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Chair

Mr. James Bezan

Standing Committee on National Defence

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● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone. We are going to start our meeting.

I want to change the agenda just briefly; we have a little bit of committee business to do. We have a motion to deal with the steering committee report. I want to get it out of the way now, so that in the event some members have flights to catch, we won't be compromising them at the end of the meeting.

Leif, did we circulate that motion? I don't have a copy of it.

Do you guys have a copy of the motion in front of you...? Bear with me, colleagues.

The steering committee met on Tuesday. I want to thank Mr. Harris for filling in as chair for last Thursday's meeting and for Tuesday's meeting on my behalf while I was travelling.

While we're waiting for the circulation of the report from the subcommittee, I shall read it: your subcommittee met on Tuesday, October 30...to consider the business of the committee and agreed to make the following resolution:

> That, on Thursday, November 20, 2012, the Committee resume consideration of a draft report on Maintaining the Readiness of the Canadian Forces, and that members submit further recommendations to the draft report to the clerk no later than Thursday, November 1....

That's today.

Can I have someone move that report?

Thank you, Mr. Strahl.

Is there any discussion?

Mr. McKay.

Hon. John McKay (Scarborough—Guildwood, Lib.): I have two points. I like and admire Colonel Scott McLeod, but I see that he is also scheduled for Tuesday.

The Chair: That could be an error in the....

An hon. member: I thought he was, but I didn't realize he had been scheduled for today. I thought we had—

The Chair: This didn't make up part of the report.... There was definitely a decision to have Colonel McLeod now; we do still have Brigadier-General Jean-Robert Bernier, the Surgeon General, appearing on Tuesday. I suspect he will bring support staff with him.

Mr. McKay.

Hon. John McKay: My second point is on supplementary estimates (B). As I understand it, they're due on the tenth of November, and we don't see the minister until the fourth of December.

The Chair: As long as we report back within three days of the tenth, we'll be all right.

Hon. John McKay: It just seems to be a bit of a rush. It seems to be a bit of a rush all the time.

A voice: [*Inaudible—Editor*]

Hon. John McKay Well, my understanding is that the supplementary (B)s have to be set out on November 10. Correct me if I'm wrong—

The Chair: They haven't been tabled as of yet, but I think the anticipation is—

Hon. John McKay: I think that's true. You take it from December 10, which is when they have to be reported back to the House, and you get 30 days. I think that's the way it works, yet we don't have the minister until six days before they actually have to be reported. I don't know how many sitting days that is, but it's probably not very many. If we want to do anything about the supplementary (B)s, other than see the minister, we don't actually have much of an opportunity to do so. I just make that as an observation, because I don't like to—

The Chair: It's a fair observation, Mr. McKay. When the supplementaries are actually tabled, we'll extend the invitation. If we have to change dates, then—

Hon. John McKay: I may want, at that time, when they're tabled —depending on what they say—to suggest that either we move up the minister or maybe get officials in as a separate meeting.

The Chair: Yes. We'll cross that bridge when we get to it. Is there any other discussion?

Seeing none, all in favour?

Some hon. members: Agreed.

The Chair: The report is accepted.

We're going to continue with our study of the care of ill and injured Canadian Forces members. We're lucky to have with us today a few people to discuss equine therapy for mental health healing.

From the Department of National Defence, we have with us Colonel Scott McLeod, who enrolled in the Canadian Forces back in 1990. He attained his medical degree in 1993 from the University of Saskatchewan, which was followed by a certificate in family medicine in 1995. Scott holds an honours degree in biochemistry from the University of Regina and a master's degree in public health from the University of Texas. He is a member of the College of Physicians and Surgeons of Saskatchewan and the College of Family Physicians of Canada and is an associate fellow with the Aerospace Medical Association. He has completed the U.S. Air Force residency in aerospace medicine and holds a U.S. board certificate in preventive medicine in aerospace.

We also have at the table Marie Josée Hull. She's a clinical social worker and has a master's and a bachelor's in social work and is a member in good standing of the Ontario College of Social Workers and the Ontario Association of Social Workers. She has been in her career for 15 years now, working as a child and family therapist and with mental health agencies. She has a particular interest in helping people by using horses.

Joining us as well is Alison Vandergragt, the program director for Hope Reins Equine Assisted Therapy Programs, who has a great deal of experience using horses in therapy. We're also joined by her daughter, Alyssa, who is celebrating her 17th birthday today.

Happy Birthday, Alyssa. We'll save you the grief of having to listen to all of us sing to you.

With that, I'm going to open it up for opening comments. Again, I'd ask that your comments be kept to 10 minutes.

Colonel McLeod, could you kick us off, please?

Colonel Scott McLeod (Director of Mental Health, Canadian Forces Health Services, Department of National Defence): Good afternoon, Mr. Chair. Thank you for inviting me today.

I would also like to thank the other presenters for their interest in helping the men and women in uniform, specifically those who are suffering with mental illness.

Mr. Chair, as the members of this committee are aware, our recent operations, from Afghanistan to Haiti to Libya, have placed heavy demands on the Canadian Forces, and specifically the personnel. This intense operational tempo has brought the challenges faced by our returning military servicemen and women to the forefront of our consciousness as a country. That's why I am pleased to see that this committee has chosen to undertake a study on the care of ill and injured personnel.

In this context, mental health care is a priority for the Canadian Forces. It is critical not only to the ability of the Canadian Forces to carry out their missions, but also, and even more importantly, to the health and well-being of our men and women in uniform and their families.

I am proud to say that our clinicians are considered experts in the field of trauma-related mental illness across Canada and internationally. Today we have access to approximately 378 full-time mental health care professionals. Within NATO, this is the greatest ratio of mental health care workers to military members.

But delivering high-quality mental health care services is about more than having dedicated and well-trained professionals; it is also about having programs suited to the needs of our patients. That's why we have a comprehensive mental health care program that is founded on evidence-based best practice. Our operational trauma stress support centres are made up of multidisciplinary teams of health professionals who use the latest evidence-based treatments and techniques and who take pride in staying up to date in therapeutic techniques.

We also recognize that there are always advances in the field of treating mental illness. For that reason, we have a systematic process for reviewing any new therapies or treatments available. Our treatment standardization committee, chaired by our senior psychiatrist, Colonel Rakesh Jetly, reviews new therapies and treatments to ensure that we continue to improve our system and provide the highest quality of care to our patients.

One of the challenges we face on a daily basis is how best to deal with adjunct therapies such as equine therapy. We routinely receive requests to consider a wide variety of adjunct therapies, such as pet therapy or even creative arts therapy, that appear to have some level of benefit on an individual basis to individuals who participate; however, there is rarely sufficient evidence to prove their long-term benefit. This is not dissimilar to adjunct therapies for physical illness and injuries as well.

In order for us to have a responsible, standardized approach for all treatments and therapies, we apply the five core principles of the Spectrum of Care Committee. They are as follows:

One, the treatment, service, or item must adhere to the scientific principle of evidence-based medicine. This principle would eliminate any new medical procedure or remedy that has not been adequately investigated and scientifically found to provide a significant health benefit.

Two, the treatment, service, or item is necessary for the purpose of maintaining health and mental well-being or preventing disease; it permits the diagnosis or treatment of an injury, illness, or disability.

Three, the treatment, service, or item is not for purely experimental, research, or cosmetic purposes.

Four, the treatment, service, or item is funded by at least one province or federal agency. This principle is in keeping with the public service health care plan criteria.

Five, the benefit sustains or restores a serving member to an operationally effective and deployable status.

If we determine that a new adjunct therapy should be considered, it is presented to the Spectrum of Care Committee for consideration.

The Canadian Agency for Drugs and Technologies in Health, CADTH, recently published a rapid response report entitled “Therapy Dogs and Horses for Mental Health: A Review of the Clinical Effectiveness”. It was published on August 10, 2012, and is available on the CADTH website.

● (1540)

In this report, 22 potentially relevant articles were retrieved for a full text review. The conclusion of this report was as follows:

> Horse-assisted therapy was found to be effective in children who have experienced family violence, patients with schizophrenia, and children with ADHD. These findings were taken mainly from a limited number of uncontrolled trials...with small sample sizes...and therefore conclusions from these studies should be taken with caution....
>
> As no studies that compared these interventions to other standards of care such as pharmaceuticals were identified, it is unknown whether animal-assisted therapy is more or less effective than these alternative therapies. Longer-term controlled trials with larger sample sizes will be necessary to further evaluate the effectiveness of using dogs and horses to facilitate therapy session[s] for patients with mental health challenges.

At this point, there is not sufficient evidence to support the inclusion of equine therapy in the spectrum of care based on any of the five criteria. However, as with all therapies, we're open to reconsidering them as more evidence and literature become available. That being said, I want to be clear that not including equine therapy in the spectrum of care does not mean that the therapy has been shown to be of no value. It only means that there is insufficient clinical outcome data at this time to justify its funding by public health care authorities as a core medical service.

There are many things that improve our mental health, such as personal holidays, hobbies, pets, exercise programs, and many more that are not funded by health care systems. We always encourage members of the Canadian Forces to participate in activities that improve their mental health. Our duty to our patients and to responsibly manage public funds, requires, however, that we devote publicly funded health care resources to therapies that have been scientifically demonstrated and accepted by the expert health community as significantly enhancing clinical outcomes.

Our number one priority is to develop and deliver to our men and women in uniform the mental health care programs that they need and deserve.

Thank you.

● (1545)

The Chair: Thank you, Colonel.

Next on our list is Ms. Hull. You have the floor.

Ms. Marie Josée Hull (Clinical Social Worker, As an Individual): Thank you, Mr. Chairman.

Thank you, honourable members of Parliament and distinguished guests.

I am honoured to be here to talk about equine assisted psychotherapy. I'd like to start by making a bit of a distinction between three practices in the field. You can have equine services for physical rehabilitation; you can have some for education, which is equine assisted learning; and you can have some for therapy. Today I will be talking more about the ones geared toward therapy.

In my private practice, I treat soldiers who have been diagnosed with operational stress injuries.

I'd like to explain something before I go on to speak about equine assisted psychotherapy. When members come in, their anxieties are usually very high. Soldiers usually function in more of a fight-flight mode, or survival mode, so in order for us to be able to use any cognitive-based approach to process traumatic events, we need to bring them to a baseline level of calm and stabilize them. In my practice in the office, I've found that for many of them it's very difficult to manage that. A lot of soldiers don't respond well to meditation and things like that. Soldiers are active, and they like to move. So it's been a challenge in my practice, and my colleagues agree with me on that.

When a soldier comes in and is diagnosed with such an illness, it has an impact on the soldier's entire life. It has an impact on their sense of safety; on their ability to trust themselves and to trust others; on their sense of power and control over themselves and over their environment; and on their self-esteem and their intimacy. It affects families, it affects children, and it affects them.

In terms of where equine assisted psychotherapy fits in, when we do equine assisted psychotherapy it's first of all based on nature. You're outside. Just being in nature has benefits on health, just being out, just being in tune with the natural rhythms of nature.

Then you are dealing with an animal that is quite large, that you can stand and look at eye to eye. You are asked to do certain activities with a mission in mind, so the pressure is on to perform. Some anxieties can come in. The situations you place people in are to imitate real-life situations. The material can be used as a metaphor for what is really at the surface for this particular member. However, these emotions come out in a safe environment where you are supported by your mental health professional and your equine specialist. You can really practice then and there. It's very experiential in nature. You can practice your natural coping mechanisms and see how they work or do not work. If they don't work, you can try to figure out a new one and practice it then and there. This is the richness of this therapy.

Now, it's active in nature but it's also very reflective in nature. One thing that stunned me when I began working with soldiers was that they have learned to soldier on and to not pay attention to the pain, to keep going: you're on tour, you have a job to do, you can't get into emotion. This becomes something of a habit, and it's hard for them to connect with emotion.

A horse is a very, very valuable tool, because a horse is not comfortable with a person saying something on the outside and feeling something else on the inside. Horses survive by reading the non-verbal, and also by being able to feel emotional states. There is a biological explanation for that, which I will not get into today, but they can feel emotional states. When a horse sees that the non-verbal and the emotional state do not go together, it doesn't work. A soldier has to look at what's inside to be able to have good cooperation with the horse and to have some success.

The idea behind this equine assisted psychotherapy is not to bond with an animal. The idea is to face your fears in a safe environment and to learn from little successes so that you can reintegrate into society with your family and with your children.

In the last phase of trauma treatment, after processing trauma using the cognitive, evidence-based approach, it is also nice to later reintegrate a member and help them develop skills, or get better with their skills, in practice with their family.

Equine assisted psychotherapy can be done with the family. It can be done with couples. It can be done with colleagues. It has very big value in that you wouldn't be able to get that working in an office.

● (1550)

That's my presentation. Hopefully, it gives you a bit of a picture. If you have any questions, feel free to ask.

The Chair: Thank you very much.

Ms. Vandergragt, it's your turn.

Ms. Alison Vandergragt (Program Director, Hope Reins Equine Assisted Therapy Programs, Vanderbrook Farm): First of all, Mr. Chair, honourable members of Parliament, and distinguished guests, I am very honoured to be here and share something that is such a passion in my heart. I was a navy wife for 10 years, and horses have always been an important part of my life, so integrating them in something that has such benefit is something that's been very close to my heart.

I'm going to tell you briefly about my background, how I got to presenting these programs, and maybe about some of the things I've found.

I am the program director at Hope Reins. I've been an avid natural horsemanship student for a number of years, and I'm fascinated with the psychology of the horse. I started to realize that there was a connection between how horses thought and how they reacted to situations, and I started relating that to how we react with our own situations and relationships in our families. I found ways in which I could communicate with my horse, and I was very effective, but I wasn't so effective at home, so I started practising some of the principles there that I used with my horse. In my situation as a mother, I found that because we rely so much on verbal communication, when we start using some non-verbal communication, things go a lot more smoothly.

I've worked in community and long-term health care for 20 years. I met a lot of clients who had unresolved mental health issues. Addressing them went way beyond the scope of my practice and not being able to be part of the solution always caused me some distress. I eventually experienced my own very deep personal loss and I started to examine the connection between my own recovery and the role my horses played in my emotional healing. I began to wonder if horses could be part of the therapeutic process as well. I found from my own experience, this has been very true.

Hope Reins Equine Assisted Therapy Programs is seeking charitable status at this point. We provide equine-assisted learning and psychotherapy programs to children and adults facing issues such as cognitive deficiencies, autism, grief and loss, anxiety, addictions, PTSD, and more. I'm going to skip over the equine assisted part. It seems that everybody here has a fairly good idea of how that works. I want to touch on why we use horses.

Horses possess unique attributes beyond their traditional uses. Generally they've been used for transportation, and we've worked with them in the fields. We have quite a history of horses in our lives, but I've found that horses are very honest by nature, and they require humans to be honest in return. They are good lie detectors and offer feedback in the form of body language.

Horses rely on a precise and well-established system of communication that can be so subtle that humans may not even be aware of the conversation that's going on around them when they're in the herd. Horses have an intricate pecking order made up of leaders and followers. Each horse has its unique what I call “horsonality”, and all play an important role within the herd.

Within the horse-human interaction as presented in the therapy session, the human participant will generally use the same coping mechanisms that they use with other stressful factors in their lives. As these issues arise, the participants reveal their true selves and may break down some barriers in the communication blocks. With the use of horses, an enormous amount of metaphorical learning can be achieved.

What does an equine-assisted session look like? You might wonder what we do. Do we sit the client on one chair, the horse on another, and the therapist on their chair? Not exactly.

We take this to the arena, of course. Typically, it's carried out in an unmounted session. An equine specialist provides an activity or a series of activities to be completed by the client. Actions and reactions of both the horse and the human are closely monitored. These observations are used to relate, sometimes metaphorically, to issues the client is facing.

In our practice, when we're working with our mental health professionals, we offer each other feedback on what we're seeing. If I see something that the mental health professional doesn't see because they're not an equine specialist who may not understand the meaning behind the flick of an ear or some kind of body language, my job is to bring about some awareness and make a comment on it that the therapist in turn can use in processing with their client.

● (1555)

Participants will learn that the easy way is not the right way. They will learn finding success with horses requires physical and mental work—very valuable characteristics. Most importantly, horses have the ability to be a mirror of what's going on inside. What we hear all the time is “this horse is stubborn” or “this horse doesn't like me”. It might be the client's reaction, but in fact what's generally happening is that the client has to realize that change comes from within, and that the horse is offering feedback on this. It's through this honesty in that relationship, in building this relationship with the horse, that a powerful message can result.

The concept of equine-assisted therapy is recognized globally, but I'm going to focus on the U.S. for the moment. I've been watching various programs and what they're doing and who's supporting them. The information I've gathered has just been for my own personal interest, but I'll share with you what I know.

There are numerous programs across the country that are supported by Veterans Affairs. Polytrauma vets are receiving care at VA medical and rehabilitation centres and are involved in programs that take place at a base or at a locally accredited riding facility. It appears that most of the VA-supported programs are considered therapeutic riding. I didn't really touch on that, but as M. J. said, that's more focusing on the physical aspect of recovery.

Another example I have for you is the U.S. Army's Caisson Platoon's equine-assisted program. They use their own horses, which are actually part of the army's famed Old Guard. The unit is responsible for guarding the tomb of the unknown soldier and for military honours during funerals at Arlington Cemetery. Volunteers are drawn from the actual platoon itself to assist in this program. The advantages of that are peer support for the soldiers in the program.

I'm going to touch a bit on EAGALA, which, for those of you who don't know, is the Equine Assisted Growth and Learning Association. They recently announced the creation of a military service program in order to streamline hundreds of equine programs across the United States. EAGALA is strictly an unmounted program, with practitioners across the U.S. They have started to branch out and are doing certifications within a specialty of treating military personnel.

EAGALA met with key ranking officers from the behavioural division of the Surgeon General of the U.S. Army, the office of the Chairman of the Joint Chiefs of Staff, Army Medical Command, Warrior Transition Command, the Walter Reed Army Medical Center, and the Human Performance Resource Center, to demonstrate the EAGALA model of equine-assisted psychotherapy in keeping with the EAGALA model, which, again, is unmounted exercises.

According to the pilot project conducted by Refuge Services, which is one of the EAGALA military service programs in Texas, after only six sessions veterans and their spouses reported up to 60% improvement in the severity of marital problems, including physical and verbal abuse, financial disputes, parenting choices, and their ability to forgive and spend time together. Couples also reported up to 50% improvement in conflict resolution, emotional closeness, increased level of trust, respect, intimacy, and reduced anger.

We've already discussed how there's not a whole lot of research being done in treating PTSD in military personnel, but there is a little bit of good news on that horizon. In the U.K., the International Society for Equitation Science offers a grant for study of the therapeutic effects of equine-assisted activities for military veterans with PTSD and/or traumatic brain injury. In the U.S., the Horses and Humans Research Foundation recently announced the awarding of a grant to help study the serious and growing problem of untreated medical health problems in U.S. veterans. So it is possible that we will see some results in the near future, and let's hope that's soon.

I want to leave you today with maybe a better understanding of how horses are used in therapy. Whether programs are conducted in the saddle or on the ground, equine-assisted therapy is a phenomenal choice for treating PTSD. The bond between horses and humans is ancient. Using horses in this type of program is a natural extension of that long-standing relationship. I ask that you strongly consider any and all of the equine-assisted concepts for use with our military personnel.

● (1600)

I also wish to tell you a bit about a meeting I had earlier this week with Joanne Moss of the Canadian Foundation for Animal Assisted Support Services. I wish to inform this committee today that the foundation is well positioned to bring together related stakeholders to co-create a public policy statement. However, before they begin the first study—if funding is accessible—it's imperative that a labour market research study and an environmental scan be conducted, because of the vast scope of services, practitioners, and organizations involved. The study will likely highlight public policy as one of the priorities moving forward. The Canadian Foundation for Animal Assisted Support Services welcomes your interest and would be pleased to meet to discuss next steps with the committee.

Thank you very much. You've been great.

The Chair: Thank you.

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

Mr. Harris, you have the first question.

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

Thank you to all our guests for coming.

I want to get to the actual therapies themselves. I think I'll start with Colonel McLeod to try to put them in a context.

You say that you have 376 or 378 mental health care professionals in the mental health services. Could you give us a breakdown as to what the categories are—doctors, nurses, whatever?

Col Scott McLeod: It includes psychiatrists, social workers, psychologists, mental health nurses....

Mr. Jack Harris: You don't have numbers offhand, do you?

Col Scott McLeod: No, I don't. I'm sorry.

Mr. Jack Harris: Could you let us have them? Could you get them for us?

Col Scott McLeod: Yes, I can get them for you.

Mr. Jack Harris: I'm getting a sense of the scope here. You have psychiatrists, psychologists, social workers....

Now, are the social workers clinical social workers?

Col Scott McLeod: They are. They are master's qualified clinical social workers.

Mr. Jack Harris: These social workers have been doing counselling, in other words.

Col Scott McLeod: Absolutely.

Mr. Jack Harris: What else? You have psychologists, psychiatrists, social workers....

Col Scott McLeod: We have mental health nurses.

Mr. Jack Harris: There are mental health nurses, yes.

Col Scott McLeod: Those are just the mental health care providers within the mental health care program. We also have our primary care physicians, nurses, medical technicians, physician assistants, and nurse practitioners, who are a part of our primary health care system as well.

Mr. Jack Harris: Are you including them in the 378?

Col Scott McLeod: No.

Mr. Jack Harris: These are separate from the regular primary service clinics.

I hear that occupational therapists have something to offer. Do you have any of them?

● (1605)

Col Scott McLeod: We do not have any occupational therapists working for us directly. We have physiotherapists, and we contract out occupational therapy as we require it, through Blue Cross. If we feel that there is a requirement for it, we can always go to a civilian occupational therapy clinic. It's done on a referral basis.

Mr. Jack Harris: It's a referral to an occupational therapy clinic. They're not part of your overall service or your advising or anything like that.

Col Scott McLeod: No, sir.

Mr. Jack Harris: Okay. Because I have learned something about occupational therapy recently by talking to some academics who are in the field. One of the things they assist in is planning for recovery for people who may have mental health challenges. Obviously, there's the psychological part of it, and there may be some of the things you're doing.

In your case, Ms. Hull, you talked about doing the therapy you do because you like horses and you've found that this helps with the personal challenges. Have you formalized this in a way such that people could say to you, Ms. Hull, that they would like to purchase your services as a clinical therapist in equine therapy? Is it set up so that you charge a fee for service or is it something less formal than that?

Ms. Marie Josée Hull: I have a private practice, so anyone in the civilian population can come to me.

The majority of my caseload is Blue Cross related. It's the Canadian Forces contracting me to treat soldiers. I don't treat soldiers using horses. Using the horses is a part-time practice for me, and I don't do it directly with soldiers.

Mr. Jack Harris: You do contract work for the Canadian Forces in your social work counselling practice.

Ms. Marie Josée Hull: Yes.

Mr. Jack Harris: Okay.

This other aspect is something that is not developed into....

Ms. Marie Josée Hull: It's not permitted with soldiers at this point because it's not evidence based.

Mr. Jack Harris: If I were living nearby and thought this was a good thing for someone who was a friend or relative of mine, I could come to you and get somebody into a program that's defined.

Ms. Marie Josée Hull: Yes.

Mr. Jack Harris: If I said that I have an 18-year-old young fellow who seems to have some need for being able to relate better or whatever and came to you and asked you what you could do for him, could you just tell me what...?

Ms. Marie Josée Hull: We would start with an assessment to see what the needs are of the person. I'd go based on what the person's needs and what they want in therapy as well. In doing therapy like this, we would need to have a willing participant.

Mr. Jack Harris: The assumption is, of course, that there's a sense that relating to horses might be a good start.

Ms. Marie Josée Hull: Yes. The way I'd do it is that I would do an in-office assessment of one to two hours. If it's judged that working with horses would be beneficial, then we'd prepare our treatment plan with some goals in mind of what we want this to look like in the end when we're finished. Then, after that, the sessions would be in a ring or a pasture.

Mr. Jack Harris: How do you make that judgment? How would you make that judgment based on sitting down and doing your in-office assessment? What would you use to conclude that this was a beneficial or positive thing or that they were a prime candidate for this particular therapy?

Ms. Marie Josée Hull: First of all, there are some things we do have to look at. If a person has addiction issues, we wouldn't want to be doing this type of work with a person who's intoxicated. That would have to be put in place at the beginning: that if they have addictions issues, they would not use while doing therapy like this. Also, if there are any medications, we'd want to talk to their physician to see if there are any physical reasons why they wouldn't be able to do this type of therapy.

Anybody who wants to learn anger management, stress management, learn about themselves.... I have in my handout a list of therapeutic goals—I think it's on the third page—that you can achieve by doing this type of work. It's usually very effective. I find that after six to eight sessions we are getting somewhere, compared to office therapy, and people get to take home the learning they are doing in the ring with the horse. They can bring it home. I even give homework to do between sessions.

● (1610)

Mr. Jack Harris: In your judgment, is this particularly suited to the PTSD types of psychological issues?

Ms. Marie Josée Hull: Yes, for a portion of the treatment of PTSD.

There are three phases I use to treat trauma. The first phase is the stabilization phase.

I believe that working with horses could be very useful for that phase; you bring a person to an arousal level that's lowered and you build their coping skills. You make sure that they are doing well in everyday life before going into the traumatic event, because you could really destabilize them a lot if you would just go into it when they're already pretty shaky. In that first phase, using the horses would be really useful.

There's the third phase of reintegration, once the trauma has been processed, once we have looked into the thoughts that keep a person feeling guilty, feeling shameful, feeling responsible, or feeling not good enough. Then we can start doing work with horses again and bring in their families or their children or their spouse and get their supports back up.

The Chair: Thank you. Your time has expired.

Ms. Gallant, you have the floor.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

First of all, Mrs. Vandergragt, you work with families and with children who have emotional, psychological difficulties, including military families. Within some of these military families, one of the parents can be a soldier or is a soldier who does suffer from PTSD. Could you describe your observations of how this affects the family?

Ms. Alison Vandergragt: Keep in mind that when we're talking about equine assisted psychotherapy, these sessions take place with a mental health professional present who has partnered with us for programming through an agency. This is always done with another agency. Approximately 35% of the clients we've seen in this past year, and 50% of the clients from a pilot project that we did a year ago with the Phoenix Centre, involved military families.

Usually the children are coming in with some behavioural issues that we're looking to address. I'm very pro-family. We can make some little changes in the child, helped by the use of the horses in the program, but when the child goes back into the home, it's very hard for them to start integrating some of the new skills they've learned, such as the new coping skills and, the new communication and relationship things they've learned in the session. So we quite often get the family involved.

For the most part, the military families were very game to come to programming with their children, but some of the activities are high energy and there's a lot going on. What we've found is that we're supposed to be there for the child and helping with some issues, but we're seeing something else. There's something else in that arena that we're not addressing, and we call that the elephant in the arena: that elephant is the mental health issues that the parent is facing on his or her own—obviously stress-related.

So we're putting on band-aids and we're getting little fixes here, but there's this big elephant that we're not even allowed to talk about or discuss: why the parent is so stressed and the factors for this family's disintegrating. We can put on these little band-aids and give little tips on how to work together as a family, but really, there's an issue here that is not being addressed, and that is a concern for someone like me. We could be doing much better in these programs if we were actually able to address the PTSD.

Mrs. Cheryl Gallant: Ms. Hull, you explained to us how you get paid through Blue Cross when you're dealing with the military. As there is not yet sufficient evidence so far to support the inclusion of equine therapy in the spectrum of care, based on any of the five criteria, have you investigated whether there are university studies going on or looked to partner with another organization to gather the data required?

Ms. Marie Josée Hull: No, I haven't looked into that. It might be really interesting, especially if I could get some of the soldiers in Petawawa on that. I think they could benefit. It would be of interest, but I haven't looked into it, no.

● (1615)

Mrs. Cheryl Gallant: Colonel McLeod, what is the process for hiring civilian mental health workers, specifically psychiatrists? Does your staff interview them or is an intermediary contracted to contract the professionals?

Col Scott McLeod: There are two options. All of the psychiatrist positions that we have are public service positions. In that process, our senior psychiatrist would be engaged in reviewing the person's application. That's our primary method of trying to fill our psychiatry spots—through the public service.

If that does not work, we can go through a third-party contracting service with Calian. That's the service we use today. They're responsible for hiring the individual to fill that clinical spot until we're able to fill the public service position.

Mrs. Cheryl Gallant: On what basis would the intermediary or the contractor be paid? Not the psychiatrist, not the provider, but Calian, for example...? Is there a salary for the professional and would Calian get a percentage of that? How does that work?

Col Scott McLeod: To be honest, I couldn't get into the details of that specific arrangement. I'd probably have to refer that to our director of health service delivery, who manages the contract specifically.

Mrs. Cheryl Gallant: So you don't know whether or not another company is getting a cut of their salary?

Col Scott McLeod: I couldn't tell you, to be honest with you. That is purely under another directorate's responsibility.

Mrs. Cheryl Gallant: So the only time that you would use a third party to recruit the professional would be when the public service could not find the person for the position?

Col Scott McLeod: If there's no clinician interested in taking the public service position, then the third-party contracting is a backup, It's an available option for us. If a psychiatrist does not want to take a public service position and if we have no applicants for the position, but that same psychiatrist is interested in coming in through contracted services, that's our backup option to ensure that we have a care provider there to look after the members.

Mrs. Cheryl Gallant: So to be hired directly by the military, the public servant has to be a public servant already.

Col Scott McLeod: No, they can apply. You could be a new graduate out of medical school, having just completed your residency and passed your exams, and you could say that you wanted to be hired as a public servant. You could go through that application process. There's an interview process, you get hired, and you are now a public servant being paid at the rate of public service psychiatry. If we don't have an applicant for the position and we need to have a psychiatrist working in the position, that's where the third-party contracted services help us fill those spots.

Mrs. Cheryl Gallant: Advertising is conducted to find these people. How is it conducted?

Col Scott McLeod: The responsibility of the third-party contractor is to look for those care providers to fill those spots.

Mrs. Cheryl Gallant: Okay, but how do you advertise for a position as a public servant?

Col Scott McLeod: We do that in a variety of different ways: publications, professional journals.... Recently we went to the Canadian Psychiatric Association meetings. The Surgeon General and our senior psychiatrists were there speaking and presenting and talking about options for working in the Canadian Forces, trying to attract people to the Canadian Forces and trying to encourage people to work in the multidisciplinary team we have.

The Chair: Thank you.

We're going to our last seven-minute question.

Mr. McKay.

Hon. John McKay: Thank you, Chair.

My first question is for Colonel McLeod.

You have what I would consider a fairly sensible five points with respect to how you evaluate treatments, therapies, recommendations, and things of that nature. I want to focus on the fifth one, which says, “The benefit sustains or restores a serving member to an operationally effective and deployable status.” Isn't this criterion just an invitation for the soldier to bury his illness?

Col Scott McLeod: I should point out that you don't have to meet all five criteria to be selected. We also look at if this is going to be able to improve the member's health, if the therapy is proven to improve health, and even at if we can help the person transition to a different job or even if it helps transition them out of the military, if necessary, but into a productive way of life. So it's not necessarily.... Ideally, what we always want to do is return our soldiers to full duty and back to what they do, realizing—

Hon. John McKay: It does kind of fly in the face of the universality of service principle, though, in the sense that most soldiers want to stay in the job that they're in—

● (1620)

Col Scott McLeod: Absolutely.

Hon. John McKay: If they believe, rightly or wrongly, that the doctor is going to say, “Sorry, buddy, you're on a desk job”, or “Really, you should be looking at taking up carpentry”, doesn't this work against the notion that the military is trying to help the soldier get better?

Col Scott McLeod: That is a very good point. It is one of the things that we continue to struggle with.

This is what we do. If we can get soldiers into care as soon as possible—to present early with their symptoms—we have a much better chance of getting them back to duty. It's always a challenge, because soldiers fear that if they present, they could be put on temporary categories or restricted service, restricted duties. That's not what they want. We've found that over the last few years, as we've had greater success in getting people in, getting them treated early, and returning them to duty, more people are starting to come forward. They're saying that they don't want this to get to the point where it's beyond treatment. If they get treatment and get that high-quality care early, their chances of returning to their job are better.

Hon. John McKay: Thank you.

My second question is for Ms. Hull.

Colonel McLeod says in his presentation that “it is unknown whether animal-assisted therapy is more or less effective than these alternative therapies”. He's applying, if you will, a scientific analysis of the therapies that both of you are proposing and saying that it's nice, but there's no evidence. Do you agree with that?

Ms. Marie Josée Hull: I would agree the evidence isn't there, because the money is not there to study this type of therapy, but in my practice I've found that not only do the evidence-based approaches work, and treating a person who has severe trauma.... When we're dealing with trauma in soldiers, they seem to have even more than the normal kind of trauma. They are placed in traumatic experiences. Sometimes it's complex trauma with many experiences over a long period. It's not a one-size-fits-all...so you have to go with what the person can relate to.

The processes that are evidence-based right now, like CPT and CBT, are very effective when you have a member who does well with that type of therapy, but there are some who I can't get to that level because they're too...[*Inaudible—Editor*].

Hon. John McKay: You were extremely articulate in explaining to people who don't actually understand what it is you do and what the impact is. Yet I have, if you will, Colonel McLeod saying that we don't have any evidence. In some respects, those are irreconcilable positions. Would it be your recommendation that something like a pilot project...?

Ms. Marie Josée Hull: Oh, definitely. I think it would be really valuable to do that. Unfortunately, equine-assisted therapies are not very old. They haven't been around. They do require us to look at many things also, but they are very efficient. I think that a pilot study specifically for military vet members would be—

Hon. John McKay: Do you have any other veterans' organizations or soldier-type organizations that actually support your work?

Ms. Marie Josée Hull: I've just asked Veterans Affairs if they would allow me to do it with a particular gentleman who has some cognitive limitations, and I was told no.

Hon. John McKay: I recently had the experience of going to the University of British Columbia, where I saw a veterans transition program, which I thought was really quite impressive.

Without getting into all of the details, it appeared that the Legion supported them, the Wounded Warriors supported them, and various others supported them. Everybody supported them except the Government of Canada, which, to his great credit, Minister Blaney rectified this week. Initially it was, “This is just a bunch of soldiers sitting around in a circle sharing their experiences and singing *Kumbaya*, so why is the Government of Canada putting money into it?”

You think a pilot project would be a good idea, Ms. Hull.

And I'm assuming you would think so, Ms. Vandergragt.

A voice: Yes.

Hon. John McKay: What's your reaction, Colonel McLeod?

● (1625)

Col Scott McLeod: I think a pilot project...anything that gathers the information that could prove a therapy for our soldiers, we would support. I mean, we're always looking for ways to improve the health care of any soldier suffering with mental illness, so if there was interest in doing that, we would support that type of pilot project. The—

Hon. John McKay: But you're saying “if there was interest in doing it”. Who is the entity that needs to be interested in doing it?

Col Scott McLeod: I think the folks who actually do the equine therapy are the experts in that field—

Hon. John McKay: They seem to be interested.

Col Scott McLeod: Yes.

Voices: Oh, oh!

Col Scott McLeod: The U.S. Army, as was pointed out, is actually looking at doing this research now. In fact, I believe they're past the pilot project now and are extending that research. It may be most valuable for us to learn from that study as well, as it's coming out. Colonel Jetly, our senior psychiatrist, has already expressed that interest. He's very interested in hearing what's going to come out of that.

Hon. John McKay: Maybe there's some real possibility of the Canadian military piggybacking on the American military to see whether this does actually work.

You talk to the vets, both people inside the military but also outside the military or who were in the military, and PTSD is the most obvious thing, but it's also PTSD-like symptoms. It seems to crop up in very strange circumstances.

Is that it, Chair?

The Chair: Thank you. The time has expired.

Hon. John McKay: Thank you, Chair.

The Chair: We are going to go onto the five-minute round now.

Witnesses, please make sure that you keep your responses as concise as possible so that members can get in as many questions as they want.

Mr. Opitz.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Mr. Chair.

Thank you very much, witnesses, for being here today. I believe in what you're doing, quite frankly, because I know that animals have tremendous therapeutic value. I've had animals my whole life. In fact, my mother is something of a Dr. Dolittle, because everything seems to find her and she seems to nurse them all back to health.

In fact, our chair himself seems to be something of a horseman, so he understands that. He was telling me that his best buddy is a horse, and that makes sense.

Voices: Oh, oh!

The Chair: If you look around the table, you can see that the people who are the most balanced are the ones who spend time with horses.

Mr. Ted Opitz: There you go. That explains why I've been thrown off a few horses.

But it is a good thing, because there are other programs involving other animals, such as the dolphins they use in particular with autistic kids. Of course a lot of groups, St. John Ambulance and others, use therapy dogs and cats in long-term care facilities for seniors. There's very much therapeutic value there, and I see that.

As the colonel just said, the Canadian Forces is not averse to this. The U.S. will do its study—of course we're allies, and we do trade these studies back and forth—and they will examine that. I'm not seeing any resistance to it; I'm just saying that, you know, we have to follow the process. Some evidence-based stuff has to happen. But I'm confident that at some point, with Wounded Warriors and others, you'll probably find some traction down the road.

So I applaud what you're doing. It makes sense. I know it's had a lot of value for a lot of people having different injuries, not necessarily operational stress injuries...like soldiers, which sometimes is a specific thing.

Colonel, with my soldiers I used to try very hard to ensure that they self-identified as often as possible. Sometimes they'll have traumatic injuries, and the issue is that you'll never find a soldier sitting around singing *Kumbaya*. But you will see them sitting around sharing experiences with one another. They'll do that only because it's only another soldier who can really understand it, especially if they've shared those sorts of experiences.

Having said that, part of that is educating your soldiers, the public, and most importantly the families. Families have to be educated. I know with pre- and post-deployment briefings the families are brought into the loop. They understand what to look for and to check for mental illnesses being able to manifest themselves. Sometimes it happens insidiously over time, and there are small changes to the personality of the soldier that only his buddies, oftentimes, can detect and pick up.

Sir, could you expand on what programs are available right now to families of the Canadian Forces who are dealing with operational stress injuries of a family member, or other mental illnesses?

Col Scott McLeod: Absolutely. That's a very enlightened question and lead-on there. It's clear that you have a good understanding of the importance of family in looking after our soldiers.

We have a broad variety of different approaches to this. As you mentioned, our education, using Road to Mental Readiness, is a big part of that in educating our family members in not only how to recognize the symptoms but also how to deal with some of their own symptoms that come up when they're dealing with a partner who's suffering with PTSD. They're also encouraged to participate, where possible, in the care of that individual within our own mental health clinics.

Our military family resource centres are available to people as well, for our family members, and they can have access to services through the MFRC. We also have the Canadian Forces member assistance program, which is the 1-800 number that they can call to get counselling services.

It's very complex. We try to approach it in many different ways. The key is the education and being available to help them be a part of that healing process as well. The family is extremely important in the healing process.

● (1630)

Mr. Ted Opitz: How do you deal with the issue of stigma? I know for a lot of my soldiers, the problem was that they would associate that with being weak. You're not trained to be that, and you don't want to show weakness. You also think that you won't be operationally effective or deployable later on. That's a career limitation that they're afraid of, clearly, which will affect their treatment.

What programs are specifically in place to deal with the issue of stigma? And this is amongst commanders, too, by the way, not just those who are affected by mental illness.

Col Scott McLeod: That's really where the Road to Mental Readiness training program is in all of our leadership stages in the Canadian Forces. We've now integrated that into professional development for military members so that they understand what mental health is. Road to Mental Readiness is not just about building resiliency but also educating people on what mental illness is in Canada, as well as in the military, specifically related to operational stress injuries. That is available throughout.

Be the Difference is a program that was started by General Natynczyk. Now we're starting to work with the Mental Health Commission of Canada to see how we can approach stigma in Canada in general. Just identifying post-traumatic stress disorder and illnesses like that as injuries that occur as a result of combat has certainly improved in terms of the stigma as well, because they can relate to a mental health "injury" easier than they can to a mental health "illness".

I hope that answers your question.

The Chair: The time has expired.

[*Translation*]

Ms. Moore, you have five minutes.

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

My questions are chiefly for colonel McLeod.

I would like to talk more specifically about mental health care provided to reservists. Many of them served in places such as Afghanistan. Many are from reserve regiments that are in large urban centres, but many of the regiments are located outside these centres.

How can we ensure that these people have access to good mental health care when they return to civilian life? They do continue to be reservists. However, it is true that they have less access to these services than do other members of the military.

[*English*]

Col Scott McLeod: The translation isn't working, but I believe the question is specifically related to access to mental health care for our reserve force when they return from deployment.

The reservists who return from deployment and are suffering with a mental health injury have the same access to care as a regular force member. They get the same post-deployment enhanced screening to look for mental illness, and they have the same access to the same services.

I have to find out how to get this working....

The Chair: Channel 2 has the English interpretation.

[*Translation*]

Ms. Christine Moore: Is it currently working?

[*English*]

The Chair: Are neither of you getting interpretation? Continue speaking on channel 2 until we get it working.

Alison, do you have it?

Ms. Alison Vandergragt: I believe so.

[*Translation*]

Ms. Christine Moore: I would like to come back to one point. I understand that reservists have access to the same services and the same care. Still, reservists who served in Afghanistan and live in Rouyn-Noranda have to drive six hours to get to a specialist. They have access to the same services, but they will have to lose three days every time they want to go see a specialist.

What kind of services will you provide these people who, when they return to civilian life, find themselves in remote regions where there are practically no specialists? There are perhaps three or four psychiatrists for that entire region and they are already overwhelmed by the number of civilian patients.

How do you ensure that you are providing good care to these people when they live in remote areas?

● (1635)

[*English*]

Col Scott McLeod: That's a very good question. That's a very difficult thing to deal with. We understand that.

With regard to anybody who has returned from Afghanistan or from any deployment and may be suffering from a mental health illness, we certainly encourage them to come to one of our facilities for assessment and treatment. We have high-quality experts who deal with operational trauma and mental health injuries. We also use the Veterans Affairs clinics as well. For people who are in extremely remote areas and need specialist care, there are ways of getting them the transport required to get that specialized care.

We're also looking at using advanced telemedicine as an option. If we can connect people in remote communities with our specialty clinics, even through remote telemedicine, that will help us. As remote telemedicine starts improving throughout the country, we start improving that as well. We're also looking at other forms of social media to at least get people in to start accessing their care.

[*Translation*]

Ms. Christine Moore: Are they compensated for the hours they lose at their civilian jobs when they have to travel for their treatment? If they have to lose three days of work to receive care, are they compensated for the salary they lose to have access to that care?

[*English*]

Col Scott McLeod: That's a good question. Offhand, I don't know the answer to exactly how we manage that. If they are still reservists, they would be considered on duty for that time, and they would be getting class A reserve pay for that time.

If they're now out of the military, they would be falling under the responsibility of Veterans Affairs.

[*Translation*]

Ms. Christine Moore: They also have a civilian job from which they will have to be away. I would ask that you obtain this information and send me an answer because I find this very worrisome. Reservists who have completed their mission and live in remote areas have to make a difficult choice: either they travel to receive care elsewhere or they try to make do with the services provided in their area, at the risk of not receiving the care they need. I imagine the same goes for their families. For example, spouses who want to support their spouses will also have to travel.

In your opinion, are there any problems that need to be fixed? Because these are not regular cases, data is difficult to obtain.

[*English*]

Col Scott McLeod: There are a couple of points.

First, if people are still serving and are reservists, they would be paid as reservists for the time they come for care. So there is some form of reimbursement. If not, it would be Veterans Affairs.

I believe where you were going is that there is a gap in the system. We'd be the first to admit that there is no perfect mental health care system anywhere in Canada. We recognize the challenge for our remote personnel. We're currently trying to work on every way possible to get that care to those people, because they deserve high-quality mental health care. We are finding as many ways as we can to do that. It may be through local contractors. But as you point out, in some of these locations, it's extremely difficult to do that.

[*Translation*]

The Chair: Thank you very much. Your time is up.

[*English*]

Mr. Chisu, you have the floor.

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

Thank you very much to our presenters.

I have a question for Colonel McLeod. As we are aware, some mental illnesses have delayed symptoms that do not present themselves for years. How is National Defence addressing these issues? Is the period of time that is currently given adequate for assessing the overall health of our forces members after they return from combat and a possible return to civilian life? I just mentioned that I was in Afghanistan in 2007. When I retired from the Canadian Forces in 2009 there was not quite so much in place for these things.

I have another question related to that. How many or what percentage of the mental health service professionals have had previous military experience? Because, you understand, the culture is important when you are treating military personnel.

● (1640)

Col Scott McLeod: Of your couple of questions, the last was, what percentage of our mental health care providers have military experience? I can't answer that for you, but I can try to track that down. It may be difficult to find, unless we ask every single one of them, but we do have a fairly significant number of retired health care providers who have returned as public servants. I can try to give you at least a rough estimate.

The time delay for presentation of operational stress injuries is a very good point, and I appreciate your bringing it up. We recognize that it can be 10 to 15 years after a traumatic event that somebody can present with post-traumatic stress disorder or any other operational stress injury. We're always available for people to present for an assessment. We're still having people present from Rwanda and Bosnia and operations such as those.

Mr. Corneliu Chisu: Do you have any information about people who participated in the Medak Pocket operation? It was the first combat operation in that—

Col Scott McLeod: Right. Do you mean the percentage of people?

Mr. Corneliu Chisu: Did you ever talk to anyone or have a patient from that....?

Col Scott McLeod: I know of those who participated in that event, but I don't know them as mental health care patients, no. I know people who have participated.

I've been in Afghanistan myself, sir. All of those are very challenging experiences. When you're exposed to a significantly traumatic event like that, your risk of developing an operational stress injury is obviously higher. We're available to help people get through that once they identify.

Mr. Corneliu Chisu: I was asking you about the Medak Pocket, because that was 15 years ago. As you mentioned, you don't know if there were any other cases of mental illness in that situation—

Col Scott McLeod: I'm sorry. I misunderstood. I don't know of any specific cases that came out of that event. We don't track specific events like that to identify percentages of people. We don't keep track of everybody who was there who may have developed that, but I suspect that there are some.

Mr. Corneliu Chisu: Thank you very much for your answers.

I would like to ask Ms. Hull and Ms. Vandergragt a question. As we are aware, some mental illnesses have very delayed symptoms. They do not present themselves for years. How does your practice, and in particular equine therapy, address and deal with this issue? I don't know if the military was saying that your service, equine therapy, is not yet recommended. The military uses HAS dogs, IED detection dogs, to detect explosives and so on, so we rely on these animals to protect us. Can you elaborate on that?

Ms. Marie Josée Hull: Basically, anybody who wants to get mental health services is usually already experiencing symptoms. They won't often go as a preventive measure. They will go when they experience symptoms. It doesn't matter to me as a practitioner whether the event was 15 years ago, six months ago, or one year ago. I treat the symptoms as they are. We deal with it pretty much the same way. We take the member at whatever point he is at.

The Chair: Your time has expired.

We are going to move on.

Mr. Kellway.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you, Mr. Chair, and through you, thank you to the witnesses for coming and speaking to us today.

This is very intriguing to me. I had never heard about equine therapy before, so I am fascinated by it.

I wanted to start with Colonel McLeod.

Your remarks conclude with the statement that, "Our number one priority is to develop and deliver to our men and women in uniform the mental health care programs that they need and deserve." It's set out that this is the number one priority.

My concern is that this notion of evidence-based therapies perhaps doesn't contradict that statement, but I don't think it's entirely consistent with that statement, because what we seem to be hearing.... Actually, you comment that this “does not mean that the therapy has been shown to be of no value”. You are identifying here that there's certainly some evidence that equine therapy is at least potentially of value to our forces. If they are our number one priority, why do we use this notion of "evidence-based" as a kind of shield to keep equine therapy out of the range of therapies that we are prepared to try for our forces?

● (1645)

Col Scott McLeod: That's a great question. The evidence base is certainly not there to exclude equine therapy. We go through a review process for all different therapies, all types of adjunct therapies that exist out there. There are many things out there that can assist all of our patients in many different ways. As was pointed out, every patient is very individual and every patient has very different needs. On at least a biweekly or weekly basis, we have people presenting different options for enhancing communication between the therapist and the patient who's suffering.

There are many different ways of approaching that. We have to have a systematic approach to determining what we're going to fund and use our public funding for. However, having said that, we're not saying these are bad things. It's just whether we can commit public funds to pay for all of the different approaches that are out there. When we decide to make it a core funded program, we have to prove that there is evidence behind it to use it. But if there were an external funding source that wanted to support that, we would certainly not say no to it. We don't necessarily use the evidence base to exclude.

Mr. Matthew Kellway: The place we start with this is that mental health issues are an enormous issue. Our very first witness for this study talked about the level of mental health issues arising out of Afghanistan and what types of mental health issues were affecting U. S. soldiers, Canadian soldiers, and U.K. soldiers, all a bit different, interestingly.

Given that it's such a big issue and that it seems as though we haven't found the silver bullet, the right key to solve these things, shouldn't the criteria we're using and this systematic approach you're talking about incorporate some way to bring new therapies into the system that look like they're potentially helpful?

Col Scott McLeod: That's what our treatment standardization committee does. It reviews all of these therapies beforehand, before they even get presented to the Spectrum of Care Committee. We have specialists—and it's multidisciplinary, including psychiatrists, psychologists, and social workers—who look at these types of therapies and determine whether they are something we want to invest in.

Mr. Matthew Kellway: To me, the five criteria listed here seem to exclude or limit the possibility of bringing in new therapies. When you look at, for example, the point that it has to be funded by somebody else first, clearly our forces can't be on the leading edge of new therapies for treating people, then, when somebody else has to go first.

Col Scott McLeod: Right—these are guiding principles. You don't have to meet all five criteria to be included. This committee is chaired by the assistant chief of military personnel, with representatives from the army, air force, and navy. It's an operationally led committee that can decide to include something, whether or not it meets all the criteria—if it meets two or three of the criteria—if it's the right thing to do. These criteria are to make sure that we are critically analyzing everything that's presented to us and that we have a structured process to assess them, so that we don't just take on every new therapy that shows up on a weekly basis.

Also, we want to be sure that we're not exposing our soldiers to any therapy that may be harmful. A lot of them may seem like a good idea on the surface, but in the long term, they may eventually be harmful. These are very delicate cases and very delicate folks we need to look after. Any care provider would agree that we want to be sure that what we do for these soldiers is the right thing to do. That's where we look for the evidence.

● (1650)

The Chair: Thank you.

Mr. Strahl, it's your turn.

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

My question is for Alison. What's the typical timeframe people are involved with this therapy? Is it as long as they're covered or they can afford it, or is it something you do and it sets you on your way? Or is different for every patient you see?

Ms. Alison Vandergragt: That's an excellent question.

Most of the programming we do is for a set period of time. It depends on the agency that we're co-facilitating with and their budget. My biggest partner would be the Phoenix Centre for Children and Families, out of Pembroke. Right now, we're looking for funding of about $130,000 for this upcoming year to provide programming. They've broken it down into a group of seven sessions because they want to see *x* number of clients.

In our pilot project, we did a group of five sessions. I found that five sessions were not enough to make huge progress. We did make fantastic progress, but there was so much more we could have done had we had the time.

Now, you can overkill this. I say that 12 weeks is usually the maximum, because then we would have done all the activities. We would have touched on a lot of things. After 12 weeks, our clients should have a really good foundation of some skills they can use in the family, coping and.... Again, it's based on budgets and what our supporting agencies decide as far as time goes, but definitely, five weeks is not enough. Our next pilot will be for seven weeks. I still don't feel that's enough. Ideally, it would be for 10 to 12 weeks.

Mr. Mark Strahl: We've heard what the CF's evaluation procedure is, and yes, that's not to say that it's not helpful.... What has the reaction been from other medical professionals to your therapy.? Are they eager to send their patients your way? What is your relationship with psychiatrists and doctors? Are they referring to you or are you in a kind of battle there to bring it into the mainstream—I won't say "legitimize it"—and to have them accept that this is something they would recommend as well?

Ms. Alison Vandergragt: Generally speaking, we don't have direct contact with or recommendations through physicians. Physicians will approach the agencies—Family and Children's Services, Community Living, and, again, the Phoenix Centre—and refer their clients to those centres, who in turn will come to us with the programming. Physicians aren't saying specifically that a client needs equine therapy or that they could try equine therapy; they're recommending that they go to the outside agencies, which then say, "Let's get them into the equine program because they seem like they fit the criteria for programming."

Mr. Mark Strahl: Thank you.

Colonel McLeod, given the high-tempo operations that the CF is coming out of in Afghanistan, Libya, Haiti, have you seen more, less, or about what you expected in terms of numbers of individuals coming forward with mental health concerns following those deployments?

How do you set up your operation so you can handle the intake without being overstaffed? Obviously that's not a problem, but if you can get where I'm going, is it about what you thought it would be, is it more, or is it less?

● (1655)

Col Scott McLeod: That's a great question, because the first thing to also recognize is that the majority of mental health we deal with has nothing to do with operations. The majority of mental health we deal with is the same as what every other Canadian in Canada deals with, so we have a baseline of health care providers who are there to pick up the majority of that.

Once you add on, to say whether it was expected or not.... Going into this, I don't think many people knew what to expect. Canada didn't know, and the U.S., Australia, and our other NATO partners didn't know. What we're finding is that the numbers of people suffering with operational stress injuries are similar to those of other nations, such as the U.K. and Australia, that have had similar deployments and similar exposures.

We're not different in any way, but as we've studied this over the past decade—and we've done a series of studies—we've been able to redirect resources as needed to different areas that we realized would have a higher percentage of people who are suffering. That's why we opened the operational and trauma stress support centres in Gagetown and Petawawa.

Mr. Mark Strahl: Thank you.

The Chair: Thank you.

[*Translation*]

Mr. Brahmi, you have the floor.

Mr. Tarik Brahmi (Saint-Jean, NDP): Thank you, Mr. Chair.

Colonel, my first question is for you, regarding mental health workers in the Canadian Forces.

Has the proportion of civilian to military personnel working in your services, within the various mental health disciplines, changed over the past 15 to 20 years? Could you give us the percentage of military members compared to civilian members?

Obviously, you may not have these numbers. Would it be possible to get them to us?

[*English*]

Col Scott McLeod: If I understand the question correctly, it's about what percentage of our mental health care providers are civilian versus military...?

[*Translation*]

Mr. Tarik Brahmi: Exactly.

[*English*]

Col Scott McLeod: Over the past decade, we've seen a dramatic increase in the number of civilian mental health care providers. Rx 2000 is the name of the project that we went through to rebuild our health services. In that, we hired a lot of civilian health care providers, so that number has gone up. With regard to the percentage of civilian versus military, I don't have that offhand, but I can certainly provide that to you, sir.

[*Translation*]

Mr. Tarik Brahmi: Absolutely. It would be a good idea to inform the committee of these figures and record them in the minutes so that they can be used in a future report.

Moreover, you said that within NATO, Canada has the greatest ratio of full-time mental health care workers to military members suffering from post-traumatic stress disorder. Is this a significant difference in ratio compared to other NATO countries? Could this be explained by the fact that Canada conducted a longer military operation than other NATO countries? Or is it due to the structure of our mental health system?

[*English*]

Col Scott McLeod: That's a good question. As for where we are in relation to other NATO nations, it all depends on the nation. Some we're actually quite close to and others.... We can provide that NATO report if you'd like to see how we compare to the other NATO nations.

Why is that? It's mainly because when we were going through the restructuring of the health services, we recognized that mental health was a significant issue in the Canadian Forces, and it was identified as something that we had to address. Also, recognizing that there was the potential for operational stress injuries going into an operation like Afghanistan, we wanted to try to ensure that we had the appropriate personnel available to look after the members.

It's difficult to say whether it's what the other nations have done—

[*Translation*]

Mr. Tarik Brahmi: Do you think it is a direct consequence of having conducted a much longer military operation than other NATO countries?

[*English*]

Col Scott McLeod: I can't really say in comparison to other NATO nations. We just made the decisions based on what we felt our risks were going to be and what we felt we should be doing.

[*Translation*]

Mr. Tarik Brahmi: I'd like to address my next question to Ms. Hull.

As a clinician, you see your therapy from a different perspective. The armed forces consider it a complementary therapy, from what I understood in the colonel's presentation.

Your presentation brings to mind a study done in 2010. Dr Valérie Tourjman, from the Université de Montréal, participated in that study that concluded that 70% of antidepressants were ineffective. Would you not say that that's good news for complementary therapies? In fact, perhaps it cannot be scientifically proven that complementary therapies are effective for some people.

● (1700)

Ms. Marie Josée Hull: Complementary therapies can be effective for certain people. However, in the case of horse-assisted therapy, no studies have been done to prove this.

Could you clarify the question?

Mr. Tarik Brahmi: In general, antidepressants are considered more effective since they are a drug, as opposed to a complementary therapy. Although some studies consider that 70% of these drugs are ineffective, we use them daily and they are covered by the provincial health systems.

Doesn't that prove then that there is no way of demonstrating that complementary therapies, such as horse-assisted therapy, are useless or ineffective? This supports your argument that we cannot demonstrate that it's ineffective.

Ms. Marie Josée Hull: I don't think that we're trying to show that it's ineffective.

Mr. Tarik Brahmi: Well not you, in any case.

Ms. Marie Josée Hull: No, and that's not what the Department of National Defence is trying to do either.

I have a really hard time answering this question. Personally, I believe in horse-assisted therapy and its potential. Unfortunately, this therapy hasn't benefited from studies or investments that could make it an evidence-based approach.

The Chair: Thank you very much Mr. Brahmi.

[*English*]

Mr. Alexander, it's your turn.

Mr. Chris Alexander (Ajax—Pickering, CPC): Thanks, Chair.

Colonel McLeod, we've made enormous progress under your leadership and the leadership of others in the Canadian Forces in reducing the stigma of and bringing resources to bear on these mental health issues, especially PTSD. What do you think the biggest challenge is now for Canada in meeting the challenge that so many of our returning members and legacy issues from much earlier conflicts represent?

Col Scott McLeod: Our biggest challenge in dealing with the mental health issues related to Afghanistan or specifically...?

Mr. Chris Alexander: Generally, in the Canadian Forces.

Col Scott McLeod: I think one of our greatest issues—and we've talked about this a lot—is dealing with mental health and the stigma related to mental health in Canada in general, in trying to open up access and having people present for their mental illness earlier and get that treated. If we're talking specifically about mental health, it's about communication, education, breaking down stigma barriers, and working with other agencies to improve that awareness within Canadian society. I think that is one of our biggest challenges.

Mr. Chris Alexander: We heard a lot about that at a Canadian-hosted seminar that you and I had the privilege of attending in Washington.

What is working best to bring members to the point where they will accept to undergo the diagnosis and then undergo the treatment? Because that does seems to be a universal weak point, not just in our system but among allies as well. Even where it's generally recognized that someone is suffering, they either feel that sense of stigma sufficiently not to have it diagnosed, or they start the treatment and don't finish. How can we make members more comfortable with this process?

Col Scott McLeod: One of the things that has helped a lot in the military is the fact that we've called this an injury. This is a mental health injury. Soldiers are much more likely to come forward for an injury than an illness.

The other thing we're trying to do is get people to recognize that a mental health injury or illness is the same as any other physical injury or illness we may have. Starting to accept mental illness as being like any other form of illness people suffer from is really the only way that we're going to continue to move this forward and break down those barriers.

We are seeing that. It is happening. It's not fast. Even since I started practising medicine in the nineties, there has been an enormous change in people's approach when they are suffering with mental illness. They are much more willing to come forward with these things. I have certainly seen that in the military population.

● (1705)

Mr. Chris Alexander: Is there a role that we in Parliament or the government can play outside of the Canadian Forces to create a public environment in which there is more pressure—benign pressure—for and acceptance of the need for members to participate in this when it has been assessed as something vital to their well-being?

Col Scott McLeod: I think it goes beyond what government can do. It's what all leaders in Canada can do by talking about what mental illness is, by accepting it as another injury or illness, and by recognizing the impact it has. It has a dramatic impact economically. It has a dramatic impact on people and their performance at work and within their families.

It's about all of us in society recognizing this as part of society. It's a treatable condition. We need to continue to invest in the different types of treatments and therapies we're talking about here today. We need to be open-minded as to how we can advance this study and this field.

Mr. Chris Alexander: We're all delighted to have you here together. It illustrates the variety of therapies that are potentially available.

Are we doing enough at the other end, though? Mental health injuries have been, from time immemorial, part of combat and part of the military experience. Are we preparing our soldiers, sailors, and air crew well enough during the recruitment and training process to have the resilience to know when they need treatment and to avoid the injury if possible? Rates vary in different populations, depending on the level of preparation and the way they go into the experience.

Col Scott McLeod: We're doing far better than we ever have in the past. I have mentioned a few times this afternoon our Road to Mental Readiness training package and resiliency package. It is being instituted at all levels of professional development in the CF. We are seeing very good results from that. We're doing studies to see what the impact is even on training success and how people get through the daily stressors that occur in basic training and in other levels of training. We're very optimistic.

The RCMP has approached us for the same program. The Ontario Provincial Police has done that. The Mental Health Commission of Canada is speaking to us about doing this as well.

As we start utilizing this type of training in bigger populations, we will only continue to improve it. We have a robust program, but we continue to learn and to try to improve it.

The Chair: Thank you.

For the last of the five-minute rounds, we have Mr. Norlock.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): I'll pass my time on to Ms. Gallant, please.

The Chair: Ms. Gallant, you have the floor for five minutes.

Mrs. Cheryl Gallant: Thank you, Mr. Chairman.

Ms. Hull mentioned that the first phase of treatment in dealing with PTSD—the trauma phase—is bringing the patient down, so to speak.

Colonel McLeod, I have had soldiers come into my office who were so drugged up they were incapacitated. They were just coming down from that phase. Besides prescription medicine, what other treatment is currently used to help these operationally stressed, injured soldiers come out of this first phase?

Col Scott McLeod: I think that's a better question to ask our senior psychiatrist, who is involved in the different forms of therapy.

In general, we prefer to use a multidisciplinary approach to care, which involves a balance between psychotherapy and pharmacotherapy. I certainly can't speak to any individual case that you may be aware of, but we try to involve all four disciplines: the social workers, psychologists, mental health nurses, and the psychiatrists. The pharmacotherapy portion of that really should play a fairly minor role. The majority of this does take place in the types of therapy that we've talked about here today.

● (1710)

Mrs. Cheryl Gallant: Are there any other hands-on types of therapy, other than sitting in a room, talking for a while, and then having another week or a month go by before the next session? Is that generally the way it goes with the interdisciplinary group?

Col Scott McLeod: Again, I'm a family physician by training, and how I would do it as a family physician is different from what our multidisciplinary teams do in one of our operational trauma stress support centres. I think we could probably get some expert opinion from Marie Josée as well, who has worked as one of our social workers in Petawawa.

Ms. Marie Josée Hull: I worked there for a year, yes. I can only speak from what I was working on. I was on the mental health team in Petawawa. We have psychologists, psychiatrists, addictions counsellors, social workers, and mental health professionals. Generally, it's the team working together.

My role as a social worker was to go through the three phases of trauma treatment with a client, but we would elicit the help of a psychiatrist who would find a combination of medications that would fit the person well. Also, if there were any addictions issues, they get addiction services.

Sometimes a member could have two meetings a week with a person, but the therapies we use in Petawawa are office-type therapies. We're in an office. They come to the Warrior Support Centre.

Mrs. Cheryl Gallant: Ms. Hull and Mrs. Vandergragt, have you approached or have organizations such as Wounded Warriors or Soldier On approached you for a different form of funding for treating PTSD in soldiers?

Ms. Alison Vandergragt: No, not directly. I have worked through a couple of agencies that have tried to make that connection, but I'm finding that I've been relying heavily on the actions of these agencies to make the connections. The agencies are extremely, extremely overworked at this point, and to take the time to make the connections.... So it has been part of my mandate to attempt to make some of these connections myself. That's what I'm doing currently. They have not approached us.

I think anything that we do through those agencies traditionally would have been through an agency, but right now I'm finding that the connections.... I'll have someone say to me that they're going to be in touch with Wounded Warriors or whatever and then we don't hear anything back; I go for a follow-up and they'll say they're getting to that. I think one of my goals is to get out there and make contact with these organizations myself.

Mrs. Cheryl Gallant: Ms. Hull, since you have worked at Petawawa as a social worker for operational stress injuries, have you noticed a difference—and I think Mr. Chisu alluded to this—between the types of operational stress injury or how that manifests itself differently from a mission in the Medak Pocket versus Afghanistan?

An hon. member: [*Inaudible—Editor*]

Ms. Marie Josée Hull: Unfortunately, I wouldn't be able to answer that question, because I only had one year of experience. My caseload during that year was mainly working with people who have come out of Afghanistan.

Mrs. Cheryl Gallant: Based on the experience you've had with these soldiers and the need for treatment, is there anything you can see that could be done to screen people who would be more apt to suffer an operational stress injury than people who wouldn't?

Ms. Marie Josée Hull: I'm only speaking from personal experience here. It's very difficult to screen somebody beforehand. I've found that sometimes you can get the best qualities in soldiers who have had previous trauma in their lives: they have been resilient and they've learned coping skills that will make them terrific soldiers. But then just a few more traumas can drive them over the edge, and their thinking is so distorted and rigid that they can't get better—but they're very good soldiers. Then again, it's also difficult because you could have somebody with a very average upbringing, and unfortunately so many things happen and they don't cope well.

It's difficult to pre-screen. I think there are some things they can look at, but it's difficult to say “yes” to one person and “no” to another. Does that answer your question?

● (1715)

The Chair: The time has expired. Thank you.

We do have time for one last set of questions from each political party, so we'll have Mr. Harris from the NDP.

Mr. Jack Harris: Thank you.

Thank you for your presentations today.

Colonel McLeod, I think we're going to have to have you back again, because this is a study on health services in general, but today we decided to at least look at the ideas of our other two witnesses who are here today. had.

Something did jump into my mind to ask you, based on a response to Ms. Gallant. Your training is as a family physician. I was looking at your resumé and all of that. In the structure of the CF health services, do all these other people, like the psychiatrists and the others, work for you? Do they report to you or is there some other sort of structure here?

I'm not criticizing your credentials, but I don't see anything here that has anything to do with mental health or any specialty work in that area. Can you explain to me how that structure works in terms of your role versus that of the people who are delivering the services?

Col Scott McLeod: Yes. That's a great question.

First of all, as a family physician, you do a significant amount of training in mental health. However, in this case, as the director of mental health, I'm responsible for the programs overall. The clinics that deliver the care report to the clinic managers have oversight from our clinicians on the ground. We have a senior psychiatrist as our adviser, Colonel Rakesh Jetly, and he's responsible for ensuring that our the treatments that we deliver are appropriate, evidence-based, and up to date.

My responsibility is more for the overall program itself, to ensure that we're delivering the care to the places that need the care. It's an overall program delivery responsibility.

Mr. Jack Harris: Okay. I would like to have you back to explore some other aspects of mental health delivery, because we do have a lot of other questions to ask about that.

To our other witnesses, because I don't think we will have you back, I think you've convinced us that there's something to offer in terms of the kinds of service that's there. If Mr. McKay's suggestion is taken up in terms of a pilot project or something like that, what form might that take? If, for example, there were a request for proposals, or if there were a desire to have a pilot project, would you folks be in a position—and do you think others would be in a position—to put forth a plan for a pilot project, a definition of a project where you would say “here's what we're prepared to do to test this out”, etc.? Is that something you could do right now or is that something where you'd have to find someone else to do it?

Ms. Marie Josée Hull: Are you speaking of us?

Mr. Jack Harris: Would you do it as individuals or in association with others or whatever...?

Ms. Marie Josée Hull: Definitely: it would certainly be a project that would interest me. I would think that probably Alison would be very interested as well.

When dealing with soldiers, I also like to have the collaboration of the mental health people in Petawawa, for sure, and to have them on board, because I don't think that we can work in silos when we're dealing with servicemen who have a lot of issues and maybe have multi-diagnoses. It definitely is something that I would love to look into, but I would want to have the support and the help of the mental health services on the bases.

Ms. Alison Vandergragt: If I could have a moment to add on to M.J.'s comments, getting back to this Canadian Foundation for Animal Assisted Support Services, they're prepared to create this umbrella over practitioners like me and the many others who are out there and who, like me, are in our own little corner of the area doing programming. If this organization can pull us together, you're going to see more consistency in the programming, and probably more effectiveness, because we're all working together using common practices and common goals. If this organization can do some of the footwork to put us under an umbrella, to give us a scope of practice, I think it's going to be grossly beneficial for a pilot project to become successful.

The Chair: Thank you.

We now have Mr. McKay for the Liberals.

Hon. John McKay: Thank you, Chair.

As Mr. Harris said, it has been an interesting and fascinating discussion, and I thank you for it.

I've been reflecting on your conversation, Colonel McLeod, about the distinction between illness and injury, and it's kind of hard to tell, at times, what is what. I just wonder whether this is language that makes it more acceptable to a soldier, which in turn will encourage him or her to seek therapy.

For instance, I think there is good literature to support the notion that if males at a certain age smoke marijuana, that will precipitate a psychotic break for a certain percentage of them and they will have a mental illness. I'm assuming—but I don't know—that soldiers who experience certain trauma will have a psychotic break, and that psychotic break will lead to a diagnosis of a mental illness.

So here's the question I have. It's a little vague, and I apologize for that. Is this distinction between illness and injury an appearance of a distinction or is it a reality? Also, is it a bit of a fiction so that you effectively can encourage everyone to get more involved in their therapeutic needs?

● (1720)

Col Scott McLeod: Well, it's a good question. How do you define an injury, and how do you define an illness? Post-traumatic stress disorder is an illness. It occurs as a result of a trauma that somebody has been exposed to. If you were exposed to a trauma and you broke your leg, we would call that an injury; they were exposed to a trauma and they have a mental health injury related to that as well.

Whether you define it as an illness or an injury, I don't think makes that much difference, but if it allows people to accept it, come in for therapy, and get their treatment early, then it's useful. If changing the terminology helps us get somebody in early and get them treated, then I am all in support of changing that.

Hon. John McKay: I see a lot of head-nodding here. I'm fine with that; I was just thinking that you can't really tell sometimes.

My second question has to do with the immense pressure that the military is under for financial savings. It's just a reality that the budgets are going to be wound down quite substantially.

This puts you in a very awkward position, I should think. A soldier has to be deployable and has to meet certain standards, and his unit has to have a certain number of available bodies. I would think that one of the ways of rationalizing has to do with injured soldiers: “let's shove them off to some other unit or get them out of the military”. Do the unique pressures that the military is under at this point create any pressures for you?

Col Scott McLeod: We have not seen any of those unique pressures in any way. We've had tremendous support in looking after anybody who is suffering with any form of injury or illness.

Having the IPSCs available on the bases allows somebody to be posted to a unit while they undergo therapy. That unit can backfill with somebody else to continue doing their day-to-day job, but it allows that person the option of recovering and then returning to the unit.

When we put people in protective medical categories to limit their activities in the job, to help them recover, doing so may pull them out of their job, but we do want to get them back in. We've trained these folks, we've invested a lot of money in them, and we want to keep them. We want to do everything we can to get them back into that job. That's the most cost-effective and efficient way to deal with these cases, so that's what we try to do. We have not been under any pressure to do anything different from that.

The Chair: Thank you.

We're going to have to move on.

Mr. Chisu, you have the last question for the Conservatives.

Mr. Corneliu Chisu: Colonel McLeod, what mechanisms do you have in place to monitor and evaluate your policies and programs for their rate of success? How are you evaluating that your programs and your policies are successful...? What is the measure of that?

● (1725)

Col Scott McLeod: That's a great question. We have just completed the Rx 2000 rollout of what we consider to be our mental health program, and we're just initiating a validation of that model to look at a variety of different outcome measures.

The other thing we're looking at doing is instituting an outcome measures tool to look at how our patients are responding to different levels of treatment. If patients aren't responding well, we can look back at the case, we can find out what more we can do to help them, and we can reinvest treatments in that person. Or if somebody is doing better than expected and they don't need as much therapy, we can redirect those resources to people who may need a little bit more. We are absolutely looking at many different ways to validate what we do and make sure that it's appropriate.

The Chair: Thank you.

Colonel McLeod, you have some homework that I'm going to have to send out with you. You have a few questions that would be good information to get back to the committee with. Mr. Harris asked you for the breakdown on mental health services out of the 378 full-time employees who are in the mental health services section. Also, Madam Moore asked about access to those services for reservists who are in more isolated communities across Canada. Mr. Brahmi asked for the percentage breakdown of civilian versus military mental health care providers within your department.

On behalf of the committee, I want to thank all three of you witnesses for participating in our study. This is a very important and timely issue and is one that all of us are taking quite seriously. I want to thank you for your commitment to help with the recovery of our men and women who have bravely served this country and who are dealing with all the stresses of the injuries that they've incurred while serving our nation.

I'm particularly thankful to both Ms. Hull and Ms. Vandergragt for being here today and talking about the use of animals, especially that great beast, the horse, in helping our men and women recover, to be more functional with their families and to be able to get over the stresses they've incurred.

Colonel McLeod, I'm sure we're going to see you again, and maybe even next week, I understand.

With that, I'll entertain a motion to adjourn.

An hon. member: So moved.

The Chair: We're out of here.

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