HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on National Defence

NDDN • NUMBER 049 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, October 4, 2012

Chair

Mr. James Bezan

Standing Committee on National Defence

Thursday, October 4, 2012

● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone, and welcome to our 49th meeting of the Standing Committee on National Defence. Pursuant to Standing Order 108(2), we're going to start our study of the care of ill and injured members of the Canadian Forces.

To kick us off today we're pleased to have, on very short notice, Dr. Alice Aiken, who is the director of the Canadian Institute for Military and Veteran Health Research. Dr. Aiken was co-chair of the 2011 Forum for Military and Veteran Health Research. She is an assistant professor in the physical therapy program at the School of Rehabilitation Therapy at Queen's University. She does health services and health policy research in the area of innovative models of care and disability policy and is co-editor of a collective on military and veteran health research that was just submitted to the Canadian Defence Academy Press. She lectures in clinical orthopedics. She is the current president of the board of directors of the Canadian Physical Therapy Association. Both her PhD and master's come from Queen's at Kingston and her physical therapy degree is from Dalhousie University in Halifax.

We're indeed pleased to have you. We understand you were also in Ottawa earlier this week speaking at a breakfast on this very subject. Of course, this being Mental Health Week, it is fitting that we start this study off.

Professor Aiken, we look forward to your opening comments. You have 10 minutes.

Dr. Alice Aiken (Director, Canadian Institute for Military and Veteran Health Research): Thank you.

I should say the most important part of my bio, and why I sit before you, is that I am a veteran. I did serve in the Canadian Navy for 14 years. I'm very proud of that, and it is part of the reason I'm very passionate about what we do at the Canadian Institute for Military and Veteran Health Research.

You've each been handed a folder that has our information brochure in it. It also has my business card and information about our third annual military and veteran health research forum. You all will have received invitations to our VIP event on November 26. It would be a great fact-finding mission for this committee to see all of the information that will be presented at the forum, so if any of you are interested in attending, please let me know.

Here is a little bit about the institute. Our vision is that the health and well-being of Canadian military personnel, veterans, and their families are maximized through world class research, resulting in evidence-informed practices and policies. We believe it's our mission to optimize the health and well-being of Canadian military personnel, veterans, and their families by harnessing and mobilizing the national capacity for high-impact research, knowledge creation, and knowledge exchange.

What we mean by that is we want to work at the clinical end of the research spectrum—on things that are going to affect practices and policies that will help the health of military personnel, veterans, and their families in the very short term.

Why is this necessary? Well, as I'm sure you know, there are more than 700,000 veterans in Canada, of whom only 11% are clients of Veterans Affairs. So the rest are out there in the wind and at the mercy of our provincial health care systems and not being tracked. We also have about 100,000 members of the military, which would include the reserve and the regular force.

Until the time we started the Canadian Institute for Military and Veteran Health Research, we were alone among our major military allies in not having an institute like this. Being Canadian, not only did we decide we needed to come on board, but we also decided we needed to do it in a really unique way. I'll explain a little of that to you.

We work very closely with our government partners in National Defence and Veterans Affairs, but what we're able to do is augment. By harnessing the national research capacity of researchers around Canada, we can augment the existing capacity that National Defence and Veterans Affairs have to do research. But we can also provide arm's-length...we have an arm's-length capacity for research.

I don't need to tell you that if the government does the science, regardless of the rigour, if the results are not what the public wants to hear, the government is criticized for it. Once it's in the independent academic world, that makes a difference.

I released from the military in 1998, and I don't believe this could have been started at that time, but with Afghanistan, the public interest was extraordinarily high, and I must say that the academic interest was also extraordinarily high in starting an institute like this.

What are we? If you pull out your little information sheets, you'll see that we're a network of 25 Canadian universities that are dedicated to researching the needs of Canadian military personnel, veterans, and their families. For any of you who have ever even come close to the academic world, you'll know that to get two universities to agree to something is kind of a miracle, so for 25 to come on board I think speaks to the importance and the interest in this topic.

We do serve as a conduit between the academic community, so the hub of CIMVHR is at Queen's and the Royal Military College. But where we really exist is across the country in the labs where all the research is being done and in the labs in the clinics where all the research is being done. We work most closely with National Defence, particularly the Canadian Forces Health Services group, and Veterans Affairs.

We've also been able to connect really nicely with our international organizations, the similar ones. We work very closely with King's Centre for Military Health in England, the Australian Centre for Military and Veteran Health, and many centres throughout the U.S. through the Department of Defence and VA. They don't have just one institute in the U.S.; they have many. As an institute, we believe that our outcomes are research, education, and knowledge exchange.

● (1540)

Education is critically important, because you can't build a research institute unless you build your next generation of researchers. We have started a graduate course, a webinar-based graduate course jointly offered by Queen's and the Royal Military College, on military and veteran health. We have 21 graduate students participating from across the country. This is our first year. We're pretty excited by that.

We also work at the knowledge exchange end of the spectrum, so we're getting the information into the hands of the clinicians who work with these people as well as the policy-makers who work with these people. What people want...everybody talks about evidence-based medicine, but we have such a captive population in Canada, especially with National Defence, and we really are able to get the best information into the hands of the clinicians who are working with soldiers, sailors, and airmen and -women.

We have been working on building partnerships and support, with meetings like this—and I'm very honoured to be here today, so I thank you for inviting me—to get to be known in the government. We have had very vocal support from the Minister of Veterans Affairs, who speaks of us often in public.

The other way that we are trying to make a difference is by linking with the national professional associations. Some of our big supporters are the Canadian Medical Association, the Canadian Physiotherapy Association, and the Canadian Association of Occupational Therapists. So we have access to the clinical community as well, which, as I told you, is important to us from our knowledge exchange perspective.

We work with a lot of university-linked research institutes, such as the Centre for Addiction and Mental Health and the Glenrose in Alberta. A lot of the clinical-based research institutes are part of us as well. Also, the Royal Canadian Legion is a big supporter. Just to show you that we take the definition of health in a very broad spectrum...the World Health Organization definition of a complete state of mental, physical, and social well-being. We were admitted to the Congress of the Social Sciences and Humanities earlier this year as well.

As for our researchers, while the majority are from the health sciences, we also have people from engineering, kinesiology, English, drama, and history, which are all different departments that are working on mental health and social health needs. In very diverse areas, people are making links that they didn't used to make.

In terms of funding and sustainability, the short answer is that we're not. We have some seed funding from Queen's for my position. I've been bought out of my teaching; I'm a professor there but have been bought out of my teaching to do this. We have been applying through the regular granting institutes, but what's happened is that a lot of researchers have come to the table with resources. They have grants for studies and what they really want is access to the populations.

For long-term sustainability, we are looking at philanthropy and industry partnerships, because the public-private partnership is the only way to go, I think, but we also have been getting universities to try to establish research chairs at their universities. Once a chair is at a university and is dedicated to military and veteran health, it stays there in perpetuity, so that ensures that this carries on. So far, there are three chairs across the country and two that are related to CIMVHR, our institute.

In terms of applicability as well, I think what is really important to notice is that while we are focused on military and veteran health, there's the applicability to other first responders such as police and firefighters—and our link through the Centre for Addiction and Mental Health, which works with people in high-stress occupations is evidence of that—but there's also applicability to the entire Canadian population. I think most of you recognize that.

Nobody likes war, but from war have come most of our medical advances. We can learn a lot in times of war. Just having come out of a period of conflict...in fact, probably the last 20 years in Canada have seen a pace of operations that is really unknown since Korea. In the medical world, we have seen that the advances coming out of peacekeeping and conflict are remarkable. Those are translating down into the civilian world.

I'll give you a tiny example of that. One of our chairs, Colonel Doctor Homer Tien, is the chief of trauma medicine at Sunnybrook. He's a military colonel embedded into the civilian health care force in order to keep him current in trauma medicine, because typically in the military you don't see it every day. At Sunnybrook Hospital, he was the one who took charge of the Scarborough shootings. He was in the papers for using the best practices that he had learned in Afghanistan in order to manage a shooting in Scarborough.

Those are just some of the things as a bit of background. I would welcome your questions.

● (1545)

The Chair: Thank you very much, Professor Aiken. That was exactly 10 minutes. We appreciate your opening comments.

With that, we're going to do our seven-minute round.

To kick us off, Mr. Harris, you have the floor.

Mr. Jack Harris (St. John's East, NDP): Thank you.

Thank you for coming, Dr. Aiken. I was pleased to hear you the other day as well.

You are a professor, but you're not a professor of medicine. What is your discipline?

Dr. Alice Aiken: My research discipline is health policy and health services, but my clinical discipline is physiotherapy.

Mr. Jack Harris: It's physiotherapy, but you are the administrative head as well as the academic head of this institute.

Dr. Alice Aiken: I am the scientific director, and if we could afford an executive director, we'd have one, but barring that, I'm doing it all.

Mr. Jack Harris: I'm happy to call you Dr. Aiken, but we're in a different field here.

I was looking at the Department of Veterans Affairs website, for example, and they have a heading called research into trauma related to operational stress injuries. They've listed a number of research studies that are under way. I think there are three that they're funding.

They list a number of publications, but in the publications, there doesn't seem to be anything after 2006. One or two are listed as being in press, which I guess means they're current but not released. They're not published by the government; they're published by journals such as the *Journal of Nervous and Mental Disease*, *The Canadian Journal of Psychiatry*, the *Journal of Traumatic Stress* , etc.

These aren't what you would just call internal government studies. These would be peer-reviewed independent studies, would they not?

Dr. Alice Aiken: Yes, they would be, if they're published in a peer-reviewed journal.

Mr. Jack Harris: Can you elaborate a little bit more on what you refer to as the distinction between government studies, which result in certain decisions that people may or may not like because the studies come from the government, as opposed to independent research, just in light of that?

Dr. Alice Aiken: If I understand your question correctly, certainly government researchers, if the research isn't classified, are free to publish in peer-reviewed journals as well. It's not usually the science that's criticized. It tends to be stuff that's a little more controversial—not treatment-based approaches or things like that.

But I will tell you that Veterans Affairs did an enormous amount of publishing in 2010 and 2011. They just may not have updated their website.

Just this past summer, we did a scoping review of all the Canadian veterans health literature, and there's been an enormous increase. However, a lot of it has come out as government-based publications since then. Now, the government tells us they are also peer-reviewed, which is outstanding. That's always good for science. But they are still doing a lot of publishing.

Mr. Jack Harris: Is that accessible? I understand that your organization is relatively new, and it's great that you have the cooperation of over 20 universities across the country. I notice the university in my riding, Memorial University, is one of those, and we're happy to see that, too.

Do you have any document that you have published that would give a sort of summary of the state of play—what's there and what's not—that might be available to us as we go forward looking into this question as a committee?

Dr. Alice Aiken: The short answer is yes, and we have several. We published a book following our first forum. We have one coming out in November from last year's forum. All the abstracts from this year's forum will be published, so it will give a very good synopsis of the research being done.

We have several special editions of journals that are in the course of being published. The work I just spoke about—the scoping review of the veterans health work—is being amalgamated into a document right now by a graduate student of mine, and we're just trying to put live links into it so that you can go to our website, look at it, click on any link, and have the document.

Mr. Jack Harris: There may be an opportunity to update prevalent studies on operational stress injury or PTSD, for example. Our committee did a study a few years ago, and the figures were from 2008, and they are modest compared to what the predictions and projections are today. That might be a way of updating that.

● (1550)

Dr. Alice Aiken: Yes.

Mr. Jack Harris: I think I'm done.

The Chair: You have two more minutes, if you want to use them.

Mr. Jack Harris: I have two more minutes. Oh, good.

The Chair: Unless you want it to be five.

Mr. Jack Harris: No, that's fine.

I said I was looking at our report there, and the indication of the studies done by the military back then when we heard the testimony was that 4% of the respondents to a survey in the military had exhibited symptoms consistent with PTSD. Another 5.8% had either PTSD or depression-related symptoms, and a total of 13% had a possible mental health diagnosis.

I suppose it's not totally necessary to be able to compare apples to oranges, but we have heard figures thrown around about prevalence rates of operational stress injuries from people who have served in combat, comparing one military to another. Would there be research of that nature included in the work that you're citing here now?

Dr. Alice Aiken: Yes, some of it is in that work. The centre in the U.K. has done a large tri-nation study on Canada, the U.K., and the U.S., showing the prevalence of operational stress injuries. What they've found is that the rates of PTSD are very high in the U.S., ranging somewhere between 20% and 40%. In Canada, PTSD tends to be at about 20%, but what's more prevalent in Canada seems to be depression, and in the U.K. what seems to be more prevalent as a mental health issue is binge drinking.

So there is very good evidence out there. Right now the numbers show about one in five, which is no different for the Canadian military, which is no different for the general population. The problem, as you know, with mental health injuries is that they don't often show up right away. And Veterans Affairs will tell us that they will get an influx five, ten, and fifteen years after an operation.

Mr. Jack Harris: I have another short snapper. What are the top three research issues?

The Chair: Very quickly.

Mr. Jack Harris: We all need to know that, I guess.

The Chair: Dr. Aiken.

Dr. Alice Aiken: It's certainly mental health, physical health and force protection, and family health. Those would be the top three.

The Chair: Perfect. Thank you very much.

We're going to move along.

Mr. Norlock, it's your turn.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much for appearing today. I'm very interested in all you have to say, quite frankly.

I have a couple of questions.

The first one has some ancillary questions after a statement. As you are an innovative organization that engages existing academic research sources and facilitates the development of new research, research capacity, and effective knowledge exchange, I believe it would be beneficial to the committee if you would explain how you conduct your research, number one. And I have some ancillary questions. Do you speak with veterans and serving CF members directly? How do you assemble and analyze your findings? Can you inform us as to the types of research methods you use, as there is such a broad scope of maladies that can affect CF members?

Dr. Alice Aiken: Yes, certainly.

In the research being done, the actual methodology for the research is really nothing new. It's the type of research where there are epidemiological studies, there are clinical studies, and there are case histories. There's everything that you would normally use in research. So standard research protocols are followed.

I think what we've done is we've just brought the idea to the research community that military and veterans and their families have unique health needs, so they're studied as a different population or included as a marker. As you're doing a large survey you would ask questions: Did you serve in the military? Were you a first responder?

You would ask those questions to be able to distinguish out the crowd.

Standard science is what is used typically, and it depends on the type of research that's being done. We have engaged, as I've said, a very broad spectrum of researchers, so there is a broad spectrum of methodology being done.

● (1555)

Mr. Rick Norlock: Do you speak directly with veterans and CF members, or do you use the interviews from other studies?

Dr. Alice Aiken: Both are done. Typically we try to give researchers access to the populations directly if that's the type of research they're doing. Some of the database research is done using existing Stats Canada databases and stuff. But no, as much as possible, we try to link the researchers with the relevant populations.

For example, one of the top PTSD researchers in the country, Dr. Jitender Sareen from the University of Manitoba, has assembled a national team together to look at conducting the Canadian community health survey again for veterans. Going back to Mr. Harris' question, it was done in 2007, and there are some old data, but they want to redo it and get new data, again with a particular focus on military and veterans. He's going across the country doing town halls with veterans.

Mr. Rick Norlock: I think you've maybe answered a lot of my second question, but I'm going to ask it just so you can fill in some of the gaps, time permitting.

Some of the institute's key outcomes in the research division fall under the heading of knowledge exchange, where listed activities are research forums, workshops, peer review publications, and extensive use—and this to me is the important one—of social media. Can you explain further how your organization liaises with educational facilities and other institutions—and again I highlighted this one—and what you've achieved thus far using these methods?

Dr. Alice Aiken: Well, I think our biggest accomplishment is having engaged the 25 universities, and people recognizing that we do focus on a special population.

On the use of knowledge exchange, we've been able to bring new research teams together. I'll give you a really concrete example. There's a huge movement afoot in the country on sport concussion research. It's in the papers every day, and the NHL is very involved. I guess they have to have something to do.

That's been a very big issue. We were able to bring the sport concussion research community and their tremendous researchers into the military realm of traumatic brain injury, because it's very similar. The head is getting jostled around and the brain is getting bruised. We were able to link the sport concussion community with the military community, and now they're talking. So some of the top research and best practices are coming to the clinicians who deal directly with those soldiers.

Was that a good example?

Mr. Rick Norlock: Yes, it is actually very good.

How much time do I have?

The Chair: Two minutes.

Mr. Rick Norlock: Going back to workshops, peer review publications, extensive use of social media, can you give us some examples of the latter?

Dr. Alice Aiken: Some of what we're doing now, along with our website and what not—Facebook and Twitter for the younger generation—is looking at apps to help people, so apps for smartphones. We're working with several different research groups around the country to look at bringing apps to serving people that can help with their health care specifically. If somebody has a mental health issue and they're going into a situation that will be stressful, they can be fed information: "This is a stressful time; here are some things you may want to do to help with your health. You're in such and such a location now. If you need emergency services, this is where you can go. If you want to contact your clinician, drop them an e-mail or text them. They are there for you."

We're really looking at that, especially for younger soldiers and sailors and airmen. That's how they function, right? They live on their smartphones.

Mr. Rick Norlock: Thank you very much for answering my questions.

The Chair: Thank you.

Mr. McKay, you have the last of the seven minutes.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair.

Thank you, Dr. Aiken. I suppose I should add a second thank you because I didn't know I should thank you for the influence or contribution made to the Scarborough shootings, which happened in my riding. Two people were killed, 43 people injured, and apparently nobody saw anything—but that's another issue.

I do remember talking to the chief afterwards and talking about how effectively the whole thing was triaged, and the various people, based on their state of injury, being farmed out to the various hospitals as they were available. So thank you for that. I didn't know it was you to whom I should direct my thanks.

● (1600)

Dr. Alice Aiken: Well, it's Colonel Tien. I can take no credit.

Hon. John McKay: The issue of concussive injuries, following on Mr. Norlock's question, is pretty vexing. It has both a civilian and a military application. I would be interested in your thoughts with respect to, if you will, the latest area of research in that field. Where do you think the research might be going? And what is its relationship to PTSD and other mental expressions of what is a physical injury?

Dr. Alice Aiken: That's a great and very timely question. A lot of the research being done now is really trying to distinguish between mild traumatic brain injury and post-traumatic stress disorder, because the symptoms people display are often very similar. Some of the higher-technology research going on and the really cutting-edge stuff is around brain mapping, which is looking at the physical changes in the brain, to see if you can distinguish between post-traumatic stress disorder and mild traumatic brain injury. But it's also brain biomarkers, so actually measuring the chemicals in the brain to see if there are different chemical changes, because there are changes in the brain with both. It's being able to distinguish them.

As I'm sure you can appreciate when it comes to a clinical level, if you make the incorrect diagnosis and you are treating for post-traumatic stress disorder and the person has a mild traumatic brain injury, they are never going to get better. So it's really critical.

I think those are the really cutting-edge things being done. We have some sensational researchers in Canada doing work, looking at eye movement, which is very closely related, obviously, to brain function—all our movements are, but the eye is in particular—and seeing if they can distinguish between different eye movements to determine it, so it's not as invasive as doing brain biomarkers and brain mapping.

Hon. John McKay: I know the forces are very keen on this research, particularly Brigadier-General Bernier. Describe for the committee the interaction between the forces and your collection of researchers and how that's working and what each brings to the party.

Dr. Alice Aiken: With respect to the brain biomarkers, one of the mental health leads from the Canadian Forces, one of the uniformed psychiatrists, is working directly with the research team. He's a co-investigator with the research team. And they were able to bring some money to that team through Defence Research and Development Canada—a small contract through them. They were able to facilitate this research, with a lab that contains the world's experts in measuring brain biomarkers. They are very engaged in that particular research.

Hon. John McKay: I'm given to understand that there is something in the order of 1,300 members or past members of the forces—I may have got my figures wrong—who have exhibited PTSD or may even have been diagnosed. I'm not absolutely certain about this. I understood at the meeting on Tuesday that this number will double. What advice would you be giving to the forces that would be unique with respect to members returning from combat and facing re-assignment or possibly leaving the military, voluntarily or otherwise? What would your research tell the military as to how to do discharges differently?

Dr. Alice Aiken: If you can make an accurate diagnosis and implement the appropriate treatment, then you have a greater chance of curing someone and allowing them to stay in. With PTSD that has been properly diagnosed, a third will be treated and get better and be fine, a third require ongoing treatment but can still serve, and about a third are not responsive to treatment. It may be that some of those have traumatic brain injury. For the military, what they want to look at is how to protect against this. They want to know what they can do to protect against mild traumatic brain injury or post traumatic stress disorder. Mild traumatic brain injury could be an equipment issue. Post-traumatic stress disorder is not.

● (1605)

Hon. John McKay: I have one final question that is not on the previous lines. It was given to me by a veteran and it is related to your research. Injured veterans might not receive the care that they need under the new Veterans Charter as compared with the Pension Act. In the face of this, what would you recommend as treatment of ill and injured prior to medical release for not meeting the universality of service?

I can't say that I actually understand that question, but it does seem to me a very important one.

Dr. Alice Aiken: That was some research that I conducted three or four years ago in which we compared the Pension Act with the new Veterans Charter in terms of financial compensation for seriously disabled veterans. That's 1% of the veteran population, the people who are deemed to have greater than 78% disability. What we found in three case studies was that the Pension Act paid more money.

What we didn't take into account was all the other programs, the focus on rehabilitation and reintegration, that the new Veterans Charter has. The Pension Act would just pay you and you wouldn't have to work. So philosophically, for 99% of the veterans, the new Veterans Charter is probably better. Unfortunately, we were misquoted a lot. But the people at Veterans Affairs know me, so they didn't get too upset. It was controversial, but they were great. In fact, it was taken into account before they made the most recent changes to the Veterans Charter.

The Chair: Thank you. Time has expired.

We're going to go to five minutes now, and I'm going to be very judicious because we only have half an hour left with Professor Aiken.

Mr. Chisu, you have the floor.

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much, Mr. Chair.

Thank you very much, Dr. Aiken, for being here with us.

As you are aware, Canada has not been in a combat mission since our engagement in Korea, and now, after 10 years, our combat mission in Afghanistan, and I was proud to be there, has ended.

Could you expand on issues not previously seen or noted that returning CF members may face? I am asking this question...we had a combat situation in Croatia. I recall the Medak pocket, which was quite similar to the situation in Afghanistan; it was a highly combative situation.

What types of services do you believe would be necessary for our most seriously injured veterans coming out of Afghanistan?

Dr. Alice Aiken: Certainly what's come more into current awareness is the mental health research, but I think that's general in society as people are more willing to talk about mental health injuries, and I think that's a societal issue.

We did see a lot of mental health injuries coming as a result of Rwanda, Somalia, the Swiss Air disaster, and other issues like that, that weren't specifically combat but were traumatic nonetheless.

In terms of physical injuries, where you're going to see the most advances coming out of Afghanistan.... We're seeing really an unprecedented number of amputees. There are now limb transplant surgeons, so if you lose a leg, they will replace it with somebody else's, and there are bionics, particularly for upper limbs. A lot of this is being done in the States by the U.S. military researchers. The bionics are actually wired into your brain. So you don't have to use other muscles to move your artificial arm; you just think about it and the arm moves very much like a natural arm.

I think in terms of really cutting-edge research, that's going to be part of the legacy of Afghanistan. I would say that if we could pick a general term for one legacy, it's trauma medicine, and the rehab following it is going to be the big legacy in the medical world.

● (1610)

Mr. Corneliu Chisu: Are you in contact with DRDC, which has done some of the advanced research in the field of artificial blood and other things? I had the privilege of being in contact with them when I came back from Bosnia. I had a problem—not a mental problem, but it was an issue of extreme exhaustion, and I was treated very well by the DRDC specialists. That is a very good research centre, so I'm asking if you have a relationship with them, because you were talking about the universities. That is a research centre, which is also doing something in the navy and....

Dr. Alice Aiken: Yes, in all the fields. The government departments we work very closely with and that we're in contact with a lot are National Defence, DRDC, the Canadian Forces Health Services, and the research directorate at Veterans Affairs. So we do work very closely with DRDC as well, and they do some remarkable research, I would agree.

Mr. Corneliu Chisu: Of course, you cover many aspects of mental and physical health in your research, I suppose. What are the most difficult injuries or illnesses to assess and treat, except for mental illness? What kinds of injuries, because they are stress-related...?

Dr. Alice Aiken: Right, the mental illnesses for sure. I would say probably environmental. The military does a lot of sampling of environment and stuff, but I think we probably don't know the environmental impact Afghanistan is going to have. It's different soil and different air.

I would have to say that I think probably the thing that is the most difficult to discern, rather than diagnose, is the impact on the family. I think that's where we really need to put some resources. We are really starting down that road with our research community as well. But we know there are impacts on the spouse and the kids. There are transgenerational impacts that really need to be investigated and are difficult to diagnose, because the family is not in the same health system as the member.

The Chair: Thank you very much.

Moving right along,

[*Translation*]

I will give the floor to Ms. Moore.

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you.

I have some questions for you.

In the first aid courses given by the armed forces, I gather that people are taught a lot about treating physical wounds, but very little about how to deal with mental wounds, if I may put it that way.

In your opinion, should that be included in military training to a greater extent? Are there any studies along those lines? For example, should colleagues and other regular people be trained to be able to detect signs and symptoms of depression and to know how to get involved when a colleague is going through a stressful event?

Everyone knows that words can sometimes do real harm, even if things are not said to be hurtful. Is a lot of work being done in these areas?

Dr. Alice Aiken: I will answer in English, if I may.

[*English*]

I would have to say that the Canadian Forces are actually considered a world leader in destigmatizing mental health injuries. They actually do build in training about mental health injuries and illnesses, from the time somebody is a new recruit, to destigmatize them. They really are trying to build it into not only the medical world but the chain of command, so into the military world as well.

They do things like encourage peer support. Peer support is enormous. For example, if you are deployed with somebody and you are feeling something, your buddy says to you that he feels terrible every time he is in an elevator or something—people are able to tell you they were feeling that way and they got help, so you should. It's not perfect, but it's really helpful, and they have built it into the whole training curriculum throughout the military.

The other thing they do for people returning from deployment is they have a time for decompression. They come to a third-party location and they get to rest, relax, and have some information about reintegrating into family and civilian life. That helps. They are also given a little pocket card that looks like a business card, with the signs of mental stress, and they are told if they are feeling any of these things to go into the medical services and they will help them out.

The other militaries look to Canada for how they would destigmatize. I was at a conference with the Mental Health Commission and I was at a table with a gentleman from the RCMP and a gentleman from Corrections Canada, both of whom said they wished they could destigmatize mental health the same way the forces have.

It's a great question because they really have been working on that. It's never going to be perfect because some people don't want to go to their own...some people still have the fear they might be released. They are trying to stop that, and they are really working hard at it.

● (1615)

[*Translation*]

Ms. Christine Moore: One more thing, in terms of research. You say that it is focused on prevention, treatment and rehabilitation. What percentage goes to each of those three aspects?

[*English*]

Dr. Alice Aiken: It's difficult to tell, only because I would say, having done a review this past summer of all the literature on Canadian veterans' health, that the vast majority of it is published in mental health literature. But I think that's a trend across the country.

It doesn't mean that's the number one problem, so the research right now doesn't always reflect the greatest need. It's a bit difficult to give the percentages. I will tell you that most abstracts for our upcoming forum were submitted from the research community on mental health, then physical health and rehab, and then the third one would be occupational health.

[*Translation*]

The Chair: Thank you very much.

[*English*]

Madam Gallant, you have the floor.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman, and through you to our witness.

Given privacy concerns, VAC and DND just can't give your organization a list of names of people who are potential subjects. How do you go about seeking out and finding willing participants for your studies?

Dr. Alice Aiken: It depends on the study. People are allowed to volunteer, but it's a bit more difficult for Veterans Affairs. They work more like an insurance company, so the information is really private. In the military, if you want to have access to people with a particular diagnosis, you'd typically go in through the health system.

If you want to access patients in the military, the approval has to come from the Surgeon General in every case. So the study has to have scientific rigour. It has to have merit. It has to be of interest to the military. Then they will put out a request and subjects can volunteer.

It's as you would do with any study. If I wanted to go to my local hospital and recruit patients who had knee pain, it would be on a volunteer basis.

Mrs. Cheryl Gallant: Has your organization done this before, for PTSD, for example?

Dr. Alice Aiken: For most of the studies on PTSD right now, the researchers are either embedded in the operational stress injury clinics—they're the clinicians—or within the military clinics. They'll often partner with a research group and recruit that way.

Mrs. Cheryl Gallant: Do they have any problem finding enough subjects?

Dr. Alice Aiken: Not yet. It's a typical scientific problem that recruitment can be an issue, but it hasn't been for any of the studies that have been done so far.

Mrs. Cheryl Gallant: Does your organization also liaise with the joint personnel support units?

Dr. Alice Aiken: Yes.

Mrs. Cheryl Gallant: Have you brought the sleep research community together with the Defence community, in the way that you mentioned the sports brain injury medical community has been combined with the Defence community?

● (1620)

Dr. Alice Aiken: That's a really great question. We've just been working on a project to bring some of the sleep researchers together with Defence researchers. The study they're proposing is under review, so I don't actually know if I'm allowed to talk about it.

It's a great question. If you think you're coping with stress, you can't fake whether you're sleeping well or not, right? I mean, you can lie about it, but you can't really fake it.

Mrs. Cheryl Gallant: Could you describe any unorthodox methods of dealing with PTSD that your organization is involved with, something out of the normal, unique ways of dealing with PTSD?

Dr. Alice Aiken: Some of the links we've made—and this is a new study that is just starting up—is looking at fitness and yoga for treating PTSD. I wouldn't say that's particularly unorthodox—typically fitness helps a lot of problems—but fitness and yoga is one.

We've recently linked with a group in the U.K. This is very tentative right now, but we're looking at building an international study looking at meditation and mindfulness. There is a tremendous amount of support for that as well within parts of the military community.

Mrs. Cheryl Gallant: How, if at all, does your organization liaise with OSISS, the operational stress injury social support group?

Dr. Alice Aiken: Again, they fall under the umbrella of the Canadian Forces Health Services group and the director general of personnel, PFSS, Commodore Watson.

We do liaise as closely with them as we can. As I mentioned to Madame Moore, a big part of what the mental health researchers look at is peer support. It's part of the way of destigmatizing mental health issues.

We work with the OSISS clinics, the OSI clinics run by VAC, the joint personnel support units—all of those.

Mrs. Cheryl Gallant: I'm also seeing applications from time to time, for example, from horse ranchers, who are helping to bring some of these people who are literally still barricaded in their basements out into daylight. They are having them interact with horses—different animals as well, but specifically horses at this time.

Are there any scientific-based studies being done on using animals to help people cope with PTSD?

Dr. Alice Aiken: Not in Canada currently. There is a very large-scale study being done by the United States VA on dogs helping people with mental illness. Unfortunately, the conclusion they've come to is that if they get every veteran a dog, they'd be bankrupt within five years. And they have a lot of money.

It's one of those things that is a bit difficult. I will tell you that in other literature not related to military populations, hippotherapy with horses has some very significant solid research behind it. There have been requests to do the work with military populations, but it's still very new for us.

To my knowledge, the horse therapy hasn't been done with military populations yet, and certainly not in Canada. But horse therapy itself has some very solid research behind it.

The Chair: Thank you very much. I have horses and dogs, and I can tell you that dogs are a lot cheaper than horses.

Mr. Kellway, it's your turn.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you very much, Mr. Chair.

Alice, thank you for coming today. I'm struck, when I look at the materials, by all the logos at the bottom. I know you said 25, but the graphic here is quite something. Congratulations to you for pulling all these organizations into one institute.

I was interested in the study reference on the incidence of PTSD and how the effects of service for veterans kind of manifest themselves in the U.S., Canada, and the U.K. I have two questions about that. First, was there an explanation offered in the study for the differences? Canada, for example, has half the incidence of PTSD but so much more depression.

Second, with that in mind, I'm wondering whether this phenomenal amount of research going on in these institutes is making its way from that research field and the academics into the Canadian Forces health system. For example, when one looks at this study and sees the incidence of depression, is that research impacting on the kinds of services being offered, such as suicide prevention or something like that, in the Canadian Forces? Are we seeing that kind of translation?

● (1625)

Dr. Alice Aiken: Yes, we are.

I'll answer your first question first.

The great thing about epidemiological studies is that it's lots of people and you can really predict population trends. What you sacrifice in an epidemiological study is the why. You completely lose that. No, there's no explanation as to why. However, recognizing that there is a problem can help you in terms of treatment, because there are lots of ways to treat depression.

Yes, it has filtered its way down to the Canadian Forces, and the Canadian Forces have done a number of studies themselves. They did a study on suicide rates. They've done a study on family violence, the results of which will be released shortly. I know that they do recognize it and make a very concerted effort to implement best practices, especially with mental health research, and with all research.

Mr. Matthew Kellway: You made an argument for such an institute being arm's length from the government departments. You also talked a bit about the clinical work and the policy work research being done. I'm wondering if you could give us, briefly, an overview of the kind of policy research being done and whether it is in fact that policy research that benefits from being arm's length from the government departments.

Dr. Alice Aiken: One of the examples of the policy work, which Mr. McKay brought up, was the work we did comparing the new Veterans Charter and the Pension Act. It was taken into consideration, certainly in some of the amendments made to the new Veterans Charter. That kind of policy work absolutely was done at arm's length from the government.

Some of the program and policy work is a little bit smaller scale. There are some tremendous programs out there. But if they're implemented, it's really critical to build in an evaluation piece so that you can know if the program is doing what you said it's going to do and how that translates into policy. If this is an effective program, and it's having the impacts you want it to have, then you keep it as a program and you fund it. It's not all big P policy change; it's really critical health policy change that we look at.

Mr. Matthew Kellway: Is this research focusing on, for example, what the government departments are doing, such as Veterans Affairs and the Canadian Forces programming?

Dr. Alice Aiken: Absolutely, yes, because that's where a lot of the programming is coming from. For example, the operational stress injury clinics Veterans Affairs runs—I believe there are 11 across the country right now—built evaluation into all of their treatment practices from the get-go. They actually are now kind of the leading experts in treating operational stress injuries around the world. In fact, they've built workshops to train clinicians. And they have really solid evidence-based outcomes for some of the treatment programs they use. That's how it translates.

The Chair: Thank you, Mr. Kellway. That was exactly five minutes.

Mr. Strahl, you have the last questioning in this hour.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Mr. Chair.

Dr. Aiken, thank you for sharing your time and expertise with us today. It was good to hear that the Canadian Forces are considered a world leader in destigmatizing mental illness. I had the opportunity to witness that firsthand when I got to welcome home some troops from Libya on the HMCS *Vancouver*. General Natynczyk himself, when he gathered around the sailors, talked about their needing to ask for help. It came from the very top, so it's good to see that's being noticed.

Following on that, you said that you focus on research, education, and knowledge exchange. I'm interested in that knowledge exchange part. What have we seen? It's maybe dangerous to ask a question you don't know the answer to, but compared to our near peers or some of our other NATO allies, how are we doing in the treatment of the ill and injured Canadian Forces members, from your research, compared to, say, the U.S. or Australia, which you said you had done some work with? How are the Canadian Forces doing compared to those allies?

● (1630)

Dr. Alice Aiken: In best practices, research, and treatment, the allies cooperate very well. They're on par. We're very similar to Australia and the U.K. The U.S., of course, as always, has a much larger force. You're really comparing apples and oranges then, so it's hard to say. We do know that they have a much higher suicide rate than the Canadian Forces.

Of the forces that we're comparable to, Australia and the U.K., not in terms of size but in terms of training and deployment length, I would say we're very similar, which is well; we're doing well. The Canadian Forces Health Services system is the Cadillac of medical systems. You get everything provided—all your medications, all your therapy—and it still costs $78 less per person than any provincial health care system in Canada.

Mr. Mark Strahl: That's interesting research right there. I'm sure we could have a large discussion about that.

I'm going to stick with the mental illness issue. It's Mental Illness Awareness Week, as the chair mentioned, so it fits in nicely. What skills are we giving to families? I know we talked about giving a soldier a card, "If you recognize this...", but often, if not always, it's going to be the family that recognizes that there is a mental illness there or signs that it may be coming.

Are the Canadian Forces doing a good job, or is there another body of research? Are there other practices out there to equip families to (a) better diagnose this or get people into treatment, and (b) to support them when a member of the forces is diagnosed with a mental illness?

Dr. Alice Aiken: I would say yes. We were at a breakfast the other day and the Surgeon General was there. He said through informal work they've done, really very few people come to seek mental help because of what the medical system told them. They come because a friend, like a peer or a family member, says, "Right, you need to go seek help, something's happening".

I think the families are well equipped for that. I think where the families are less well equipped is to deal with their own issues. So they don't have a centralized system. They live in a system that doesn't understand unique needs, and, believe me, we're working on trying to change that. I think they're probably less capable of recognizing their own needs. But in terms of the needs for the soldier, yes, I think they're doing a good job in helping families and peers to recognize when there's a mental health issue.

Mr. Mark Strahl: Thank you, Mr. Chair.

The Chair: Thank you.

Our time is up with Dr. Aiken. We scheduled her for one hour.

I certainly appreciate your coming on very short notice and providing your expertise and comments to help us kick off the study. Some of the other researchers you mentioned in your testimony today will be people we'll want to follow up on. As well, as a committee, we're going to take a look at the reports you talked about.

I want to thank you for your service to Canada, both as a member of the Canadian armed forces and as one of our vets, and now for the work you're doing with Canadians for military and veteran health research. You really are doing a great service for our members of the Canadian Forces and our veterans.

With that, I want to wish you a very happy Thanksgiving.

We're going to suspend. For anyone who is not tied to a member of Parliament or does not belong to a whip's office, I'm going to ask that they vacate the premises.

Thank you.

[*Proceedings continue in camera*]

MAIL POSTE

Canada Post Corporation / Société canadienne des postes

Postage paid / Port payé

Lettermail / Poste–lettre

1782711
Ottawa

If undelivered, return COVER ONLY to:
Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5

En cas de non-livraison,
retourner cette COUVERTURE SEULEMENT à :
Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5

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

SPEAKER'S PERMISSION

Reproduction of the proceedings of the House of Commons and its Committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the *Copyright Act*. Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.

Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a Committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the *Copyright Act*.

Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its Committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this 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

Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la *Loi sur le droit d'auteur*. Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre.

La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la *Loi sur le droit d'auteur*.

La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.

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