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Chair

Mr. James Bezan

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● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone.

We're continuing with our study on care of ill and injured Canadian Forces members. We're very lucky today to have coming back to join us Brigadier-General Jean-Robert Bernier, who is the Surgeon General of the Canadian Forces and commander of Canadian Forces Health Services Group. He's responsible for the delivery of all health care services to CF members, from primary care, to mental health care, to health care for deployed CF members.

According to the Surgeon General's report for 2010, he is also responsible for providing medical advice throughout the chain of command. From a strategic perspective, this includes advising senior departmental authorities on significant health issues, liaising with other military and civilian health organizations, formulating an overarching strategy for professional health technology, organization, policies, and procedures within the CF health services group, and maintaining a constant watch on the world's literature on health issues.

Joining him is Lieutenant-Colonel Alexandra Heber, who is a senior psychiatrist and clinical head of the Ottawa Operational Trauma and Stress Support Centre.

I welcome both of you to committee.

We're going to open it up for your opening comments, General. If you could keep them under 10 minutes, I'd appreciate it.

[*Translation*]

Brigadier-General Jean-Robert Bernier (Surgeon General, Commander Canadian Forces Health Services Group, Department of National Defence): Thank you, Mr. Chair, members of the committee.

Ladies and gentlemen, I want to thank you for your ongoing interest in and support for the health of Canadian Forces members. I also want to thank you for this opportunity to speak to you again on that crucial topic.

Given your interest in the mental health of Canadian Forces members, with me today is Lieutenant-Colonel Alexandra Heber, one of our senior psychiatrists. She is also the clinical head of our Ottawa Operational Trauma and Stress Support Centre.

[*English*]

Since my last appearance before this committee, several developments have progressed in our health programs and services. No human institution can be perfect, and the nature of some illnesses and injuries precludes cure or full rehabilitation in many cases, but we recognize the need to continually learn and improve. We have an advantage over other health jurisdictions in that the CF has central control over most aspects of our organization and population that influence health.

For example, 1 can direct the efforts, scopes of practice, employment, practice standards, education, and training of our health occupations in such a manner as to maximize the coherence and coordination of health services, while the non-medical leadership can control occupational elements that contribute to health, such as general health education, cultural and leadership attitudes to reduce stigma, peer support, and other casualty and family support measures, etc.

This central control of most factors related to health partly explains why the Canadian Forces can deliver a unit of care at slightly less cost than civilian jurisdictions, while providing a more extensive program in such areas as mental health, and why we can implement change fairly rapidly in response to internal and external evaluations, such as the recent reports of the CF ombudsman and the Auditor General. While all concerns listed in these reports are being acted upon, most related CF actions were under way or completed before the reports were released.

Centralized CF control and coordination are also particularly critical to mental health, for which the best outcome results from a close partnership among the medical staff, the patient, and the chain of command.

However, we have challenges that require ongoing aggressive effort and focus. Whereas the end of combat operations in Afghanistan reduced the tempo for many arms of the Canadian Forces, this is not the case for the health services with respect to mental health. Many trauma-related mental health cases take years to present. Our study of the cumulative incidence of Afghanistan-related operational stress injuries shows, for example, that we can expect about another 1,300 to 1,500 cases of post-traumatic stress disorder over the next few years, each requiring extensive care and support to minimize progression and maximize the chances of recovery.

A special challenge is identifying and getting into care all reservists who suffer service-related health conditions after their return to part-time duty. Their reserve units may be distant from CF bases in areas with limited provincial mental health services, and they may have less local military and social support at home than their regular force colleagues, given their distance from a large population of military colleagues with deployment experience.

Our challenges, however, generally affect both regular and reserve Canadian Forces members. They must be addressed in the context of a national shortage of mental health professionals, the need for strong leadership and peer support to get casualties into care early, and the nature of some conditions that can adversely affect a casualty's recognition of the need for care, compliance with treatment, and clinical improvement.

● (1540)

[*Translation*]

Although the objective and relative perspective continues to highlight that the Canadian Forces has perhaps the best overall health system in Canada and NATO, we must and we can keep improving. In mental health, for example, we are well-resourced and have an aggressive plan to enhance the recruitment of clinical staff, so as to further reduce wait times for care, and further enhance communication, education and treatment.

Our challenges, which are systemic, are being progressively addressed, and we have much shorter overall wait times for care and more mental health care providers per capita than any other Canadian institution.

[*English*]

The quality of our programs and our leadership in mental health also continues to be recognized by independent external authorities. For example, Senator Dallaire was told at this year's American Psychiatric Association conference that “Canada's program on operational stress injury was held as the example to be applied in the United States and, they hope, in other countries”.

Dr. Fiona McGregor, the outgoing president of the Canadian Psychiatric Association, recently stated publicly that “the Canadian Forces is right to take pride in its mental health program which has been recognized by its NATO allies and civilian organizations”.

Also, the CF ombudsman states in his recent report that the “care and treatment for Canadian Forces members suffering from an operational stress injury has improved since 2008 and is far superior to that which existed in 2002”.

This high standard of care results not only from centralized, holistic control of the military health system, but also from the extreme motivation and dedication of Canadian Forces members. Health services personnel, for example, treated many horrifically injured casualties in Afghanistan, saw death often, suffered the highest number of casualties and killed-in-action after the combat arm, and suffer suicide and mental illness, like other elements of the armed forces.

Although the medical experts who develop our health programs are non-combatants, they're soldiers first. Most have deployed to operations knowing better than anyone else that their own lives and health, as well as those of their friends, depend upon the quality of the programs and services they develop.

Strong defence leadership support also contributes greatly to the quality of our program and to our confidence that we can progressively improve to meet our challenges. This was most recently demonstrated by strong leadership participation in and support for a series of regional CF mental health briefings this year, a recent Canada-U.S.-U.K. military mental health symposium at the Canadian embassy in Washington, and the Chief of Military Personnel's mental health symposium for senior CF leaders in October.

Most significantly, it's reflected in the defence minister's initiative to increase the military mental health budget by an additional $11.4 million, for a total of $50 million annually, despite the need for all defence department elements to contribute to national deficit reduction.

As Field Marshal Viscount Slim, one of the greatest commanders of World War II, correctly noted, “More than half the battle against disease is not fought by doctors, but by regimental officers”. Efforts to promote, protect, and restore the health of CF members have been strongly supported by the armed forces leadership, and this support is expected to continue.

The CF is equally aggressive and equally recognized as a leader in other areas of military health. For example, Colonel Homer Tien, medical director of Canada's largest trauma centre, was widely recognized for his expert leadership of the life-saving medical response to Toronto's mass shooting incident of July 16, 2012.

The Canadian Forces health information system is the first pan-Canadian electronic health record system. It permits military clinicians to access the health records of our highly mobile population anywhere in the world, on land or at sea. An award honoree for this year's government technology exhibition and conference, it's held as the model for other departments by the federal government's chief information officer. We have established a Canadian Forces Chair in Military Trauma Research and are working on establishing a CF Chair in Military Critical Care Research.

Our Deputy Surgeon General was selected by NATO to chair its research committee on health, medicine, and protection, and CF Health Services personnel have a leadership role in virtually all its mental health-related research activities. This year, NATO has selected Canada as the recipient of the Larrey award for the greatest medical contribution to the alliance, in recognition of our excellence in establishing and leading NATO's first ever Role 3 Multinational Hospital in combat operations.

● (1545)

[*Translation*]

By virtue of the extreme risks and sacrifices accepted by Canadian Forces members in protecting our country, they merit the Canadian Forces' strong focus on providing them a standard of health care that maximizes their protection and their chance of recovery after illness or injury. National Defence leaders and the Canadian Forces Health Services are committed to maintaining or improving this standard.

[*English*]

I'd be pleased to answer your questions about the Canadian Forces health system to the best of my ability and to obtain any information that I can't immediately provide.

Thank you.

The Chair: Thank you, General Bernier. I appreciate these opening comments.

We'll go to our seven-minute round.

Mr. Harris, you have the floor.

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

Thank you, General Bernier, for joining us today. We're pleased to have you here.

Your responsibilities are of course legion, to use a military term, but obviously force protection is extremely important for a military operation, and the care of wounded and ill soldiers is one responsibility that we're studying now.

As for one of the concerns we have, or that I certainly have, based on some recent events, including your predecessor's concerns about being forced to make reductions on the administrative side, and in light of General Leslie's report, of course, of which I'm sure you're aware, as well as some comments of the Prime Minister the other day at the change of command for the CDS, I guess the crude way of putting it is to ask, do you see your work as part of the tooth or the tail of the Canadian Forces?

Are you concerned that you'll be considered part of the tail and that your ability to administer your programs can be affected?

BGen Jean-Robert Bernier: Thank you for that question, sir.

There is sometimes a perception, particularly with long periods of peace, that the health system constitutes more of a sustainment arm, because we do have the dual role of maintaining the domestic, static health system, the whole Ministry of Health function, with elements of the Ministry of Education, Ministry of Labour, etc—everything related to health. But all of that is now recognized, particularly after a decade of operations in Afghanistan. Virtually all military commanders who have deployed to those kinds of operations dearly recognize the force protection role and the impact on morale.

There have been some who have approached me arguing that we should be considered a combat support arm, at the very least, rather than a combat service support, because of the critical importance. Our clinicians, particularly our medical technicians, but even our physicians, are out forward with the infantry at the pointy end, either on patrol or in a forward operating base and that kind of thing. The commander of the army has told me several times that the morale of the troops, their willingness to fight, and their willingness to sacrifice are very much related to their confidence that they will be well looked after and will be given every chance of survival by the medical system should they be injured.

Equally, I'll just mention incidentally that the support of politicians and the general public also plays a great role in their motivation and their willingness to make sacrifices.

I'm confident, particularly after 10 years of operations, that the visibility in some operations—for example humanitarian assistance operations in Haiti—the medical service is the supported arm rather than the supporting arm of the service. There's widespread global recognition, not just at the senior leadership level but across the armed forces, that the health system is critical, and many elements of it are considered to be at the pointy end.

Mr. Jack Harris: I take it, then, that you agree with your predecessor that any reduction in support for the medical services would be detrimental to the ability of the Canadian Forces to continue to operate effectively.

BGen Jean-Robert Bernier: Any reduction to the health resources would have some impact, but most or virtually all elements of any impact can be mitigated in various ways. We can achieve many efficiencies. We are extremely efficient as a result of a Public Works and Government Services Canada review by an independent auditor, which found that we were less expensive than civilian health systems. There are various ways—financial means—of mitigating and ensuring that the services our soldiers need medically will be provided in one way or another.

The clinical coal-face support to the troops will carry on in one way or another. We'll maximize. Like all elements of the defence department, we have a responsibility to the taxpayer to maximize our efficiency and to avoid any unnecessary costs. We're undergoing the same kinds of reviews that all elements of the defence department and all elements of the government must undergo to make the most responsible use of taxpayers' money.

However, that being said, the services that the soldiers need will continue to be provided.

● (1550)

Mr. Jack Harris: One issue that's come up from time to time—and you've mentioned it here today—is the difficulty in recruitment, which is shared by other health professions, particularly the mental health professions. It was raised at this committee as part of its study a couple of years ago.

We see, for example, complaints from people providing these services, such as what took place in Petawawa back in April. The suggestion then was that the clinical services were suffering because the caseloads were very high and there was an actual lack of flexibility on the part of the Canadian Forces. They said their salaries weren't competitive compared with those for similar positions outside the base; that staff retention was at risk because of complete rigidity and no flexibility in terms of part-time versus full-time work or flex time, etc., therefore creating a high staff turnover; and that even for a diagnosis of mental illness, the wait times to pass on to the next step, in terms of clinicians, were unreasonable.

These complaints indicate a lack of resources or a lack of ability to deploy those resources to ensure that Canadian Forces serving members receive assistance, and we're talking about serving members here, let alone their families. Do you have a solution for that, or is it something that concerns you?

BGen Jean-Robert Bernier: It is a concern, and it's a problem that afflicts all health authorities in Canada and in most of the world, but I can tell you that the obstacles to fully staffing our ambitious targets for mental health personnel, for example, are not related to resources. They're related to geographical difficulty or convincing people to go to relatively remote and rural locations when they have the opportunity, in the context of a national shortage of mental health professionals, to find work in larger urban centres. That's the main one.

Another one is simply that the public service hiring process takes time. However, we have an out; we have a third party contractor called Calian that will pay market rates to attract people and has a much faster hiring process. The problem, though, is that even with Calian paying market rates, even with the speed with which they can employ people, even with all of that, some people are simply not willing to move to certain areas of the country or to displace themselves.

Mr. Jack Harris: Surely that would be true of some people, but if they're complaining of lack of flexibility, lack of competitive incomes, lack of part-time work, etc., there seems to be something more fundamental than just not wanting to go to a rural area.

The Chair: Your time has expired.

Moving on, Mr. Alexander is next.

Mr. Chris Alexander (Ajax—Pickering, CPC): Thank you very much, Chair.

Surgeon General, it's wonderful to have you back with us.

I'd like to begin first by paying tribute to you and all of your colleagues in the Canadian Forces Medical Service.

From personal experience, from everything we have heard on this committee, and from everything we have all read, I honestly think that one of the untold stories of valour and achievement for Canada in the Afghanistan mission has to do with your service—your service in the plural—in that Role 3 hospital and all across the board within ISAF, within the Canadian contingent.

You have our unreserved thanks—I think from all members of this committee—for that unbelievably brave and professional work. There's a long tradition of this in the Canadian Forces.

I think of Sir Frederick Banting, whose name is now on Colonel Tien's chair of research, where he's trying to be a bridge for some of the experience of Kandahar, to bring it in to clinical trials and application in civilian life. We'll hear more about that later we hope in these hearings.

I think of Private Richard Thompson—not known to that many people—from the South African War, who won the very highest honour, even higher than the Victoria Cross, the Queen's Scarf, for bravery there as a stretcher-bearer.

I also think of a visit this weekend to Mr. Opitz's riding, where a Victoria Cross winner lies in a cemetery near where we had a Remembrance Day ceremony. Corporal Frederick George Topham, who was literally a medical orderly but who showed enormous bravery on the east side of the Rhine in March 1945.

You are at the front line often and your work is absolutely central to morale and to what the Canadian Forces set out to achieve.

Given that we still have troops in training roles in Afghanistan in harm's way, could you lay out for the committee what would happen to a Canadian soldier were they to be injured today in Kabul, in Mazar-e-Sharif, or at some other place of deployment? Take us through the stages of treatment that soldier would undergo—some Canadian, obviously, and some international—and then the forms of support that would be available in Canada for a person with a serious injury. Could you describe in general terms how that service, that process, has changed now compared to 10 years ago?

● (1555)

BGen Jean-Robert Bernier: Thank you very much for those comments, sir, and for the question.

For our folks deployed overseas now, in the event of a serious injury or illness, we always deploy at least a minimum amount of primary care with those individuals. Sometimes it's pre-hospital care. Depending on the size and extent of the mission, we may send them all the way up to a full tertiary care hospital to support them—or at least one with surgical capability.

Because health resources are difficult and scarce for all of our NATO allies, there are probably greater multinationally integrated health resources than there are in many other elements of the armed forces. Where there's a smaller mission, as in the case of the current operation, Operation Attention, in which Canadian troops are mentoring Afghan National Army folks, because our people are dispersed everywhere we provide Canadian Forces members with immediate acute care at the primary care level—physicians and medical technicians—but we're relying primarily on the U.S. or in some cases the French military hospitals to provide the tertiary care.

So there's always a pre-hospital care component, where people with additional training in tactical combat casualty care.... Very acute life-saving measures are applied within the first 10 minutes to control those things that tend to cause death early, like airway management and excessive bleeding. They apply that kind of care within the first 10 minutes. Then there's always a rapid medical evacuation process to try to get people onto the operating table, if necessary—if surgery is required—within an hour or a maximum of two hours, followed by stabilization in a tertiary care centre before tactical evacuation to, usually, a higher-level hospital.

For us, it will usually be Landstuhl Regional Medical Centre in Germany for additional stabilization and additional detailed surgery before strategic medical evacuation back to Canada to a quaternary care hospital, where all additional care and rehabilitation can occur as close as possible to the maximum social supports and the adequate clinical supports that are necessary.

One of the big changes that has occurred is recognizing the value of providing clinical care as far forward as possible. So for the tactical combat casualty care component with that initial life-saving care, with specific procedures that in Canada may often only be done by an emergency room physician, we've pushed forward and trained not only our medical technicians but our combat arm folks to be able to do a number of those procedures. That intervention within the first 10 minutes will buy a lot of time.

We have good data from something called the joint theatre trauma registry, which was used widely in Afghanistan to demonstrate that we can extend the time to do necessary surgery by up to two hours before, and still maintain the same life-saving capability.

That's a quick summary of the process.

Mr. Chris Alexander: Congratulations on your recent appointment, by the way.

Could you quickly add a couple of comments about your own experience in Afghanistan and Kandahar and what you think Canada should be doing to ensure that we apply the medical lessons of that combat operation as fully as possible in order to be prepared for the next mission?

● (1600)

BGen Jean-Robert Bernier: I was the director of health service operations, so the commanders of all the medical units in Afghanistan reported to me in Ottawa at the height of the conflict. We're extremely highly respected by all of our allies for the speed and nimbleness with which we could modify our program. Our participation in that joint theatre trauma registry and system permitted us to essentially do research, with almost real-time modification, of clinical protocols and process that resulted in life-saving.

For example, through that system, the Americans in Iraq were able to reduce mortality by up to about 15%, simply as a result of that data analysis. We have developed tremendous lessons learned as a result of that operation. We've incorporated those into our process. We've published them as widely as we can, including in the NATO Joint Analysis and Lessons Learned Centre, so the whole alliance has that kind of benefit.

We need to continue conducting research and continue maintaining the capabilities we've developed, even at a skeleton level, so that will require us to maintain all of the capabilities. We don't know what will happen next. We can't base our lessons and our restructuring of the armed forces on the past conflict, because the next one will always be different.

We need to have a capability-based structure where we have at least a skeleton capability in virtually every area to be able to meet every kind of operational threat and health hazard, so that we're ready to magnify, expand, and deploy it should the next operation not be what we expect.

When the Americans went into Iraq, the last thing they expected was to have to perform offensive manoeuvre operations again with armoured forces, after the end of the Cold War, but they were ready and they were able to maintain those capabilities. We have to do the same thing. Publication, ongoing research, and maintenance of our current structure with capability in all different areas are what is required for us to be ready the next time Canada needs us.

The Chair: Thank you.

Mr. McKay, you have the last of the seven-minute rounds.

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

Thanks to you both for coming.

I want to get your comments on *Fortitude Under Fatigue*, Pierre Daigle's report, because the picture you're painting in your presentation seems to be at some variance with what Mr. Daigle said. In recommendation 5, he indicates:

> The most significant is the considerable gap which remains between the *capability* to deliver the care CF members with OSIs need and deserve, and the actual *capacity* to deliver it. This gap is primarily the result of a chronic inability to achieve, or come close to achieving, the established manning level of the mental health function. The impact this has had on the frontline delivery of care, treatment and support to CF members with PTSD and other OSIs and their families has been profound.

I'm sure you've read his report, and I'm sure you've had time to think about it, but it does strike me as being at some variance with what you're saying. I'd be interested in your observations.

BGen Jean-Robert Bernier: Mr. Daigle is correct, and we welcome those kinds of external reviews;everything is relative, however, and we need to continue improving. I mentioned the obstacles to our ability to achieve the number of mental health professionals that we need. We're working hard. We have an aggressive recruiting plan to deal with that. We have additional commitments to try to accelerate the staffing process for those individuals who we need to fill the gaps in mental health staffing.

Wait times, however, are far less than they were. In Petawawa, for example, in the last few months we've reduced the wait time to less than half of what it was previously, so it's now at about one month for a specialized Operational Trauma and Stress Support Centre assessment. For the general mental health assessment, we've reduced it by 30%. I don't think any civilian authority in Canada can meet those wait times. They're dramatically lower than pretty much anywhere else.

Nevertheless, our troops require additional focus because of the extreme sacrifices and threats and stresses they encounter, so they merit that kind of support, and nevertheless, we're always striving to do better.

We now have, for example, over 200 applicants to fill some of our public service positions to try to achieve the 447 target that we're aiming for. Once we do achieve that 447 target, we'll be reviewing at that time—based on a Canadian Community Health Survey coming next year, conducted by Statistics Canada in collaboration with us—whether even that number is sufficient.

There is a willingness to if necessary increase that number to whatever the requirement is to provide a good level of care, keeping in mind that primary care in this country and in most of the world provides much or most of mental health treatment. So it's critical that we get a specialized mental health assessment early on, but then, most of the ongoing care in some countries and in some models, like RESPECT-MIL in the U.S., is even primarily conducted by nurses.

When a wait time for care for a specialized mental health assessment takes time, people are not just left to their own devices. They continue to be followed by primary care physicians. Their prioritization on the wait list can be changed immediately and at any time if there is an acute urgent case they'll be seen immediately.

● (1605)

Hon. John McKay: One of the things he says in his recommendations is that there is a "requirement for a national database" to accurately reflect "the magnitude of the CF's evolving OSI imperative", which has not been met.

Your argument is that we've really improved at Petawawa, that our wait times are better and our system will stand up against any civilian system in Canada—which may be a good argument, I don't really know—but absent national data, it's pretty hard to say whether you're right or he's right. What are your comments on his desire to collect national data?

BGen Jean-Robert Bernier: We do collect extensive national data. The ombudsman's focus is on an OSI point prevalence case count database. We will eventually have that with the rollout of an application of the Canadian Forces health information system, where we'll be able to enter any particular diagnosis and get an instantaneous count. A PTSD diagnosis may be related to sexual assault, a car accident, or a military operation, so teasing that out is a very difficult thing to do.

We'll be better able to do that at some time with an application of the Canadian Forces health information system, but even that will not help us better determine where we should be modifying our policy program and resource allocation. We have better population level studies that we conduct for that purpose. That serves that purpose far better—for any health authority, not just us.

Hon. John McKay: The government has argued that this is invasive of soldiers' privacy. What's your reaction to that?

BGen Jean-Robert Bernier: We definitely do not want to further stigmatize mental health beyond what it already is. There is a risk that if we deliberately set up a separate database specific to post-traumatic stress disorder, operational stress injuries, and that kind of thing, it will work somewhat against everything else we're trying to do to normalize operational stress injuries to be like any other operational injury. If somebody gets on the list, it may be misperceived as being—despite the good intent—an adverse thing.

Hon. John McKay: There is always the argument that a soldier is going to bury whatever it is he feels, because he does feel that this will be contrary to the best interests of his career or that sort of thing. I assume that is, if you will, an underlying distortion of the data.

BGen Jean-Robert Bernier: For that reason, we rely on population level, on anonymous large population level studies that give us a much more reliable long-term picture of where the mental health burden is and how great it is.

For example, a case count at any given moment from an OSI database would give us only the prevalence at that moment. It may change five minutes later. It will certainly change a day later, and it will change a month later, so we look at longer-term periods with large studies like the Canadian Community Health Survey and the Canadian Forces health and lifestyle information survey and others that give us, over a longer period of time, a more reliable basis on which to make our policy and program design and to determine what our long-term burden is.

For example, the cumulative incidence study of operational stress injuries for Afghanistan, which assessed 30,000 people who deployed between 2006-08 and over four and a half years of follow-up, gave us a relatively—as far as reliability can be achieved through those kinds of studies—much, much more reliable picture of what we can expect as far as a burden coming down the road goes than would an OSI database.

● (1610)

The Chair: Thank you. Your time has expired.

We're going to go to our five-minute round.

Ms. Gallant, you have the floor.

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

Thank you to our witnesses.

Earlier in your testimony you mentioned Calian as an entity that was a third party to find providers. What percentage of a doctor's pay would Calian receive? How is Calian or a company like that compensated when they find a professional, such as a psychiatrist, to work for the armed forces?

BGen Jean-Robert Bernier: Calian does receive a certain percentage of the money that they charge the defence department. A certain proportion of that money they keep for overhead; I can't recall the exact percentage, but I think it's between 10% and 20%—something like that—because of all the recruiting they have to do. But then, they all pay whatever the market rate is above that to pay for the salary of the clinician who's hired to do the job.

They have much greater flexibility, nimbleness, and speed with which they can find and hire people, not just with respect to process, but also in their ability to pay what the local market demands. It won't necessarily be one pay scale that they'll apply for physicians or physiotherapists, say, across the country. Depending on the specific region and the difficulty in attracting people to work in that specific region, they have the liberty and the flexibility to increase the charge or the salary in order to be able to attract people and fill the capability gap.

Mrs. Cheryl Gallant: So that remuneration for the third party is a percentage of what the doctor is being paid. If a doctor is being paid $100,000, the recruiter would get $120,000?

BGen Jean-Robert Bernier: That's correct. Over and above whatever they pay the clinician, they would also be receiving from the defence department, as part of the contract, an amount to cover their overhead cost, the cost for them to do their recruiting and personnel management function.

Mrs. Cheryl Gallant: To go over to operational stress injuries, has there been a difference in the manifestations of PTSD arising from the soldiers who were in the Medak Pocket versus Afghanistan? Has there been a difference emerging in the PTSD manifestations?

BGen Jean-Robert Bernier: I don't think we have specific data for OSI cases from the Medak Pocket, or even data on whether...

May I ask Dr. Heber to respond to that question on the clinical aspect?

Lieutenant-Colonel Alexandra Heber (Psychiatrist and Manager, Operational and Trauma Stress Support Centres, Department of National Defence): Again, thanks for that question.

I've worked for DND since 2003, so when I started working there I was certainly seeing a lot of people from Bosnia, Rwanda, and Somalia. Those were most of the people I saw. Now, of course, the majority of people we see in the operational trauma clinic are from Afghanistan.

I also want to say that if we put it in context, the majority of people we see in mental health in any of our clinics are not people who come back with an operational stress injury. It's people who, like the general population, suffer from a depression or an anxiety disorder and who probably would have that no matter what kind of an occupation they had. But in the OTSSC, in our operational trauma clinic, I've seen that scope of patients.

In terms of symptoms, the symptoms are the same, and that makes sense because our diagnosis is based on a certain spectrum of symptoms, right? Those don't change. If somebody who'd been in Bosnia receives a diagnosis of PTSD, and if someone who was in Afghanistan receives a diagnosis of PTSD, the profile of the symptoms are the same.

How people suffer is sometimes different. How long it's taking people to come forward for care is different. When I first started working in the clinic in 2003, it was very typical for a soldier to come in and tell me that he'd had nightmares every night for 10 years. That was very typical.

Now we see people from Afghanistan, and in fact, at three to six months post-deployment, after Afghanistan, when they are doing the enhanced post-deployment mental health screening that we do, if they are identified in that screening procedure as probably having PTSD or another OSI, almost half of them are already in care. When they're told by the social worker that it looks like they need to see somebody, almost half of the people already are seeing someone. That's a big difference that we see.

● (1615)

The Chair: Okay. Thank you.

The time has expired. I know: it goes by fast when you're having fun.

[*Translation*]

Ms. Moore, you have five minutes.

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

I would like to come back to the personnel shortage in remote regions. Regarding the reserve force, currently, non-medical regiments—for instance, field ambulances and medical companies—don't have the positions of physician's assistant, nurse or physician. Therefore, they cannot hire someone from the region who could work part time according to the regiment's needs.

Should that rule be maintained, or would it be better to allow reserve regiments to have the positions of nurse, physician or psychiatrist, if they can recruit them as part-time employees to care for people in remote regions?

BGen Jean-Robert Bernier: Thank you for the question.

In addition to certain medical units, we currently allow certain people associated with the establishment of field ambulances to work and live with a remote militia unit. So we are talking about a combat arms unit or any service weapon unit. However, the process is still problematic. We cannot recruit people and create the positions of physician or nurse, or a similar type of position, for each unit.

We have, however, established what we call field ambulance medical link teams. Those people work part time. They are mostly nurses whose responsibility is to monitor injured part-time members or reservists who have fallen ill or suffered injuries as a result of military operations or military service. They must ensure that those members receive the care they need, normally in the regions.

Regarding mental health issues, we encourage members to have their mental health assessment done at a specialized centre of the Department of Veterans Affairs, the Department of National Defence or the Canadian Forces. We will pay all their travail expenses and the wages of a part-time militia member. However, we are very open. If they are unable to travel, we will accept assessments by regional mental health clinicians and allow them to be monitored and treated in the region.

Normally, reserve members want their initial assessment to be carried out at a centre of expertise specializing in military medicine, and that is always in their best interest.

Ms. Christine Moore: I want to go back to one point. There is apparently a shortage of health care professionals across the country, both in mental and physical health. For instance, all the hospitals are competing for nurses. We are seeing that it is also difficult to recruit nurses for the Canadian Forces. Currently, it is virtually impossible to recruit people outside the major centres. Let's take Rouyn-Noranda as an example. You know where that town is located. A nurse who may be interested in working part time in Rouyn-Noranda for the Canadian Forces would have no opportunity to do so as part of the reserve. So this person would move to join the Canadian Forces full time to be on a base where they would be sent 10 hours away from their home and would have to be brought back.

Isn't that a problem? The goal is to recruit more people, but the structure is such that people can only be recruited in certain locations. In addition, a range of health care professionals who are open to working across the country, and not only in major centres, are not being used.

● (1620)

BGen Jean-Robert Bernier: We can send our patients to any civilian health care professional. To do so, we use the Blue Cross, which covers the costs for us. All that can be paid. Any clinician in Canada will be paid to care for our injured or ill members.

In the reserve, we also have the framework of the primary reserve, which is part of the first field ambulance and hospital. That enables us to enrol clinicians from any part of the country. They are not active; they only work two weeks a year with the Canadian Forces. They are volunteers who are part of the reserve force—that reserve is inactive, except when its members are called up for military service.

When necessary, we can call them up for a minimum period of two weeks a year for military service. They may be called up to provide health care, participate in an operational deployment, take courses or anything like that.

So we have mechanisms that enable us to enlist members of a professional health care corps who live in regions where there are no militia units or Regular Force units.

[*English*]

The Chair: Mr. Opitz, it's your turn.

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

Thank you very much, General and Colonel, for appearing today, and congratulations on the NATO distinction we received for our work. It certainly demonstrates that the Canadian Forces, as General Hillier used to say, certainly punches well above its weight. It's noted by our allies and is recorded over and over again.

General, you mentioned OSI cases. How many OSI cases are coming down in the next couple of years? I think 1,300 was your estimate.

BGen Jean-Robert Bernier: There are many qualifiers, based on the quality, the methodology, and the many, many variables, but based on what we know now, we expect roughly probably about 1,300 to 1,500 more just from Afghanistan. These are cases specifically related to Afghanistan, as opposed to the normal baseline that constitutes the majority of our cases: the same cases of mental health illness as a result of stresses that afflict all Canadians.

Mr. Ted Opitz: That could be anywhere from today to five years to 10 years from now.

BGen Jean-Robert Bernier: Roughly, based on that study, we'd probably anticipate it in the three-year to five-year range. But we're still having people present from Bosnia, from the Swissair disaster of 1998, and also from the Korean War—Veterans Affairs has people presenting from that far back.

Mr. Ted Opitz: Understood.

Colonel, feel free to weigh in on any of these questions.

I'd like to talk a little bit about stigma and post-traumatic stress and maybe delve a little more into what actually creates it. There's a relationship between mild traumatic brain injuries, concussive injuries, post-traumatic injuries: what do you think are some of the main contributors to developing PTSD in the first place?

LCol Alexandra Heber: In terms of risk factors for PTSD, what the research has shown us is that, first of all, we understand about half of what they are about. There's a lot that we still don't know, but out of the risk factors that we do understand, generally they tend to be divided into three groups.

The first is the pre-trauma group of risk factors, which includes things like people who have had a previous mental health problem and people who were abused or neglected as children. Interestingly, another pre-trauma risk factor is lower socio-economic status.

Then there are the risk factors that occur during a trauma and they tend to be, again, how severe the trauma is and whether it's repetitive.

Post-trauma, there are also risk factors. Those risk factors, which are also significant, by the way, include lack of social support—which is a big one—and being re-traumatized.

The good news about this is that we can't change what happened to people when they were children, but we can change what we do after the trauma. I guess in a lot of ways that's where our efforts are being deployed.

● (1625)

Mr. Ted Opitz: That's great. Your quote from Field Marshal Slim was a good one, because you're right: officers are key to helping this happen. In my unit, I always encouraged guys to come forward. Two did, we got them treatment in good time, and I think they're doing well.

But stigma is a huge part of a soldier's perception of what this is. Oftentimes, it's related to being weak, and we know that's not the case. I'd like you to discuss briefly, if you wouldn't mind, if there is a noticeable increase in the awareness of operational stress injuries and other types of injuries—especially, General, since you began as a CF member—and how stigma factors into this. Related within this, of course, just broadly, are the family unit's involvement and the role of children and so forth in all of this awareness. I know that it's a big question.

BGen Jean-Robert Bernier: There has been a very significant reduction in stigma, but it will always be there, particularly in an organization like the armed forces, but in society generally. Stigma exists not just for mental health conditions but for injuries generally, for various types of illnesses.

We do have objective evidence that the level of stigma has dramatically decreased. There was a study in I think 2008, published in the *Journal of the Royal Society of Medicine* in the U.K., comparing the five Anglo-Saxon allies. It showed that the Canadian Forces had the lowest level of stigma overall. A study in the U.S. by Charles Hoge, I believe, found that we had roughly about a third the level of stigma found in U.S. forces.

Colonel Heber was just talking about how people presenting at the three- to six-month enhanced post-deployment screen with their mental health conditions are already in care. A few years previously, it was about 5.5 years before people would present for care, which is another demonstration of a significant reduction in stigma.

A lot of that has come from various measures, from all the educational measures that you're probably aware of with your the armed forces, such as the various campaigns, the educational program, Road to Mental Readiness, and the enhancements for confidentiality protection. If the troops understand and if our patients know that their health information will be well protected, that increases their confidence.

Peer support has been very, very significant in getting people forward, as has education, not just for the chain of command and the military leadership, but for families. I'm not sure we have data on it, but certainly anecdotally, in many cases, people present not voluntarily on their own, but because they've been pushed to present by their family members, their peers, or their colleagues at work. The whole treatment of operational stress injuries—like any other injury in the armed forces—and the fact that we award the Sacrifice Medal to people who wish to receive it, who have suffered an operationally related operational stress injury, send a very clear message.

We continue to treat people. We deploy them even outside the wire in Afghanistan if they're stable. We do everything we can not to stigmatize, not to treat them differently, and to treat this like any other illness, and it objectively has borne fruit.

Do you have anything to add, Dr. Heber? No?

Thank you.

The Chair: Thank you. The time has expired.

Mr. Kellway, it's your turn.

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

I want to thank the witnesses for coming today.

I'm going to hand my time over to my colleague, Christine Moore, who, because of her time in the forces as a nurse, has much more intelligent questions than I do.

[*Translation*]

Ms. Christine Moore: I would like to come back to recruitment.

You may not have these figures on hand, but I would like to know, across various professions, what percentage of those who wear the uniform are already trained when they join the Canadian Forces and what percentage of them receive their training through programs.

● (1630)

BGen Jean-Robert Bernier: The majority of Canadian Forces members—I am not talking about our civilians, who are members of the public service—are trained by the Canadian Forces.

We have programs that enable us to directly enrol people with certain clinical skills, especially when we are experiencing a shortage. In most cases, the training of our people is financially supported by the Canadian Forces, once they have been enrolled. In addition, it all depends on the profession.

We use civilian institutions as much as possible for their training, so that we can establish the same standards and skills as those the general public has access to. We also provide them with additional training that meets the specific needs of the Canadian Forces.

Ms. Christine Moore: Okay.

Unfortunately, the recruitment process can sometimes take more than a year or two. People with professional qualifications—so people who are already nurses, physicians or dentists, for instance—already have a job. So they are not in need nor do they have a minimum-wage job. In other words, they don't especially need the work conditions offered by Canadian Forces, compared with those offered by civilian employers.

Is priority given to those people's files to ensure that they don't change their mind during the process?

BGen Jean-Robert Bernier: In the case of professions experiencing a shortage, health services is trying to find candidates by accelerating the recruitment process. The process is long, and it is often slowed down by certain complications. For instance, candidates may have a medical condition, or the file may not be complete enough for the recruitment authorities to make their decision.

For occupations facing a shortage, we try to provide additional support through a health services employee. Health services has a directorate for the employees who help those people and are involved in the recruitment system, especially when there is a shortage in a profession and needs have to be addressed.

Ms. Christine Moore: A dozen recruitment centres have been closed in Canada, especially in remote regions. Aren't you worried that this may influence staff recruitment?

It is already difficult to recruit qualified personnel. Candidates, especially those in remote regions, sometimes have to miss two or three days of work to pass medical examinations or aptitude tests. It should be understood that nurses, for instance, may have accumulated over 40 days of leave because their employer refuses to give them time off.

Aren't you afraid that this will influence or negatively pressure the recruitment process?

BGen Jean-Robert Bernier: Yes, that is a concern. I am not familiar with all the details, but I know that those in charge of recruitment look into all kinds of other ways to make up for those drawbacks. They are working on making the recruitment process more streamlined and quick. For instance, they tend to use the Internet more, and they send recruitment teams to the regions, to villages and cities that no longer have a recruitment centre.

I cannot talk about this any further, as it is beyond my area of expertise. Nevertheless, this is a concern. I know that we are currently taking certain measures and making changes to not only fill in the gaps, but also improve the situation.

Ms. Christine Moore: Thank you.

The Chair: Thank you very much.

[*English*]

Mr. Chisu, it's your turn. You have the floor.

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much, General, for being our witness today.

First of all, I would like to thank all the medical corps who served for years in Afghanistan, especially the personnel at the Role 3 hospital in Kandahar. Also I share the grief of the lost lives of medics in combat at the front line. I know there were several of them.

General, are you able to expand on your experiences of running the NATO combat hospital in Kandahar? That was a very interesting operation and a very interesting role that Canada had in an area of allied operations. You didn't see only Canadians who were injured. You have seen all kinds of casualties from different nations.

What kinds of physical and mental health-related injuries did you see the most? Was the hospital ready to give you the services needed to address the injuries that came in? How did this situation evolve over time? How did the hospital improve over time? Were there any injuries or cases that you did not expect to see?

As you know, and as I explained to the committee, the Role 3 hospital was very important to stabilize the injured survivors and save lives; before we speak about any kind of operational stress injuries, we speak about saving lives first. In this context, can you elaborate on the lessons learned from Afghanistan to be applied at home in order to increase the time to treat the operational stress injuries, in order to reintegrate the soldiers more quickly to be combat ready? That is the role of the forces: to have soldiers ready to be deployed again.

● (1635)

BGen Jean-Robert Bernier: Thank you very much for your comments about the medics and their tremendous sacrifice. Reading their citations for some of their valour declarations is breathtaking: their bravery, their courage, and their sacrifice.... Thank you very much for that.

It was a very complicated thing to run that Role 3 hospital, because it's the first time NATO has run a multinational hospital in a combat zone, with mass casualties coming in almost daily. There were many obstacles to overcome with respect to differences in national standards, credentials, and cultural differences in the types of different scopes of practice for different health occupations, and to coordinate them into a smoothly running team, particularly with trauma teams and in the operating room.

Generally, it went very well, particularly with allies who share the same common types of medical practice in their home countries, like the British, the Americans, the Australians, and the New Zealanders. Things evolve progressively. The biggest challenge was that the vast majority of the casualties treated were not NATO casualties. The original mandate to be there was to treat NATO casualties, coalition casualties. The majority, about 80%, were Afghans, and Afghan civilians, mostly. That was a difficult thing that we weren't entirely ready for right at the start. We had to react to it fairly quickly.

The medical rules of eligibility for care in the NATO hospital change, depending on the senior leadership of NATO and the political drivers. For us to take on more and more care of civilians, including children.... Military hospitals, except in humanitarian assistance missions, typically aren't structured to deal with large numbers of casualties. They're designed to have a minimal medical footprint on the ground and a very efficient medical evacuation so that we get people, give them the stabilization care necessary in surgery, and get them to a hospital with greater capabilities in a more secure zone.

Equipping is based on that: equipping in equipment, capability, and clinical skills. With the Afghan population, we could not medically evacuate them to other countries. There were sometimes some very difficult ethical situations faced by our clinicians in having to do the best they could with Afghan casualties, particularly children.

On the other hand, if we were to establish a full-up pediatric centre of excellence, say, we would essentially positively harm Afghanistan's development of a pediatric capability in their own region, because we would basically put all of their clinicians out of business for the entire local population. That was a big challenge.

As for mental health-related lessons learned, I'll ask Colonel Heber to mention this.

● (1640)

LCol Alexandra Heber: There are a couple of things that come to mind. At least one of them has been mentioned already. One of our big lessons learned there was the importance of the leadership's role, the role of the chain of command, in dealing with mental health issues. When the leadership supported the person and, even more importantly, told the member, “I expect you to have a couple of days of rest, and after that, I'm expecting you to be fit again”, it was amazing how important that sense of expectation from their leadership was.

One of things we learned quickly in Afghanistan, as the mental health team, was to really engage leadership and really do training with the chain of the command about how to handle people who came in with what we were calling combat stress response. We weren't calling it PTSD, and most of these people did not go on to develop PTSD. They would get a bit nervous. They hadn't slept for several days. Leadership really took on the role, often with the help of the medical technicians, of dealing with that. That was one thing.

The other thing was how much mental health needs to be integrated into all the medical services. The best example of that was the casualty management teams we set up for people when they came home. We made mental health part of that right from the beginning. It was very important.

The Chair: Your time has expired.

Part of my job here is a little bit like a traffic cop in having to direct things.

[*Translation*]

You have the floor, Mr. Brahmi.

Mr. Tarik Brahmi (Saint-Jean, NDP): Lieutenant-Colonel Heber, I think I heard you say, in English—I am not sure I have understood the sentence properly—that most people you treat would have the same symptoms even without their military experience. Does this mean that, in most cases, you cannot establish a connection between combat-related stress and those symptoms, since they are the same as they would be in civilian life? Can you elaborate on that?

[*English*]

LCol Alexandra Heber: Thank you very much for that question.

PTSD is of course considered a mental condition or a mental illness, and it has a certain number of symptoms that we look for. Then there are a number of other things. We have to rule out certain things. We look at the person's level of functioning and how long he's had the symptoms. But there are very well-prescribed symptoms. Whether somebody has developed PTSD because they were sexually assaulted or abused as a child or has been in a combat zone, although the details of the events are different, the symptoms they suffer from essentially are the same.

That's I think what I was alluding to in terms of, yes, there can be people we diagnose with PTSD who, again, perhaps were abused as children, entered the military, and spent many years in the military, and who then for some reason come forward. They can have PTSD; it may not be related to combat. But certainly, most of the PTSD we treat is related to, yes, being in the war zone.

[*Translation*]

Mr. Tarik Brahmi: You talked about predetermining factors, and that brings me to my next question.

Do combatants—those who are really sent into combat—undergo a systematic psychological assessment before and after? I assume that is the case, but I would like your confirmation. Those assessments of combatants when they return from combat could help identify factors that would explain the onset of symptoms that could occur several years later. That would help establish a connection between identifying trauma in combatants when they return from a combat zone and the onset of symptoms later on.

● (1645)

[*English*]

LCol Alexandra Heber: There's a couple of things. First of all, before we deploy people, they go through a medical, which includes an evaluation. We don't test people, but they are seen by a family physician who looks at their history, both their medical history and their psychological history. We do that.

Again, when we talk about risk factors for PTSD, let's say that somebody has a history of childhood abuse, they've joined the military, they want to be and are a fully fit military member, and they want to deploy. Again, I think it would be a disservice to them, if they're functioning well, to tell them that because of this childhood abuse we don't think they should deploy. Again, it's important to remember that for those risk factors I talked about, there are many, many other people who have those risk factors but never develop PTSD—

[*Translation*]

Mr. Tarik Brahmi: I have to interrupt you, as we don't have much time.

Are you saying that the soldier recruitment process does not involve a systematic assessment of psychological risk factors? Is that what you are saying?

[*English*]

LCol Alexandra Heber: It's in the recruiting process. Again, people have a medical history taken, and that includes their psychological history—

[*Translation*]

Mr. Tarik Brahmi: So you are telling me that this assessment is not done by a military psychiatrist . It can be done by a family doctor.

[*English*]

LCol Alexandra Heber: At the recruitment stage, yes. It's done by a physician's assistant or a family doctor.

[*Translation*]

Mr. Tarik Brahmi: It is not done by a psychiatrist.

[*English*]

LCol Alexandra Heber: No.

[*Translation*]

Mr. Tarik Brahmi: Thank you.

The Chair: Thank you very much.

[*English*]

Mr. Norlock, you have five minutes.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Chair.

My thanks to the witnesses for appearing today.

This question is for you, General. When you took over as Surgeon General from Commodore Hans Jung this past summer, what were the personal goals you wanted to fulfill in this new job of yours?

BGen Jean-Robert Bernier: Thank you for the question.

I was Commodore Jung's Deputy Surgeon General for three years, so we were quite aligned in where we wanted to go. We achieved tremendous capability as a result of operations in Afghanistan and had tremendous support from the government for the capabilities that we managed to establish. My priority, given that operations were winding down and that deficit reduction must occur in this country, and given our responsibility to assist in balancing the books, is to maintain the capabilities that we've established so we're ready for the next operation, whatever it might be.

We've developed quite a breadth of capability and expertise. I want my priorities to progress in areas such as establishing an institutional memory of lessons learned and at least a minimal capability in everything that we needed in greater quantity in Afghanistan, as well as in other elements of operations that we've undertaken over the years, such as the response to the earthquake in Haiti.

First of all, we must maintain all those capabilities to some extent, and we must expand them in those areas where the lessons learned demonstrated that we had some shortfalls—for example, in modularization. I have focused a lot on modularizing and on having a much more rapidly deployable surgical capability, which may not have been necessary for Afghanistan but may be necessary in the next operation, whether it be humanitarian assistance or otherwise.

We should lighten the load. If we break up the deployment of a field hospital so that, instead of requiring seven chalks of a C-17 to move the whole field hospital before it's functional, we break that up into smaller chunks, there will be a surgical capability with the first chalk that lands, which will simply increase in quantity with subsequent chalks of C-17 flights.

There are some things like that related to the lessons learned, but the primary thing is to maintain our established capabilities, particularly with respect to mental health. We must equally maintain our operational capabilities to support the armed forces for the most extreme types of missions that they may have to undertake in future.

● (1650)

Mr. Rick Norlock: Thank you very much.

Changing gears a little bit, can you speak about how our forces are discharged after deployment? Do you think the method of third location decompression is one that helps in the transition from active duty to everyday life?

BGen Jean-Robert Bernier: After deployment, everyone undergoes medical screening that's fairly thorough at the three- to six-month point, and then they carry on being followed up on with a periodic health assessment every four or two years, depending on their age group. At the time of release, there's a final evaluation.

There are multiple measures to try to identify and screen for mental health conditions along the way. As far as third location decompression goes, there was no data that justified its establishment before we established it. It was based on a common-sense review of what had happened in the past when colleagues had the opportunity to take advantage of social support after wars such as the Second World War and the Korean War, in which they had a long time together before complete demobilization back in Canada, as well as on the experience of the Americans in Afghanistan, who sent individual patients and demobilized soldiers from the theatre of operations directly back into North American society without that kind of opportunity.

I'll just ask Colonel Heber if she has any additional comment to make on third-location decompression.

LCol Alexandra Heber: I think the general was referring to Vietnam when he mentioned the Americans. That really did not work well, so we developed this idea of doing a third location decompression. Anecdotally, people talk about it having helped, about having that space with their buddies, with their colleagues, prior to coming back home to their families and to Canadian society, to everything that is here that wasn't over there. It's like a little safety time for people.

This is totally anecdotal, but I always remember a spouse from Petawawa telling me that her husband had deployed to Afghanistan both before we had third location decompression and after. She said TLD was wonderful. Her way of measuring this was that beforehand it would take six months before she could take him to Tim Hortons when he came home, and after he had gone on his second deployment and had had third location decompression, it took only about a month and a half. That was her measure for the difference: he was able to be around people and not be hypervigilant and not be triggered.

Mr. Rick Norlock: For the people at home, what is third location like? Is it a specific geographic area or a social atmosphere or both?

LCol Alexandra Heber: It's the geographic area of being not in the war zone anymore, but not home, so yes, that's the first thing, and it's both social and educational. People are there with the troops they deployed with.

We also have quite robust mental health teaching that goes on there, reminding people of what they learned pre-deployment about what kinds of things they may feel and helping them in how to deal with it. There are also mental health folks available there 24-7 for people to talk to at any time. We would sometimes get referrals right from the third location before people hit the ground at home.

The Chair: Thank you.

Mr. Strahl.

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

Thank you to the witnesses.

You spoke about the great work of our medical teams in Afghanistan. I've read two books this fall by Dr. Ray Wiss, reserves doctor: *Fob Doc* and *A Line in the Sand*. Thanks to John for bringing those to committee members. I think any Canadian who wants to learn more about what our forces did in Afghanistan, and certainly what the atmosphere was like for front-line medical services personnel, would do themselves a great service by reading those two books.

I asked a previous witness if she could compare the mental health services or the medical services that CF members receive in Canada to those of other jurisdictions. She called our services the Cadillac of the health care system, I think for some of the reasons you have outlined, such as the ability to move quickly to respond to different situations. That's what she said it was like in Canada.

How do our military injury support centres measure up against the services that our allies have in place for their injured forces members? Have we looked into that? You mentioned some awards, but for our near peers, how are we doing in treating our men and women in uniform compared to how our allies are?

● (1655)

BGen Jean-Robert Bernier: On the administrative support side, the integrated personal support centres were partly modelled on the U.S. model. They were well ahead because of their years in Iraq and the number of casualties they've had. They have been doing very well in terms of administrative and casualty support to families and all taht kind of thing, but objectively, when it comes to things like suicide, there are so many variable differences in the way we operate, in the duration of our deployments, in the way we treat and consider mental health conditions, and in our levels of stigma. That may account for the differences. For example, among Canadian Forces members, we have a significantly lower rate of suicide compared to our American colleagues.

For example, some governments don't have a ministry of veterans affairs—like the U.K.—so the follow-up and the services provided to their veterans are quite different and are primarily taken on by private charities. On the other hand, they have a far, far higher number of private foundations and charities focused on the welfare of former armed forces members than we do in Canada.

Other than that, I can't comment much on the differences on the casualty support element. As far as the clinical support is concerned, there are significant differences, but it is widely recognized by NATO and by our allies that the standard of care we provide to Canadian Forces members is very, very high.

Mr. Mark Strahl: We also heard a little bit about the efforts that the CF makes to educate families who have loved ones in the forces or specifically deployed overseas in Afghanistan, for example. What resources are available to military families? Is that part of your oversight? Is that under your structure?

Again, I just want some comparison as to whether we have learned lessons from our allies there as well. How does our family support structure stack up against our near peers?

BGen Jean-Robert Bernier: Thank you.

Family support is not part of my mandate. There's a separate organization that provides the family support that the Constitution and our legal framework permit us to provide. Also, health care, under the BNA Act and the Constitution Act, is a provincial jurisdiction and responsibility, so there are limits to how much we can provide there.

But certainly on the mental health side, because it's influenced by many things that are not purely clinical, there are significant services that are provided to families. The Road to Mental Readiness program, which assists with resiliency skills development and the identification of symptoms related to mental health conditions, how to deal with them, and how to get people into care, includes a family module. Family members are included in elements of that.

The Strengthening the Forces health promotion programs that deal with education on addictions, various elements of social wellness, stress management, anger management, and things like that—various factors that contribute to mental illness—are available to families in addition to Canadian Forces members. There is a specific couples counselling program that can include families. Our chaplains and our social workers—if it's relevant to the health of the Canadian Forces member—can include family members in their services.

There are military family resource centres everywhere, many of which include social workers or other mental health folks to assist them. Finally, the Canadian Forces member assistance program, which permits confidential access to counselling services, is available to family members.

Do you have anything to add, Dr. Heber?

LCol Alexandra Heber: I have just one thing. In the OTSSCs, as part of our assessment when we do our diagnostic assessment of the military member, we routinely ask the member to bring in his or her spouse. We will also interview the spouse. For many reasons, that's very helpful.

First of all, we get collateral information. We often find that military members are stoic and will under-report their symptoms. The spouse usually will tell us the real story about how difficult things are getting and how much the person is suffering. It also gives us a chance to see how the spouse and family are doing. We can then provide some support in terms of education. If the couple needs some help, we can always do couples therapy with them.

● (1700)

Mr. Mark Strahl: Thank you.

The Chair: The time has expired.

Before we go on to the third round, I want to ask one question myself.

Mr. Strahl brought up the books by Captain Ray Wiss. I have read both of his books and was quite interested in his pioneering use of ultrasound in the FOBs to do diagnostics.

Earlier in this session, our committee travelled to DRDC—Defence Research and Development Canada—and met with some of the scientists there. They are working at how we increase survivability of CF members, especially from blood loss, and how we do those transfusions.

I'm just wondering what new technologies are coming online that the Canadian Forces Medical Service is looking at to increase survivability and to reduce the trauma that is inflicted upon our members in the line of combat. Also, what might we be able to expect as outcomes from this new research and from new adaptations of these technologies and medical techniques?

BGen Jean-Robert Bernier: Thank you for the question.

Research is critical for us, because we need to stay ahead of the enemy. We need to stay ahead of operational threats from hostile action, and ahead of naturally occurring industrial threats as well, because we deploy to places where there are threats that Canadians generally don't face.

Chemical, biological, and radiological defence is a big aspect. We have a quadripartite memorandum of understanding to work on a wide variety of medical countermeasures. There's a specific medical countermeasures coordinating committee to integrate our research to achieve economies of scale. We have a $160-million program that has been going on for several years now, in concert with the British and the Americans, to develop biological warfare defence vaccines.

We have an internal Surgeon General's health research program, through which a lot of our clinicians are embedded in university trauma centres or academic medical centres. In collaboration with either DRDC or their civilian academic partners, or both, they conduct specific health research related to military-specific health issues in critical care, trauma management, and a variety of other things. This is a very large program. We leverage elements of our contribution with that of the Americans and civilian academia. The Americans are paying about 40 times the amount we're paying.

In many cases, by virtue of having embedded our people in civilian facilities, we can leverage the research grants they receive from the Canadian Institutes of Health Research or their own university funding to address military-specific issues.

We are working on various diagnostics. Telemedicine is a key focus as well. There's quite a wide variety.

We publish elements of the research in the *Journal of Trauma and Acute Care Surgery*, the world's top trauma journal. A couple of years ago, we had a whole Canadian Forces supplement on operational medicine. We were invited to prepare it for that world-renowned journal and for the *Canadian Journal of Surgery*.

We've also helped establish the Canadian Institute for Military and Veteran Health Research, a collaboration of 26 universities led by Queen's University and the Royal Military College, to specifically address health issues relevant to military populations, their families, and veterans.

We have quite a wide variety of approaches and means by which we're focusing on research in too many areas to list in the time available.

The Chair: I appreciate that.

We're going to go to our last round. Each party gets another five minutes.

Go ahead, Mr. Harris.

Mr. Jack Harris: Thank you, Chair.

This is a most interesting presentation.

I want to follow up on something Colonel Heber spoke about, but first of all, I will say that I'm extremely impressed by the level of change that has taken place, particularly at the senior level of the military. It is exemplified by the former CDS and the attempts to de-stigmatize mental health issues in the military and to have a regime that seeks to have a strong understanding of that throughout. I know that there are the efforts to talk about this as an injury as opposed to a mental illness, to treat it the same as an injury. These are all very positive.

I wonder if I could ask Dr. Heber, or you, Dr. Bernier, to talk about this aspect of whether you're dealing with treatment or with discipline. I want to bring it back to your comments about the soldier who was in a traumatic circumstance. He comes back, and the commanding officer or the leader says, “Okay, you're off for a couple of days, but I expect you to get back on deck”. I'm not saying that this is a bad thing. It's helpful.

How is that different, then, from the “buck up, soldier” attitude? I know it is, but can you tell me how that distinction is made from the medical perspective, from the point of view of setting medical policy and dealing with that at the operational level?

You talked about the symptoms of PTSD. It's suggested that 90% of individuals diagnosed with PTSD have at least one psychiatric disorder, including drug abuse, depression, and suicidal thoughts. Sometimes there's a lot of overlay. How do you make that distinction? How do you do that from a medical perspective, as medical officers, and how do you see that operating at the pointy end, I guess?

● (1705)

LCol Alexandra Heber: Thank you for that question.

First of all, when I was talking about combat stress reaction, this was something we were doing in Afghanistan. The idea was about trying to keep people near their colleagues, to not separate them, because there's always a lot of shame involved. It was interesting. If somebody was in a FOB, a forward operating base, it was better if there was something that we could do there. Sometimes we would send our nurse or social worker out there, actually, if we felt it was necessary, rather than bringing them back even to Kandahar airfield. That was very much something we developed in Afghanistan.

In terms of what we do back home, you're right, in that there's always a tension between the confidentiality around patient care versus the chain of command wanting to have some information so they can help their members. One of things that we do now is a lot of education of the chain of command—the Road to Mental Readiness. People get this at every level of their career courses.

Last week I was in Kingston presenting to the army officers' course. These are people in the army at the level of captain who are being promoted. This is the thing we talked about. We talked about how we work together. We've set up, of course, a system of medical employment limitations that are recommended by the GDMO, the family doctor, not by mental health. The medical employment limitations state that "these are the things the person can't do" for *x* period of time, but it doesn't name what the conditions are.

Mr. Jack Harris: Okay. So how do we get into situations, like when you're sent back home...? We've heard a case of it recently. A soldier is complaining that he's put on so-called light duties, where basically he's sweeping up the area in the presence of people who he was superior to and obviously being treated in a different way while supposedly being treated for PTSD. That's very wrong. I think you would agree. How does stuff like that happen?

LCol Alexandra Heber: First of all, I can't speak to individual cases—

Mr. Jack Harris: I don't ask you to speak about that particular case, but that scenario doesn't sound right to me.

LCol Alexandra Heber: Right.

Certainly, we would never recommend something like that. People who are given medical employment limitations...sometimes they work part time. Of course, there are also times when people are taken out of the workplace because their symptoms, at that time, are so severe that they aren't able to function in the workplace.

The whole system of the JPSUs, the joint personnel support units, was set up for this purpose: so people can come out of their workplace, get the help they need for the period they need it, and then, hopefully, reintegrate back into the military. In the JPSUs, they have their own chain of command. The JPSU is there to assist people and help them with their recovery. As well, for the people who, for whatever reason, aren't able to recover and will end up leaving the forces, the JPSUs work with us around helping those people transition into civilian life.

● (1710)

The Chair: Thank you. The time has expired.

Mr. McKay, for the Liberals.

Hon. John McKay: Thank you, Chair.

I wanted to change tack a bit and get your observations with respect to the use—and maybe abuse—of drugs by forces personnel. Frankly, I don't know whether the use of illicit drugs is greater or lesser than in the civilian population, but it certainly does exist.

Clearly, from an operational standpoint, the consequences are far more significant for a member of the forces than for a member of the civilian population, possibly, in terms of deployability, I suppose, and in terms of danger to self and others. There is some self-medication going on and all that sort of stuff, so I'd be interested in your thoughts with respect to how illicit drugs affect you, as medical practitioners—i.e. you want to help—and also how it affects deployability and how much masking is going on, because soldiers are particularly clever at making sure their superior officers don't know about what they're doing. I'd also be interested in your observations with respect to psychotic breaks, which, in the case of a military person, particularly on a battlefield, are extremely serious.

I'd be interested in hearing your general observations and about your unique challenges.

BGen Jean-Robert Bernier: Thanks, Mr. McKay.

The illicit drug use is a concern. It's a disciplinary concern. Even though the health system will screen at enrolment for illicit drug use, it's not enforced by the medical system in any way. It's completely separate. We don't want to be seen as potentially.... It would harm those individuals who may want to be treated for an addiction if they suspect in any way or perceive that the health system is involved in the disciplinary enforcement of the rules related.

We'll treat people with addictions to the maximum extent and we'll do it confidentially. We have a series of in-patient addiction referral centres and one of own residential referral centres, in Halifax, to treat people with addictions and maximize, as the whole institution wants to maximize, their recovery and their ability to remain productive and stay in the armed forces.

With respect to the other elements, to psychotic breaks, Dr. Heber...?

LCol Alexandra Heber: As to psychotic breaks, I have to say, again, that this isn't something we have researched in terms of how many people have had psychotic breaks, but from my experience, it's pretty rare. If we look at people with serious and persistent mental illnesses like schizophrenia or bipolar disorder, where people will have psychotic episodes, we'll see that generally those people are not in the Canadian Forces.

Part of it is, again, the medical history that's taken when people come into the forces. Quite frankly, I think that some of the rigours of being in the forces.... Also, there's the fact that the community is small, so somebody is having those serious kinds of problems where they're becoming psychotic, it's usually picked up, and often fairly soon after recruitment. Those are the cases that we tend to see of people—

Hon. John McKay: So your argument is that they're screened out at the beginning, in effect.

LCol Alexandra Heber: Generally, it seems to be that that's what happens. Certainly, if somebody on their recruit medical said, "Yes, I've had a psychotic episode", they would be looked at very carefully. But I think that even for people who wouldn't tell us, if they're going to have a psychotic episode early in their career, they're going to come to our attention fairly soon—

● (1715)

Hon. John McKay: The interaction of treatment and discipline is a curious challenge, a unique challenge for both of you, because you do have a patient confidentiality understanding, yet you can't be sending people out into highly stressful situations when you have every reason—and maybe you have absolute knowledge—to believe that this person is doing drugs.

LCol Alexandra Heber: Well, again, for people who've come forward for treatment, as General Bernier said, again, whether it's illicit drugs or alcohol abuse, we would be treating these people and they would have the appropriate medical employment limitations put in place. So that for a period of time, until they've completed their treatment and no longer had that problem, one of the medical employment limitations would say something like "this person cannot be deployed for *x* amount of time while they're in treatment".

The Chair: Thank you.

I understand that on the Conservative side Madam Gallant and Mr. Chisu want to split their time.

Ms. Gallant, you have the floor first.

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

Given the reports of a positive correlation between the use of Mefloquine and mental illness—depression and other manifestations—why is it still being used as an antimalarial when other alternatives exist?

BGen Jean-Robert Bernier: Thank you.

We list Mefloquine as a medication because it's very effective, and the U.S. continues to use it, contrary to misperceptions misreported in the media. It remains recommended by the Public Health Agency of Canada's committee on advice on tropical medicine and travel, the World Health Organization, and the U.S. Centers for Disease Control. The big advantage is that it's just once-a-week dosing instead of daily dosing. A life-threatening illness like malaria, as a result of missing one dose of one of the alternatives, could cost your life. It's not obligatory; it's elective.

We usually offer a choice usually of three drugs: Doxycycline, Malarone, and Mefloquine. Most people will now take Malarone, but in some cases, because of various contraindications—intolerance of Malarone or Doxycycline—they will decide to take Mefloquine, or simply because of the convenience of having to use it only once a week. Many countries among our allies continue to use Mefloquine exclusively because of its effectiveness against malaria.

In the U.S. and Australia, all they've done is take it away from being the primary drug of choice as an antimalarial to making it one of the second-line treatments. The reason the Americans did that is not because of concerns about mental health or its psychological impacts, but because of the logistical burden of the time it takes them, with the mass number of troops they deploy: to screen them for the potential contraindications was just too much of a burden. For that reason, and that reason alone, they made it a second-line drug.

There has also been a suggestion of a causal link between Mefloquine and post-traumatic stress disorder by one paper in the U.S., but the author of the paper indicated that it was likely an idiosyncratic, unusual, extreme reaction in only one specific case.

We screen people for any of the contraindications that make them more susceptible to potentially having an adverse reaction to Mefloquine should they themselves, individually, choose to take Mefloquine.

The Chair: Thank you.

Mr. Chisu.

Mr. Corneliu Chisu: Thank you very much, Mr. Chair.

I have three quick questions.

First of all, on the first aid kits for soldiers, when I was in Afghanistan, we used the Israeli tourniquet. Is there any improvement in the first aid kits issued to the soldiers going into combat operations? Are there any new products, and not the old bandages that we had for the last 20 years?

Second, what is the situation for the vaccine? If it's ordered—you need to be vaccinated because you are going to Haiti, or you're going to Afghanistan and so on—you can't say, "By the way, I don't want to have it." You need to have it.

The third question is about medical files. Do soldiers have access to their medical files? I have put in personally for my medical file.

● (1720)

BGen Jean-Robert Bernier: In the kit for soldiers, the two key life-saving additions were: the self-tightening tourniquet—

Mr. Corneliu Chisu: Yes. It's a very good one.

BGen Jean-Robert Bernier: —which has saved many, many lives from blood loss, and the use of a concentrated powder substance called QuikClot; and now, a better clotting gauze that doesn't produce a chemical burn, but that can be inserted into areas where bleeding cannot be stopped by compression because of the depth or the extent. Both the QuikClot and the gauze are extremely effective in stopping the bleeding. That has saved many, many lives, and we know that for sure from the analysis

In addition, there's additional training provided to the tactical combat casualty care people who get first-aiders, but with a very advanced, battlefield, traumatic-injury-focused training.

As far as vaccination goes, by Canadian law anyone can decline vaccination. However, should they decline vaccination, then in most cases they would be deemed to be incompatible with military service, so administrative measures would be taken to have them released from the armed forces, or certainly not to deploy. It's not only for the individual's protection. If the individual fulfils a specific function in certain deployed operational settings, and if that individual unnecessarily falls ill, then not only is that individual's life at risk, but he is now placing all of the lives in the whole unit at risk.

As far as access to a medical file goes, yes, people can have either informal or formal access to their medical files, either through a request to their local clinic of through the access to information process, whereby they can get a complete copy of their file.

Mr. Corneliu Chisu: Thank you.

The Chair: Thank you.

The time has expired on our meeting today.

I want to thank you, General, and you, Lieutenant-Colonel Heber, for coming in and for sharing your thoughts.

I want to thank both of you and all your staff for the great work they're doing in the Canadian Forces, including those who work in all the medical centres across Canada, and of course those who have served on the front lines as well, outside the wire, where they often have to be both a medical professional and a soldier. I know that at any point in time all of our people in the medical services are prepared to make that switch when it's deemed necessary.

Again, thank you so much for coming in and helping us with our study.

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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