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Chair

Mr. James Bezan

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● (1615)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): I'm going to call this meeting to order.

We're going to be interrupted here in about half an hour for votes, so we will to try to get as much testimony in as possible.

With that, I'm going to ask our witnesses to keep their opening comments as succinct as possible. If you have recommendations to make, make sure you put those on the record. Then we'll go to a five-minute round of questioning by members and see how far we can get.

Appearing today we have Zul Merali, the president and CEO of the University of Ottawa Institute of Mental Health Research; from the Mental Health Commission of Canada, we have Louise Bradley, president and CEO; from the Canadian Psychiatric Association, we have Don Richardson, consultant psychiatrist; and from the Mood Disorders Society of Canada, we have Phil Upshall, national executive director.

We welcome all of you to the committee and thank you for helping us with our study on the care of our ill and injured Canadian Forces members.

With that, I'm going to ask Mr. Upshall if he could lead off the testimony.

Mr. Phil Upshall (National Executive Director, Mood Disorders Society of Canada): Thank you, Mr. Chair and members. We certainly appreciate the opportunity to have the time we do today to present to you some issues that I think are worthy of your indulgence. With that I'll give you a very brief background on the Mood Disorders Society of Canada.

We're a virtual organization. We work with families and people living with mood disorders, depression in particular. We have a very active website, and we're very involved in trying to get help for people who need it. We're also a collaborating organization that works very closely with the Mental Health Commission of Canada, the Royal Ottawa Institute of Mental Health Research, and all of the professional medical associations.

Our interest in this particular subject flows from the fact that a few years ago we had a research study undertaken that showed that mental health care was really a stigmatized issue within the health care profession itself. As we delved into that, we found that our health care providers required better education. As a result we developed an anti-stigma continuing education course for Canada's 76,000 family physicians.

We did that because over 85% of Canadians suffering from a mental illness and anyone needing any form of health care go to their primary health care physician first. So we felt if we could get to them first and get them to change their mind about how to deal with people with mental illnesses, it would be of benefit. It has turned out to be of benefit.

Shortly thereafter, along with the commission and the institute, we held a meeting at the War Museum called “Out of Sight, Not Out of Mind” dealing particularly with PTSD. I think some of you were at that meeting. I'll read you the recommendations that came out of it so that they're in the record.

The recommendations presented in the report are aimed at reducing and eventually eliminating the stigma surrounding PTSD; enhancing the knowledge of physicians on the identification and treatment of PTSD, including information on available resources and support networks; educating PTSD sufferers and their families on available support networks and resources to improve their accessibility, the last of which is a huge issue; promoting ongoing collaboration and dialogue amongst government and leaders in the field of mental illness specializing in PTSD, including health care providers, innovators, and researchers; improving educational platforms for children and parents suffering from PTSD; and enhancing research efforts to further understand triggers and optimal treatments of PTSD.

Those recommendations led to our brief to the parliamentary committee, the pre-budget brief that we presented two years ago, which resulted in the funding of the Canadian Depression Research Intervention Network. That funding of $5.2 million was announced last year and we are currently finalizing the development of the agreements with Health Canada. The context of that is that two of the issues that the Government of Canada asked us to specifically attend to were PTSD and suicide. They are both high on our radar screen.

The budget announcement also provided $200,000 for the Mood Disorders Society of Canada to develop, in collaboration with the commission and the institute and the Canadian Medical Association and others, a continuing medical education program directed at Canada's 76,000 family doctors, developing the theory of stigma but also advising them on how better to treat PTSD.

The expert panel is just being put together, but it will be a panel of significant scientific and clinical knowledge.

I think I should stop there, because that's five minutes. I have a bunch of other notes I'd be happy to reference. Perhaps what I could do, if I might, is to read into the record the focus of the Canadian Depression Research and Intervention Network.

Our focus in relation to prevention is that CDRIN is concerned with the identification and development of policy- and program-based initiatives that contribute to reduced incident rates for depression and depression-related suicide and PTSD. In relation to treatment, CDRIN will focus on developing improved approaches and protocols for the screening and engagement, diagnosis, treatment, and reintegration of people experiencing depression and PTSD. So our continuing medical education, CME, regarding PTSD is ongoing.

● (1620)

Our project manager, Richard Chenier, is here. The reason I point him out is that he was an RCMP officer who, in the early seventies, saw his partner shot to death in front of him. He became an alcoholic and was rousted from the RCMP. He had some significant difficulties in life, recovered as best he could, became a deputy minister in the government of Manitoba, had some other significant difficulties, became a child and youth mental health expert in northern Ontario and subsequently started to work with the Mood Disorders Society of Canada.

As he worked with us it became clear that Richard was an exceptional person, but there was something more. It was only five years ago that he was identified as suffering from PTSD, and only three years ago did he stop dreaming about his partner being shot to death and his brains being blown all over him, as he did for 35 or 40 years, however long that was.

That's the balance of my brief, Mr. Chair, and I'll turn it over to Louise Bradley.

The Chair: Thank you.

Ms. Bradley.

Ms. Louise Bradley (President and Chief Executive Officer, Mental Health Commission of Canada): Thank you very much, Mr. Chair, and members of the committee, for this opportunity to speak this afternoon. As you've heard, I'm the president and CEO of the Mental Health Commission of Canada. We're a little more than halfway through the mandate that takes us up to 2017. I'll speak a little bit more about that mandate in a moment.

I just want to reference that in my career as a registered nurse, I was also head of a very large hospital in Edmonton. We had members of the Canadian Forces come back to us, where they received the very best of care—the very best of physical care. At the time, I worried about the psychological part of it.

In addition to that, I was happy that a year later I was also a part of the opening of the OSI clinic in Edmonton. I won't regale you with the stories I've heard. I'm sure you have heard many such stories from people who have had to access OSI clinics across the country.

The commission last year released Canada's first-ever mental health strategy. Within the strategy we've identified many recommendations that look at improving the lives of people with mental illness in all spheres across the country. Certainly, we have a real interest in what happens to people with PTSD, and of course, their families.

The commission very much works in a collaborative fashion. We're happy to collaborate with CDRIN, which my colleague Mr. Upshall just referenced. We have a number of other components in the strategy. I would be happy to provide you with copies, should any of you wish.

We've also done a number of projects with the Canadian Forces. You've heard testimony from Lieutenant-Colonel Stéphane Grenier. We very much acknowledge the peer support work he has done, and the commission has certainly benefited from his expertise.

I mentioned the families. This is really critical, and it's something I want to make you aware of. The commission, within the next short while, a number of months, will be releasing national guidelines for family caregivers. This will hold recommendations on types of services and supports for people looking after people with mental illnesses. The principles within the document will certainly be helpful in matters of PTSD as well.

The other item we are working on with the Department of National Defence is our stigma program. I'm sure you've heard much about the impact that stigma and discrimination have on people with PTSD. Again, I read the testimony from Stéphane Grenier, and he acknowledged the difficulties he and his colleagues have had because of this serious issue.

The commission has decided to take a novel approach to stigma. We're evaluating programs to see what works. We're very happy to report that the road to mental readiness program is looked upon quite highly and is regarded quite well. The outcomes of that evaluation are also available.

I have some final comments in terms of health human resources. Mental health has been referred to as the orphan of the health care system, and this still very much holds firm today. There are a number of items within the strategy and elsewhere in the work of the commission that speak to ways of managing this and of helping out with it.

We've recently done a great deal of work on mental health in the workplace. Of course, the workplace is everywhere; it's not just an office building. In particular for the military, that definition expands considerably. And we are embarking on suicide prevention strategies.

● (1625)

With that, our recommendations are, really, to access the work that we have done as a catalyst throughout the country. We look forward to any report and recommendations that this committee will develop and would be very, very happy to provide any kind of support and assistance that we can with the development or dissemination of that important report with our knowledge exchange centre, and the results that will come out of it at the end.

I thank you most kindly.

The Chair: Thank you.

Dr. Merali.

Dr. Zul Merali (President and Chief Executive Officer, University of Ottawa Institute of Mental Health Research, As an Individual): Thank you very much.

Good afternoon and thank you for giving us the opportunity to express our views on a very critical issue facing Canadians.

As you have heard, I'm the president and CEO of the University of Ottawa Institute of Mental Health Research, but I'm also the scientific director for the Canadian Depression Research Intervention Network, called CDRIN. The conceptual framework for CDRIN, as a pan-Canadian network, was transitioned into a real entity with the infusion of $5.2 million by the federal government in the previous budget, as Dr. Upshall mentioned. The mission of CDRIN, as endorsed by the government, is to focus on depression, but also on related issues that include post-traumatic stress disorder and suicide.

We are in the process of building this network, with the close collaboration with the Mental Health Commission of Canada and the Mood Disorders Society of Canada. We will bring the best minds together from coast to coast to coast.

Excellence in research is really what's going to take us to the next step. We have already enrolled over 150 of the brightest minds into this network. By working together collaboratively, rather than competitively, we hope to transform how we prevent, how we detect, and how we treat mental illnesses. Through the network approach, we hope to make major advances brought to the field as they have done through a network approach for cancer and cardiac health.

We would like to recommend that the CDRIN serve the Government of Canada and the Department of National Defence to help find research-informed solutions for post-traumatic stress disorder, suicide prevention, and depression.

We would also like to recommend that more attention be focused on understanding brain circuits contributing to mental illness. As you may have heard, the Obama government has recently launched a major approach on this front, a major assault, and has declared the brain as the next frontier. We are all part of the same wave and we need to be doing what's essential for Canadians.

We would like to recommend also that more attention be paid to sleep disturbances, that are so tightly associated with post-traumatic stress disorder. For a full recovery, if you're not able to address those issues, it's very difficult.

Finally, we would like to recommend that the government consider establishing research chairs as a way to bridge the military and the armed uniform services with civilian research enterprises. This is one way we can enhance the collaborative effort to really solve the problem that is not just facing the people in uniform but, really, facing the country at large.

I'm going to stop there and would be happy to answer any questions that you may have.

Thank you.

● (1630)

The Chair: Thank you very much.

Dr. Richardson.

Dr. Don Richardson (Consultant Psychiatrist, Canadian Psychiatric Association): Thank you.

Mr. Chair, I'd like to thank you for this opportunity to speak with you and the members of the committee. The CPA shares your interests regarding the mental health needs of the men and women in uniform and the veteran population.

As clinicians and researchers, we have seen advances in our understanding of the effects of psychological trauma on both the mind and body. Evidence has shown that PTSD can be treated with evidence-based treatments, including pharmacotherapy and psychotherapy, which is talking therapy.

Unfortunately, treatment outcome research has consistently shown that military-related PTSD does not respond to treatment as well as civilian PTSD. The exact reason is unknown. However, it might be related to the type of trauma or the higher rates of co-morbidity seen in military-related PTSD.

Co-morbidity is when PTSD and other psychiatric illnesses or substance abuse occur together. Military-related PTSD rarely occurs in isolation, but often occurs with other psychiatric illnesses, including major depressive disorder, other anxiety disorders, and addictions. Therefore, significant work is still needed to better understand the poor treatment response in the military and veteran population and how to match the various treatment modalities to the individual seeking treatment.

As a national organization, the CPA has been a vocal advocate in promoting evidence-based treatment for PTSD and operational stress injuries. In February 2009 the CPA devoted its February publication of *Canadian Psychiatry Aujourd'hui* to the theme of mental health and the military. Last year, in collaboration with Veterans Affairs Canada, the CPA delivered a PTSD module as part of its "Perspectives in Mental Health Care". The perspectives program offers a series of continuing medical educational programs aimed at both psychiatrists and family physicians across Canada. This year's perspectives in mental health care program will again provide an update on PTSD, focusing on military-related PTSD and its effects on veterans and military members.

The CPA is also working closely with military and civilian psychiatrists to establish a CPA military and veterans section. This section will bring together both researchers and clinicians working with veterans and military members to collaborate on and provide evidence-based care and research.

The CPA would like the committee to consider four recommendations. The first is regarding screening. Although still-serving members receive post-deployment screening, periodic screening for PTSD and common co-morbid conditions such as major depressive disorder, addictions, and suicide would enhance early detection and facilitate treatment.

As well, reserve members and many still-serving members with PTSD are released and living in the community. Encouraging primary care physicians and specialists to ask patients "Have you, or anyone close to you, ever served in the Canadian Forces?" would help open up the dialogue for primary screening of operational stress injuries. This question has been very successful in the U.S.

The next recommendation involves knowledge dissemination. Military members and veterans need to know that PTSD can be treated successfully with evidence-based treatments, including pharmacotherapy and/or psychotherapy. Clinicians also need to be aware that PTSD rarely occurs in isolation, but often presents with co-morbidity. This co-morbidity needs to be treated aggressively in order to optimize treatment outcomes, especially if they are going to get involved in trauma-focused psychotherapy—that is, talking about the traumatic event in treatment.

The next area of recommendations focuses on research. Most treatment guidelines focus on PTSD and not co-morbidity. Treatment outcome research is desperately needed to enhance our understanding of military-related PTSD and how to best tailor treatment, including pharmacotherapy and psychotherapy. Research is needed to enhance our understanding of the neurobiology of PTSD, as already indicated, risk factors and resiliency for PTSD, and how psychological trauma affects other medical conditions, such as chronic pain and cardiovascular conditions. Also, more research is needed to better understand the specific needs of reserve members.

● (1635)

Finally, and also very important, there is the whole issue of family support. PTSD and operational stress injuries not only affect military members and veterans but also his or her family. Often spouses and children struggle to obtain services in the community. Enhanced services to spouses and children and improved coordination with provincial community services are crucial to better meet the needs of the families, and by extension, military members and veterans.

Again, I thank you for your ongoing interest and support in the mental health of military members and veterans, and I'd be more than happy to answer any questions.

Thank you.

The Chair: Thank you.

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

Mr. Harris.

Mr. Jack Harris (St. John's East, NDP): Thank you, Chair, and thank you all for your presentations.

First, I have to say that you all have a lot to offer, and we don't have much time to hear the great things you have to say.

Dr. Richardson, if I may ask you first, you said with respect to military circumstances that they don't respond as well to PTSD treatment as in other circumstances.

Does that mean it takes longer to achieve results? And does that have implications for the kinds of programs that ought to be available, depending on how much time it does take to deal with treatment of PTSD of military members?

Dr. Don Richardson: That's a very good question. It's not necessarily that it might often take longer, but when they've studied veterans and combat-related PTSD, the civilian studies show that the outcomes of people who have civilian types of trauma tend to be better, when looking at one study compared to the other.

But, clinically, what we tend to see is that because a lot of the military-related PTSD, as I mentioned, rarely occurs with just one condition but also with others, the treatment tends to be more intensive, and with that it might take longer also.

● (1640)

Mr. Jack Harris: We've also heard complaints from the civilian mental health group in Petawawa about the complexity of the cases characterized by those series of things, and in fact, high suicide rates, rampant addiction, and the lack of and need for medical addiction specialists.

Do you see any special considerations in dealing with addictions among serving members?

Dr. Don Richardson: I think addictions, both alcohol and drugs, are an issue with PTSD. When they have looked at whether or not the rates are higher than on the civilian side, I think we're probably seeing higher rates of depression. But I do think that when we're looking at treatment focus specifically, the first part is stabilization. That involves looking at all, not just PTSD, but all of what the person is presenting with. So if it is addiction, that needs to be addressed, whether it's assessing for depression and suicide or making sure the person is stable before they start doing specific, trauma-focused therapy.

Mr. Jack Harris: For that, of course, you need resources.

Ms. Bradley, your organization is a very welcome one in Canada. It has been active since 2007. Given our government's attitudes toward some kinds of bodies, they might try to call you a talk shop because you've been talking about these issues for such a long time.

You mentioned your work with the military. Has there been a direct relationship in the sense that the military has asked you for advice on how to solve some of these problems because of what we've seen? This has been going on for some time: we're still talking about stigma, we're still talking about basic treatment like Dr. Richardson has just been talking about.

Is there a fix here that you can help with? Have you been helping with that? Or does the military try to find its own solutions?

Ms. Louise Bradley: We work collaboratively. Have they come to us specifically and asked for help to fix something? No, and I'm quite grateful they haven't, to be honest with you, because I'm not sure there's any quick fix to any of this.

And by the way, we do far more than talk. We have many active programs. We have evidence-based programs that actually show where stigma can be resolved or can be reduced considerably. We've focused on health care professionals, as one group. This is something that would apply right across the board.

It saddens me, as a registered nurse, that we have to focus on health care professionals when we hear they are one of the biggest barriers to people getting care. I know these issues are very similar in the military. I don't know whether they are worse or not, but all roads lead to stigma. Other than this one program, we haven't been able to evaluate other programs in there, but I think the work the commission is doing can very much be generalized to the military.

The Chair: Thank you.

The bells are ringing. According to Standing Order 115(5):

> Notwithstanding Standing Orders 108(1)(a) and 113(5), the Chair of a standing, special, legislative or joint committee shall suspend the meeting when the bells are sounded to call in the Members to a recorded division, unless there is unanimous consent of the members of the committee to continue to sit.

Since it is a 30-minute bell, I would ask for consent.

Mr. Jack Harris: Do we have the timer on?

The Chair: Yes, we can turn on the timer. It's been ringing for about five minutes, so we should have about 25 minutes.

Can you make sure it's muted, please?

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Mr. Bezan, it's just for an intervention from the Conservatives, the Liberals, and then me?

The Chair: Yes. Then we'll go. I think we'll do two more quick questions of five minutes each, and then we'll go. Okay? We have 26 minutes.

So do I have consent?

Some hon. members: Agreed.

The Chair: Mr. Strahl, you have the floor.

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

Thanks to all of you for your testimony under pressure. We appreciate that and your being here today.

I've been on the health committee before and certainly mental health is something that we found touched all of the other studies we were doing, whether it was chronic disease, or innovation, or anything. It all comes back; there's always a connection there.

I am going to ask you, Mr. Upshall, for your perception of this, which may be following on Mr. Harris' question. How receptive have the Canadian Forces been to working with outside groups, with civilian researchers? Do they welcome that collaboration or are they...? Just generally, from your perspective, have you seen a willingness from the Canadian Forces to work with outsiders to address an issue that affects their members?

● (1645)

Mr. Phil Upshall: What did I do to you to deserve that question?

Some hon. members: Oh, oh!

Mr. Phil Upshall: I come from the consumer-patient-family community. I work closely with the Mental Health Commission of Canada and the institute, so it may well be better to ask them.

I can tell you that the military does not come to patient organizations that are, in our case, experts in peer support and community supports and ask us to provide them with either guidance or advice as to how to move forward. I think it's fair to say, based on our experience, that the armed forces, like a number of other paramilitary organizations and other organizations that will remain unnamed, are not open to advice from outsiders. There's a sense that their community will have the expertise within, in most instances. Obviously, calling on operational stress injuries clinics and others to provide assistance is one thing, but—

Mr. Mark Strahl: Do any of you work with active Canadian Forces members or are you primarily dealing with members who have been discharged as a result, perhaps, of their mental illness? Are you working with active soldiers, with CF members?

Dr. Zul Merali: Yes, at the University of Ottawa Institute of Mental Health Research we do have a partnership where we are exploring sleep disorders, in particular, associated with post-traumatic stress disorder.

On the silos that have existed, I see that they are starting to dissolve and there is much more resolve for coming to solutions through partnerships. I see a lot of hope in that growing even more in the next while.

Mr. Mark Strahl: Are there any specific recommendations or barriers that you think the Canadian Forces can address directly to better work....? Is it just, as Mr. Upshall said, that they think they have it covered in-house? Are there specific legislative or regulatory barriers that prevent them from reaching out to what, in my opinion, are excellent civilian organizations like yours that could provide some assistance?

Ms. Louise Bradley: I don't see there being any barriers. I do want to point out, in answer to your question and a previous one, that DND did come to the commission and say, “Look, we have something to offer and we think you can help to enhance it with the peer support project.” That is something that is widely recognized throughout Canadian Forces, and now by the commission.

It's certainly an avenue that can be built upon and that the commission is very supportive of. It's something that has proven to be effective, and I think it's something that can definitely be enhanced.

Mr. Phil Upshall: I was just reminded by our project manager that in fact the Mood Disorders Society of Canada and CDRIN generally are working with DND and Veterans Affairs on PTSD. DND has opened its vaults of video and information that will inform the work we are doing.

I should have referenced that earlier. I don't want you to think that they're not openly supportive.

Mr. Mark Strahl: Thank you.

The Chair: The final question goes to Mr. McKay.

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

Thank you all for coming.

Recently we did an order paper inquiry on military suicide, and we received an answer back today. As happens around here, the press gets on it rather quickly.

I looked at the answer on the last five years of military suicides, and the pattern is that there doesn't seem to be any pattern. It seems to go through all the ranks. It seems to go through all the age groups. It seems to go in theatre and out of theatre. It averages somewhere around 15 a year.

Dr. Richardson, your comment about the more difficult response from treating soldiers piqued my interest.

Have any of you made any observations with respect to military suicides—I'll start with Dr. Richardson, but I'll ask the entire panel—and is there something the statistics are not showing?

● (1650)

Dr. Don Richardson: The research I was involved in was looking at the population within our clinic. This is an outpatient clinic that probably serves close to 20% who are still serving, but the majority are veterans, so these are release members. The best predictor of having suicidal ideation—this is not completed suicide, obviously—was depression. Although PTSD is associated with suicide and suicide attempts and suicide ideations, PTSD often occurs with depression. What we found was driving the suicidal ideation was actually the depression.

Hon. John McKay: It was depression.

Were there any other observations?

Dr. Zul Merali: I think you're putting your finger on the nail. If you look at the U.S., for example, right now more returnees are dying from suicide than those in theatre. The numbers are enormous and it keeps growing, because as it says, post-traumatic stress disorder is post-trauma, and take years and years. They're back here now and experiencing trauma and having issues dealing with that.

The other point Don made was about co-morbidity. Depression and post-traumatic stress disorder go very much hand in hand. Depression is a major risk factor for suicide. I think they're all tied in. Sometimes we see them as different balloons, but they are not; they are all interlinked, and I think we need to get to the bottom of this to be able to—

Hon. John McKay: The other thought that crossed my mind was that this was five years' worth of suicides by people in the military. It didn't track the people who have been recently discharged. It would be interesting to see what it looks like in a five-year window, post discharge.

Do any of you have any observations?

Dr. Zul Merali: I don't have observations in Canada, but in the States they certainly track that, and it shows that it keeps increasing with time.

Hon. John McKay: I have one final question. The military set up the JPSU unit, which is for people who are having difficulties. On the base, I think it's frequently regarded as a dumping ground. It speaks to the issue of stigma. Once you're in that unit, you're well and truly stigmatized.

I don't impute bad motives to the military, because you have to get these guys out of handling live ammunition and things of that nature. I buy that argument. But once they're in there, their career is pretty well....

Do you have any suggestions?

Ms. Louise Bradley: This is something that is pervasive throughout. For anybody to acknowledge that they are having mental health problems in any workplace is akin to career suicide in many cases. So much so.... The work the commission has done with the psychological safety standard for the workplace will hold equally well anywhere, in any workplace. What we have found is that people would rather suffer than actually admit they are suffering from mental health problems. To admit is to be seen as incompetent or unstable.

The standard that the commission has developed provides a number of tools—and not rules. This isn't something for which you have to do A, B, and C.

One of the critical pieces of that work is accessing the workplace at the very beginning. This can be done on a small scale or a larger scale. Oftentimes, we simply don't know what the situation is. So the very first step in the standard is to do a thorough analysis and assessment, which is not that hard to do. Then very small things can be implemented to address them.

The workplace standard isn't designed for military settings, but I think it's something that we could well look at generalizing.

But stigma is a huge problem; there's no question about it. It keeps 40% of adults who have kids with mental health problems from going for help.

When we extrapolate it to that kind of setting, it's bound to be far worse than that.

● (1655)

The Chair: I'm going to have to cut it off there. We're down to 14 minutes, and we have to get back to the House to vote.

I'd like to thank Mr. Upshall, Ms. Bradley, Dr. Merali, and Dr. Richardson for coming in. I apologize for the disruptions today with the votes.

If there's something you want to say that we didn't have time for or even if you have recollections afterwards that you want to bring to our attention, put those in writing and drop them off with the clerk and we'll make sure to review them as a committee. I appreciate that very much.

With that, do we have a motion to adjourn?

An hon. member: So moved.

The Chair: We're out of here.