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Chair

The Honourable Peter Kent

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● (1145)

[*English*]

The Chair (Hon. Peter Kent (Thornhill, CPC)): Thank you, ladies and gentlemen.

Apologies for the vicissitudes of parliamentary procedure, but welcome to this continuing study of the care of ill and injured Canadian armed forces members.

Because of time constraints, I will suggest to members that we move Ms. Rigg, the director general, civilian human resources management operations, from the second hour to come to the table should members have questions for Ms. Rigg. Do we have acceptance?

Some hon. members: Agreed.

The Chair: Thank you.

Major-General Millar, welcome to our committee on national defence.

With us, members, is Major-General Millar, chief of military personnel; Colonel Scott McLeod, director of mental health, Canadian Forces health services; Colonel Rakesh Jetly, mental health advisor of the directorate of mental health; and from the Department of Veterans Affairs, Michel Doiron, the assistant deputy minister, service delivery; and Raymond Lalonde, director of the operational stress injuries national network. As I said, joining at the table for the time that we have available, Ms. Jacqueline Rigg, director general, civilian human resources management operations. She is also assistant deputy minister, human resources civilian.

We will open with statements.

General Millar, you have 12 minutes.

Major-General David Millar (Chief of Military Personnel, Department of National Defence): Thank you very much, sir.

Mr. Chairman and members of the committee, my fellow officers and I are very pleased to have the opportunity to talk to you about caring for our own programs—much that you've heard over your adjudications in the last while—and specifically, the care of our ill and injured Canadian armed forces personnel and their families.

I'm very delighted today to have family members from the Canadian Forces and family members from our veterans here with us today. I was speaking with Claude and Jenny as well as Paula, and it's wonderful to hear some of the words and the praises that we have for them as we help our military members get back onto their feet, back into the Canadian Forces, or to transition from our hands to our communities and into the hands of Veterans Affairs.

Joining me, as the chair indicated, is Scott McLeod, my director of mental health, and Rakesh Jetly, my chief psychiatrist for the Canadian armed forces.

When Canadian armed forces members are seriously injured or suffer an illness to the extent that they cannot function in their regular duties, they are admitted into the care of our own program consisting of three phases, as you've heard from Colonel Blais: recovery, rehabilitation, and reintegration. Administered by our 24 integrated personnel support centres across the country, such as Petawawa, which you visited recently, the program is compassionate, tailored to the members' needs, and has no set timeline, as recovery from an injury or illness does not have a schedule. It's a perfect marriage: the IPSCs provide the valuable administrative support while our Canadian Forces health system provides the care.

In some individual cases, the road to recovery is measured in months, where at the request of the member, because of a job opportunity from outside of the military, the process only takes six months. However, more typically, the road to recovery, rehabilitation, and reintegration is measured in years, from the point of injury to when our members no longer need our help. Members like Corporal Glen Kirkland, a budding real estate agent, and Master Corporal Jody Mitic, of *Amazing Race* fame, are for me the ambassadors of our program as they epitomize how, through their will and determination, combined with the care and comfort that we provide, anyone can overcome injury and illness and move on in life to do amazing things.

Let me briefly describe our programs. Recovery and rehabilitation phases are mostly in the hands of our medical experts who lead in the fields of physical and mental recovery and rehabilitation. Our seven operational trauma stress support centres, such as the one here in Ottawa; our state-of-the-art rehabilitation equipment and centres of excellence; our extensive military health research program, along with our many external partners such as Veterans Affairs, with its 10 operational stress injury centres; the Royal Ottawa Mental Health Centre, which we partner with; and the Canadian Institute for Military and Veteran Health Research form this tremendous network of care and support.

The reintegration phase becomes a shared responsibility among the members, our medical staff, and the chain of command. Reintegration may entail working part-time with another military unit or going back to school for academic upgrading, or it could perhaps be working at Royal LePage real estate in order to acquire an operating license, or it could be working with The Royal Canadian Legion, with Canada Company, or with another government department, all the while receiving a military salary.

One of the purposes of reintegration is to re-instill confidence, self-esteem, and a sense of pride and self-worth, which are key ingredients for military warriors on the road to recovery. Working outside the Canadian armed forces is often more conducive to recovery as working in the military can sometimes be contributory to the ailment. Often members will find a new niche, a new vocation, and actively release to pursue a new beginning outside of the military. For those transitioning out of our care and into the hands of Veterans Affairs, we offer vocational rehabilitation in the form of on-the-job training and an educational upgrade program.

Our latest initiative is the military employment transition program led by Canada Company, where up to 200 employers are offering jobs to our veterans through the “1,000 jobs in 10 years” campaign. Our new military employment transition program features career assessment, market analysis, resumé writing, job search, job coaching, and job mentoring. Currently, there are more jobs than applicants, but this is because we're at the leading edge of the program.

● (1150)

[*Translation*]

Thanks to the True Patriot Love Foundation and its research into employers' tendency to hire veterans, and thanks to leading companies like Prospect Human Services—which has an 85% success rate in finding jobs for veterans from the Edmonton area—we have set up a single-window job access capability to assist our veterans and mitigate their concerns at the prospect of starting a new career.

For members transitioning into the community and planning to seek outside employment, Veterans Affairs Canada and Department of National Defence staff start working together six months before the member's release.

For veterans who are leaving and have complex needs, an integrated transition plan is prepared—a task that includes the member and all relevant personnel. The plan sees to it that the member's needs relating to medical care, education, future employment and Veterans Affairs Canada support are met.

Once this process is completed, the member either signs the plan, indicating their agreement, or states that the plan is inadequate. There have been few cases in the past where members have disagreed with the plan, but in such cases, the plan undergoes a review to mitigate the member's concerns.

[*English*]

The focal point for this entire effort is the joint personnel support unit, of which there are 24 integrated personnel support centres across Canada employing 97 civilians and 179 military staff, housing families, spiritual, social, and financial support specialists along with our Canadian Forces health services managers and Veterans Affairs Canada staff in location. This collaboration has greatly facilitated the comprehensive care for our members and their families. You undoubtedly witnessed the care and the compassion of those who work at the IPSC when you visited Petawawa.

The program has been successful at demystifying the stigma associated with getting help. Today, we have 1,924 members assigned to the joint personnel support unit across Canada. Of these, 60% can have some form of mental illness ranging from PTSD to depression and varying forms of anxiety associated with the rigours of military life in general. The fact that our numbers are increasing is indicative that the barriers are coming down slowly, but more needs to be done.

You will have read that we recently lost soldiers to suicide. Our suicide prevention program, our education and awareness, the resiliency training, the screening, our outreach, and research are all a part of our mental health strategy. Although our suicide rate is lower than in the rest of Canadian society, although our rate has not increased since 1995 despite our heavy commitment in Afghanistan, although 2013 was one of the lower rates in years, although those in need can get immediate mental health care from a medical officer, and although we have first-rate mental illness facilities, resources and support, and the best mental health practitioner ratio to service population in NATO, we can do more.

A significant percentage of those who do commit suicide appear not to have a diagnosed mental disorder and were likely suffering in silence. The most prevalent barrier to care is that most of us with mental disorders do not appear to recognize that we have a problem. This barrier is seen in almost 90% of those who have an apparent disorder. The next most prevalent barrier is the desire to manage one's problems on one's own, being stoic and proud. Impacts on career and negative attitudes towards mental health are also common.

The key to success in dealing with mental illness is early intervention. To help our members, we need to accentuate the positives because every time we give the perception that we are criticizing the outstanding work being done by our JPSU and our health services, the less likely it is that those on the fence will come for help.

We need to balance the narrative with stories such as Mr. Sneddon's. Corporal Moe Sneddon's father called the JPSU in Halifax following his son's suicide to say that his son's death had nothing to do with his PTSD but was related to other cause factors. He said that in the note his son left, Corporal Sneddon asked the staff at the JPSU in Halifax to be thanked for their help, as he would not have survived as long as he did without them.

From our suicide investigations, roughly 60% of personnel have deployed, whereas 40% have not. Of the cause factors, the most prevalent triggers are 45% relationship-related, 21% disciplinary career problems, 16% financial, and 10% legal.

● (1155)

De-stigmatizing mental illness, addressing psychosocial factors, greater education and awareness, and building resilience are my areas of focus as we strive to better understand the complexities behind mental illness and enhance our programs to support our men and women and their families.

Regrettably, time does not permit me to describe the various programs. However, we have provided copies of “Caring for Our Own”, our “Mental Health Strategy”, the road to mental readiness pamphlet, our morale and welfare services pamphlet, our comprehensive aide-memoire and benefits, and the programs and services of the Canadian armed forces and Veterans Affairs.

You've heard about Soldier On, the Injured Soldier Network, home modification, vehicle modification, and all of the other benefits. We can address some of those during our question and answer period.

Mr. Chair, thank you very much.

The Chair: Thank you very much, General Millar.

I turn now to ADM Doiron, please. You have five minutes, sir.

Mr. Michel D. Doiron (Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs): Thank you, Mr. Chair.

It is my pleasure to be here this afternoon with Major-General Millar and other Canadian armed forces colleagues to discuss how we work together for the care of the ill and injured Canadian armed forces personnel and veterans.

Joining me today is my director of operational stress injuries, Raymond Lalonde. So if we have technical questions, Mr. Lalonde can take them.

[*Translation*]

I am very new to my role at Veterans Affairs Canada. It is month three for me, as I started in late December. However, I am not new to serving Canadians or to a service delivery, operational organization.

[*English*]

I joined that from Service Canada, where I was a regional assistant deputy minister accountable for the delivery and administration of programs for the Atlantic region. Prior to that I worked with various senior management positions in the Government of Canada, such as Transport Canada, Public Works and Government Services, and the former Canada Customs and Revenue Agency.

First, in that context I will briefly discuss the VAC—Veterans Affairs—and Canadian armed forces joint steering committee, which I co-chair on behalf of Veterans Affairs alongside Major-General Millar.

[*Translation*]

Veterans Affairs Canada and the Canadian Armed Forces have distinct mandates, but it is in the care of the ill and injured that our efforts on behalf of Canadians merge. Those we serve may still be in uniform, in the process of being released from the Canadian Armed Forces or former members.

Those who were injured during their service have a right to expect us to coordinate our services and efforts as much as possible to meet their needs, as do the loved ones of those who were killed in service. This is why the steering committee exists.

● (1200)

[*English*]

The committee brings together VAC and CAF personnel at the senior operational and policy level, fostering a strong working relationship between our organizations to address program and policy gaps and ensure continuity of services received by the ill and injured members and their families as they move, as they transition to civilian life.

It's more than an advisory body. It's a decision-making body that identifies, manages, coordinates, and prioritizes the activities and the initiatives that involve and impact both organizations and those we have the honour to serve.

The committee's recommendations go to our deputy heads for final ratification.

[*Translation*]

The committee's joint priorities generally fall under the effort to ensure a continuum of services, including in the areas of mental health and family support. There is a focus on joint research, as well, where applicable.

So what does this cooperation look like? At our last discussion on January 14, for example, we agreed to focus on how we can more effectively integrate efforts to harmonize and streamline support to Canadian Armed Forces members in the areas of employment transition, rehabilitation, mental health and suicide prevention.

I look forward to our next meeting, on April 1, when we will continue discussing these issues.

[*English*]

Now that I've explained a little bit about the steering committee and how we strategically work together, allow me to speak more specifically about VAC and the role in caring for our ill and injured.

As Major-General Millar has mentioned, the CAF has primary responsibility for the care of military personnel while they are still in uniform. CF members may, however, be eligible for VAC disability pensions for a service-related injury even while in uniform.

Following release, VAC is responsible for the care, the treatment, and the re-establishment of veterans into civilian life. We share this responsibility with provincial and territorial governments and with the communities.

[*Translation*]

Our goal is to ensure the continuity of care the member and their family have come to expect from the Canadian Armed Forces and to do so as seamlessly as possible. This is why, as my colleague explained, our teams work side by side at integrated personnel support centres.

Today, Veterans Affairs Canada has more than 100 employees working with Canadian Armed Forces personnel at these centres on or near bases or wings.

[*English*]

VAC's responsibility to care for ill and injured CF members begins in most cases before the member leaves the forces. VAC's staff meet with members as they begin their release process to provide a personal transition interview where needs are explored and identified before release occurs. In the last fiscal year there were 4,145 of these interviews completed. The interviews serve to identify potential risks and/or barriers to the successful transition to civilian life as well as offering VAC staff the opportunity to explain the benefits and services available from the department and other service partners for the releasing members and families.

For those who may require individual case management the information provided by the member is then used to create a personalized VAC case plan in close coordination with the CF care and service providers.

[*Translation*]

In the case of veterans with complex needs, a Veterans Affairs Canada case manager works with them and their family to do a detailed and holistic assessment of their circumstances and to develop a case plan to address their needs, as well as determine potential eligibility for Veterans Affairs Canada programs and services.

[*English*]

The Chair: Can you please conclude, sir?

[*Translation*]

Mr. Michel D. Doiron: In conclusion, the benefits and services Veterans Affairs Canada provides to eligible veterans and their families are intended to reduce the burden of disabilities related to military service, thereby reducing the pressures that can hinder successful transition to civilian life.

[*English*]

Thank you for the opportunity to address the committee.

The Chair: Thank you very much, Mr. Doiron.

Ms. Rigg, please, you have five minutes.

Ms. Jacqueline Rigg (Director General, Civilian Human Resources Management Operations, Assistant Deputy Minister, Human Resources - Civilian, Department of National Defence): Mr. Chair and members of the committee, I'm very pleased to have the opportunity to appear before you today as you continue your important study on the care of ill and injured CAF personnel.

In my position as director general of civilian human resources management operations with the assistant deputy minister of human resources at the Department of National Defence, I oversee the operation of six regional civilian human resources service centres. These regional human resources service providers work in partnership with civilian and military managers at National Defence to address the strategic and operational human resources management needs. HR service providers offer leadership, advice, and support services related to human resource planning, recruitment and staffing, employee relations, classification, compensation, and learning. In essence we are responsible for developing and enabling the delivery of services to recruit, develop, and retain civilian employees to effectively support DND/CAF. This includes the recruitment of mental health professionals, which I know is of particular interest to this committee, DND, and ADM HR-Civ to ensure that CAF members receive the support they require.

With respect to staffing, DND, as well as other departments, conducts staffing practices according to the Public Service Employment Act. The PSEA governs how appointments are to be made to ensure a public service based on merit and non-partisanship, in which the values of fairness, transparency, access, and representativeness are safeguarded. In making hiring decisions at National Defence, we always ensure that we maximize flexibilities to meet operational needs and requirements with respect to the PSEA appointment policy.

The care of ill and injured CAF personnel is one of DND/CAF's highest priorities. Today the Canadian armed forces have approximately 400 full-time mental health workers at 38 primary care clinics and detachments and 26 mental health clinics across Canada. These mental health workers include psychiatrists, psychologists, social workers, mental health nurses, and addiction counsellors. We take all opportunities to recruit mental health professionals, including advertising online and in trade journals, recruiting at conferences such as the annual Canada Psychiatric Association conference, and working with the Canadian Medical Association and the Royal College of Physicians and Surgeons.

The reality is that Canada as a whole currently faces a shortage of health care providers. As the Chief of the Defence Staff recently noted, National Defence is therefore in competition for psychiatrists and other medical health professionals with the provinces and territories and the private sector. National Defence's challenge in attracting and recruiting qualified and experienced mental health professionals in a competitive market is due in large part to the limited labour market availability of these professionals in Canada.

An added challenge for National Defence is that the locations for certain positions are either remote or not metropolitan, such as Cold Lake and Bagotville. As is the case in the private sector, it can be difficult to attract medical professionals to these areas.

In light of these challenges, National Defence has been working to address the current shortfall of medical health professionals by reducing red tape and improving incentives. We have engaged our central agency partners, including the Public Service Commission and the Treasury Board Secretariat, to maximize the flexibility within the public service legislative construct to successfully attract and recruit mental health professionals.

To help address the issue of relocation, including to isolated regions, the Treasury Board Secretariat has approved a temporary increase in the maximum amount that can be reimbursed for the relocation of external candidates. Until March 31, 2015 we can reimburse up to $40,000 of the cost of relocation, an increase from the normal maximum of $5,000.

The Public Service Commission has also agreed to refer priority persons to National Defence if they meet our recruitment needs and requirements. A priority person is a person who has entitlement under the PSEA and regulations for a limited period to be appointed ahead of all others to vacant positions within the public service. The person must meet the essential qualifications of the position. In addition the Public Service Commission is facilitating the priority clearance process to reduce the time required to staff a position. Priority clearance is a clearance to staff granted by the PSC when an organization has first considered priority persons for the position in question.

● (1205)

In order to be in a better position to compete with the private sector, we are also offering the top of the pay scale in each of the clinical categories of new hires.

The Chair: Ms. Rigg, could I ask you to conclude, please?

Ms. Jacqueline Rigg: Okay.

Nevertheless, more work remains to be done. Since there will be a continued need for mental health professionals due to both future needs and to fill vacancies, National Defence is proactively working on a recruitment strategy. In addition to normal staffing processes and practices, the recruitment strategy addresses the need to develop communications products promoting us as an employer of choice as well as participating in activities and events in support of recruitment targets. This sees the department collaborating with professional associations and advertising in medical-related publications.

I'd like to thank you again for inviting me to appear before the committee today to discuss the work that is being done by the joint civilian-military team at National Defence.

● (1210)

The Chair: Thank you, Ms. Rigg.

We'll now proceed with the opening round of questioning.

Mr. Norlock, you have seven minutes, please.

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

Through you, I'd like to thank the witnesses for appearing today.

My first set of questions will be to General Millar, and they have to do with the universality of service policy.

Both individually and collectively at this committee we've some concerns with regard to the policy. I wonder if you could succinctly outline what the policy is, why it is in place, if you feel it is effective, and whether you feel it would be detrimental if it were not in place.

As well, perhaps you would address some of the issues with regard to members who are suffering from a visible and non-visible injury as they attempt to meet, after the injury, the universality of service model, and why we're hearing that there seems to be a disconnect between what we hear from the senior chain of command and what's actually happening in the field.

Could you address that, please?

MGen David Millar: Universality of service is an exemption to the charter that ensures that all Canadian Forces members are employable, deployable, and physically fit in accordance with the standards of the Canadian Forces. Indeed, the Canadian Forces is meant to deploy—to Libya, to Afghanistan, and domestically in terms of crises and emergencies. As a result of that, you need a fully fit, functional fighting force to be able to respond to the needs of Canadians.

The charter means that we do not have to hire one of the designated groups, that being the disabled. It also means that when members are no longer able to be deployed, to be employed within their trade, or to meet the physical fitness standards that are reflective of the rigours of war fighting, they too no longer comply with universality of service, and therefore, based on their medical conditions, will be released from our care into the care of Veterans Affairs.

So the exemption to the charter, the universality of service, allows us to ensure that we have a fully fit and functioning Canadian armed forces.

Do I believe it is effective and important? Yes, I do. I fully believe that in order to maintain and be able to meet the three roles and six missions of the Government of Canada for the Canadian armed forces, yes, we need to have that in place.

Now, I do not see the universality of service as a negative thing. It is indeed something that says, if you're no longer fit to fight, can you be employed in another occupation within the Canadian Forces; if not, are there other places that you can be employed in the Canadian Forces, such as the cadets and rangers; and ultimately if not, how can we help you transition from the Canadian Forces, with the requisite benefits from Veterans Affairs, into community life and standing up and starting up your second career?

That is what Michel was talking about in terms of the military employment transition plan. We have a tremendous capacity now to educate, offer employment, and start our members off anew in our communities in their second careers.

Therefore, the universality of service is only one part of the equation. The other part of the equation is all of the other programs we have in place so that, when you no longer meet universality of service, you can do something else inside the military or outside the military.

Mr. Rick Norlock: I particularly asked that question because we hear about visible and non-visible injuries. We've heard some anecdotal evidence to believe that a physical injury is much easier to transition from a person who is getting better to meeting the universality of service, as opposed to a person who has suffered from a non-visible injury. There appears to be a more difficult ability to prove to leadership that they are indeed now fit.

I wonder if you could address what you're doing in that regard.

MGen David Millar: I'll ask Scott and Rakesh to speak, but what I will say first is we have Canadian Forces members who are amputees. We have Canadian Forces members who are suffering from OSIs, operational stress injuries, and PTSD who do not breach universality of service, who continue to be warriors in the Canadian armed forces.

In terms of the invisible illness, if a member has post-traumatic stress disorder or a serious enough operational stress injury, it does not mean they cannot function as an individual out in society. As a matter of fact, they can prosper and we have so many examples of that.

When we diagnose someone and identify that they breach universality of service, it's because we do not want to put them in a position of more fighting where they would experience another traumatic incident that really could do permanent damage. That's our criteria.

In terms of visible and invisible, I'd ask Dr. Jetly to comment.

● (1215)

Colonel Rakesh Jetly (Mental Health Advisor, Directorate of Mental Health, Department of National Defence): Yes, it is a challenge. I use a lot of analogies and examples—sometimes it's difficult with a back injury as well. After somebody has recovered from a back injury and after physiotherapy, it's difficult to say can they stand the rigours? You can test them by having them march 13 kilometres, that kind of thing. It's really difficult predicting the future of what would happen if we took this person again and dropped them out of an airplane—for a back injury—or the rigours of places like Rwanda, Somalia, the former Yugoslavia, and all the current operations.

To the best of our abilities we have ways of trying to predict it: realistic training, how they did in their training, their work of training. We try to do it. But as General Millar says, it's to protect the mission and the members themselves. Ethically, there isn't a lot of evidence that shows how people are going to do in the future. So if somebody is completely interested in carrying on and they've had a complete resolution of their symptoms for several months, they're no longer in regular therapy, they've been able to do their work-up training and their training without any concerns at all, we will certainly give them the opportunity to continue with their careers in organizations like the combat arms.

It is a possibility. It is a little bit more difficult in mental health, but it's difficult in physical health as well.

The Chair: Thank you very much, Colonel.

Thank you, Mr. Norlock.

Mr. Harris, please, seven minutes.

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

First of all, I believe we're going to have to have these witnesses back. We have six witnesses and we've got 40 minutes perhaps to question them. But thank you for your presentation and your information. We know you're doing a lot. Our concern is, are the needs of the soldiers, sailors, airmen and women, as well as of our veterans, being met?

First of all, General Millar, last week retired Sergeant Ronald Anderson sadly took his own life. He was 11 months out of the service; he was a veteran with 21 years of service, including seven overseas deployments, two in Afghanistan. Yet according to our information, he would not be included in your suicide statistics, nor would women or reservists.

This committee asked the government and the department to follow all soldiers for five years post-deployment in order to ensure that their mental health needs were being met. How can we really think we have a good picture of what's going on with your suicide statistics the way they are?

MGen David Millar: Thank you, sir. I'll ask Scott to add a few comments.

In terms of post-deployment follow-up that is being done, and I'll ask Scott to elaborate specifically on that, indeed from our studies during Afghanistan and our expectation of mental health for individuals presenting for mental illness, we know—we think we know—what that percentage will be over time. So we do have a good research analysis capability and we do have some excellent outcomes that Scott will speak to.

In terms of tracking, when we report statistics we report Canadian Forces regular force male. We do that because from a statistical reporting perspective that's the preponderance in the Canadian Forces. But we do track reservists and we do track women. We track all our suicides within the Canadian armed forces. I can give you the statistics since November 25: five regular force, three reserve force Class A, one reserve force Class B. We conduct our military professional technical suicide investigations on all of those. So, yes, we do track them.

You're absolutely right, outside of the Canadian Forces we do not. We are fully made aware of them and we do our own internal assessment to determine where we need to improve our mental health system.

I'll ask Scott to comment.

Mr. Jack Harris: Colonel McLeod, I wonder if you could present that in writing to us afterwards as to how the follow-up works and how the tracking takes place. We have limited time here today, but I would like to know the details of that.

General Millar, you talked about getting it right in terms of the follow-up to suicides, but we have this persistent story about boards of inquiry, which are not technical assessments. They are standard military inquiries to determine lessons learned, what went wrong, and what might be done in the future, and yet we're told that there are now as many as 75 of these that haven't reported.

How can that be acceptable? I realize that it's a military procedure. I realize they take time. But if you're telling us that you're looking for every way to prevent these things, how is it that this particular basic military procedure for investigating an accidental or other death is not being completed in a timely fashion?

● (1220)

MGen David Millar: First and foremost, for every suicide, we immediately launch, through our Surgeon General, the military professional/technical suicide investigation. That is launched within three days of an actual suicide. It's given a period of about a month in which to come back and identify what the circumstances were and if there were preventative measures.

It involves speaking with the families, speaking with our clinicians, and speaking with the unit with which the member worked, so right away we have a good sense of what led our members to commit suicide. Again, I can give you the latest statistics from our recent suicides, because that's how closely we monitor them.

To your point about the boards of inquiry, the boards of inquiry—you're absolutely right—are an administrative process to assign attributability for the purposes of Veterans Affairs benefits. However, the time that it has taken—you're right, sir, it has been too long—does not prevent us from assigning attributability and getting the benefits for the family members.

I will conclude by saying that we have launched a tiger team to take those 70-plus and complete them, and we are conducting a reorganization within the Canadian Forces so that boards of inquiry are under one organization, as opposed to two.

Mr. Jack Harris: Thank you, sir.

There was a StatsCan study in 2003 or 2002 resulting in a goal of 447 mental health professionals to look after these issues within the military. First of all, why would that number still be valid after all of our experience in and exposure to Afghanistan?

Second, we heard that there were barriers to hiring people, but the major barrier in the last six months seems to have been the hiring freeze, and the failure, the inability, of your department to be able to hire people. Because they couldn't actually fill them. This goal of 447 has never been met. We were 60 shy in the fall. How can that be? How is it that we didn't hear complaints from you folks that you were being stymied in hiring people because the freeze was affecting you?

MGen David Millar: First and foremost, sir, I think the best answer I can give you is the response times in terms of access to mental health practitioners. I, as a military individual experiencing mental illness, can go into our Canadian Forces clinics across the country and get immediate care—immediate care. Typically, if it's deemed that I need a full psychiatric assessment, it takes three to four weeks for that to occur, compared to, on our civilian side, one year for the same psychiatric assessment. So to answer your question, it wasn't an issue of a lack of availability of clinical support to our members and to our families.

The number is 452: 452 mental health practitioners and support personnel, of which today we have filled 417, leaving 35. Ms. Rigg explained the process for expediting so that we can fill those 35 as quickly as possible. Because our service delivery we felt was meeting and is meeting the needs of the members of the Canadian armed forces, we, as I mentioned, need to do more, and in doing more, we are going to need more clinicians and support staff. That is what we're doing now—hiring those.

The Chair: Thank you very much, General.

Mr. Harris, your time has expired.

Ms. Gallant, please. You have seven minutes.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman. All my questions will be through you to General Millar.

General Millar, you mentioned that the “program has been successful at demystifying the stigma associated with getting help”. Would you please explain what is meant by that?

MGen David Millar: Thank you, ma'am, very much. It's good to see you again. The last time, we were in Afghanistan together.

There is a natural propensity amongst all of us as human beings to think that someone presenting with mental illness has a problem; therefore, we have a different perception of individuals. That's true across Canada, I believe, because in Canadian society we haven't demystified, de-stigmatized, mental health as being not an illness that cannot be reckoned with, but instead, as with physical health in the Canadian Forces, something that we have programs for to get us physically well and mentally well.

Therefore, when I say stigma, it's the stigma about being side by side with your battle buddy in Afghanistan and coming back, and your battle buddy is not having problems but you're having problems, and perhaps you're too proud to be able to admit it and come forward. And as I mentioned earlier, at times the preponderance of thinking is “I don't have a problem, and if I do, I can cope with it myself”. Getting people to feel comfortable that if you're not feeling well when you get up in the morning, you're feeling depressed, you should walk into the clinic, you should walk into your chain of command and say you're just not feeling well. You should call one of your peers. Getting that to be an automatic reaction, as opposed to “I'll see how I feel tomorrow” and then “I'll see how I feel the next day”, is what I mean by de-stigmatizing.

The other issue ma'am, is the career issue. There is a very strong perception, as you've been told, that if I present for mental illness, indeed if I present for a physical problem, there is a potential that I will be released from the Canadian Forces under the universality of service, which we spoke of earlier. Part of de-stigmatizing is our education and awareness about all our programs and our success rate at returning our members back to work, but also, in those cases where you breach universality of service, about the tremendous programs that we have for starting a second career, to set you off on the right foot, to provide you the education and retraining, and also provide you the benefits and support so that you can have a healthy and vibrant second career.

● (1225)

Mrs. Cheryl Gallant: Thank you. I asked that because in the chamber, in reference to PTSD the opposition has stated that it's just a figment of the person's imagination and it's all in their head, which is totally false.

Now, you had also addressed the issue of our repeatedly hearing from the opposition that if a soldier seeks help, it's the beginning of the end of the rest of their career, yet you've talked about recovery and getting help early. But there are soldiers who are attending the clinic, and at their very first meeting with a nurse practitioner they are advised that if they seek treatment, in all likelihood they will be medically released in three years. It's not anecdotal. It's real.

Can you explain why these soldiers would be told this?

MGen David Millar: I will look into that case specifically, and if we can talk afterwards I'll be sure to examine it, because no, that is not the intent of our program. That is not our outlook, and that is not the way we should be treating our men and women. Indeed, as I mentioned, it's very compassionate. You cannot make that assessment when one of our soldiers presents coming through the door whatsoever. Our success rate through our return to work program is at least 23%.

When I was a young airman along with Scott, and a young soldier along with Rakesh, we did not have one-stop care and comfort. The likelihood that when I presented for a problem I would be leaving the Canadian Forces was very high. Today our sole focus is to get our men and women back on their feet, back in their jobs, staying in the Canadian Forces. Our return to work program, as I mentioned, has at least a 23% success rate, so we're very proud of that.

So I am concerned about what you've heard.

Colonel Scott McLeod (Director of Mental Health, Canadian Forces Health Services, Department of National Defence): Sir, I agree. That's certainly not the approach that we would have in a case like that. There is no way you can make a determination as to what somebody's prognosis is by a first meeting. As General Millar pointed out, our primary goal above all is to be able to treat the person and return them to their job. It's in everybody's best interest to do that.

I would also be very interested to know more about those cases.

Mrs. Cheryl Gallant: We're trying to have the military spouses employed wherever possible. However, there are spouses or the spouses of their buddies and in some cases when they go into the medical clinic the receptionist is that spouse and that is a barrier to some of our soldiers going forward. If we could address that in the future it would be helpful.

You mentioned Master Corporal Jody Mitic and how successful the program has been for him. I want to emphasize that Master Corporal Jody Mitic is extraordinary. He is amazing. Not every soldier has that personality where they can come out and do the things and work through the program the way he has. He's probably the highest calibre. We have to think about the person who's having trouble coming forth at the very beginning.

The last question I have has to do with military personnel transitioning into civilian life, especially where people have physical illnesses. As you mentioned earlier, the provinces just aren't generating enough professionals, especially specialists, psychiatrists in particular. The soldiers are just very afraid of being medically released because once they're back to civilian life, the medical care does not exist.

● (1230)

The Chair: A very short answer, please.

Col Rakesh Jetly: That certainly is a challenge. Part of the cooperative work that we're doing with Veterans Affairs is to educate more and more, increase the awareness of mental health professionals in communities, because the shared care model.... While they're within the CF we can manage most things with us and through our Blue Cross providers. But when people leave, just like the reservists, they're going to communities throughout the nation and many of those areas are underserviced. Part of our thrust of education is to try to increase the awareness, the education, of professionals in the community, and in many ways to demystify the idea of working with ex-soldiers and to promote the fact that they're incredibly compliant and incredibly good patients to work with. It's a privilege to work with people like this. That's part of our thrust as we educate people in the communities.

The Chair: Thank you, Colonel.

Ms. Murray, seven minutes, please.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you.

Thank you for being here to present to the committee.

I'd like to follow up on a question that was asked earlier. It has to do with screening returning service members to see whether there are any concerns with mental injuries. I understand this was something that was done on returning. Is there a structure in place for repetitive screenings so that if the person isn't caught by the first screening, the symptoms aren't presenting at that point, they will be identified in future screenings?

MGen David Millar: Thank you, Madam.

We've come a long way in terms of our program called road to mental readiness. We have adopted mental resilience, mental illness coping, recognition of the symptoms throughout all of our professional development in the Canadian Forces, including a real focus on pre-deployment and post-deployment follow-up.

I'll ask Scott to speak to that.

Col Scott McLeod: In terms of the follow-up, we have a series of follow-ups. As you pointed out, it's important that you can't only have one because you could miss people. Immediately on your return, in the third location decompression, there's an opportunity for people. They will sign a declaration and identify any high-risk involvement they've had with any other traumas, combat, and so forth that would identify them as being in the higher risk population. Then when they get home, anybody who's been identified at that point is picked up and immediately referred.

After that we do our enhanced post-deployment screening, which takes place anywhere from four to six months after their return, where they do a very in-depth questionnaire about anything related to mental health. They also have a personal interview with a mental health care provider. That's an opportunity for somebody to tease out a little bit more information. On top of that we have routine periodic health examinations that also go through and do extensive screening for any type of mental illness.

Ms. Joyce Murray: So there are ongoing health examinations with mental health professionals. I'm referring to recommendation number 14 in the standing committee's report of June 2009. This recommendation is that the Canadian Forces should monitor the mental health of its members for five years after deployment. Could I ask Colonel McLeod whether there has been a specific reference to the recommendations in the 2009 report by National Defence and if so whether this is a recommendation that's being followed by the department?

Col Scott McLeod: The recommendation really has been followed, because we have that screening in place. The enhanced post-deployment screening is done by a mental health care professional.

● (1235)

Ms. Joyce Murray: Is it for five years?

Col Scott McLeod: For five years the primary care team does that evaluation, and they are specialists. The family physicians are specialists who look after mental health; they are trained to be able to do that. They work closely with the mental health specialty clinic as well. They are actually tracking this, as any other family physician would be routinely tracking them.

Ms. Joyce Murray: Thank you.

I want to confirm something that I thought I heard Major-General Millar say, and that is that the total number of mental health professionals identified in 2003—you named it as 452—is in your judgment enough.

Is the goal from ten years ago, from before the Kandahar deployment of the armed forces, still seen to be an adequate target to be shooting for?

MGen David Millar: Our current number is 452, based on the services that we provide, based on access by our military members to our health care providers and mental health care providers, yes. But as I mentioned, we can always do more, ma'am.

Ms. Joyce Murray: Thank you for that answer.

I'm interested in whether there are surveys, or any data, or any analysis, because anecdotally we're not hearing that the number is anywhere near to being enough. I appreciate that hiring has filled a third of the gap since the recent outcry related to the institutional barriers that government has put in place with hiring freezes and budget cuts; that those barriers are being removed. But I am not clear what research or analysis is showing that 452 would be enough.

MGen David Millar: We, as an institution of continuous learning to understand the complexities of mental illness and suicide, are continually assessing it through our own research ability and are looking to the future of new programs and new practices supporting families and our mentally ill. So, yes.

Ms. Joyce Murray: Can I ask that any research or analysis that concludes that this is adequate be tabled with this committee?

MGen David Millar: Yes.

Ms. Joyce Murray: Thank you.

Now I'd like to talk a bit about support for families.

I met with a spouse of a serving member and a spouse of a former member, both of whose serving partners were diagnosed with PTSD. Those spouses do not support the contention that there are good services for the partners and the families. There were a number of recommendations in the 2009 report, which I go back to quite often, because it was quite a comprehensive study of these same issues.

There are recommendations such as recommendation 9, which talks about providing services to family members who are at risk of or suffering from domestic violence related to PTSD. There is number 11, which says that family members should be included in the treatment program and should be educated as to how to support their partner. There is a set of recommendations that are quite targeted at making sure that the spouses are not casualties of their partner's illness.

Can you tell me, Mr. Millar, whether there's been an analysis of the recommendations in the 2009 report and what has been done to address the specific gaps in support for families, education for families, counselling, marriage counselling, and all of the support that we're being told is not adequate to this day?

The Chair: Ms. Murray, I'm afraid you have talked out your seven minutes.

Ms. Joyce Murray: Couldn't we have a short answer? I'm sure all of the committee members are interested.

The Chair: We'll hear a very short answer.

MGen David Millar: Families are the lifeline for our members. Our spouses are the lifeline. They are here today.

We have enhanced our program tremendously. At our military family resource centres across the country we have education programs for our children to help them understand what mental illness is all about. Those programs have been so successful that they have had the effect of causing the parents to come forward to seek help. We have programs for our spouses at our military family resources centres. We have sent couples who have experienced mental health issues across all our military family resource centres to round tables. Yes, we are putting even greater focus on our families.

● (1240)

The Chair: Thank you, General.

Members, we had budgeted 15 minutes to conduct some committee business at the end of our scheduled two hours, which we have lost. I'm asking for unanimous consent to continue questioning until the top of hour, then adjourn, and then to run over for just a few minutes to do....

Voices: [*Inaudible—Editor*]

Mr. James Bezan (Selkirk—Interlake, CPC): If there's time, five minutes at the top of the hour.

The Chair: Okay? Thank you.

Mr. Chisu, you will begin the second round of questioning, please. You have five minutes.

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

Thank you very much to the witnesses for coming to testify to our committee.

I served in Afghanistan in combat. I will quickly go back to the concept of universality of service. You mentioned that it is very clear, except that you have a branch that does not have the universality of service, which is the cadet corps. The cadet corps allows the uniformed members to have, for example, an age limit of 65 instead of 60, and so on, and they are not rigorously physically tested.

Why I'm making these remarks is that I'm going through a transition, a transition in the military from the military to other branches of DND or to civilian life. I have a couple of very short questions.

First, on average, how long can a CF member be on the medical category list until you start the process of releasing them? Second, on a yearly average, how many CF members are on the medical category list? Also, how long does it take for a member to be discharged from the CF due to a medical or a requested release? I'm asking this about timing because it can be very long. The CF members are held in so-called holding platoons, and that is very much a deterrent to their morale. When I was serving in Meaford, they had a couple of suicides in these platoons.

Also, I have a question for Ms. Rigg. How many civilian DND personnel have a military background?

MGen David Millar: To start off, I'll ask Scott to address the medical aspects.

Col Scott McLeod: For the MELs, the time that somebody can have medical employment limitations, it can vary depending on the patient. It varies dramatically from one person to another, and there is no specific time limit that says you must be given a permanent restriction after a period of time.

The biggest thing we look for—and Dr. Jetly can expand on this—is stability in their care once they've actually plateaued and we know that it's the maximum level of care that can be delivered. For some people, that may be six months. For some people, it may be two, three, or even four years.

Also, then, how long it takes to release somebody also depends dramatically on what the situation is. For a lot of the cases where it's a complex-care case, it can be up to three years after the permanent category is assigned, to establish a transition plan for that individual and to make sure that they do transition into Veterans Affairs care and then into the civilian workforce as well.

As for the number of people currently in the Canadian Forces who have medical employment limitations, I don't have that number with me. The director of medical policy would be the one who would have to tell us that.

I believe that answers the questions, sir.

Mr. Corneliu Chisu: I have an additional question. How are you connecting this with the new recruiting standards that lately are lowering the physical standards in the Canadian Forces? Recruiting will affect the situation in the Canadian Forces in the long term. Nobody was asking about recruiting, but it is an important element in the Canadian Forces area.

● (1245)

Col Scott McLeod: From a health perspective, we have not changed our requirement that if somebody has an illness that is non-compliant with universality of service, they're not selected. That has not changed over the past several years. We've maintained that. From a physical fitness perspective or otherwise, I would have to defer on that, because that's not my area of responsibility.

MGen David Millar: From a physical fitness perspective, yes, the standards are lower. That is symptomatic of our demographics—of my boys, who are electronic wizards. We'll make you physically healthy and physically fit. We have warrior platoons at our boot camp to do that.

You would be familiar with that, sir, from when you went through boot camp.

The Chair: Thank you, Mr. Chisu. Your time has expired.

Ms. Michaud, please.

[*Translation*]

Ms. Élaine Michaud (Portneuf—Jacques-Cartier, NDP): Thank you very much, Mr. Chair.

I want to begin by thanking the witnesses for their presentations. My first question is for Major General Millar.

Let us go back to the concept of universality of service, which has been discussed at length today. You say you are sure of that doctrine's benefits on soldiers. However, I think that prevents soldiers from obtaining assistance. It prevents them from seeking help for fear of being forced to leave the Canadian Armed Forces.

Do you think that modifying the universality of service principle could ensure that our soldiers who are recovering from a mental illness or a psychological injury would occupy positions that do not involve combat or deployment? Some positions within the forces do not require members to be constantly deployed.

I come from a military family. My father was always in administration. He never had to be deployed in his career. So that would be a possibility. I think this could have a major impact on the state of mind of our soldiers in the forces.

Could you briefly comment on that possibility?

MGen David Millar: As I said, I think it is important that all our military members have a good understanding of the available services, opportunities and benefits.

[*English*]

I feel that part of the stigma is that not all our military members understand what services are available from the medical and health services to help address the actual medical problem of mental illness. We need to have a greater awareness, so that people understand that a physical ailment and a mental ailment are not different and that we have the services, so that if they come forward, we can return them to work.

[*Translation*]

Ms. Élaine Michaud: I have to interrupt you because my time is very limited.

My question is about the possibility of amending the universality of service principle. I understand that services are available. You promote them, and that is important. We want our soldiers to seek help. However, here is what I would really like to know. Are you planning on exploring the possibility of amending the concept of universality of service, so that soldiers recovering from a psychological injury can continue to occupy positions that do not require deployment? Is that a possibility you intend to explore? I would like a yes or no answer.

MGen David Millar: I think it would be more important to explore the benefits and programs provided by the Canadian Forces.

Ms. Élaine Michaud: So, for the time being, I will consider the answer to be no.

[*English*]

Mr. Jack Harris: The answer is no.

[*Translation*]

Ms. Élaine Michaud: Exactly. That was also my understanding.

I want to go back to the issue of suicide in the forces.

My colleague, Mr. Harris, has already mentioned that there were no statistics on suicide cases among reservists. You said that you had limited information or that you had much older information on people who had been released from the forces, but who should normally be monitored for five years.

Do you have ways to determine how many people have experienced distress and attempted suicide unsuccessfully? Do you have an idea of what is happening, since this is a very clear sign of distress among our troops? Do you have any information on such cases?

MGen David Millar: Are you talking about soldiers who leave the Canadian Forces?

Ms. Élaine Michaud: Yes.

Mr. Michel D. Doiron: Are you talking about people who are still in the forces?

Ms. Élaine Michaud: I am talking about both the people who are in the forces and recently released members. I think the two go hand in hand. The Department of National Defence still has a responsibility towards those people, even if they now fall under the jurisdiction of Veterans Affairs Canada. That is at least my opinion.

That is basically why I am interested in both types of cases.

Mr. Michel D. Doiron: Veterans Affairs Canada does not compile statistics on suicides or suicide attempts. We work with individuals.

Ms. Élaine Michaud: At National Defence, do you have that kind of information on suicide attempts?

MGen David Millar: Do you want to know whether we have statistics on our members?

● (1250)

Ms. Élaine Michaud: I want to know whether you have statistics on suicide attempts by either members still with the forces, or recently released soldiers.

[*English*]

Col Rakesh Jetly: I think I have testified here before that the attempts are incredibly difficult to track, because we're never sure that we have a complete number.

We have a system in place with serving members. We have a policy in place under which the priority, when somebody makes an attempt, is that the chain of command and the medical people—the senior authorities on the base—are talking, communicating, and making sure that the people are in care.

That's the priority: it's not about investigating; it's not about embarrassing the members to ensure that they are in care. We have had an approach whereby the chain of command, the senior leaders and the senior doctor on the base, talk and make sure they are aware of it—if they become aware of it. If somebody attempting to take their life on a Saturday wakes up, doesn't tell anybody, or 911 is not called, we're not going to know about it.

The Chair: Colonel, thank you.

Ms. Michaud, your time has expired.

Mr. Bezan, please, for five minutes.

Mr. James Bezan: Thank you, Mr. Chair.

I want to thank all the witnesses for appearing today, especially with the votes earlier. I want us to have as much time together as we want to.

I just want to touch on a couple of things.

General Millar, you talked about having success and demystifying the stigma associated with getting help. How do you measure that? What are the metrics that you're using to say that you've had success?

MGen David Millar: At demystifying?

Mr. James Bezan: Yes.

MGen David Millar: My indicator of success is the number of people who are starting to present, the number of people who are coming forward recognizing that mental illness is not a negative problem; it's something that we can treat and help our members with. As I see more people coming out of the unit lines into my JPSUs, that's an indicator of success.

I see more conversations, more open conversations about mental illness and a greater acceptance both within Canadian society and the Canadian Forces that mental illness is not something bad. It's just something that we can all discuss and treat. As I see families coming forward to present on behalf of their members, those are all indicators to me that the stigma is starting to come down, but we have a long road to go.

Mr. James Bezan: You're saying that 60% of the members who are currently in the JPSU have some form of mental illness. I take it that probably a lot of the people in the JPSU are on the physical side, recover from their injuries, and are of course put back in. You're saying about 23% return to work. How much of that 23% would be people who suffer from mental health problems?

MGen David Millar: When you have a physical illness, you can have a mental illness as well, as you can appreciate, or just a mental illness. In terms of the numbers that return, we don't track what the difference is between physical illness and mental illness. That's really on the medical side, and because of doctor/patient confidentiality, we don't distinguish that.

Rakesh, do you want to add to that?

Col Rakesh Jetly: I just want to talk a little bit about the stigma. We do have some data that we can forward. When we compare ourselves to our allies, we ask questions of members like a battle group returning...we ask whether they would think less of a colleague who sought mental health care, and our figure was around 6%. We've had specific questions that we've all asked. Frankly I think we're ahead of society in that area.

We also have the data that when we first set up our trauma clinics, on average people waited about seven years before they came forward for care. Now when we do enhanced post-employment screening in three to six months, over half the people who screened positive are already in care. We really have the evidence that we're moving things forward. We're never done there but we do have evidence and we do have metrics that things are heading in the right direction.

Mr. James Bezan: I'll just follow up on that, because you're talking about screening and that they're already in care.

There are two questions here; one is on the JPSU. Of those who return back to work, how many of them are reinjured and have to come back in, especially from the mental health side?

Also, the *JAMA Psychiatry Journal* just released a U.S. study of soldiers down there. They found that one in ten suffered from a diagnosis of intermittent explosive disorder, which has a higher rate of suicidal tendencies. I was just wondering if you're familiar with that and whether or not that is part of some of the pre-screening that we may do at recruitment, at pre-deployment, as part of the road to mental readiness.

Col Rakesh Jetly: I think with the whole research, the long-standing.... One of the biggest risk factors for suicide is impulsivity, so even if somebody doesn't have a severe mental illness, you would think that severe depression is the risk, but it's the actual impulsivity of the act. We look at post-traumatic stress disorder, we look at depression, we look at these illnesses, so we are on that. Part of where we need to really get at—General Millar talked about how many people in care still commit suicide—is getting a better understanding of what happens in the care itself. That and many other studies are being done to try to understand the actual act of suicide independent of the illness, and intermittent explosive disorder and impulsivity as a trait are all part of the factors that we need to look at.

● (1255)

Mr. James Bezan: Can you describe the Canadian armed forces suicide prevention program that you have in place?

Col Scott McLeod: The suicide prevention program came out of the suicide expert panel that sat in 2009 that addressed the issue that suicide in the vast majority of cases is related to a mental illness. If you look at risk factors and try to intervene on specific risk factors, there are anywhere from 3,000 to 4,000 members of the Canadian armed forces at any one time who have the risk factor for suicide.

Our approach has been about educating people through our road to mental readiness program, enhancing mental health literacy, decreasing stigma so people come into care, and enhancing the care that they get on a regular basis, as well as educating all levels of the chain of command on what mental illness is in the individuals, enhancing that triad of care between chain of command, the person with the illness, as well as the health care system, so it's trying to enhance education more.

The Chair: Thank you very much, Colonel.

Mr. Larose.

Ms. Joyce Murray: I have a point of order, Mr. Chair, that I would like to ensure that I have time for before the committee is over.

An assertion was made by a member of this committee, Ms. Gallant, who asserted that an opposition member has talked about self-stigma when we noted Ms. Gallant is on record—

The Chair: This is debate.

Ms. Joyce Murray: I would like Ms. Gallant to table any evidence she has that any opposition member has done exactly what she is on record as having done.

The Chair: Ms. Murray, your point is made.

Mr. Larose, you have until the top of the clock.

[*Translation*]

Mr. Jean-François Larose (Repentigny, NDP): Mr. Chair, I will share my time with Mr. Harris.

I have a quick question.

[*English*]

You mentioned stigma.

[*Translation*]

Where is that problem situated in terms of leadership? Members of the Canadian Armed Forces influence one another once they become corporals or master corporals. That factor is an obstacle, right? I would like a very quick answer, please.

MGen David Millar: You are correct. As I mentioned during my presentation, I think the level of stigmatization is personal. I lose if I say the following:

[*English*]

"I have a mental illness." That's the level of stigma.

[*Translation*]

Mr. Jean-François Larose: Yes, but they can influence each other. They can influence their subordinates, who may develop the same concern.

Thank you.

[*English*]

Col Rakesh Jetly: That's an excellent question.

Again, when we surveyed, we didn't ask the question. We should have asked if you would think less of somebody else who sought mental health care. People said 6%. We didn't ask what you would think of yourself if you sought mental health care. I suspect it would be higher than 6%.

I think we have an organization...and I asked people when I was in Gagetown talking to battle groups to cut themselves the same slack that they would cut a battle buddy. I think guys would march their battle buddy into care, but they would be hesitant to have their battle buddy march them to care. So I think it's in terms of what a person thinks other people are going to think of them, which is more than what the other person would think. After 10 years of war, I think people understand that people come back broken and they'll give each other the hand-up for that.

Mr. Jack Harris: Thank you, Chair.

General Millar, I heard you describe the services available to family. I know we have an extensive network across the country for that, but I'm somewhat incredulous in that we talked about our going to Petawawa, when one couple I met—we only had a very short time with individuals who came forward—the spouse of the serving member, a woman whose husband had PTSD, complained that it took her four years to get counselling for herself to understand her husband's PTSD, what it was, what it was doing. They almost didn't make it as a couple, she said. They both complained about this.

How is that adequate when we talk about how the vet families are the bedrock? I understand all that, and I know you folks are doing a lot of work, but how can it be that some woman said she'd asked many times; it took her four years to get counselling?

● (1300)

MGen David Millar: Without knowing the specific case, we have learned a lot. We have learned that it's important to educate and to provide the tools to our spouses so they can understand the signs, the impacts, and how a member feels when they're depressed, or they have post-traumatic stress disorder, to allow them to help their loved ones. Certainly, we've taken Chris and Kathy Linford as part of our education program and they have travelled across the country explaining their own predicament so that other families can understand. We have put programs in place since that time for our spouses and our children to educate them in the symptoms, the signs, and the coping strategies. When I say we can do more, that is one area we're focusing on.

The Chair: General, thank you very much, and to all our witnesses today, again our apologies. I share committee members' frustration that time was short, and I'm giving you a heads-up that you may receive a follow-up invitation to discuss more fully some of the issues before us today. Again, thank you for your appearance today. Thank you for your patience in dealing with the vagaries of parliamentary procedure.

This meeting is now adjourned.