networks that will be clinical research networks that will help us evaluate innovations, bring things more efficiently from the bench to the bedside, evaluate innovative treatments, and also evaluate current treatments and eliminate what we're doing that is useless or does more harm than good. It is less glamorous, but it's equally important to do that if we want to improve the impact of that great research we're doing in Canada on the quality of our health care system, and of course in the quality of health outcomes.

The same is particularly critical in the area of mental health, where we have excellent research, but yet not enough clinical research. We have fantastic people, but not enough, and they're not sufficiently networked across the country. That's what we want to do: we want to support the establishment of clinical research networks in mental health.

● (1715)

Ms. Siobhan Coady: Thank you for that. I couldn't support you more in those initiatives.

Having said that, I note that with veterans we are in a cycle right now where we have a tremendous number of veterans returning from the theatre of war who are suffering, a lot of them, from PTSD. We know that. We have peacekeepers who are suffering from PTSD. Their symptoms are still fresh even though they may have been returned from duty 10 years ago; they still have these issues.

So I think that with veterans, because they are the responsibility of the federal government...I know they utilize the provincial health care system, but the federal government still has the responsibility. I believe my honourable colleague across the way said earlier that we have to ensure that really we have a lifelong care of veterans.

So I guess we have an opportunity now, utilizing some of the research that you've done, of actually applying that for veterans and probably getting out of the inter-jurisdictional quagmire that we have between the province and the federal government. I would encourage you—and I know that you do work with Veterans Affairs Canada—to cross that chasm.

Dr. Alain Beaudet: But it's exactly what we've been starting to discuss with our colleagues at Veterans Affairs—

Ms. Siobhan Coady: I would suggest that this committee could recommend that, because we really need to apply that research that you've done, that good research, and get results today. It can't be a 10-year negotiation—

Dr. Alain Beaudet: No, absolutely. Quite frankly, there are some results we already have that need to be implemented in a more systematic fashion and evaluated. One thing is implementing them, but evaluating the long-term effect of treatments, comparing them, doing true clinical trials, and ensuring that we truly exert the effective—

Ms. Siobhan Coady: Well, here's an opportunity to do translational research quickly.

The Chair: The time is up.

Dr. Alain Beaudet: Thank you.

The Chair: Thank you.

Mr. André, please.

[*Translation*]

Mr. Guy André: Thank you for being here.

What I found interesting in your comments was the entire issue of the diagnosis of individuals experiencing post-traumatic stress. I always wonder about screening, and this is the first time someone has talked about it here, in committee. I think it's the most important aspect.

You said that 25% of people who are victims of stress can, according to Henri Laborit's theory—I remember because I studied in this area back then—be more likely to develop post-traumatic stress, and that 75% of them are not. I do have a question to ask about that.

The level of stress can also be different. I can be exposed to stress…

Dr. Alain Beaudet: Absolutely, and it is always difficult to assess. We are clearly talking about an average.

It seems that about a quarter of people are much more likely to react over an extended period of time after being exposed to intense stress, as we are seeing in this case. But, in others, the system restores itself normally.

Mr. Guy André: Based on what you said, we are on the verge of being able to screen soldiers before they take part in a mission.

Dr. Alain Beaudet: Unlike economists, I don't like making predictions. But, it is clear to me that we need to continue subsidizing research that focuses on making early diagnoses, so we can prevent rather than cure. I think that, once the stress is established and these people have entered a vicious circle, it is clear that there are considerable neuronal and hormonal malfunctions. We are seeing that it is very difficult to treat. It would be tremendous if we could have biomarkers that would enable us to make a diagnosis earlier, and therefore prevent the illness.

I also want to stress one of the major problems that is enormously harmful to the treatment of people dealing with post-traumatic stress: either people don't believe them or, as your colleague described earlier, they are sent from one office to another, and so on. Afflicted individuals, the poor people, have the impression that it's their fault, so it's a biological reaction. But as soon as this is explained to them, the treatment becomes much easier. Not only do we need to listen to these people, but we have to explain this to them, too.

● (1720)

Mr. Guy André: We know that men seek help less than women. It is a phenomenon peculiar to men.

Dr. Alain Beaudet: Absolutely.

Mr. Guy André: They do it much later in the process. This affects the prevention aspect less than the curative aspect. The obstacles are more difficult to overcome. This is why we find a lot of men in prisons and detox centres.

Dr. Alain Beaudet: Yes, and reacting this way is seen as a weakness. It's tragic.

Mr. Guy André: It must be still more pronounced in soldiers, given that it can even affect their promotion, their professional situation.

What is being done in terms of screening is interesting, but there is another phenomenon. I think that we should better equip the families that these soldiers return to. A lot of witnesses have told us about their spouse who returned from a difficult military mission and who then gradually developed post-traumatic stress. One spouse told us that no one explained to her what post-traumatic stress was, that she noticed changes in her spouse's behaviour and that she had to adjust. All the same, we are in a position to better inform these people. It is a lack of follow-up.

Dr. Alain Beaudet: Mr. André, this problem is not unique to post-traumatic stress. It affects mental health as a whole. There is still a stigma surrounding it, and there is still a lack of information. I must also say that my psychiatric colleagues do not always take the time to explain to families what it involves, to tell them about what we know about the illness and why a given treatment is administered. In fact, it involves explaining that, in the case of depression, a person takes an antidepressant, like a person would take insulin if they had diabetes. Insulin boosts an insulin level that is too low, and the antidepressant boosts a serotonin level that is too low.

Mr. Guy André: I agree with you, but we are here to talk about post-traumatic stress.

Dr. Alain Beaudet: Yes, but it's the same thing. It takes time to explain these things.

Mr. Guy André: What information is indispensable and must be given to the soldiers' spouses?

Dr. Alain Beaudet: Removing the stigma would already be a huge step. It would involve explaining that it is not a weakness or an inadequate behaviour coming through, but an actual biological phenomenon.

Mr. Guy André: So we aren't too far from developing a medication.

[*English*]

The Chair: André, I'm going to have to move on.

[*Translation*]

Dr. Alain Beaudet: We already have medications. Sometimes they aren't as effective as we'd like them to be, but they exist already.

[*English*]

The Chair: I have to move on now to Mr. Stoffer, please.

Mr. Peter Stoffer: I have a quick question, sir.

With regard to the cultural differences between the forties and fifties and now, you obviously see a lot more violence on television, in various games, and in the exposure people have to it. Is there any research you know of that is linking cultural differences between, say, what World War II and Korean veterans went through compared to what our modern-day veterans are going through in terms of just the atmosphere around us? The situations are completely different. It was more black and white. You saw the blue enemy over there, you were the red enemy, and you just fought. Now you don't know who the enemy is. It's quite different.

As Roméo Dallaire and others have testified before, it is a really difficult circumstance to ascertain what to do in a particular situation even though you've been given all the training. And the aspect of our cultural differences of what you witness.... The gentleman who wrote that book *FOB DOC* about his experiences as a medical officer at the front line—I believe he was from the Sudbury area—said that for relief the guys in the forward bases would play these very violent games on their Play Stations or whatever it is they have out there.

So here they are, patrolling in real life, shooting at people, and then, for relaxation, they shoot in simulation. Would you know of any research that shows a connection in that regard?

● (1725)

Dr. Alain Beaudet: I think it's a very interesting question. I don't know.

Mr. Peter Stoffer: I'm just throwing that out there, because I can't help but think.... I find it rather amusing in some ways—I don't know if that's the right word—that a guy who in the daytime goes out with a live C7 rifle, hunts down people, and maybe takes a shot at them, for relief goes back to his game station and does it in simulation. I just wonder if there's a connection in any way to what happens when they get out of the service.

Dr. Alain Beaudet: It's a very interesting question. It's very possible that there's research funded in that area. I don't know. I could try to find out. But it's an intriguing thing.

I'm going out on a limb here. I think that all these video games may appear violent, but I think that's totally symbolic. I think the true violence has been removed from them. It's not truly violence you're dealing with, I think.

Mr. Peter Stoffer: Okay. Thank you.

The Chair: Thank you.

I have the last question. You said earlier that there's research that says that the depression rate for people leaving the military is twice what it is in the general population. Could you send us that research?

Dr. Alain Beaudet: Certainly.

The Chair: If you could, through my clerk, I would appreciate that.

With that, thank you very much for appearing today. We're very appreciative of your remarks.

Dr. Alain Beaudet: It was my pleasure. Thank you for your attention.

Mr. Peter Stoffer: Mr. Chair, Dr. Westwood had indicated that he hadn't applied to DVA for a while. I'm just assuming that he may be unaware of an application he may be able to make to this organization here.

Is it at all possible that we could reconnect with Dr. Westwood and let him know that, him being with the University of B.C., it's possible that he could put in an application? Who knows? He may get more funding to assist him in what he does.

The Chair: I'll get the clerk to send an e-mail on that.

Mr. Peter Stoffer: Thank you.

The Chair: With that, the meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca