HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on National Defence

NDDN • NUMBER 060 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, December 6, 2012

Chair

Mr. James Bezan

Standing Committee on National Defence

Thursday, December 6, 2012

● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): I call the meeting to order.

Good afternoon, everyone.

I want to make sure that we stay on schedule because we have a busy agenda today.

Welcome to meeting number 60, as we continue on with our study of the care of ill and injured Canadian Forces members.

Two service members are joining us today as individuals, Bill Nachuk and Geoffry Logue. I want to welcome both of you to the committee. I'll let you give your backgrounds. We're very interested in your experience within the CF and with your service dogs.

With that, I'll turn it over to Bill. You have the floor, sir.

Master Corporal Bill Nachuk (As an Individual): Hello, Mr. Chair. Thank you for the opportunity to come to speak to you and to the committee today.

I am Master Corporal Nachuk. I joined the regular force in 1996. I am a signaller by trade, and that gives me an opportunity to deploy and work with several different units within the military.

I have had several tours. I have been to the Golan Heights and worked on both sides, in Syria and Israel. I've had three tours to Bosnia and Afghanistan. My latest return was in September 2008, when I returned from my last tour in Afghanistan with 2 PPCLI.

I'm not 100% sure where to begin. There is a lot of information I want to pass on to you.

About a year after I returned from Afghanistan, in July 2009, things really went bad for me. That's when the total effects of what was later diagnosed as PTSD really struck home. I was taken to the emergency room on July 29, 2009, after my first suicide attempt. That's when I began seeing mental health people at CFB Shilo. They did their testing and realized I had what they classify as OSI, operational stress injuries. That encompasses a major depressive disorder, which I've been diagnosed with, as well as PTSD, anxiety, and anger issues.

Within six months I was taken to emergency four times for suicidal threats and attempts. Once I started working with the mental health unit on base, it took a few months to be able to go in. After I was referred to the OSI clinic at Deer Lodge Centre in Winnipeg, it took several months for me to get to see them, at which point they did their initial assessment. They discussed whether or not to take me on as a patient. About a week later, they decided that they would, but it took several months for me to get my first appointment. In total, it took approximately six months after they recommended that I go to Deer Lodge Centre for me to actually start my treatments with the civilian psychiatrists and specialists.

During that time, I met Mr. George Leonard in the fall of 2010, partway through my treatment. I met him because my OSI doctors started mentioning dogs. I was telling them that I didn't have a dog and I noticed that when my friend came over with his dog I found myself more relaxed, and that opened up the discussion of the benefit of dogs. I got hold of George and found out a little bit about the program and took it upon myself, knowing I needed additional help and tools along with my therapy treatment and medication.

I'd like to read a letter from my doctor, which explains a little bit about how the dog actually assisted me at that time. This letter is dated May 14, 2012, a little after I had done my treatments. It goes as follows:

> MCpl. Nachuk engaged in psychotherapy for Post Traumatic Stress Disorder and Major Depressive Disorder from August 27, 2010 to June 01, 2011 at the Occupational Stress Injury Clinic in Winnipeg, Manitoba. During the time of therapy, MCpl. Nachuk met his dog Gambler. They entered into the Manitoba Search and Rescue Association (MSRA) Elite Service Dog Program.
>
> A significant component therapy for MCpl. Nachuk was to actively work against the tendency to avoid social situations and to acquire emotional regulation skills. With the aid of his dog Gambler, MCpl. Nachuk successfully engaged in the exercises of therapy that required him to place himself into settings in which he felt anxious. Gambler helped decrease the need for hypervigilance by providing a sense of protection for MCpl. Nachuk. The presence of Gambler assisted in helping regulate M/Cpl Nachuk's intense emotional response to triggers by providing...a more flexible thought process in order to challenge emotional responses with more functional cognitions. Caring for his dog Gambler, has provided MCpl. Nachuk with a renewed sense of purpose and motivation. In addition to experiencing a decrease in symptom intensity, MCpl. [Nachuk] has experienced an increase in self confidence and improved mood.
>
> I fully endorse individuals establishing a service dog relationship to help achieve the goals of therapy and to maintain gains made in therapy.

That was from my therapist, Chris Enns, at the OSI clinic in Winnipeg.

I've also given the clerk several independent statements. I had Gambler on a career course with me in Kingston just recently, which I would not have been able to attend if I hadn't had my dog with me.

Those statements are provided to you as well.

I thought it was possible for me to get extra help by getting a canine because of the documentation I had read on them and on how they help. I know the British and Americans have been using them with their soldiers for a number of years now. In my opinion, medications will help dull the sense of your PTSD, but the dog actually helps in the treatment of it. The dog will force you to engage in conversation. It forces you to get out of bed in the morning, to get out, because you must take care of that dog. The dog takes the focus off of you. I know many of you may think that it must draw more attention to you when you go out, but that's not the case. When we go out, we feel everybody is staring at us and watching us. Now when we go out with the dog, that attention automatically goes right to the dog, and you see and hear so many positive remarks. That forces us to engage, and it also gives us a sense of protection.

Before I got the dog, I could not spend more than 10 minutes in the mall. For you that are aware, I was in Shilo, which is about a half-hour ride from Brandon. Every time I needed to get groceries or anything like that for daily living, I had to drive a half an hour into town. I could not accomplish my daily tasks of getting groceries, food, or anything like that because after 10 minutes, I would become very angry.

I will always remember one particular event. I saw a small child, maybe five or six years old, in the bulk candy section. The kid had his mouth full of candy. I just snapped, and I yelled, "Does candy taste good?" I was all about the rules and regulations and safety. Where are your parents? Why are you doing this? That's how I would become so angry. Having Gambler took that focus away from me. It made me more relaxed.

When I mentioned to the medical doctors on base that I was thinking of getting a dog, I was told, “You can barely take care of yourself. How are you going to take care of a dog?” That belittled me even more, and it's actually the dog that's taking care of me, not me taking care of the dog.

When I first started working with the dog, because it was a new thing to the CF, I was faced with a lot of problems on base. I was threatened with medical release. I was told to contact the JPSU myself to see if there was an opening there and if they could take me on. When I didn't do that and I was back in the office again, I was punished for not going to the JPSU to see if they could find a spot for me.

That is not a soldier's job. It is the chain of command's job to try to place a soldier, not the job of a soldier. I felt as though I was being penalized and segregated because I wanted to use this other tool available to assist my well-being. I had to take care of myself.

My dad always told me to watch out for number one.

Well, in 2010 I went from almost being released from the military to starting to work with the dog. I was then posted to Gagetown, at which point, in 2012, in my last session, I was ranked within the top 10 out of 187 regular force master corporals.

The point I want to bring home is that we cannot lose hope for the soldiers if they have a problem with PTSD. They're not forgotten problems. We have to give them every opportunity. We fight for this country, and I'm really hoping that the country will fight for us and give us just another tool that we need for this.

● (1540)

A member sent me an e-mail after the show aired on *W5*, and it broke down his costs for medication. In one year alone, medication was almost $24,000. In the month of October 2012, his meds cost $4,000. Out of that $24,000, roughly $18,000 was paid by our group plan. I am not sure who picks up the remainder. What we're asking for and what I would like to see is a public announcement made by the CF saying that this program is supported by the CF. Until that happens, I firmly believe there are many members out there who are going to fear to come forward; I know that, because it happened to me. We had a lot of people coming up for this. We need to show them that we are supporting them.

I ask you: please, give us all the tools that we require.

Thank you, Mr. Chair.

● (1545)

The Chair: Thank you, Mr. Nachuk.

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

Mr. Geoffry Logue (As an Individual): Good afternoon, Mr. Chair, and ladies and gentlemen of the committee.

My name is Bombardier Geoff Logue. Currently I'm posted with the joint personnel support unit in Shilo. Prior to this, I served with the 1st Regiment, Royal Canadian Horse Artillery. I've served in the Canadian Forces since May 15, 2003. I was part of Operation Athena, rotation 5, task force 1-08, Afghanistan. I served with the provincial reconstruction team. My tour, to say the least, was very difficult.

I came home and I couldn't leave my house. I couldn't go out and get groceries. I had to get my wife to do that for me, because I couldn't even leave. I was too terrified of the people around me.

When I came back from my tour, I was sent home on a civilian flight. I was repatriated to Canada on a civilian flight. I had no decompression time. My decompression was at the Boston Pizza in Portage la Prairie, Manitoba. I was presented a leave pass and told that I had the next two months off. I didn't have any support. I didn't have anyone to go to.

Since I've been back from my tour, I've been to six treatment centres. I've spent over a year in treatment centres and psychiatric wards. I've put tremendous stress on my family and all my friends. I attempted suicide three times, one of which was last year, when I overdosed on a large number of sleeping pills. I was on life support in intensive care for a week. My wife has hung in there and has been by my side this entire time.

Last year I got my service dog, Luna, from a pet store in Brandon, Manitoba, when she was only eight weeks old. I didn't realize the full impact of having a dog until I started training and working with Mr. Leonard, with the Manitoba Search and Rescue program. Since coming forward with the program...it's done me wonders. I can now leave my house, and not in fear.

My journey through my military career has been very challenging, but I've always done the best job that I could. I've always tried to perform at the highest level that I could perform.

I am going to be medically released from the Canadian Forces. I'm currently waiting for a disclosure package, which will have my release date. I've been told that I could be released within six months, I could be released within thirty days, I could be released within two years, three years, but it's not up to me.

Personally, I am not ready to be released right now. I have a lot more work that needs to be done. Now that I'm getting better, I want to have the opportunity to continue to serve in the military. I don't want to be abandoned. The military is all I've every known; I joined when I was 18 years old.

When I came back from my tour I was on a large freezer bag full of medication. I was on so many medications that I couldn't keep track of what I was taking. My mind was cloudy, foggy. I was a zombie.

● (1550)

The joint personnel support unit that I'm with in Shilo has been incredibly supportive. In fact, they had mentioned to me about Mr. Leonard and the program, and that is how I got in contact with them.

Something needs to be done here. Our soldiers are killing themselves, and this is wrong. The Department of Veterans Affairs Canada recognizes Seeing Eye dogs for soldiers, but they do not provide funding for psychiatric service dogs. Mr. Chair, I am pleading to you and to the committee to please provide funding and have this recognized through the Department of National Defence and Veterans Affairs Canada so that we can save our soldiers. The war may be done, but there is still battle going on with our troops at home in our own minds.

Thank you.

The Chair: Thank you, Mr. Logue.

We want to thank both of you for your very honest and candid comments that you just made. You have bravely served as soldiers, and I just want to say that this took a lot of courage to come here and share your personal experiences and struggles, and for that we are grateful, first for your service to your country, but we are also very thankful that you're here to share your experiences with us as a committee so that we can put together good recommendations to go to the government.

With that, we'll go to our first round of questioning. It's going to be a seven-minute round.

Mr. Harris, you have the floor.

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

I want to thank you both for coming here today. I believe you demonstrated the bravery and courage that we expect and admire in soldiers. As you pointed out, it's a different field of struggle or battle, and I know it's difficult to appear before a committee like this and tell your personal stories, but I want to say that I certainly, and I think all of our committee, still regard you as soldiers who have served your country honourably, and you deserve to be treated properly in return as part of our duty to you. Thank you for coming and telling these stories.

I do have some questions. I have some previous experience with individuals who have suffered from PTSD and other related types of psychological injuries.

Master Corporal Nachuk, you read a couple of terms from the letter. Maybe if you could help us with it, we could understand how this interaction with the use of a therapeutic dog would help. The letter says that you had experiences of what was called “hypervigilance” and that these symptoms were assisted by or diminished by the availability and the presence of the dog, and also that the dog helps to enable you to “regulate...emotional responses to triggers”.

Could you give us a little help with what that means in practice? What is hypervigilance, and how does the dog help? What does it mean by “emotional responses to triggers”? How is that helped by the presence of the dog, or is it helped?

● (1555)

MCpl Bill Nachuk: Yes, sir. First of all, hypervigilance is basically always being on guard. You're always looking around, checking what's going on. Basically you're always on alert, and that mixes to the emotional response triggers.

For example, you're in a mall and somebody drops a can on the ground. You hear that sharp crack, that bang. You're hypervigilant because you're always seeing what's going on around you. Your emotional response to triggers is you're hearing a bang or a shot or something, and you're startled. You're brought back into that time when you heard it.

When I first got back, I went golfing, and right near the golf course was a firing range, oddly enough, so I wasn't golfing, I was hearing gunshots, and that just brings you right back to the incident time. That hypervigilance and the emotional triggering go hand in hand. Does that answer your—

Mr. Jack Harris: Does the dog have some effect on this?

MCpl Bill Nachuk: Yes. For the hypervigilance, I focus on the dog. I am not always scanning around for what's going on; I'm focusing on the dog. For the emotional response, he gives me a sense of protection. I feel that somebody is there watching my back, so to speak.

Mr. Jack Harris: He's not excited; you're not excited.

MCpl Bill Nachuk: Yes, sir.

Mr. Jack Harris: The dog would respond to real danger.

MCpl Bill Nachuk: Yes, sir. He just gives me that sense of security, and I know that someone has my back, so to speak. Over there, someone always has your back.

Mr. Jack Harris: Can I ask you a quick question? In addition to that aspect of it that you talked about so well, would it be a benefit to be engaged with the dog as a handler?

For example, I'm just thinking of something I ran across by accident in my hometown. It was a group of people who were learning to train dogs to act as ground search animals. A woman from Alberta who was an expert trainer was there helping people and training them. Would a program that allowed you to play a role in perhaps having yourself trained at having some role with the dog, aside from it just being the companion and therapy animal, but actually having a relationship like that, be a benefit, do you think?

MCpl Bill Nachuk: I am so happy you asked that question. That is actually our goal here, sir. Our goal in a perfect world is for Mr. Leonard—who graciously volunteered to help me, Geoff, and maybe a couple others—to train us so we could actually expand this to the other bases that we're on to be able to help other soldiers with their dogs.

That once again would be answering your question. Yes, that would be truly beneficial. He had volunteered to do this for us. I would love the honour and the opportunity to be able to take him up on that offer. It's a sense of repaying back.

Mr. Jack Harris: Thank you.

Bombardier Logue, thank you for telling your story. I know it's difficult to recount some aspects. When you were in the PRT, were you in Camp Nathan Smith?

Mr. Geoffry Logue: Sir, yes, I was. Prominently, first of all, I was the only regular force member on the civil-military cooperation team. I was looked to by all of the guys for help to ensure that things went smoothly as much as possible.

Mr. Jack Harris: That was pretty isolated from the Kandahar air base. Some members of the committee have been to Afghanistan and to Camp Nathan Smith, and they went there by Black Hawk helicopter and all that goes with it.

I was disturbed to hear you were sent home on a civilian aircraft—what, by yourself?

Mr. Geoffry Logue: Yes, sir.

Mr. Jack Harris: Are you serious?

Mr. Geoffry Logue: Yes, sir.

Mr. Jack Harris: And there was no decompression or assistance along the way?

Mr. Geoffry Logue: No, sir.

Mr. Jack Harris: That is quite disturbing.

Can you tell us when you came back? I know you joined the military and went to Afghanistan in 2003.

Mr. Geoffry Logue: No, sir.

Mr. Jack Harris: Sorry, you joined up in 2003. When did you come back from Afghanistan?

Mr. Geoffry Logue: I served in Afghanistan from March 2, 2008 to July 7, 2008.

Mr. Jack Harris: You have been in treatment since that time, and then have subsequently been working with the JPSU.

Mr. Geoffry Logue: Yes, sir.

Mr. Jack Harris: How long have you been working with JPSU?

Mr. Geoffry Logue: For just over one year, sir.

Mr. Jack Harris: You say you are being considered for medical release. You are not happy with that. Do you feel you could continue to provide a service to the military in the JPSU?

Mr. Geoffry Logue: Yes, sir. I would like to have the opportunity to be a soldier again. The JPSU is a unit that is for the ill and injured soldiers. Typically, when you get posted there, people get medically released.

● (1600)

Mr. Jack Harris: People typically get medical.... This is a stage as part of the medical release, as opposed to...?

Mr. Geoffry Logue: Yes, sir.

Mr. Jack Harris: Are you actively engaged in assisting people who come to the JPSU for assistance? Is that part of your job?

Mr. Geoffry Logue: Sir, right now, my place of duty is I am going to school and upgrading my high school education. I think it's important that I have that.

Mr. Jack Harris: You would be a client—

The Chair: I'm sorry, Mr. Harris. Time has expired.

Mr. Jack Harris: Okay.

But are you a client of the JPSU?

Mr. Geoffry Logue: Yes, sir.

The Chair: We're going to move on. Mr. Strahl is next.

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

Master Corporal and Bombardier Logue, that was some sobering testimony, to be honest, for me.

I will continue where Jack left off with Mr. Logue.

One of the other committees I am on is the health committee. We talk about mental health issues all the time. I'm a little bit concerned when I hear that someone who has PTSD, anxiety, and everything that comes along with it has been advised that he may be released in 30 days, or it may be three years. How does it play on your mental health to have that hanging over your head?

Mr. Geoffry Logue: Sir, in a way it makes my condition worse, because I don't know what I'm going to do. I love working with dogs. I love the fact that we are helping other soldiers with the dogs. Since the *W5* story came forward, several soldiers have come forward now. The JPSU in Shilo is packed full of people who have service dogs now, thanks to Mr. Leonard.

Mr. Mark Strahl: Either one of you can comment on this: is it a common practice, when someone is being prepared for medical release, that there is just an open-ended—I don't know how else to say it. Is it a common practice that the end of your active military career could come at that large of a time span? I'm concerned that it would be a practice. I don't know enough about it to comment intelligently on it, but maybe you could advise me of that. Is that common practice, or is Mr. Logue's experience perhaps unusual?

MCpl Bill Nachuk: If I may, fortunately I haven't personally gone through the medical release part of it, but for a soldier who wants to be medically released or does not want to, yes, the time can really vary, basically depending on your unit. If they feel that they still need you, they could hold on to you and they could draw out that frame. If they feel that they don't want you anymore, you can be out within 30 days.

Mr. Mark Strahl: For the condition that we're dealing with, that seems like an unusual practice—an unhelpful practice, if I might say so.

MCpl Bill Nachuk: There may be other speakers here today who may be able give more light on that. I'm just speaking from a soldier's point of view and from my understanding. Others speaking later today may be able to give more of a detailed correct statement on that aspect.

Mr. Mark Strahl: Okay.

To move on to the animals themselves, as a dog owner myself, I often lament the costs. He's part of our family, our dog is, so when things come up, it's not a cheap experience, with vet bills and all the rest of the associated costs.

Did both of you have to purchase the dogs, or are they on loan? Who is responsible for the costs associated with their care?

MCpl Bill Nachuk: For myself, personally, I actually purchased my dog from a rescue, so he cost me $150. I purchased him prior to getting involved with Mr. Leonard.

When you deal with vets or whatever and you inform them that your dog actually is a service animal, most vets will.... Well, for myself, one vet, I don't have to pay the tax, which, when you're talking about big vet bills, isn't that much. I had the dog prior. I paid for him.

Now, Mr. Leonard, who I believe is speaking later, may be able to give you more insight, but I know from dealing with the program that if a soldier is in dire need, usually MSAR has a dog that's trained that he will loan out to that individual to help him get through his or her time of need, at which point—at least now we have some funds—we could look at getting that individual his or her service dog at that time.

● (1605)

Mr. Geoffry Logue: Sir, I purchased Luna from a pet store. It cost around $150 as well. As you said, yes, the vet bills and things add up. It's not cheap to bring the dog to a veterinarian. It's a minimum of $100. It's very challenging at times.

Mr. Mark Strahl: We've heard a lot over the last number of months from General Natynczyk and now General Lawson about the efforts to reduce the stigma of PTSD and mental illness in the military. Certainly I take them at their word at the highest ranks that this is happening, but especially from your comments, Master Corporal, it doesn't appear that is always making its way down the chain of command.

Have you seen improvements in the reduction of stigma? That comment that you can barely take care of yourself was very troubling, if that was coming from someone in authority over you.

MCpl Bill Nachuk: Yes, sir, that actually came from a medical officer. It was my doctor, a military doctor.

I will say, being in 2B of 2 PPCLI, that we are truly a close net of brothers. There has been, on our part, a little bit of betterment on that aspect. We actually start comparing meds among ourselves, but that's us trying to take care of our brother. We're doing it among ourselves.

The stigma still is there. When you have to go to a medical appointment and you have to put your name on a board that everyone can see saying you have to go to mental health appointments, that's drawing more undue attention to yourself.

I was told by two doctors, one in Shilo and one in Gagetown, that if I have a relapse any time later in my career after being diagnosed with PTSD, I am placed on permanent category and on my road out for medical release. That means soldiers will not get help again if they ever have a relapse, and PTSD does not just go away, so now, being told that, I automatically know I could never ask for help again without fear of losing my job.

The Chair: Thank you. Your time has expired.

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

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair, and thank you to you both.

This has been.... You guys are pretty gutsy is all I can say. Man.

We're going to have Colonel Jetly speak after you. I have his notes for his appearance here.

It says in the last paragraph:

> ...canine assisted therapy can have a positive health impact in some patients, in a non-clinical, social way. But at this point, there is not sufficient evidence to justify the inclusion of canine therapy in our spectrum of care.

What would you like to say to Colonel Jetly?

MCpl Bill Nachuk: I have to apologize. When I'm being read something, there are times when it's hard for me to put it back into—

Hon. John McKay: Essentially what he's saying is there's no scientific proof that this canine therapy works.

MCpl Bill Nachuk: You know what, sir? I would respectfully say I don't care what the science is behind it: it saved my life. It saved lives of friends of mine in Shilo. I am getting phone calls from a friend of mine who used to suffer very badly from seizures. He got a dog. He's able to get into the malls and carry on with his life.

I'm just a soldier. Science to me is you take it the way you want. I personally know the effects of it. I've seen it first-hand with me, and I've seen it with my friends, so science, in my opinion, is debatable.

Hon. John McKay: Yes.

Mr. Logue, would you comment?

Mr. Geoffry Logue: Sir, I'd like to add on that. The United States and the United Kingdom both endorse and fund psychiatric service dogs for their soldiers, so the science is there.

● (1610)

Hon. John McKay: Are either of you aware of any science-based studies being done, i.e., empirical evidence or anything of that nature?

MCpl Bill Nachuk: I'm not sure if this falls within what you're asking, but Dr. Meaney, I know, has done research on it with the levels of the release of oxytocin in our bodies when interacting with animals. The release of that will help you with the decrease of anxiety, stress, and depression. I know he's done studies to that level.

Hon. John McKay: So there is some potential evidence, but anecdotally we all know what you're saying is correct, because dogs, in particular, have the same effect on all human beings.

MCpl Bill Nachuk: Yes, sir. You see them widely in hospitals, in hospices. Just going through Confederation Park earlier today was kind of ironic, because I saw the statue of the dog from way back in the wars. If they're good enough to be mascots and basically soldiers back in history, why did we get away from that?

Hon. John McKay: Yes. I buy your argument that if Veterans Affairs will fund a dog for the blind, why wouldn't they fund a therapeutic dog? That makes perfectly good sense to me. There was your other argument that it's either meds or the cost of a dog, and if you can drop your meds from $24,000 to $4,000.... You can get a lot of dog for $20,000.

MCpl Bill Nachuk: With that, sir, from my point of view, after I started working with my dog, I went from being driven from Shilo to Brandon twice a week for appointments at the OSI clinic. After I started to work with my dog, my meds went down and my appointments for depression went from twice a week to once every two weeks. Therefore, within a month that would pay easily for the subsidy of the dog.

Hon. John McKay: Could you describe your problems with the chain of command and the CF medical system? Like Mr. Strahl, I'm somewhat shocked that anyone, whether it's within the chain of command or the medical system, would say that you can barely take care of yourself, so how are you going to take care of a dog? Could you tell us what other issues you've had with either the chain of command or the medical system itself?

MCpl Bill Nachuk: Yes, sir.

Because I was one of the first trying to get involved with this on our working base in Shilo, I was hauled into the RSM's office. There were approximately four other officers there, including my OC, the adjutant of the unit.... I basically got chewed out for what I believe is trying to get myself additional help. That's when I was threatened with medical release, saying that if I needed a dog, obviously I'm not stable enough to be in the military.

When I informed Mr. Leonard about that, I was fortunate to get some support from some other people here in Ottawa. I'm not sure if it's proper that I mention their names, but they got involved, and fortunately for me, a few calls were made and I was given some leeway, because I'd asked to try to get involved in this program that I know was presented to the CF in 2010 by Mr. Leonard. They did begin a trial with the service dog program, and that was what I wanted to try to get involved in. In doing so, I was threatened with medical release. I was scrutinized.

Hon. John McKay: Well, you're still, in some respects, threatened with medical release—

MCpl Bill Nachuk: Yes.

Hon. John McKay: —because you know that if you have any kind of a relapse, of whatever kind, you're cooked.

MCpl Bill Nachuk: Yes. I was told that by my medical doctor in Shilo. As well, once I got to Gagetown, I was told that there as well, by another military doctor there.

Hon. John McKay: Have you had any encounters with the military police?

MCpl Bill Nachuk: Yes, I did.

Because I'm a member of the military and of course they got called when I was having problems with suicide, I became what I feel is like a target. They'd be circling my house all the time, almost every half hour on the hour. They would be watching everywhere I go. They'd pull me over just out of the blue to see if I was drinking or how I was.

Being on a snow machine.... I was inside a house, and my snow machine wouldn't turn off. They came there. My machine wouldn't turn off after I was driving it for hours. We had a couple of drinks inside the house. They actually charged me with a DUI. This went to court, and all the charges were dropped because I was in the house, not even on the machine, nothing.... They would do whatever they could to try to keep tabs on me, and that would just add extra pressure.

● (1615)

Hon. John McKay: Does the base fear that you're going to do harm to yourself or others? Is that the theory the military police would be following?

MCpl Bill Nachuk: I couldn't speculate on that. All I know is that I felt like I was targeted because I was having mental health issues.

The Chair: Mr. McKay, your time has expired.

Hon. John McKay: That's fine. Thanks.

The Chair: To be fair to the rest of the members, we have to keep moving along, especially since we only have another 15 minutes with these witnesses before we move to the next section of the agenda.

With that, Mr. Chisu, you have five minutes.

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

Thank you very much for coming before the committee. Thank you for your service.

From us to you, Bombardier, happy Saint Barbara Day; probably I will be able to tell you “more years to come” with these best wishes.

I would like to ask both of you this question. I was in Afghanistan in 2007. I understand that you were there in 2008. Can you describe your roles during the mission in Afghanistan and explain to the committee your respective experiences on deployment, if they are not too gruesome to tell?

MCpl Bill Nachuk: I'll start because I'm sure I haven't had as much as he has in this. It also relates to why I have what they call survivor's guilt.

Compared to my friends who I lost over there, I had it easy. I was in charge of the crypto. I was the one and only person involved with ensuring that all the crypto got out to all the FOBs and all the bases.

Mr. Corneliu Chisu: So you were in Kandahar—

Hon. John McKay: Could we ask for a translation?

Voices: Oh, oh!

Hon. John McKay: Crypto is...? FOB is forward operating base; I understand that.

MCpl Bill Nachuk: Crypto? Sorry—

A voice: Signals—

Hon. John McKay: I figured that, but I just wanted....

MCpl Bill Nachuk: Okay.

I was fortunate enough, whenever I had to go around, to be flying in a helicopter, but when we were engaged with ground air attacks, I felt helpless. I was basically at the mercy of the door gunners. It gives you a sense of no control. You're at their will. You can't do anything, right?

I feel bad; I have survivor's guilt because a lot of my friends died over there doing, I feel, a lot more important job and a harder job than I did, and I feel bad because here I am having problems.

Mr. Corneliu Chisu: I'm making a connection between your having a dog and also in Kandahar their having dogs and handlers to detect mines. The dogs were very much helpful for people. Actually, I remember that one dog was injured and was transported by helicopter, like a person.

MCpl Bill Nachuk: Their dogs are soldiers. Their dogs have ranks. They have service numbers. Their dogs usually have a rank higher than the owner, which protects the dog, because if the owner mistreats or abuses that animal, the animal has a higher rank than the soldier.

That's something that I think would benefit us: incorporating it into the dog program here and getting these dogs recognized as members of the Canadian Forces.

Mr. Corneliu Chisu: I'm making the connection between their dogs and these dogs that are helping you out in your recuperating from PTSD.

You mentioned the chain of command and so on. As an officer, my first role is to protect my soldiers, and even to take care of my soldiers. I would like to know what problems there are with the chain of command, because what you are reporting to me were disturbing events.

MCpl Bill Nachuk: Yes, sir, they were.

They even went as far as wanting me to cancel one of my regular appointments so that I would not miss our Christmas dinner. When I refused to do so, I was raked over the coals.

To me, my mental health and my regular appointments are more important than going to a Christmas dinner, which promotes, as we all know, drinking and everything else. I wanted to get away from that. I refused to go to Christmas parties—after hours, on our time—because alcohol was a big factor, and I was trying to get back on track.

Once again, because I did not want to take part in those functions while trying to get better, I was scrutinized and raked over the coals.

Mr. Corneliu Chisu: Has anything changed lately, or do you see a change?

MCpl Bill Nachuk: I've moved off of that base, thankfully. I go back there to visit. I see friends of mine.

If anything, sir, I can honestly say that I feel it's gotten worse in Shilo. Shilo is a very isolated base, for those who don't know. It's very isolated. There are a lot of problems down there because the troops are afraid to come forward.

That's why I feel, once again, this has to get pushed down from the highest levels in the CANFORGEN to say that this program is supported by the CF so that the soldiers are not afraid to come forward and ask for the help they deserve and need.

● (1620)

Mr. Corneliu Chisu: Thank you very much.

MCpl Bill Nachuk: Thank you, sir.

Mr. Corneliu Chisu: Master Bombardier Logue, I'd like to ask you about your mission in Afghanistan. I understand you were in PRT, which is a much smaller base than Kandahar. How many people were there, around 300?

Mr. Geoffry Logue: Sir, I actually wasn't at PRT very much. I was a relief driver and gunner. I did a lot of dismounted operations. I was involved in several combat operations. I witnessed vehicles hitting IEDs. I was involved in several firefights with the Taliban.

I spent a lot of time predominantly in forward operating base Wilson, and I did a lot of operations out of Zhari-Panjwai, which, as you know, is probably one of the most dangerous areas.

Mr. Corneliu Chisu: Were you with the artillery or with another unit?

Mr. Geoffry Logue: Sir, I had nothing to do with the artillery. Our job with the civil-military cooperation team was that basically we would go out and build schools and water wells, provide children and families with food and clothing, and provide tentage for the refugee camps.

Mr. Corneliu Chisu: When you finished your operation in July, you went to hospital, is that right?

Mr. Geoffry Logue: Yes, sir.

Mr. Corneliu Chisu: Were you in the Role 3 hospital in Kandahar?

Mr. Geoffry Logue: No, sir. I visited the Role 3 very briefly. I was diagnosed there with severe PTSD, but I felt abandoned.

Mr. Corneliu Chisu: Did somebody accompany you—

The Chair: I'm sorry, Mr. Chisu, your time has expired, and I do have to be fair to other committee members here.

Mr. Brahmi, *vous disposez de cinq minutes, s'il vous plaît.*

[*Translation*]

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

I will ask my questions in French.

I want to pick up on what you said, Mr. Logue, about not having any decompression time when you were given leave upon your return to Canada. That somewhat contradicts what other people have told the committee. We were assured that soldiers returning home from tours of duty systematically received decompression time and a reintegration period. How did you handle being left in such a state, without any decompression time?

You also said you were diagnosed with severe PTSD when you were in Afghanistan. Is that right? We were told that all soldiers returning home from Afghanistan had decompression time. Could you elaborate on your experience, given that it contradicts what the committee was previously told?

● (1625)

[*English*]

Mr. Geoffry Logue: Yes, sir. I didn't have a decompression. I was in a tent by myself at the Kandahar airfield. I didn't have any support. Nobody was with me.

[*Translation*]

Mr. Tarik Brahmi: Are you aware of others who were treated differently?

[*English*]

Mr. Geoffry Logue: Yes, sir. I've been told by other soldiers that they have gone through the same thing.

[*Translation*]

Mr. Tarik Brahmi: Okay.

I have a question for both of you about the use of service dogs. I am curious as to whether you had dogs as pets growing up? Could this special arrangement work for anyone, or must it call to mind a relationship you had with a dog as a child in order to work?

[*English*]

Mr. Geoffry Logue: Sir, yes, I grew up with three German Shepherd dogs. I have to say that I've always been a dog lover. It's in my nature to be around dogs.

I believe this program could work for anyone. Dogs do such amazing things. They're very loyal. They will react with you if you're having an emotional breakdown. If I have an emotional breakdown, my dog will disrupt me. She'll climb on me. She'll lick me, and it's very comforting. It relaxes me. It lowers my blood pressure. It allows me to be calm so I can function in normal life.

[*Translation*]

Mr. Tarik Brahmi: Mr. Nachuk, what would you say to that?

[*English*]

MCpl Bill Nachuk: I had a dog at a very young age, which I can barely even remember, so I personally don't believe it's just based on having a dog as a child.

I believe anyone who wants to get involved is a dog lover. For someone who doesn't like dogs, obviously this program isn't for them. You have to have that bond with a dog, but the dog also has to have that bond and be able to trust you as well. It's a mutual give-and-take, sir.

[*Translation*]

Mr. Tarik Brahmi: Very well.

Do I have another minute?

[*English*]

The Chair: You have about a minute and a half.

[*Translation*]

Mr. Tarik Brahmi: We've heard from witnesses about equine therapy, in other words, animal therapy using horses. Do you think, in your case, that type of therapy would be different? Could it be helpful even though a horse obviously can't always be by your side? Would you say having the animal with you at all times, 24 hours a day, is what you find reassuring? Would it be possible to develop another sense of security with a horse, say?

[*English*]

Mr. Geoffry Logue: Well, sir, having a dog.... I mean, it would be pretty hard to take a horse into a shopping mall.

Some hon. members: Oh, oh!

[*Translation*]

Mr. Tarik Brahmi: I was referring more to the relationship. Do you think this therapy depends on the connection you have with the animal or on the animal's presence 24 hours a day, something that would not be possible with a horse?

[*English*]

Mr. Geoffry Logue: Yes. Being present with the dog 24 hours a day gives you that 24-hour support. It's almost like counselling. You have that therapy with you all the time. Rather than going to see a psychologist, say, once a month, having the dog there all the time prevents chaos.

● (1630)

MCpl Bill Nachuk: For me, sir, I'm fortunate; a friend of mine actually has horses, so I've been exposed to both.

With the dog, it's a different relationship. The dog gives you a sense of protection. When we're walking through malls, it gives us that buffer zone and it gives us a sense of protection. The horse will give that sense of calmness and everything while you're with the horse, but the dog is different altogether because it gives you that sense of security. It helps you sleep as well, knowing the dog is right beside you. However, the horses do you give you that feel-good time in the moment.

The Chair: Thank you. Time has expired, and our time on the agenda for these two witnesses has expired as well.

Again, I want to thank you.

As a comment, the difference between dogs and horses is that you can take the dog into the mall; you're not going to be taking the horse into the mall with you. As somebody who has both dogs and horses —

Hon. John McKay: Except during Grey Cup week.

The Chair: But they won't let them into the Royal York.

Again, thank you so much, to the two of you, Bombardier Logue for bringing in Luna and Master Corporal Nachuk for bringing in Gambler. We really appreciate having both dogs here with us, and for your being so honest in sharing your personal experiences. We want to wish both of you all the best in your recovery.

Mr. Logue, I understand you're expecting a child fairly soon. Your wife was going to accompany you, but unfortunately couldn't travel because she is getting so long in her term. We want to wish you all the best with that, as well as a very merry Christmas as we're entering into the holiday season.

Again, thank you.

We're going to suspend briefly as we change witnesses. With that, the meeting is suspended.

● (1630)

(Pause)

● (1635)

The Chair: We're back in order. We'll continue with our study.

Joining us now as a witness is Colonel Rakesh Jetly from the Department of National Defence.

Colonel Jetly is a mental health adviser at the directorate of mental health. A medical officer, he was trained back in 1989, graduating from the U of T. He has a doctorate in medicine and served in a number of different units across the world, not just across Canada, including twice through Afghanistan. He has been on two separate missions there, commanding the mental health detachment of the Canadian-led Role 3 Multinational Medical Unit, which we were just talking about. He was promoted to lieutenant-colonel in 2007 and posted to Ottawa in 2008. He was appointed in 2011 to his current rank as senior psychiatrist and mental health adviser for the Canadian Forces Surgeon General.

With that, Colonel, I will turn it over to you for your opening comments.

● (1640)

Colonel Rakesh Jetly (Mental Health Advisor, Directorate of Mental Health, Department of National Defence): I want to begin by thanking you, Mr. Chair, for this opportunity to speak with you and the members of the committee.

I also want to thank you for your ongoing interest and support regarding the health of our men and women in uniform and our veterans. Your support is particularly important, as we know from history that interest in the mental health of veterans can fade soon after wars. We also know from history—our own research and that of our allies—that the full mental health impacts of difficult deployments will not be realized for years to come, if not decades.

As you are all aware, the Canadian armed forces have witnessed a decade that involved many important operations abroad, from Afghanistan to Haiti and Libya and beyond. All of these operations have placed heavy demands on the Canadian Forces and specifically on our personnel.

Now that we are coming down from this high operational tempo, we know that we will likely face challenges in providing health care services—particularly in mental health—to our returning men and women in uniform. I can assure you that the care of our ill and injured personnel is a top priority, and we recognize the unique circumstances we now find ourselves in.

I do not like to use terms like “bow wave” or “surge”, but there will likely be a steady increase in Canadian Forces members and veterans presenting symptoms of operational stress injuries in the coming years. For this reason, our clinics must remain prepared.

One of the imperatives we have is to ensure that the ill and injured have timely access to evidence-based care. I would like to expand on that last phrase, “timely access”. It's essential that when someone finds the courage to come forward and seek help, we stand ready to provide them with that support.

As I am sure members of this committee can understand, it can be difficult to come forward and seek assistance with operational stress injuries. For any number of personal reasons, the window of opportunity when someone feels comfortable to seek help can be limited. This is why we must maintain a well-resourced system that is agile and readily available, such as we currently have, with both primary care clinicians and well-trained mental health specialists. In addition, the flexibility to have clinicians in uniform, in the public service, and contractors is key to meeting the needs of our men and women.

The second imperative is evidence-based care. That is demanded of us by existing rules and regulation, but it is also a crucial element of any health system.

Simply put, our patients deserve the best that medicine has to offer: that is to say, treatment supported by sound clinical research. That is why we explicitly use treatments, whether medication or psychotherapy, that have been demonstrated to be both safe and effective in our patient population.

Evidence to support these treatments usually involves multiple large controlled studies that are published in peer-reviewed academic journals and are endorsed by international organizations such as the International Society for Traumatic Stress Studies. These studies cannot, of course, predict that 100% of people will fully respond to a treatment, but rather that for most people with a particular condition, this is the suggested approach. I can expand on this point later, if desired.

Not only is it best practice to use evidence-based treatment for everything from strep throat or lung cancer to post-traumatic stress disorder, it is also part of our governance. In his appearance before this committee, Colonel Scott McLeod described to you the function of our spectrum of care committee. Essentially, all services, treatments, or items made available to CF members must adhere to scientific principles of evidence-based medicine; be necessary for the purpose of maintaining health; be funded by at least one province or federal agency; benefit, sustain, or restore a serving member to an operationally effective or deployable status; and not be purely for experimental, research, or cosmetic purposes.

Now I will go to the topic that I believe you have asked me to discuss today: canine-assisted therapy, or, more specifically, psychiatric service dogs used by mentally ill people, including CF members and veterans suffering from a psychological injury.

As Colonel McLeod discussed, animal-assisted therapy does not currently fulfill the guidelines within our spectrum of care. Existing scientific literature on the topic, as well as information from our major allies, does not yet provide us with sufficient evidence to support the use of canine-assisted therapy in our approved treatment programs. I should also mention that our practices in this field are in line with those in the U.S. and U.K., which do not use canine-assisted therapy in their core treatments.

However, this does not mean that canine-assisted therapy has no value in support of the ill or the injured personnel. I, like many Canadians, watched the television program *W5* a few weeks ago and was moved by what I saw. These men appear to have benefited quite profoundly from the empathic relationship they have developed with these dogs, but without substantive research, one can only speculate as to what role these dogs play in the treatment of the ill and the injured. I feel it is a positive social relationship that affords a level of safety and comfort in previously unsafe and anxiety-filled situations.

● (1645)

One thing that I want to make clear is that many things that are good for one's health are not health care per se. Among the many determinants of health, the World Health Organization lists the following elements: where we live, the state of our environment, genetics, our income and education level, and our relationship with friends and family. The World Health Organization also states that these determinants all have considerable impacts on health, whereas the more commonly considered factors, such as access and use of health care services, often have less impact.

With this in mind, we can see how important housing, income, employment, and education are. These issues were all discussed at the Tri-National Military Mental Health Symposium in Washington this past September, and the importance of relationships has already been demonstrated by our DND and Veterans Affairs operational stress injury social support program.

In this regard, canine-assisted therapy can have a positive health impact in some patients in a non-clinical social way, but at this point there is not sufficient evidence to justify the inclusion of canine therapy in our spectrum of care. Our commitment is to provide our ill and injured CF members with the best health care possible, and that means a standard of care that is supported by therapies and practice that are scientifically proven and accepted.

Of course, both General Lawson and Rear-Admiral Smith told you we are committed to continually improving how we care for our own.

Thank you again for your interest in this very important issue, the care of our ill and injured forces members. I'd be happy to answer any questions.

The Chair: Thank you, Colonel. We're going to stick with five-minute rounds, even though we'll start over.

Mr. Harris, you have the floor.

Mr. Jack Harris: Thank you. I don't want to focus too much on the dog therapy issue, but it seems to me that aside from the clinical trials that might take years, an application of common sense might help some people.

Do you agree with that?

Col Rakesh Jetly: I'm not sure what you mean by common sense.

Mr. Jack Harris: As you say, it's pretty evident from watching the television program—which I didn't see, by the way—and listening to these gentlemen here today that there can be benefits from the knowledge that already exists about the positive aspects of a relationship between animals and humans, particularly in the case of PTSD-type symptoms.

Why wouldn't you provide that assistance to people when the benefits are obvious, even if it may take a long time and a lot of money to scientifically prove those benefits? Meanwhile people are hurting.

Col Rakesh Jetly: I think that decision lies elsewhere in the department than in health services.

Mr. Jack Harris: Thank you for your answer.

Are you as disturbed as some of us around this table to hear that Bombardier Logue was discharged from Afghanistan unaccompanied on a civilian aircraft back to Canada? Is that something that you would tolerate? I don't know if that happens to other injured soldiers from Afghanistan. Are you concerned about that?

Col Rakesh Jetly: I am concerned hearing that, yes. I was disturbed to hear that.

Mr. Jack Harris: Why do you think something like that could happen?

Col Rakesh Jetly: I can't speak for the specific case.

Normally a medical evacuation is a process that involves many people: communication, determining the route the person goes, whether they're accompanied or unaccompanied, whether it's a STRATEVAC, whether they go via Landstuhl, so I can't speak to the specifics of this case. In every case I was involved in, a lot of thought was given to how the person was repatriated.

Mr. Jack Harris: Colonel, you're the mental health expert in the forces. Presumably we all agree with the kind of high-minded notions of how people ought to be looked after that we heard from Colonel Lawson, from the chief medical personnel, and from the chief medical officer, but how is it that we keep hearing reports such as we just heard about the medical officer telling an individual if he can't look after himself, how can he look after a dog? Individual soldiers are afraid to come forward or afraid to admit to a relapse because they might lose their jobs; they are postponing seeking treatment until it's perhaps too late. How is it that these things continue to happen and we continue to hear about them?

● (1650)

Col Rakesh Jetly: I think it's an ongoing process of education. We continue to need to educate leadership, members, and our own medical personnel to continue to encourage people to come forward. We believe that the best chance people have of retaining their careers is to come forward for treatment.

Mr. Jack Harris: I have a report in front of me prepared by some civilian clinicians in Petawawa on April 25 of this year. It is complaining about the mental health services that are being offered. They say, for example, that “addictions are rampant and we lack medical addictions specialists”, that “clinicians do not have access to any formal clinical supervision”, that “too often psychiatric clinical diagnoses and recommended treatments and opinions are dismissed by the medical officers”. They say that “some medical officers believe clients should have six months' sobriety before they can participate in a residential treatment program” and that “some medical officers do not believe in PTSD diagnosis and some do not believe that PTSD is treatable”.

How can we offer the kind of support to soldiers that you say they deserve if we have medical officers behaving in this way? This comes from civilian clinicians who are trying to see that we get better treatment for our soldiers.

Col Rakesh Jetly: There have been major gains in Petawawa since that report was written.

Mr. Jack Harris: That was in April, sir.

Col Rakesh Jetly: Absolutely. I'm not sure what I....

Mr. Jack Harris: But that was April. We're talking six months ago.

Col Rakesh Jetly: Yes, and I said there have been major gains.

Mr. Jack Harris: So the medical officers have been removed and replaced?

Col Rakesh Jetly: No.

Mr. Jack Harris: Can you tell us what's happened?

Col Rakesh Jetly: There's been a change of leadership within the mental health clinic. There has been some hiring, some increased staffing. We've posted an experienced major psychiatrist in to help out also. The continued working between the mental health folks and the relationship between the primary care folks is being worked on with weekly meetings, regular meetings, education.

Mr. Jack Harris: Are you convinced that Petawawa is the only place where we have this kind of difficulty? We heard testimony just within the last hour that at Shilo, for example, there are similar types of situations in terms of relationships, and that things are perhaps getting worse. As a result of what was discovered or what became public in Petawawa, has there been a full national review of how problems are being dealt with on bases?

Col Rakesh Jetly: We have regular meetings, national meetings, and national meetings to which the senior medical officers come. I often speak at those. We continue to explain, understand, and educate on the perspectives from all the folks.

The Chair: Five minutes is up, and we have to keep moving on.

Mr. Norlock, it's your turn.

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

Through you to the witness, thank you for attending today.

I asked my confrere here what your qualifications are. You're a psychologist?

Col Rakesh Jetly: I'm a psychiatrist.

Mr. Rick Norlock: You're a psychiatrist. Okay. Thank you very much for that, because that's helpful to me.

A psychiatrist must, to provide proper care for his or her patients, follow the dictums of psychiatry—in other words, the scientific training that you would have undergone to get your Ph.D. and then other qualifications. I understand that for some time in the world of psychiatry, PTSD was not thought of as really a legitimate mental illness. Am I correct?

Col Rakesh Jetly: That's not entirely true. For thousands of years people have recognized the suffering of people post-conflict. There have been times—during World War I, for example—when people speculated that it might be a physical result of the shaken brain. I think people, especially in the health professions, have always recognized that people have suffered after wars. It's been called different things, but since 1980, which is the timeframe of most of our careers, the American Psychiatric Association coined “post-traumatic stress disorder” largely to explain the phenomenon of the group after.... Certainly my generation wouldn't be part of that.

Mr. Rick Norlock: Yes, but it's fairly new in the medical world.

Col Rakesh Jetly: Yes.

Mr. Rick Norlock: Thank you.

It is regarded to be a fairly new diagnosis.

● (1655)

Col Rakesh Jetly: Yes.

Mr. Rick Norlock: Thank you.

We live in a society, of course. We know that academia and science move very slowly. In order to accept certain regimes as beneficial to the patient, I think the rule is that we want to do no harm. I'm basing my question on that premise—do the patient no harm. We see and we just heard—in the medical world you would call it anecdotal—that canine therapy is helpful. We just heard from two people, and through them we heard about other cases. We've just been provided some documentation by one of the witnesses from his psychiatrist, who said, “For you, it's working”.

I also understand that in the United States there is a program called Paws for Purple Hearts, in which trained dogs are placed with military personnel suffering from PTSD, but once the patient is seen to be getting better, the dog's removed. I wonder if you are aware of this therapy and if there is a contemplation on the part of the CF, and in particular the medical side of the CF, to incorporate that or to think about incorporating that into therapy.

Col Rakesh Jetly: I'm aware of some of the programs that exist. There isn't a plan right now. I'm in communication with my U.S. and U.K. counterparts. The U.S. actually has been trying to fund studies for about five or six years. There's lots of money available; they haven't yet been able to find a group that can conduct the study itself with a primary investigator. My colleague there was saying, “Hey, if there's a primary investigator who you think can run a study, we're willing to fund it.”

I think we need to do the research before I can endorse this as a treatment. That said, if the organization, somewhere else within the office of chief of military personnel.... If people see this as a beneficial thing, nothing stops people from funding it.

Mr. Rick Norlock: You are aware of the program. Are you aware of the outcomes from the program?

Col Rakesh Jetly: The outcomes are sort of anecdotal and testimonial. I haven't seen any randomized control study for demonstrating its efficacy in targeting symptoms or reducing symptoms.

Mr. Rick Norlock: Thank you very much.

Do you think it worthy of the Canadian Forces to contemplate an actual regime or an actual application of canine therapy utilizing the people who are claiming that it is of benefit? Do you believe it appropriate for you to align yourselves with...? We had a witness in here, whose name I forget—Aiken, I think—and she works with 25 universities, studying....

What do you think forming a partnership such as that, with the assistance of other people in the regime of assisting people in the Canadian Forces, working with clinicians from various universities? Do you think it would be worthwhile to work with them to commence bringing in a program like Paws for Purple Hearts, or whatever we want to call it in Canada—we could give it a Canadian name, Canadianize it—and see how that program would work?

It seems to me that we live in an age where, yes, we look to people like you—a scientist, an expert in his field—but then we see an immediate need. We see a reluctance on the part of science and academia to treat people who are saying, “I'm getting some help here. I don't take medications that we know have side effects. I don't need to see the doctor. I don't need to bother the hospitals as much”, and this program is very cost-effective.

Do you see where we could encourage or entice CF, through this committee, to embark on such a thing?

Col Rakesh Jetly: I think it's worthy of study. I do think it's worthy of study. I mean—

Mr. Rick Norlock: Do you have a suggestion as to how we might do that?

The Chair: Mr. Norlock, your time has expired,

Colonel, you can give your response, if you have one.

Col Rakesh Jetly: Yes, I can give a brief response.

It's worthy of study. When you sit at my desk, you see many, many ideas come across it. There's equine therapy, agrotherapy, soapstone carving: the list is unbelievable. You could fill your entire agenda for the next 10 years reviewing every one of these. There are anecdotes that they have merit, but I think you have to put the research in place or else it's a slippery slope. I have no doubt these gentlemen have benefited from having these dogs, but we need to have the research.

The Chair: Thank you.

It's Mr. McKay's turn, but since he's out, we'll have to fit him in later. Technically we're in the first round, which is normally seven minutes. It is the Liberals' turn, but with Mr. McKay out, we'll put him in again in the five-minute round, just to keep them all five minutes.

Next on the list is Mr. Opitz, and then we'll come back to Madame Moore.

● (1700)

Mr. Ted Opitz (Etobicoke Centre, CPC): Colonel, thank you for being here today.

I did want to address something quickly. We were disturbed to hear the master corporal say that he was advised that if he had a relapse, then he was on the train out to release.

What's your view of that, sir?

Col Rakesh Jetly: Well, I don't think it's appropriate to say that to something. I don't think, on the whole issue of medical release and the idea of when somebody is fit to serve, that it's a simple issue of relapse or not.

In fact I've been championing—quoted, or misquoted, in *The Globe and Mail*—sending people back with post-traumatic stress, because to my mind, if people are better, it's a good-news story. If people recover fully from their illness and want to continue to serve, we champion that; that's a success story.

When it comes to medical and medical limitations and release items, what happens is there are a few reasons for it. One is the safety of the individual and one is the safety of the organization around them. If you have a bad back, a bad knee, visual problems, dizziness to such a point where there's risk, and it looks like recovery isn't going to occur, then permanent categories are assigned and those types of things. However, I've had soldiers who I felt were fit; we send them back, and as they go into Wainwright they start getting re-exposed to the scenarios and they realize, themselves, that it's difficult.

I don't think it's appropriate to say that if you have a relapse, you're out. I think if you've made a good recovery and you have a relapse, we have to re-evaluate your clinical history and your stability in terms of being able to remain in the forces.

Mr. Ted Opitz: Are you saying, then, that the underlying goal is to retain them—

Col Rakesh Jetly: Absolutely.

Mr. Ted Opitz: —and make sure that people carry on with their careers?

Col Rakesh Jetly: Absolutely.

Mr. Ted Opitz: They might even be in a different trade.

Col Rakesh Jetly: Yes, absolutely.

Mr. Ted Opitz: Okay.

Col Rakesh Jetly: It would be their own trade first. The goal is full recovery in their own trade, and if not that, in another trade. For every mental health professional, that's the first goal when they first sit with a patient.

Mr. Ted Opitz: So remustering is an option.

The CF has launched a pilot program of virtual reality therapy. It is an audiovisual technology developed in the U.S., of course, that allows patients to relive the situation and the traumatic event. Can you talk a little bit about that?

Col Rakesh Jetly: We're working on it.

Mr. Ted Opitz: So there's not a lot of data.

Col Rakesh Jetly: No. We're embracing it and we're exploring it. There are some American platforms. We are working right now on trying to Canadianize the software. I don't want Canadian soldiers to be exposed to American uniforms and Humvees. I want it to be our LAVs and where our folks are.

Mr. Ted Opitz: Understood.

Col Rakesh Jetly: We're on the way.

Mr. Ted Opitz: You spent time in a Role 3 hospital in Kandahar and you've dealt with various operational stress injuries throughout. You've witnessed them. You've treated them. Can you tell us about some of your experiences there and the differences you found in treatment? One size does not fit all for an operational stress injury.

Col Rakesh Jetly: Absolutely.

Mr. Ted Opitz: You have variances.

Col Rakesh Jetly: Operational stress injury is a paradigm. It's a non-clinical term. Treating PTSD is different from treating depression and is different from treating panic disorder.

What I have found, as somebody who's served 20 years, is that nothing is perfect, but what I've found really impressive is how much people are talking about it and how many people are coming forward in the Role 3s, right in theatre. They are describing their differences and the difficulties they're having. Chain of command will walk in with a soldier and say, “I'm a little bit worried about how this corporal or master corporal is doing, doc. Can you check him out?” That's the main thing I've noticed.

You know, when we deployed to Rwanda, there was absolutely zero mental health support. By the time we reached Kandahar, we had psychiatrists, social workers, and mental health nurses. We have a full psychiatric team. To a psychiatrist, that's a dramatic difference.

Even in theatre, our first aim is to help the soldier complete his or her task and to complete his or her tour. That's very important for most soldiers, so we do our best and work in a confidential way with the chain of command to try to keep people in. Sometimes it's a respite inside the airfield for a couple of weeks and learning some grounding techniques, much like you heard about what the dogs do, to stay grounded and not get caught up in the hypervigilance and arousal and those things. Our first aim, even in theatre, is to help people complete their tours.

● (1705)

Mr. Ted Opitz: You talked about education being a factor in being able to treat soldiers affected by the various forms of OSIs. In my own experience, dealing with my own soldiers, it was a constant round of ensuring that they would self-identify and come out and feel secure about doing that. I think security is paramount in giving a soldier the confidence to actually self-identify and seek that treatment.

Now, in cases where you may find that the educational process has not exactly sunk in and they're not actually reacting to somebody effectively, as Mr. Harris described in Petawawa, what are some of the things you can do, in your field, and that the chain of command can do, to rectify that situation in terms of education and how you sort out—

The Chair: Mr. Opitz, your time has expired.

Colonel, you can respond.

Col Rakesh Jetly: Sure. What we're requiring is an attitudinal shift. Quite often, I find that people talk forever about the middle ranks—the junior officers and NCMs, the master corporals and sergeants—saying that they're the ones who don't get it. However, I think they also have the most difficult jobs.

I think it's very easy for a general or a colonel to say that all of the guys need this, but if you're running a small section that has three people responsible for driving people back and forth from Petawawa, and two of them are sick, it gets very difficult. I think the junior leaders have the hardest job. I think they have to decide when someone needs a pat on the back, when somebody needs time off to go deal with difficulties, and when someone need a nudge, so I empathize with the junior leaders. I think that's probably the hardest job.

The Chair: Thank you.

We're going to keep on.

[*Translation*]

Ms. Moore, you have the floor.

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

I would like to discuss the labour shortage in the mental health field. Since 2010, the number of workers has not risen past 380, and yet the goal is 447 practitioners. What's more, the ombudsman's report describes the burnout plaguing caregivers.

Clearly, providing mental health support to military members is not necessarily easy. Indeed, we're hearing accounts of difficult experiences. This can weigh quite heavily on health professionals as well. What steps do you take to make sure your health professionals —your nurses and doctors— don't end up burning out? Do you assess them? What do you do to make sure you aren't making them sick, as well, as they try to care for everyone, despite the lack of staff?

[*English*]

Col Rakesh Jetly: That's a good question. Thank you.

Care of our own is certainly a very important issue within health services and certainly within mental health, and the risk of burnout is something that we certainly do recognize. Mental health professionals are passionate and dedicated.

It has been a while since I've run a clinic—it has been a few years —but there were some things I did in Halifax, such as, for example, no lunchtime meetings. At lunchtime, take your break. Everybody calls a last-minute rush meeting and calls it lunch.... Also, go home at four o'clock; I may still be here, but you go home. There were those kinds of practical things.

Also, training is a big issue—training, understanding your boundaries, understanding your limitations, and being good at what you do. We run regular training in the leading-edge psychotherapies of cognitive processing therapy, EMDR, and those kinds of things. We offer people clinical supervision when they're stuck with difficult cases so they can consult an expert. We have four mandates, for example, within the operational trauma and stress support centres—assessment, treatment, outreach, and research—so we rotate your job so that you're not always sitting three feet from people who are suffering. Sometimes you're doing some assessments, sometimes you're getting out of the office to teach.

There are a lot of things in place to protect people from themselves, almost, from burning themselves out and continuing to go through things.

[*Translation*]

Ms. Christine Moore: The Directorate of Mental Health where you currently work has a staff shortage rate of 41%. That means nearly half of your positions are vacant. I'd like to know how the directorate fulfills its mandate if all the positions are not staffed. What projects and programs are on hold because of this staff shortage? What can't you do right now because you are short on human resources?

● (1710)

[*English*]

Col Rakesh Jetly: I missed your numbers. How many below are you saying we are?

[*Translation*]

Ms. Christine Moore: According to the statistics I have, 41% of the positions within the Directorate of Mental Health are vacant.

[*English*]

Col Rakesh Jetly: That's not true.

Ms. Christine Moore: Okay.

Col Rakesh Jetly: Did you say 41% or 41 individuals?

[*Translation*]

Ms. Christine Moore: It's 41%.

[*English*]

Col Rakesh Jetly: No. We have 370 or so of some 400 or so people. It's not 41%. I'm not sure what.... I might have it here. It changes every day....

Yes: we have 379 filled of 447.

[*Translation*]

Ms. Christine Moore: Regardless, there must still be things you can't do because those positions aren't staffed.

[*English*]

Col Rakesh Jetly: It depends. That's a good question.

We're working very, very hard to fill the positions. Your colleague asked about virtual reality therapy. We're bringing in interesting, innovative therapies. Again, the idea really is to impress upon the potential employees in our clinics that we have leading-edge clinics with good team environments, so we're doing that. We've embarked on positive relationships and are moving forward with the Canadian Psychiatric Association and the Canadian Psychological Association in terms of the membership becoming more educated about the programs we have.

In terms of whether there are things we're not doing, one of the things that has to be kept in mind is that the number we came up with 10 years ago—or I could say that “they” came up with—was basically a best guess. A lot of people ask, “Is 447 enough?” I'll say that I don't know, because we've never been at 447. There's not a health care system in the world that doesn't feel overworked and doesn't feel that more staff could help; you can go to any hospital in the country.

We're keeping up with the tide. We're seeing patients. We prioritize the lists. We're able to do things and post our uniformed people into places. We've upskilled. We've increased Petawawa, Valcartier, and Gagetown; we've created OTSSCs in those clinics. We've moved people. We're doing the most we can.

Ms. Christine Moore: May I have just a short comment, Chair? I will not ask a question.

The Chair: The time you have has expired, Madame Moore. You're just over.

[*Translation*]

Ms. Christine Moore: I really wanted to know whether any programs or projects were not being administered because of the lack of staff. I would very much appreciate it if you could get back to me in writing as to whether any programs are pending.

[*English*]

The Chair: If you can get back about that, it would be great.

I'm going to continue moving on.

Ms. Gallant, you have the floor.

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

One of our prior witnesses today said he was interested in participating in a pilot project involving service dogs, but when he told his superiors he wanted to do so, he was highly discouraged from doing so.

I'm familiar with that pilot project. Were you involved at all with the forces in that realm at the time of the study?

Col Rakesh Jetly: I think that was the Director Casualty Support Management program, the DCSM, Colonel Blais' folks.

Mrs. Cheryl Gallant: If there were to be such a pilot project initiated again, how would the organization conducting the study or the project go about finding the soldiers who would be interested in participating—not veterans, but actual service soldiers?

Col Rakesh Jetly: There's a whole process of doing research, and part of the research is having a research ethics board by a university approve it. Part of it would be how you would recruit people.

I think in a study like this it would be very difficult, because you would have biases, and if you have dog-friendly people who take the study and do well, the people reviewing it later on might say there's a bias in the people you selected.

I can't speak to how I would design the experiment per se, but what you would have to do is randomize people. You would have to give some people dogs, you would have to compare it to regular therapy, and you would have to control for all of the factors that are going on in people's lives. It's complicated.

● (1715)

Mrs. Cheryl Gallant: I wasn't referring to a study. It was a pilot project in which they had service dogs that were trained to help.

Col Rakesh Jetly: I wouldn't be the person to speak to about that.

Mrs. Cheryl Gallant: Okay.

As a mental health adviser, are you familiar with any biological chemicals that are released just prior to or during an episode by somebody who is suffering from PTSD? Are there pheromones?

Col Rakesh Jetly: There are many. A cortisol surge usually occurs.

Mrs. Cheryl Gallant: Is this something perhaps an animal can detect through its olfactory organs?

Col Rakesh Jetly: I would have no idea. It's not a pheromone. It's a central brain chemical. I don't know if dogs can smell cortisol.

Mrs. Cheryl Gallant: So there is a possibility there are chemicals released that could be sensed, and this could be why they can sense a seizure or an episode coming on, but that is for the scientists to determine. Thank you.

My dear friend Mr. Harris was mentioning Canadian Forces Base Petawawa. Do you know if the current requirement of psychiatrists has been met?

Col Rakesh Jetly: Petawawa is actually overmanned now. They have 4.8 psychiatrists for a population of about 6,000, and there probably isn't a community anywhere in the world that has that many psychiatrists for 6,000 people.

There's not any civilian population, so we're doing very well there in recruiting and interest and passion, and soldiers are getting care on a very timely basis now.

Mrs. Cheryl Gallant: That is remarkable, because for a catchment area of 100,000 people, I believe there are only two psychiatrists available for the civilians.

There was quite a bit of concern when the satellite office to which our soldiers had been bused to in Ottawa was closed, and we lost the two psychologists. Can you tell me whether or not those two psychologists, or the two persons or the weekly hours, are now being filled at Petawawa?

Col Rakesh Jetly: Yes. The psychologists themselves have moved to continue offering services in Petawawa. Unfortunately, I think it might have been our fault in the way we communicated it, but it was actually a good-news story.

We were closing the satellite that was requiring soldiers to travel away from their families for two hours, just like our friends from Shilo travelling to Winnipeg. The satellite closed. That allowed the staffing in the Ottawa OTSSC to increase, so soldiers are getting their care in the Warrior Support Centre in Petawawa.

Mrs. Cheryl Gallant: When I was visiting CFB Petawawa with the veterans affairs committee, which held a meeting there, we met a soldier from Afghanistan who had been home for a year and still hadn't seen a psychiatrist. By some miracle, that day he was going to have his first appointment.

Can you bring me up to date on what the wait times are for a crisis situation? How long does a soldier who is in crisis have to wait to see a psychiatrist, and how long is it for a less critical situation?

Col Rakesh Jetly: Do you mean for Petawawa specifically?

Mrs. Cheryl Gallant: Yes.

Col Rakesh Jetly: I might have it in front of me.

In terms of the way our systems are set up for crises, we have the psychosocial services, which wouldn't involve a psychiatrist but another mental health professional. That would occur in the same day—to see a professional, not necessarily a psychiatrist.

Psychiatrist wait times in Petawawa for a routine case are now 16 days from referral.

Mrs. Cheryl Gallant: It's 16 days from—

The Chair: Ms. Gallant—

Mrs. Cheryl Gallant: Just one more.

The Chair: Your time has expired. I am sorry.

Technically we're supposed to suspend at a quarter after. I know there are some burning questions here, so to be fair, I'm going to do two four-minute questions, one for the NDP and one for the government.

With that, Mr. Harris—Dan Harris—you have the floor. I am going to keep it tight to four minutes. If you want to pass it off, you can.

Then I'll come back to you, Mr. Alexander.

Mr. Dan Harris (Scarborough Southwest, NDP): Thank you very much, Mr. Chair. There are too many Harrises.

Colonel, thank you for the testimony. I want to follow up on the other Mr. Harris' questions. You mentioned there have been significant improvements in Petawawa in the last six months, through hiring and changes to leadership.

Have there been any measurables put in place on the changes to ensure that what has been in place will lead to greater success?

● (1720)

Col Rakesh Jetly: That's a great question.

The ultimate measure that we're working on right now is to put in place an outcome management system, to look in a systematic way at the actual clinical progress that people are making. We're working on that.

Today we were talking about the same thing—

Mr. Dan Harris: Great.

Is there anything—

Col Rakesh Jetly: Wait times and things like that are the hard data we are using right now.

Mr. Dan Harris: Is there anything written that you could perhaps provide to the committee?

Col Rakesh Jetly: Do you mean changes in—

Mr. Dan Harris: If there's a plan in place and you could provide it, that would be great.

Col Rakesh Jetly: Sorry; do you mean for outcome measures or for the changes in Petawawa?

Mr. Dan Harris: Both, if you have them.

Col Rakesh Jetly: Sure.

Mr. Dan Harris: You mentioned that there are regular national meetings with medical officers. Mr. Harris was asking a question on whether problems have been identified at other bases. Have you put anything in place for those meetings to ensure problems that existed at Petawawa haven't happened elsewhere?

Col Rakesh Jetly: There is a free discussion that occurs. All of our clinicians have different training, different experiences, and those kinds of things. We have uniformed clinicians and civilian clinicians. The way we work is that we bring people in to talk about the issues they have at hand. Sometimes it might be disciplinary issues with people who have mental health issues. In all of these areas we will discuss the clinical approach and how we, as medical folks, can best serve our patients.

Mr. Dan Harris: I would hope that perhaps in that process there might be a bit more prompting. Folks generally won't mention when there are mistakes and things going wrong without some specific prompting.

Col Rakesh Jetly: You would be surprised. If you close the door —

Mr. Dan Harris: I'm going to pass the rest of my time on to my colleagues to continue.

Thank you.

The Chair: We can have Madame Moore or Mr. Harris.

Mr. Jack Harris: Thank you, Chair.

Can I clarify something, Colonel?

I know Mr. Norlock was suggesting that PTSD was new, and I suppose in the grand scheme of things and in the course of medical history, it's new. As you mentioned, in your generation of medical professionals PTSD has been recognized since the 1980s as part of the *Diagnostic and Statistical Manual of Mental Disorders*—III, IV, and 5 anyway.

This is something that has been available throughout the last 10 or 15 years in military practices. Am I correct with that?

Col Rakesh Jetly: Yes.

Mr. Jack Harris: The medical officers are saying they don't believe that PTSD can be treated, for example.

That's an error, isn't it?

Col Rakesh Jetly: Absolutely.

Mr. Jack Harris: I was interested in the discussion. You were speaking as a medical professional and you are trying to evaluate this canine program, as opposed to drugs or anything else. Particular drugs don't work for everybody, either; some are successful with patient A, but not patient B.

I liked your notion that it may take a period of time to do a study, but that perhaps this is something that some other branch—the chief of personnel—could investigate, as opposed to a "medical therapy".

That seems to make sense to me. Is that what you were suggesting?

Col Rakesh Jetly: Yes. I think for a health service to be put into place, we have to have evidence on the spectrum of care.

Mr. Jack Harris: I understand.

Thank you.

The Chair: Time has expired.

As I said earlier—Mr. McKay had left the room—the Liberals are allowed one intervention. We are running short on time, though, and I know that Mr. Alexander hasn't had a chance. We do have one bit of committee business, so if the committee is willing, we're going to extend a little bit longer.

With that, Mr. McKay, you have the floor, and then I'll go to Mr. Alexander. We're doing four minutes.

Hon. John McKay: Thank you, Chair, for the consideration.

I apologize for being away while you were speaking, sir.

I once went to a fascinating lecture by an emergency room physician from New York who was lecturing a bunch of U.S. state governors and Canadian premiers about evidence-based medicine. He talked about how evidence-based medicine killed George Washington, because at the time bloodletting was considered to be an appropriate therapy.

He then went through a whole bunch of routine therapies that are given by the medical profession and he disaggregated the evidence on whether or not they worked. That went from mammograms to prostate...the whole routine, and basically it was a bit of an eye-opener for me as a politician, with no medical background, that some of this evidence base is something less than full empirical evidence.

When our previous witness reacted rather strongly to evidence, he reacted as a lay person would react, saying, "Well, I don't know about evidence, but I know that this works for me."

I apologize if this has already been covered, but if a number of your soldiers are saying that this is really working for them, what are the forces doing to develop an empirical metric that may actually result in this becoming an appropriate therapy, or not, as the case may be? I don't understand.

● (1725)

Col Rakesh Jetly: Your point is well taken. Is all the evidence out there that we quote perfect? It's probably not, and that's why things change. The thing that changes what we do is the evidence.

For years and years people thought that esophageal and duodenal ulcers were a weakening in the lining, but then they found out there is a bacterium that causes them, and now they're treated with antibiotics. It took evidence to change the previous evidence.

Hon. John McKay: So what are we doing to gather evidence about what these soldiers are saying?

Col Rakesh Jetly: We're not doing anything for this. We're monitoring what our U.S. counterparts are doing and what other studies are doing.

Hon. John McKay: Isn't that the issue, though? The CF has quite a number—certainly in the thousands—of people coming in with PTSD and various other OSI ailments, and a significant percentage of those folks are saying, "This works for me", so why aren't the forces following up on that?

Col Rakesh Jetly: We cannot study every proposed treatment for every illness that comes forward. We're simply not big enough to do that.

We are part of an organization called CIMVHR, which is an research institute to which 25 or more universities have signed on. I'm not sure if you were out when I spoke about my U.S. colleague, who is saying that he has funding and he has tried for years to find a principal investigator to study canine therapy specifically, and things haven't gotten off the ground. I have said that in partnership, if people are interested, research is possible, but the list of proposed treatments that come across my desk on a regular basis is endless.

Hon. John McKay: Out in Vancouver there was a self-help group involving some Vancouver-based soldiers and the University of British Columbia. They got funding from everybody except the forces. Finally, to the credit of the Minister of National Defence minister and the Veterans Affairs minister, they actually did fund it. I don't know what it is that pushes that over the edge.

Anyway, my time is up.

Thank you, sir.

The Chair: Thank you, Mr. McKay.

Mr. Alexander, the last four minutes are yours.

Mr. Chris Alexander (Ajax—Pickering, CPC): Thanks very much, Colonel Jetly, and thanks for your emphasis on the science and the clinical proof that needs to be behind treatment.

We all understand it is very difficult to decide where to invest, especially when therapies are emerging. We do support you in your drive to be as scientifically grounded as any mental health professionals in the world, certainly among militaries. That was among the forms of praise we saw for Canada at the tri-national meeting we were at together in Washington.

I have two questions for you, and they are related. The first is relevant to the two witnesses we had before you with their very personal stories from Afghanistan and their very strong conviction that working with dogs has helped them when other, perhaps more clinically validated therapies, haven't helped as quickly as they would like.

Tell us what you are doing and what research and practice are prompting you to do for those cases in which victims of PTSD don't respond to therapy. We all know already from our study that six to 12 sessions with the right therapist, in the right conditions, can have a positive impact for many, maybe even the majority of cases, but in some cases they don't. Where do you take people after that?

● (1730)

Col Rakesh Jetly: I think there are two issues. There are people who respond perfectly by the book as per the evidence, and after 12 or 13 sessions they get well. However, when I was in the U.S. last week, they were talking about a large centre where their completion rate for the therapy was only 18%. Everybody else was dropping out from the rigorously evidence-based treatments, so we've already adapted our therapies to slow things down a little and give people more time for stabilization and those kinds of things.

There are people who respond very well initially; luckily, people are coming forward more than ever. There are people who have a partial response, and these are people we hope stay in the military, although maybe not in their profession. Then there's a group that doesn't respond well, so we try multiple different treatments.

Other than that, I think the important thing that we do in conjunction with Veterans Affairs is the transition toward civilian life. There are the JPSUs and case management. As we're looking at spending some of the additional funds, we're thinking about occupational therapy coming back into the fold for us beyond the two that we have to help people with vocational rehab transition. These are young veterans; these are people in their twenties and thirties with young families, so we want to give them the best transition to life.

Mr. Chris Alexander: Thank you.

The second question is about the other end of the spectrum, the soldiers who haven't deployed. Maybe they have recently been recruited, haven't been on a mission, aren't yet suffering from PTSD. What are we doing to build the resilience that we know can help prevent this condition?

Some militaries, notably the Israeli, but others as well, seem to have invested heavily in researching and in building.

Col Rakesh Jetly: A lot of our allies and we in particular have developed different types of resiliency training. The idea from resilience isn't to have a shield against stress; it's more that stress is inevitable in life and in deployment, and you can bounce back, so we have a cradle-to-grave, if you will, road to mental readiness program in place that starts in basic training.

We're conducting a research study in basic training in biology as well, looking at people's stress and their epigenetic changes in basic training to see if it benefits throughout their career cycle. Leaders, junior leaders, and members themselves get it. We enhance it during deployment, in the pre-deployment phase, in post-deployment, and in the part in TLD that people receive. There is a family component of it as well that families are receiving at the same time.

It's a program that has drawn a lot of international attention. A NATO group is looking at similar training across NATO nations, and they have adapted the Canadian model, with our American colleagues in the same room. Police forces are interested, and we have just started with the Royal Canadian Mounted Police in New Brunswick to help train some of their people to give it themselves. It's a huge area.

I think when we talked about 1980 to 1990 we were looking at trying to identify people who were sick. We've made that shift in the scientific community to say the vast majority of people exposed to trauma don't get ill, so let's try to see what helps people cope and let's try to instill that in people.

The Chair: Thank you. Our time has expired.

Colonel, I want to give you a little bit of homework. I had a few questions, but I'm just going to give them to you and you can respond to them in writing, because we are out of time. The analysts will provide them to you in writing as well so that you'll have them.

Essentially, our earlier witnesses talked about suicide, so I am interested in the issue of suicide prevention from the standpoint of what we are doing to train our officers, particularly in our academic programs at the Royal Military College, Saint-Jean, and others, to deal with suicide prevention within their units.

Also, what are some of the results from the Canadian Forces Expert Panel on Suicide Prevention? You reviewed that study, and we want to get some information on it.

Also, we never touched on some of the brain injuries that happen. We've been concentrating on the mental health issues, but there are also the brain injury issues. There have been some reports provided on brain injury, what type of trauma it is, and how you deal with that within the Canadian Forces.

With that, I thank you for your testimony today. I will provide those questions to you in writing so that you have them and can respond in a very timely manner.

We are going to suspend. As a committee, we have one piece of business that we have to deal with. We need to clear the room, so I'll ask anyone who is not directly tied to any committee members here to leave.

With that, we are suspended for a brief couple of minutes so we can go in camera.

[*Proceedings continue in camera*]

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

SPEAKER'S PERMISSION

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

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

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

PERMISSION DU PRÉSIDENT

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

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