HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on National Defence

NDDN • NUMBER 019 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Tuesday, April 8, 2014

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● (1105)

[*English*]

The Vice-Chair (Mr. Jack Harris (St. John's East, NDP)): I would like to call the Standing Committee on National Defence meeting 19 to order. I believe we have a quorum, so we can start.

The orders of the day for today are pursuant to Standing Order 108(2), the study of the care of ill and injured Canadian Armed Forces members.

Our witnesses today are from the Department of National Defence. We have Brigadier-General Jean-Robert Bernier, Surgeon General, Commander Canadian Forces health services group and Jacqueline Rigg, director general, civilian human resources management operations, assistant deputy minister, human resources - civilian.

I am sitting in for the chair, who is unavailable today. Mr. Kent is unable to make it.

I guess we can proceed. Mr. Bezan can come along when he is ready.

We have written remarks from General Bernier.

Sir, welcome to the committee to you and to Ms. Rigg. You may proceed, sir, with your opening remarks.

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

[*Translation*]

Hello, honourable members of the committee.

[*English*]

Thank you very much for the opportunity to appear before you again and especially for your ongoing focus on the health of Canadian Armed Forces members.

The welfare of those who are willing to sacrifice their lives for the protection of Canadians deeply merits your attention, and your committee's commitment to studying it so closely sends military personnel a positive message that helps make the risks and sacrifices they accept more tolerable to bear. In saying that, I include all of my medical personnel, most of whom served in operations overseas, saw far more trauma in Afghanistan than any other arm in treating daily horrific casualties, and suffered the most physical and mental health casualties after the combat arms. Given that their own health so directly depends on the quality of their own work, they are powerfully motivated beyond just their duty and compassion for others to provide the best possible health care, research, policies, and programs.

You've already been briefed by me and some of my senior medical officers on the uniquely comprehensive extent of the health programs available to Canadian Armed Forces members, but there have been many developments since I last appeared before you in November 2012 to further address areas that could be improved.

Perhaps most relevant to your current focus was the development and launch last fall of my updated military mental health strategy based on a detailed year-long analysis of accumulated experience, data, lessons learned, and research over the past few years.

The existing military mental health program had been based on extensive research and analysis over several years, but it predated combat operations in Afghanistan. It was incrementally enhanced through annual reviews, but a longer-term and more detailed strategy was needed to guide and prioritize our efforts given the end of Afghanistan operations, the major increase in the military mental health budget from $38.6 million to $50 million, clinical and technological developments, a collective review of previous recommendations from your committee and other external bodies, and our greater understanding of mental health in the Canadian Armed Forces through accumulated health surveillance data and research.

Our analysis of the “Medical Professional Technical Suicide Review Report”, our operational stress injury incidence and outcomes study, as well as the ongoing analysis of the 2013 health and lifestyle information survey, and the Statistics Canada mental health survey will further enhance the strategy's implementation over the next five years. They will also help us more objectively re-evaluate whether the professional composition and capacity of our targeted cadre of 452 mental health staff are appropriate to our current and projected mental health care demands. The strategy and its supporting analysis will help us further optimize use of our resources and data in dealing not only with our Afghanistan-related mental health burden, but also with our much larger baseline toll of mental illness arising from the normal stresses of military service and those that affect Canadians generally. At least four of Canada's top national mental health organizations have publicly praised the strategy as a comprehensive model.

[*Translation*]

The strategy and our mental health program were also praised by representatives of the major national mental health organizations at a recent meeting with the Defence and Veterans Affairs ministers and senior officials. They made excellent suggestions for enhancing our programs, and all of their recommendations were either already implemented or are part of our mental health strategy, particularly their emphasis on the critical need for mental health prevention and treatment measures to be based on solid evidence.

[*English*]

Other significant developments include greater success in the recruitment and hiring of public service mental health staff, which my colleague Ms. Rigg can address in greater detail. We are now much closer to our target of 452, which will help reduce our reliance on contracted mental health staff and on our external referral network of up to 4,000 clinicians.

Although our wait times for assessment and care have, in general, long been far below those in any other health jurisdictions, this is helping reduce the number of local situations where wait times exceed my aggressive targets, in concert with other measures to enhance efficiency through staff reallocation, process modifications, the use of tele-mental health, and others. Reaching and maintaining our staffing targets will unfortunately remain a persistent challenge, given the national shortage of mental health professionals.

Since 2013 our procurement of high-definition tele-mental health technology is also helping us accelerate care to underserved locations and reduce patient inconvenience of travel for care, while our procurement and trial of virtual reality technology for PTSD exposure therapy is promising. In parallel with the Canadianization of the virtual reality software through our partnership with the True Patriot Love Foundation , we plan to provide the technology to all our operational trauma and stress support centres.

[*Translation*]

There have also been beneficial new developments with some of our other external partners since 2012. We have now twice partnered with Bell's national Let's Talk campaign which, along with many other efforts by the Chief of Defence Staff and senior military leaders, is helping further reduce stigma surrounding mental illness in the military culture.

The Canadian Psychiatric Association has established a special military and veterans section to support its military and civilian members with an interest in the mental health of serving and retired military personnel.

[*English*]

The Canadian Institute for Military and Veteran Health Research, established at the behest of my predecessor, has added several more universities to its network and is receiving additional support from the Wounded Warriors project and the Royal Canadian Legion in the form of mental health research scholarships. The Legion is also expanding its efforts to disseminate information throughout the country about support programs available from the Defence and Veterans Affairs departments, an initiative that will help better inform veterans and reservists distant from military bases and Veteran Affairs offices.

With respect to research, several joint projects with our partners are providing new insights and technological applications that will help enhance understanding and treatment such as two ongoing joint projects on the use of transcranial magnetic stimulation for the treatment of mental disorders, a validation study of our road to mental readiness education and resiliency program, neuroimaging studies with magnetoencephalography and functional magnetic resonance imaging, and a military-civilian symposium hosted last month by the Toronto Hospital for Sick Children's research centre on neuroimaging for the diagnosis and treatment of PTSD and traumatic brain injury. The Canadian deputy surgeon general continues to chair NATO's health research committee and mentor its military suicide research task group, Canadians continue to have a leadership role in almost all its mental health-related research activities, and a year ago a royal Canadian medical service expert was asked by NATO to co-chair its international symposium on best practices in post-combat rehabilitation and reintegration of patients suffering physical and mental injuries.

Despite the need to focus continually on improving our mental health programs, I also have to maintain capabilities and improve them in all areas necessary to protect health and lives in humanitarian and combat operations as well as in routine domestic care. To that end, one of my surgeons, Colonel Homer Tien, continues to head Canada's top trauma centre and hold the military trauma research chair at Sunnybrook in Toronto.

In 2013, I also established a new military critical care research chair affiliated with Western University that is held by Naval Captain Ray Kao, one of the world's top critical care researchers, and other military health research chairs are under consideration. Through collaboration, training, collaboration with allies, and other measures, we have also enhanced capabilities and readiness in deployed surgical and critical care; medical defence against chemical, biological, and radiological threats; and health care in Arctic, humanitarian, and special operations.

With respect to the care provided by our domestic health system, we received accreditation with distinction last fall following a three-year assessment by Accreditation Canada, the National Health Service quality authority, and we recently established a more robust quality assurance and patient safety program in collaboration with the Canadian Patient Safety Institute.

I have noted only a few examples of improvements and recognition by national and international health authorities highlighting Canada's leadership in military medicine and mental health. The greatest recognition and the rarest of honours came from our sovereign last October with the presentation of a royal banner by Princess Anne to the royal Canadian medical service in recognition of the valour, sacrifice, and clinical excellence of its members during a decade of operations in Afghanistan. It was only the third royal banner ever presented to a Canadian Armed Forces element since Confederation, and the second royal banner had also been presented to the medical service by Her Majesty the Queen Mother.

● (1110)

The Vice-Chair (Mr. Jack Harris): Thank you, General Bernier.

Our first person for questioning the witnesses is Mr. Norlock, for seven minutes.

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

Through you to the witnesses, thank you for appearing today.

My first question will be to the surgeon general. According to your mental health strategy from 2012—I will give you a quote—

> Combat exposure and exposure to atrocities are risk factors for post-appointment mental illness. Deployment, however, accounts for relatively little of the overall burden of mental health disorders in the CAF. Military personnel experience nearly all the non-operational risks and vulnerabilities to mental illness as their civilian counterparts.

I wonder if you can address and explain this? I want to deal specifically with the change in the type of battle our Canadian Armed Forces face, in particular in Afghanistan and in modern times recently in other places in the world. The difference is that traditionally the enemy had a uniform or you were somewhat protected because the roads you were travelling had been previously travelled on. What we were faced with in Afghanistan is the enemy could be anybody out there. Our Canadian military were at the pointy end of the spear as they drove through cities, towns, and villages, as well as the countryside. The enemy could have been anyone they saw. We heard stories from serving members from that area who basically gave anecdotal evidence to indicate that this posed a significant burden for them when they got back into regular society and there was no decompression, I guess.

The other is even the roads they drove on, they never knew what road had an bomb on it or you didn't know what street.... So I'm just wondering how you could say what you said based on...if you could explain that I guess is what I'm asking.

● (1115)

BGen Jean-Robert Bernier: Yes, sir. Thank you.

It's the quantitative burden of mental illness. Mental illness affects anywhere from one in four to one in five Canadians in their lifetimes according to the Mental Health Commission of Canada. So it's purely the math.

We experience a similar prevalence of mental illness in the Canadian forces. The one study we have from 2002 shows double the risk of depression in Canadian forces members related and unrelated to military operations. So from the pure quantitative perspective overwhelmingly we have a far greater burden resulting from mental illness that we have to treat that's not related to combat or deployment operations.

There is an increased risk, proportionately, among those who do deploy to operations, particularly operations that involve the risk factors of combat and risk to life and threat to not just themselves but particularly, as you described, the inability to respond when atrocities are being committed. So there is a general consensus in the mental health community that the risks of being deployed in operations where you have rules of engagement and a mandate that permits you to intervene when innocent people are being harmed is somewhat less stressful than being deployed in operations where rules of engagement are imposed, for example by the United Nations authorities, in order to maintain a neutrality and the perception of neutrality; that is more stressful on soldiers who are prevented from intervening except where their own personal lives are at risk.

So that was a major stressor for people who deployed in operations in the 1990s, particularly where the rules of engagement were very difficult. One particular case for example is the Dutch commanding officer of the battalion at Srebrenica. That was the Dutch battalion during Bosnian operations that was charged with the protection of the Muslim population that was subsequently massacred when the Serb army arrived. That individual was directed... It is well-documented that many people at that time suffered mental illness as a result of their inability...in fact, their direction not to intervene.

So you are absolutely right, the inability to intervene when atrocities are being committed against innocent people is an extreme stressor.

Mr. Rick Norlock: Thank you.

My second question surrounds the appearance before the committee in November 2013 of Dr. Anne Germain. She was studying the link between sleep and mental health. The committee heard evidence that a disturbance to sleep procedure occurred shortly after exposure to stress or traumatic events and was a very strong predictor of poor psychiatric outcomes, and she went on with further evidence and said that there was improvement when there was proper sleep.

I have another three or four questions surrounding that. I think you are probably familiar with that evidence and with that study or that area of study. I guess my questions would be as follows. To what extent is the Canadian Forces incorporating sleep treatment into its clinical mental health care programs? To what extent is the CF incorporating sleep training into its cradle-to-grave mental readiness and resilience programs such as the road to mental readiness? Third, the American military personnel are receiving warfighter sleep kits before and after deployment. Is the Canadian Forces considering this? Last, Dr. Germain also noted that sleep issues are a non-stigmatizing entry into mental health care. Would you agree with that statement?

● (1120)

The Vice-Chair (Mr. Jack Harris): Mr. Norlock has left you 30 seconds to deal with these questions.

Mr. Rick Norlock: You could perhaps respond in written form later if you don't have time.

BGen Jean-Robert Bernier: I can answer all of that. Yes, we recognize that. Everything we do and all of our practices are based on the best evidence. We are actually involved in a sleep research study to find better ways of enhancing sleep. It's a major problem with PTSD. Some people in particular have gone 10 years without sleep. It's part of our patient care protocols for PTSD and for any other mental health issues, because people cannot get better until they get over that. We're even sponsoring research involving drugs that enhance sleep and reduce nightmares in order to address that particular problem.

Education about it is in our road to mental readiness program. I'll have to look up whether the sleep kit.... I'm not sure exactly what it is the Americans are providing other than education.

Mr. Rick Norlock: Thank you.

The Vice-Chair (Mr. Jack Harris): General, perhaps you could provide us with something in writing on this whole issue of sleep. I would suggest there are more of us than just Mr. Norlock who are interested in it. I think the committee was interested in that testimony and that would be helpful to us.

We now have Ms. Michaud for seven minutes.

[*Translation*]

Ms. Élaine Michaud (Portneuf—Jacques-Cartier, NDP): Thank you for your speech, Brigadier-General Bernier.

In your speech, you mentioned that the Canadian Armed Forces intends to re-evaluate its target of hiring 452 mental health staff. Has that process already begun?

BGen Jean-Robert Bernier: We will be re-evaluating all of our programs on a yearly basis. In this specific instance, the re-evaluation is more comprehensive and based on a larger quantity of data. We are awaiting the results from two major studies that are currently under way. All of the data has been collected from our military personnel. There was a health and lifestyle survey, as well as a major Statistics Canada survey on the mental health of armed forces members.

We are expecting that Statistics Canada's analysis will be equally as thorough as the one from 2002-03, which formed the basis of the current program. Once we have the results of these analyses, we will re-evaluate and determine what abilities, delivery methods and skills we require in order to provide the best care possible.

Ms. Élaine Michaud: In other words, you are working on meeting that target of hiring 452 mental health professionals and will continue to do so until the studies are completed.

BGen Jean-Robert Bernier: Yes.

Ms. Élaine Michaud: Since the civilian hiring freeze was lifted last fall, how many mental health professionals and support staff have been hired?

BGen Jean-Robert Bernier: I will let Ms. Rigg answer that question.

Ms. Élaine Michaud: Of course.

BGen Jean-Robert Bernier: However, I can tell you that despite the freeze, we have still been able to continue hiring people, recruited through Calian, who can provide health care. We can also access our network of 4,000 external clinicians.

Ms. Élaine Michaud: I would like to know how many civilian professionals were hired for internal positions, not as part of the external network, since the freeze was lifted.

[*English*]

Ms. Jacqueline Rigg (Director General, Civilian Human Resources Management Operations, Assistant Deputy Minister, Human Resources - Civilian, Department of National Defence): I am thankful to have the opportunity to appear before you once again in this committee and I am glad that I can provide you with some progress that we've made on those hires since the last time I appeared before this committee.

In my previous speaking address on March 4, we shared with you that we had 29 letters of offer out, 18 hires, and 11 conditional offers. As of yesterday that has increased to 46 letters of offer that have gone out, 27 mental health practitioners have been hired, 10 offers have been accepted, but they're pending conditions to be met such as medical or security clearances. Nine have declined.

We had a gap of 54 hires to do. We are now only down to 17 positions. We are currently doing staffing actions to finish those other 17 positions. So far with our rate we're having an 80% acceptance rate for our letters of offer that we get out.

● (1125)

[*Translation*]

Ms. Élaine Michaud: Thank you very much for that information.

Brigadier-General Bernier, in your speech, you spoke about the various measures that have been taken that have allowed the Canadian Armed Forces to increase their ability to offer health care, including critical care during deployment.

We recently learned that there were no on-site psychologists available for francophone soldiers deployed in Afghanistan. They had to rely on care provided by American military personnel, in English only. That issue was raised in the past and was in turn acknowledged by National Defence. A solution was found but, in my opinion, it was far from ideal and didn't comply with the Official Languages Act.

Have steps been taken to address that issue so that a similar situation does not arise during a another mission?

BGen Jean-Robert Bernier: For one thing, there's a major shortage of mental health professionals across Canada. For another, we can only deploy uniformed military personnel abroad. As a result, we have to rotate our psychiatry and mental health personnel. We typically do whatever we have to to make sure that at least one of the three members of the mental health team is bilingual.

Ms. Élaine Michaud: That didn't happen that time.

BGen Jean-Robert Bernier: I don't know. I would have to look at exactly what happened that time to find out why.

Ms. Élaine Michaud: Okay, but—

BGen Jean-Robert Bernier: It's important to remember that mental health specialists are not the only mental health professionals we have. All of our doctors are expected to provide mental health services.

Ms. Élaine Michaud: Would you agree that someone suffering from post-traumatic stress syndrome needs a specialist? The faster soldiers get help, the better their outcomes and the more likely they are to feel better.

Are the Department of National Defence and the Canadian Armed Forces planning to hire military clinical psychologists who can be deployed to address such situations? If so, Canada's military will no longer have to rely on our allies to get services in French for our soldiers.

BGen Jean-Robert Bernier: We are committed to hiring social workers, mental health nurses and psychiatrists to the extent possible.

Ms. Élaine Michaud: I am talking about clinical psychologists. That's where the need is.

Social workers have certain skills, and their services are very useful. We can't ignore that. However, when people have post-traumatic stress injuries, they need qualified people who have the skills to provide specific services.

BGen Jean-Robert Bernier: We don't currently have any psychologists in uniform. We have lots of civilian psychologists.

Ms. Élaine Michaud: I understand. That's the problem.

BGen Jean-Robert Bernier: We don't deploy psychologists because we haven't identified a need that can't be met by psychiatrists, mental health nurses and social workers.

We've been conducting an analysis over the past year. We'll find out the conclusions at the end of April, and that's when we'll know if we have to go ahead with hiring clinical psychologists in uniform.

Ms. Élaine Michaud: You're telling me that there aren't any right now. I don't understand why you're talking about going ahead with hiring when no psychologists have been hired.

BGen Jean-Robert Bernier: Because so far, we haven't identified a need. The way we deploy—

Ms. Élaine Michaud: I think the cases that have made headlines lately indicate an obvious need. Our military personnel are in distress. Many French Canadians have been deployed. Many of them were from Valcartier, which is in my riding. These are francophones who needed those services but didn't get them. Those soldiers made it clear there was a need.

So there's a report coming in April. People have already publicly expressed a need for access to the services they didn't have access to.

BGen Jean-Robert Bernier: They all have access to services in French.

[*English*]

The Vice-Chair (Mr. Jack Harris): Very shortly, please.

[*Translation*]

BGen Jean-Robert Bernier: Usually, people who need to see a psychologist are removed from the theatre of operations. They are deployed farther away, behind the lines.

So far, care provided by psychiatrists, general practitioners, mental health nurses and social workers has met the needs of those who remain in the theatre of operations.

We are evaluating data from the Americans and other nations that have psychologists in uniform to see if it is beneficial. That study is underway.

● (1130)

Ms. Élaine Michaud: Thank you.

[*English*]

The Vice-Chair (Mr. Jack Harris): Thank you very much.

Next, Mr. Williamson, for seven minutes.

Mr. John Williamson (New Brunswick Southwest, CPC): Thank you, Chairman.

To the witnesses, thank you so much for coming in today.

This is to follow up on Mr. Norlock's question. I want to repeat this quote again, because I'm reading it over in my mind and trying to kind of break it down. It's this quote:

> Combat exposure and exposure to atrocities are risk factors for post-deployment mental illness. Deployment, however, accounts for relatively little of the overall burden of mental disorders in the CAF. Military personnel experience nearly all the non-operational risks and vulnerabilities to mental illness as their civilian counterparts.

I'm trying to get at the heart of what is being expressed in this quote from 2012. I'm not sure if it is to say that this is a constant challenge, which I agree with, but what we've seen coming out of Afghanistan is not unusual and might well be in line with what we're seeing in the population at large.

BGen Jean-Robert Bernier: I think the point there is that we have to have a complete mental health system that doesn't exclusively focus on operations-related mental injuries because the bulk, from a volume quantitative perspective, of our burden are the illnesses resulting from the same stresses that affect the general population. So we have a lot of PTSD, for example, from childhood trauma or car accidents or sexual abuse or sexual assault. So we have to be ready for all of that.

There are some subtle differences in the form of presentation of people who have suffered combat-related post-traumatic stress disorder, for example, or resulting from other traumatic exposures. But in general the signs and symptomatology are the same, and the same kind of diagnostic criteria apply. The treatment is generally roughly the same but tailored to the previous trauma.

Mr. John Williamson: Thank you. I would agree with that. But is there any evidence or a belief that what some of our soldiers have experienced in Afghanistan puts them in a class of their own? Are there unique elements here that are outside of what the public is perhaps going to...? I don't want to say that because obviously terrible things can happen at homes as well, in some of the cases you identified.

My concern is that this risks downplaying some of the symptoms we see coming out of Afghanistan. I don't think that's your intent, but I'd like you to clarify that, please.

BGen Jean-Robert Bernier: Not at all. In fact that's why we award the Sacrifice Medal to people who've suffered an operational stress injury. It is treated like any other combat injury.

The name of our seven most specialized centres in mental health are called operational trauma and stress support centres to focus on the unique aspects of military operation. So mostly our 26 general mental health clinics deal with the routine, everyday stresses and illnesses arising from routine illnesses as a result of the stresses that affect all Canadians. The operational and trauma stress support centres are specialized specifically in doing a much more detailed assessment for those who have an operational stress injury. The context and the understanding of the operational context is critical to doing that, to understanding what kinds of things happen and what kinds of exposures in military operations our troops are exposed to in guiding the trauma, the exposure therapy, and other elements.

Mr. John Williamson: Thank you. That is very helpful. I appreciate the clarification for my benefit.

In April a year ago the Canadian Psychiatric Association informed this committee that more research into the specific mental health needs of reservists is required. I have three questions. Do you agree with that statement? If so, or regardless, how is CAF currently evaluating the mental health care needs of reservists? And how is CAF working with the provinces to ensure that reservists are getting the mental health care they need?

● (1135)

BGen Jean-Robert Bernier: Every study we do, and we do a lot, we specifically include reservists. So far, consistently, all the research has been demonstrating that the rate of mental illness among reservists, whether related to deployed operations or not, is actually lower than it is among the regular force. Up to half in one study—half the rate of certain prevalent mental illnesses.

However, they're at greater risk because they don't have the social supports when they're demobilized, when they come back from deployed operations. Particularly those who return to units where they were the only person deployed on that operation, or a unit that's distant from a military base with a military clinic and the social setting, the social supports, that would help them either resolve their issues or encourage them to get into care.

For that reason, we have various things like the field ambulance medical link teams or the reserve field ambs whose job is to educate and to try to identify those individuals and get them into care.

There's education of all the chain of command for the same purpose. The Royal Canadian Legion has joined us as a partner because they have—I can't remember—2,400 or 1,400 centres across the country in every community. So they've agreed to set themselves up as a storefront for all of the programs available. They already do that to some extent, but they're going to expand that to all of the programs available to get people into care from within the armed forces or from Veterans Affairs, for those released from the reserve force.

We recognize that it is a special vulnerability that we have to pay particular attention to, and we have measures to try to get the word to them, identify them, and bring them into care and, if necessary, transport them. We permit them to get local care, if necessary, but the ideal is to get them to our specialized military mental health centres.

Mr. John Williamson: When you say local care, that would be the provincial health systems?

BGen Jean-Robert Bernier: Right. So if they have an injury or illness, including a mental illness that occurs subsequent to their demobilization, their return to part-time service, or even after release from Veterans Affairs, they're eligible to have all their care that's not covered or not accessible by the province, covered by the armed forces.

The Vice-Chair (Mr. Jack Harris): Thank you, Mr. Williamson, your time's up.

And I have the next seven minutes to Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you. Thank you for being here to help us understand the work being done by the armed forces to support those who are ill and injured.

Just a follow up on my colleague's question on this side. With respect to the re-evaluation of the number of medical mental health professionals needed, when will you have that review done, and a recommendation?

BGen Jean-Robert Bernier: Thank you, ma'am.

The 2014...the analysis of those two major surveys will be completed. Subsequent to that, it will probably be a couple of months of evaluation to determine matching the distribution of and the anticipated projected need over the years, based on the data that comes out of there. It will take probably two months after that.

Probably early 2015 we'll do a complete re-evaluation. It could turn out that we have too many. Or it could turn out that the skill distribution is not right, that we need other skill sets. We don't know. We know that we're currently at double—

Ms. Joyce Murray: Ok. Thank you. Now could I—as you know, my time is short and I have quite a few questions—I'm going to your mental health strategy. On page 27, you say that:

> Our success depends not only on the quality of our services and system, but equally on establishing the trust and confidence necessary for CAF members to present for, and to remain engaged in, mental health care.

Now would you say that you have succeeded with that, and that you have successfully established that trust and confidence in terms of the members and their families, as well? That there will be the proper support and care?

BGen Jean-Robert Bernier: We don't have the mandate to look after the families, but we have succeeded to some extent, and we have objective data to demonstrate it with respect to people presenting for care. There's still reluctance: 90% of those people who don't show up for care don't show up because they think their problem doesn't merit it. We know from hard data that we have the lowest rate of stigma for presentation of all the Anglo-Saxon allied nations. We know that people are in care far earlier than they were in the past, just a few years ago. I can give you all those details.

● (1140)

Ms. Joyce Murray: You feel you're a success in that?

BGen Jean-Robert Bernier: No, we still have challenges. One of the big challenges is that if the troops don't trust there are two problems. One is if the troops perceive that operational stress injuries are the only things that are important and that the bulk of illnesses that come from the routine exposures of day-to-day life are less important, which is sometimes what is represented in society. Some of those folks will feel guilty about presenting for care and taking away from what they misperceive is an overwhelmed system, and then they don't get care and they will downward spiral.

The second thing is if they don't trust the quality of system. If there is any misrepresentation about the reality of the care they'll get, that also discourages individuals from presenting themselves for care.

Ms. Joyce Murray: Then we hear from members and their families that the quality of the system is not there for them.

I've been listening to the other questions in French, which is not my first language, so what I understood you to say is that you've determined that there's not a need for uniformed registered psychologists in the employ of the armed forces and that psychiatrists are filling that gap. And I think you mentioned that you came to that decision a year ago. Did I hear your testimony correctly?

BGen Jean-Robert Bernier: No. We're currently re-evaluating whether to our psychologists we would add uniformed psychologists. We have psychologists. We need them and we use them extensively.

Ms. Joyce Murray: Yes. I'm talking about uniformed clinical psychologists. Is that a need or not a need from your perspective?

BGen Jean-Robert Bernier: Until now, we haven't found a need for it because the only reason we would have them in uniform is for deployed operations.

Ms. Joyce Murray: Okay. So may I ask then why—

BGen Jean-Robert Bernier: But we're re-evaluating now as to whether or not.

Ms. Joyce Murray: So if you didn't find a need for it, I'm really confused by that, because exactly a year ago the Director of Mental Health, Colonel Scott McLeod, wrote a briefing to the minister himself saying:

> Clinical psychologists have unique skill sets that the other mental health professionals do not have and are crucial in the assessment and treatment of mental health conditions. However, there are no uniformed clinical psychologists in the CAF to support deployed operations.

And he goes on to make a very strong case and a recommendation that "...there is strong indication that the addition of a uniformed clinical psychology capability would greatly enhance the mental health care of CAF members...". So do you disagree with the conclusions of Colonel McLeod?

BGen Jean-Robert Bernier: No, in fact, I approved that briefing note.

We need psychologists. That's why we have them. The question is do we need them in deployed operations.

Ms. Joyce Murray: Okay, the recommendation is about uniformed clinical psychologists and the case that's made here is that they are needed in the CAF to support deployed operations. So I'm confused about why you're now saying it's not needed.

BGen Jean-Robert Bernier: No. What I said in French is that we're conducting an evaluation of whether we need it overseas. So up until now, up until this evaluation and our experience in Afghanistan, we didn't find a need for them. However, as a result of the experience of others as a result of the experience of Afghanistan —

Ms. Joyce Murray: Excuse me, I'm really confused. This briefing note says that you do need them, and this is from a year ago. So I'm not sure why you're saying that you're re-evaluating because you didn't think there was a need for them.

BGen Jean-Robert Bernier: That briefing note was the launch.... If you look at the end of the briefing note, you'll see that it talks about the need for us to evaluate but within a year there will be a re-evaluation of whether or not we need uniformed psychologists.

Ms. Joyce Murray: This is a request for funding. So this talked about using the $11 million in it. This is as clear as you can get from my perspective.

The Vice-Chair (Mr. Jack Harris): Sorry, you have about thirty seconds, please.

Ms. Joyce Murray: So has any progress been made on that?

BGen Jean-Robert Bernier: We have psychologists. The question is whether or not do we need them—

Ms. Joyce Murray: Uniformed clinical psychologists.

BGen Jean-Robert Bernier: Yes. We have clinical psychologists.

Ms. Joyce Murray: Uniformed clinical psychologists.

BGen Jean-Robert Bernier: No. But the question is do we need uniformed clinical psychologists and does the requirement to deploy them in deployed operations exist sufficiently that it would be of sufficient benefit. And that is what Colonel McLeod's working group is evaluating right now, with the report to be out by the end of April.

The Vice-Chair (Mr. Jack Harris): Thank you, Ms. Murray.

We're now into the second round. The first questioner will be Ms. Gallant and I will be taking the second slot, so I'm wondering if Ms. Murray can replace me here as the chair so that I can ask my questions from a more appropriate place. When Ms. Murray is here, we'll start with this round.

● (1145)

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

Mr. James Bezan (Selkirk—Interlake, CPC): Point of order.

The Vice-Chair (Ms. Joyce Murray): This isn't sneaking into my time, is it?

Mr. James Bezan: No. This isn't on your time.

I believe that in the rules—and I should have brought my book with me because I can find it really quickly—the person who is sitting in the chair has to stay in the chair unless they're not available. So, in the event that our current chair is ill today, unavailable, you are the first vice-chair. First vice-chair is in the chair and has to maintain the chair position, unless, of course, they need to leave, in which case our second vice-chair would take the seat.

I don't believe—

Mr. Jack Harris: Let's check with the rules, and maybe the clerk can help out.

Mr. James Bezan: Yes. I believe that if the chair is in the room, they need to be in the chair.

Mr. Jack Harris: You may be correct.

Mr. James Bezan: I would definitely allow for the chair to ask questions from the chair.

The Vice-Chair (Mr. Jack Harris): That's fine. We've done this before; that's why I just did it again.

Mr. James Bezan: And I'm just thinking that—

The Vice-Chair (Mr. Jack Harris): If it's not possible, I can ask them from here, that's not a problem.

Mr. James Bezan: You always have your prerogative, but if there's time left near the end of the meeting, you can ask your questions.

Mrs. Cheryl Gallant: If there's time left at the end of the meeting, they don't just hand over the gavel.

The Vice-Chair (Mr. Jack Harris): I think in order to just deal with this question, we will go ahead with Ms. Gallant, and we'll see if we can get some information.

Mrs. Cheryl Gallant: Okay. Through you to the Surgeon General, are you tracking the length of time between the point at which OSI patients first present and onset of symptoms? So a patient presents and gives you the date when they first started feeling the symptoms at the point at which treatment is actually sought by the member. It's to be able to confirm that we're providing empirical data that there's a positive correlation between early treatment and the likelihood that a member's career in the military will not be adversely affected.

BGen Jean-Robert Bernier: Thank you, ma'am.

We track wait times for care. We also have the Statistics Canada study going on right now tracking people who don't present for care and the reasons why. We're establishing, as part of the strategy, some quality assurance, a clinical outcomes management tool that will help us look at and map responsive care, presentation care—from the presentation on—the response to care against standardized reference tables, and models that have been established as to what the normal response should be to help us identify folks who are falling off the recovery curve, to intervene, to have a red alert trigger for those cases where recovery is not consistent, where response to care isn't consistent with what should be expected based on the available evidence for that kind of clinical case.

I'm not sure if that addresses what you're asking.

Mrs. Cheryl Gallant: It would be helpful to demonstrate to Canadian Armed Forces members that the outcome is more positive the sooner treatment is sought for an OSI.

In terms of the responsibility of health care, if a Canadian Armed Forces member is hurt off duty, off DND property while not in theatre, is that CAF member supposed to report to a base hospital, a military doctor? Or is there another source of medical coverage in place?

BGen Jean-Robert Bernier: Everybody is issued a Blue Cross card, or a third party insurer card, so that no matter where they are—even if they're on holiday in Thailand—they'll have all their health care paid for. For regular force members, full-time members of the armed forces, the armed forces aren't only responsible for injuries and illnesses related to military service, but any injury or illness for any reason.

Mrs. Cheryl Gallant: If they're not on duty, it is the Blue Cross then that covers them. Is that what you're just saying?

BGen Jean-Robert Bernier: If there's a military facility nearby, and it's open, they go there and they'll get care. It depends on what kind of care. If it's a traumatic injury that requires immediate surgery and critical care, then it would be 911, but all costs are covered by the defence department. So anything that's available in the community, whether in Canada, overseas, with allies, etc., anything that's required would be covered by the defence department.

● (1150)

Mrs. Cheryl Gallant: Okay. Does a separate insurer have responsibility for disabilities and care when an incident or illness occurs while members are not on duty?

BGen Jean-Robert Bernier: They don't for full-time regular force members. There are insurance programs available—for example, SISIP, the service income supplement insurance program—but for their care, so long as they're members of the armed forces, any element of their health care would be the responsibility of the defence department. Some of it might be provided by a third party, but the cost would be the responsibility of the defence department, and arranging for the care would be the responsibility of the defence department.

Mrs. Cheryl Gallant: If someone in a motorcycle accident, off duty, in the city, off base, had to go a civilian hospital because it was closer, then that would be covered by Blue Cross. If that person suffered a severe disability and could not return to work, or even if they could return to work, the disability insurance may come directly through DND—or through SISIP?

BGen Jean-Robert Bernier: While they're in service, they receive all their regular salary, etc., so they don't need disability insurance. But once they're released, once they're transferred, if they have to be medically released because the severity of their illness precludes their ongoing service, then it becomes the responsibility of both Veterans Affairs Canada with their programs to look after them as well as SISIP.

Mrs. Cheryl Gallant: From time to time we have Canadian Armed Forces members who are waiting longer than they would like to wait for some kind of care, especially as it applies to an OSI. They feel they need treatment right away. Sometimes they want to seek treatment off base, just because they would prefer a non-military practitioner.

The Vice-Chair (Mr. Jack Harris): You're over your time, Ms. Gallant. Could you speed up and get a quick answer, please?

Mrs. Cheryl Gallant: Why is it that Canadian Armed Forces members are discouraged from seeing mental health practitioners outside of the military?

BGen Jean-Robert Bernier: They may be referred to outside sources by the military, but the general principle of continuity of care requires that they be part of the military health system, that their care be quarterbacked. There have been some tragic, tragic circumstances, in cases that have led even to deaths, where care was sought, unbeknownst to the armed forces, outside, and then, not knowing what their circumstances were, they were deemed fit to deploy to operations.

The Vice-Chair (Mr. Jack Harris): Thank you, General. I'm afraid we have to leave it there.

On the point of order raised by Mr. Bezan, I'm told by our assistant here that this is regularly practised in other committees. Given the fact that there's a controversy about it, however, I'm not prepared to make a ruling. I would ask for the consent of the committee to use this procedure now, and then we'll find out the policy afterwards, if that's all right. If that's not all right....

Is there unanimous consent to allow me to do it at this point?

Mrs. Cheryl Gallant: I just want to make a point, Mr. Chairman.

The Vice-Chair (Mr. Jack Harris): Yes.

Mrs. Cheryl Gallant: I understand that these are unique circumstances, but I would not want it to become a practice that the chair took time, or made time, in a meeting so that he or she could ask questions, because often we are cut off due to a variety of reasons.

I'm just making that point. I'm not dissenting.

The Vice-Chair (Mr. Jack Harris): Your point is valid. The question is whether it's permitted for a member of the committee to ask questions as a member of the committee. I'm serving as vice-chair now.

I'm not prepared to make a ruling on it. Is there unanimous consent to allow this practice at this meeting, at this time, and to get a ruling later? If not, we'll just continue.

Ms. Joyce Murray: Yes.

Mr. James Bezan: I would just say this: the chair always has the prerogative at the end of the meeting to ask some questions.

The Vice-Chair (Mr. Jack Harris): I'll use that.

Mr. James Bezan: I think that's the proper process, Mr. Chair.

The Vice-Chair (Mr. Jack Harris): That's fine.

There being no unanimous consent, we'll move to Mr. Larose, please, for five minutes. Thank you.

[*Translation*]

Mr. Jean-François Larose (Repentigny, NDP): Thank you very much, General Bernier, for being here today.

[*English*]

You mentioned earlier, and when we went to the base in Petawawa it was mentioned, that there's a recognition of the Canadian Armed Forces that there's a little bit of a stigma on troops coming forward, correct? I believe you mentioned 90% as an estimate of what we think the number would be. Is that correct?

BGen Jean-Robert Bernier: Sir, 90% of those who don't present for care don't present for care because they think they don't need care.

Mr. Jean-François Larose: Do you have an estimate of how many troops that 90% would be, all ranks?

● (1155)

BGen Jean-Robert Bernier: Of those who do not present for care? No, we don't. That comes from the Statistics Canada mental health survey that's ongoing.

Mr. Jean-François Larose: The surveys there right now are done on a voluntary basis, correct? So it's possible that people aren't answering them correctly; they either don't feel comfortable about bringing it up or they don't have the knowledge to bring it up, correct?

BGen Jean-Robert Bernier: Except the Statistics Canada survey is anonymous, and it's not conducted by the defence department.

Mr. Jean-François Larose: Okay. But then again there's an education also, to recognize.... That was one of the....

BGen Jean-Robert Bernier: Yes. Stigma will always exist and not just for mental illness, for many things. We can bring it down, but it's going to be a constant battle. We have improved dramatically so we know, for example, that we have a higher rate of people presenting for care than the civilian population does—a greater willingness.

Mr. Jean-François Larose: The number that came up in 2002 was 452, post-deployment. Is that correct?

BGen Jean-Robert Bernier: I'm sorry, 447 was the number, and it has since been increased to 452.

Mr. Jean-François Larose: My question is, if there is a re-education—and I know that you're doing programs to bring that forward, and that's my other question after, how much are you doing?—what happens if the number doubles from what was expected? How much resistance is there going to be? Because we just don't know. There's a lot of information, and you mentioned it earlier, that you're waiting on to make a reassessment. We could end up with surprises. My worry isn't how valid that information is and how much more information we need to make the correct decisions, but more, once those decisions need to be made and we realize that we have to double the amount of money to help those troops, how much resistance is there going to be? Is there an openness right now that no matter how the numbers come out, we are going to give all the services that they deserve, without any doubt?

BGen Jean-Robert Bernier: I and my predecessors asked for a lot of things during combat operations in Afghanistan.

Mr. Jean-François Larose: Post-deployment, also?

BGen Jean-Robert Bernier: Intra-deployment and post-deployment. Everything we asked for, we received: for example, an unprecedented 4.8 psychiatrists in Petawawa for a population of 6,000. There's no other community in the world, I think, that has that level.

Mr. Jean-François Larose: Considering the knowledge of PTSD —even in 2002, even when I was in the forces we were talking about this—why was it not in the planning to have a psychologist on field deployment? I don't understand. Because we've known this for a long time.

BGen Jean-Robert Bernier: The type of work that clinical psychologists do is necessary in our clinics, and that was part of the evaluation. At the time, the determination of whether or not there's a need for them in the...because in deployed operations we can't hang on to people for long times. We have a very small medical footprint, and the whole point is either they get back to duty right away or we evacuate them out of theatre.

A clinical psychologist's work tends to take longer: psychotherapy, psycho-evaluation, the bulk of the work. So the determination at the time was that, with what would be deployed among the competencies of physicians, psychiatrists, mental health nurses, and social workers, the duration of the treatment that we'd want to provide in theatre did not justify having clinical psychologists in theatre.

As a result of all our experience, seeing what the Americans and others do in Afghanistan, but primarily the Americans, and our own national experience, we're re-evaluating now whether or not we should have some or not.

Mr. Jean-François Larose: But I'm a little confused here. In 12 years of operation, only now you're re-evaluating?

BGen Jean-Robert Bernier: We've continually re-evaluated it, and there was never a crisis, there was never a need that wasn't being adequately met by the existing cadre of mental health professionals deployed overseas.

Mr. Jean-François Larose: So basically you're saying that the American services that were being used in Afghanistan were adequate? Because they were used.

BGen Jean-Robert Bernier: Yes. If they were available, they were used.

Mr. Jean-François Larose: Okay. But they were not used, and I think there is a language barrier here. We have, on one side, stigma on troops who do not come forward for all kinds of reasons. Correct? We have a language barrier that's definitely there, and then there's also an evaluation done by the Canadian Armed Forces, post-deployment—correct?—on numbers that are not real, and afterwards on numbers that are still not real, because we don't know. We have an idea. And then in 12 years, not once did it come up that the language barrier shouldn't be an extra barrier to having a psychologist available on deployment, if they're using American psychologists? In 12 years...not once?

The Vice-Chair (Mr. Jack Harris): Very quickly, General.

BGen Jean-Robert Bernier: There's only one incident I know of, and it's unrelated to whether or not.... The issue of French language services is one thing, and we strive to always provide that.

Mr. Jean-François Larose: How can they come forward if they can't even speak their own language?

BGen Jean-Robert Bernier: Right. So there was one incident that you've discussed, that we're aware of, and I don't know exactly what the circumstances were that led...but that's a separate issue than whether or not clinical psychologists in uniform are necessary. And we do have good data telling us what the burden is, from our operational stress injury incident study, 2009.

● (1200)

The Vice-Chair (Mr. Jack Harris): Thank you, General.

The next is Mr. Carmichael for five minutes.

Mr. John Carmichael (Don Valley West, CPC): Thank you, Chair.

Thank you to our witnesses.

General, I'd like to just briefly follow up. I recognize that you're going to be providing something in writing to us, based on Mr. Norlock's question earlier with regard to sleep treatment, etc., but I wonder if you could just give us a quick understanding of the difference between PTSD and depression, as it relates to causing suicide—what we know. And is there a connection between depression and a lack of sleep? Can you give us anything concrete on that at this point?

BGen Jean-Robert Bernier: I'm not a psychiatrist, but we know that they're both related. Depression, particularly from a volume perspective, is related more to suicide than has been post-traumatic stress disorder, in our experience. PTSD in particular is affected by lack of sleep, more so than depression. One of the symptoms of depression sometimes is excessive sleep, an inability to get up.

The burden of depression is greater in absolute numbers. Prevalent in mental health illness in the Canadian Forces is depression. As I mentioned earlier, our 2002-03 Statistics Canada mental health survey of the armed forces found that regular force males, in the armed force data, almost doubled the depression rate of the general public. It's a major concern for us.

Mr. John Carmichael: Thank you.

In your presentation, you talked about some of the research that's being carried out right now. Some of the work is at the Hospital for Sick Children. You also have one of your colleagues working in the trauma chair at the Sunnybrook hospital.

I wonder if you could tell us, as we're learning more and more about PTSD and brain trauma, about what has been accomplished so far. Just give us an idea of what that research is generating in terms of knowledge that we can work with today. Also, what's the timing on some of the research that is currently under way? You've talked about neuroimaging and some of the different technologies that are being applied. What are we learning and how soon are we going to be able to truly apply some of this learning?

BGen Jean-Robert Bernier: For some of it, it's difficult to predict when it will lead to actual, practical, clinical therapeutic results. For example, for the virtual reality technologies that we have now...we're finding some greater willingness for soldiers to stay in treatment.

It's one thing to get people to start treatment. We lose a lot of folks because they withdraw from care for various reasons. Then they don't get fully cured. They don't get the best benefit from therapy.

Neuroimaging is probably the most promising element, particularly something called “magnetoencephalography”. That provides real-time imaging with no delay, whereas even a functional MRI has a certain delay that occurs in the imaging of the brain's functions. It provides both a functional...and the FMRI provides a structural demonstration of what's happening in the brain. Because the magnetoencephalography is so rapid, that is going to help us. It's already permitting us to detect patterns in the functioning of the brain that are physiologically different in depression, post-traumatic stress disorder, and mild traumatic brain injury. That's moving very quickly.

The more broadly the equipment gets disseminated across at least the academic centres for now—and ultimately the treatment centres—the more it will enhance the speed with which we can do diagnostics, the confirmation of the trajectory of care and recovery, and possibly even predict who will have greater susceptibility to post-traumatic disorder or other conditions.

Mr. John Carmichael: In advance.

BGen Jean-Robert Bernier: Yes, in advance. We don't know that part yet, but that's theoretically possible, depending on how much.... It may even allow us to tailor, in combination with other technologies—genetics, particularly—specific pharmaceuticals up front, to know what will work best, and thus save many months of time in many cases in selecting the correct treatment.

Mr. John Carmichael: Is that work being done strictly at the Hospital for Sick Children? Or are other facilities now working on that?

BGen Jean-Robert Bernier: We're working with several universities and the U.S. defence department, and with allies in Europe and the U.S. Department of Veterans Affairs. There are multiple research groups doing work in those areas. There are all kinds of others related to transcranial magnetic stimulation. That's showing some benefit with regard to the treatment of depression, and now we'll be applying it to PTSD as well. There are two research centres in Canada, in Toronto and Quebec City, that we're working with. There are others in the U.S. that are doing the same kinds of things.

There's quite a wide variety. We're integrated in virtually anything that can contribute to military health. We're integrated in one way or another domestically through the academic world, through the Canadian Institute for Military and Veteran Health Research, through the quintipartite technical cooperation program with the Anglo-Saxon allies, and, through NATO's science and technology organization, the world's largest research network, with the health research committee, which is chaired by my deputy.

● (1205)

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Your time is up, Mr. Carmichael.

Next, for five minutes, we have Madam Michaud.

[*Translation*]

Ms. Élaine Michaud: I would like to come back to another aspect of how services are provided to our soldiers in French.

Last week, Colonel Gerry Blais, Director of Casualty Support Management of the Canadian Forces, appeared before our committee. I asked him if it was possible for all military bases to provide services in French, considering the needs, whether this involves volunteers or staff.

Is that the case or not? Is it possible for all military personnel to receive mental health services in French on every base in the country?

Although this is not linked to mental health, I have seen cases where people have been sent to certain bases to take a course that was supposed to be bilingual, but since most of the people on site were anglophone, the course was given entirely in English. Even when a service was supposed to be offered in French, that is not what actually happened. This really worries me.

I wonder if you could talk about the situation on all bases across the country.

BGen Jean-Robert Bernier: Some bases do not have a single psychiatrist. When it comes to health care, we always try to have enough clinicians, nurses, physicians, physician assistants and people with enough mental health literacy to act as interpreters, if necessary, or to provide part of the care in French.

In francophone units or certain francophone regions, of course, all services are provided in French.

Ms. Élaine Michaud: Yes.

BGen Jean-Robert Bernier: In the rest of the country, especially in the western provinces like Alberta and British Columbia, we try to have enough people with the skills required. It depends on the proportion of francophones on the military base and in the military community. It is hard, considering the shortages that exist in many fields across the country.

Ms. Élaine Michaud: What do you mean by “enough people”? Does that mean one person per shift?

If I understood correctly, you are saying that someone does not need to provide the service entirely in French; they need only be able to translate the information to a unilingual anglophone professional. In your opinion, this constitutes providing service in French.

BGen Jean-Robert Bernier: If the resources are not available in the military community, we try to find them externally. For instance, in a city like Victoria, there is likely at least one psychiatrist or psychologist who is bilingual. So we will then be able to provide the necessary service, especially to those whose language skills may prevent them from receiving services completely in that language.

Ms. Élaine Michaud: Beyond language skills, it is important to feel comfortable and be able to talk about health concerns, particularly mental health. Although I consider myself perfectly bilingual, when I go to my doctor, I speak to him in French. This is the same situation.

It doesn't sound to me like the service obligation is being met. I can imagine the additional delays that francophone soldiers are experiencing before they can access mental health services when they are posted outside of a francophone region.

Since I have other questions, I unfortunately have to change the subject. In any case, based on the information you are giving me, the situation regarding the services provided to our francophone soldiers seems extremely troubling.

[*English*]

The Vice-Chair (Mr. Jack Harris): You have a minute and 15 seconds.

[*Translation*]

Ms. Élaine Michaud: When a member of the Canadian Psychiatric Association appeared before our committee on April 17, 2013, he recommended that the Canadian Armed Forces carry out periodic screening for PTSD and common co-morbid conditions such as depression, addictions, and suicide, which would enhance early detection and facilitate treatment.

How often does the Canadian Forces carry out such period screening?

● (1210)

BGen Jean-Robert Bernier: Do you mean individual screening?

Ms. Élaine Michaud: Yes.

BGen Jean-Robert Bernier: A full assessment is done at the time of recruitment and then every five years until age 40, or thereabouts. We also do an assessment before every deployment and sometimes one during the deployment. Between three to six months after the deployment we do another comprehensive assessment. This goes on throughout the soldier's entire military career until the end of his service. One final assessment is done before the person is released from the armed forces.

Ms. Élaine Michaud: You mentioned earlier that taking care of the families was not part of your mandate. Nevertheless, do you do any outreach with the military families to find out whether they are satisfied with the services and determine their needs? How often is that done?

BGen Jean-Robert Bernier: That is beyond the purview of the Canadian Forces Health Services Group. Another organization with the Department of National Defence deals with family support and services.

Often, these centres offer the families on the base services from sociologists and other specialists. What is more, they have service networks in the community. Nonetheless, their clinical care is not subsidized by the Department of National Defence.

Ms. Élaine Michaud: Thank you.

[*English*]

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Mr. Bezan, for five minutes.

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

I want to thank our witnesses for coming back and helping us wrap up our study on the care of the ill and injured, and helping us fill in some of the holes on the report that we're putting together.

Ms. Rigg, when you were here last time, we talked briefly about the shortfall in trying to meet that goal. Two numbers were floating around. One is 447 mental health professionals, another one is 452.

What were the challenges in trying to find those people? There seems to have been a bit of a wait in trying to meet that number and reaching that goal. Can you just fill us in why it's taken as long as it has?

Ms. Jacqueline Rigg: Absolutely, there have been some challenges in filling these positions. We'd identified a gap of 54 positions that needed to be filled and we've been working very hard to do that.

One of the first challenges is our limited labour market availability of these professionals in Canada. That's why it spread. DND falls into that same challenge of finding the right skilled professionals.

We also have a challenge because we are staffing these positions in remote locations or non-metropolitan areas. For example, staffing in Cold Lake, Alberta, in Shilo, Manitoba, are quite challenging for us to get folks who are willing to relocate to do that.

We're also competing with the private sector. Notwithstanding that we offer the top of the scale salary in our wage bands for these positions, it doesn't make us fully competitive with the private sector salary bands. To do this, we realize that we need some mitigating strategies to have this happen, so we are running specific processes in these remote areas to attract them.

We have partnered and worked with Treasury Board Secretariat and the Public Service Commission. We went to Treasury Board Secretariat, so that we can increase the amount of money that we can offer to external hires for relocation. That's often a barrier. Previously, we could only offer $5,000 to support external hires to the public service. We got it increased. Until March 31, 2015, we can offer up to $40,000. This we feel will help us in our remote locations, which has been a very big barrier.

With the Public Service Commission, you cannot make any hires unless you check all the priorities in the system. We've created an expedited process with them, basically telling them, “Because we have such a shortage in this area, just refer to us any priorities who have that skill set and we can automatically bring them on board”. Also, for the priority clearances that we require before making a letter of offer, we ask them, “Can you please give us a faster process to get this done because we can't wait?”

While we're waiting for some information as well, we moved to giving a lot of conditional letters of offer because you've got to get your official languages done, you've got to get your medical done. We figure that by providing a conditional letter of offer we're getting a bit more stickability to the person who may be getting another offer while we're trying to get those ducks lined up.

Mr. James Bezan: Have you found that there's any particular occupation or profession that has been more challenging to fill than others within the mental health field?

Ms. Jacqueline Rigg: I think our hardest—and it's largely probably due to the wage band issue—are psychologists and psychiatrists. Those are the two hardest areas.

Mr. James Bezan: General, now that we've been able to bump those numbers up, and I know it's been relatively recent, have you seen any reduction in wait times?

We heard from some of our witnesses that we've had here, as well as when we went out to Petawawa, that there were some complaints regarding the wait times especially to see the psychiatrists or psychologists. Have we started to see any reduction in wait times for our members?

● (1215)

BGen Jean-Robert Bernier: Yes, we have, but we weren't exclusively relying on the public service. Many of those positions were filled by Calian. We're pursuing other methods, like tele-mental health, which I mentioned, and process improvements.

For example, I've just come back from Quebec City. The base in Valcartier, where there was at one time a four- to six-month wait time that we identified through our regular monitoring about a year ago, is now down to one of the shortest wait times in Canada. I just want to congratulate them. We routinely look and conduct site assistance visits as well to look for process changes that could make things better.

But, yes, overall, there are now very few places where there's an exceedance of a 28-day wait time for initial treatment and assessment for specialized care, which is far faster than is generally available. There are still individual cases that we have to pursue individually when we hear of circumstances that don't sound right. Though, in many cases, when we hear about such cases and we look into it, it turns out that there was something else to explain why there was either not a requirement or they were getting the appropriate care that was not requiring or was unrelated to a perceived delay. Most of the delays that we have, we have data that shows that wait times are not a barrier for almost all of our patients, that the barrier is in other areas, and that most of time when there is a delay—

The Vice-Chair (Mr. Jack Harris): Thank you, General. Can you clew up?

BGen Jean-Robert Bernier: —it's because of the self-imposed delay in presentation.

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Your time is up, Mr. Bezan.

Mr. Larose, you have five minutes.

Mr. Jean-François Larose: Thank you, Mr. Chair.

[*Translation*]

I want to pick up on what Mr. Bezan was saying.

You said that at Valcartier, the wait time had been reduced by several months. What precisely is the wait time now?

BGen Jean-Robert Bernier: It's 28 days. That is what the Canadian Psychiatric Association recommended. Ideally, no community in Canada would have to wait longer than that.

Mr. Jean-François Larose: So, the wait time was reduced from several months to 28 days.

BGen Jean-Robert Bernier: On average, that is correct. However, the wait time varies depending on the circumstances. For example, a female psychiatrist might go on maternity leave and her team is made up of only three people.

Mr. Jean-François Larose: That is the association's recommended wait time, but what is the wait time you are aiming for, for the armed forces?

BGen Jean-Robert Bernier: Everyone should have immediate access to medical care and psychosocial care. Some cases require a more comprehensive assessment by a specialist such as a psychiatrist or a psychologist. For those cases, we aim for a 28-day wait time.

Mr. Jean-François Larose: Is special training provided? We agree that

[*English*]

mental health is growing—I mean, our knowledge is.

[*Translation*]

As far as cooperation between the armed forces and the civilian system are concerned, you mentioned a number of times that there is a clear shortage of specialists in the civilian system. Do psychiatrists with specific knowledge and experience doing research and development in the area of post-traumatic stress disorder provide training to the social workers who assess the people they meet before this 28-day wait time lapses?

BGen Jean-Robert Bernier: Together with the doctor, an assessment is made to determine what type of care people need immediately. The more complex cases will need a more comprehensive assessment. In Canada and in most countries around the world, general practitioners provide the bulk of the mental health care for cases that are not complicated. Accordingly, most of our patients who need drugs will have already gotten them before a psychiatrist or a psychologist begins a specialized assessment. This is recognized as the best practices based on—

Mr. Jean-François Larose: There is no doubt that there have been advances in research and development. Earlier, you shared your opinion by talking about the difference between post-traumatic stress disorder from a peacekeeping mission and post-traumatic stress disorder from Afghanistan. I do not necessarily agree with you, but I am no expert.

Many soldiers who took part in missions such as the one in Bosnia are now veterans. Would it be a good idea to have them take part in the study, which would in turn provide more samples and help in making new discoveries? In light of that study, you might realize that we should have given these soldiers, who are now veterans, specific drugs or treatment, or provided them with certain support. Is there any interest in looking to the past, and acknowledging our mistakes and that we should proceed in a different way? It is good to help our current soldiers, but let's not forget those who have been veterans for a number of years now and all those who will become veterans. Your study is important in that sense.

● (1220)

BGen Jean-Robert Bernier: In fact, last week we met with researchers from McGill University who are looking for serving and retired members of the military in order to conduct a study that will evaluate certain new technologies.

Mr. Jean-François Larose: Is there an interest in the treatments?

BGen Jean-Robert Bernier: The Canadian Armed Forces health services cannot provide the treatments directly. That is a problem. In our country, we have socialized medicine and health care is a provincial jurisdiction. With the exception of its 10 mental health clinics, Veterans Affairs does not provide health care directly. Our group is integrated and Veterans Affairs...

Mr. Jean-François Larose: Nevertheless, the knowledge required to properly assess cases of post-traumatic stress disorder and provide services and treatment accordingly is not found in the provinces. We all agree that the problem of PTSD really is an area of expertise of the Canadian Armed Forces. I know that there is cooperation, but to what extent does that solve the problem?

BGen Jean-Robert Bernier: Knowledge is shared across the country. Our group is plugged into all clinical community services so that it forwards new information emerging from our research. Veterans Affairs Canada is doing the same thing.

Mr. Jean-François Larose: According to the reports, veterans and regular and reserve force members say that services offered to families are inadequate. The wait times that you are working hard to reduce for members of the armed forces are not diminishing in the civilian system. According to the reports, it seems that the problem is being handed over to the civilian health system. At the same time, the armed forces recognize that civilian health care is not adequate for post-traumatic stress. You are the experts on that subject.

Does the government intend to change provincial participation in this area?

BGen Jean-Robert Bernier: That goes beyond my mandate, which is limited to the health care provided to members of the Canadian Forces.

Veterans Affairs Canada would be able to answer that question.

Regardless, we help them as much as possible—

[*English*]

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Your time is up, Mr. Larose.

We now have Madam Gallant. Or is it Mr. Bezan?

Mr. James Bezan: I'll go first. We'll have time for another round anyway, so I'll take five minutes and Madam Gallant will go in the third round.

The Vice-Chair (Mr. Jack Harris): Mr. Bezan.

Mr. James Bezan: I want to come back again to the issue concerning the number of medical health professionals.

You mentioned, General, that we're going through a review. Colonel Blais mentioned it when he appeared here on April 1. The ombudsman's report also raised the question of staffing. There were 40,000 troops deployed who have returned home from Afghanistan, and we aren't sure when some OSIs are going to present themselves over the next number of years.

Can you give us some indication? I know you're still in the review, but when do you plan to reach a conclusion about what the right numbers are and what the mix is? And where do you already see that there could be some need for improvement?

BGen Jean-Robert Bernier: Thank you, sir.

As I mentioned earlier, by early 2015 we expect to receive the results of the Statistics Canada mental health survey and the health and lifestyle information survey, which will give us better global data to help guide the optimum distribution and requirement.

We already have some good data. The operational stress injury cumulative incidence study permits us to project out, over about a decade, what we can expect for Afghanistan-specific related operational stress injuries. But we need more than that. We're trying to now update what we did in 2002 and 2003 for the global Canadian Forces requirement. As I mentioned, Afghanistan-related operational stress injuries constitute a minority of our global mental health problems.

We have adjusted incrementally over the years. It has crept up from 447 to 452, based on our evaluation of the success of the road to mental readiness program and various other evaluations, including the operational stress injury cumulative incidence study, but these have been piecemeal evaluations and tweaks based on limited data. Now we have spent the last year, before producing this strategy, to look at all the available data. We are now just waiting for these two missing pieces, these comprehensive studies, to give us everything we need to get the best possible determination of the distribution in the future and the number, the volume of care.

We're already at double, on average, what the civilian population has per capita and we have the highest ratio per capita of mental health clinicians within NATO. But is that enough, or is it too much, or will technology permit us to change things because things have changed?

● (1225)

Mr. James Bezan: Thank you.

One thing we heard from members when we were meeting with them is that, if they're at the JPSU and have made the decision to transition out or are at the cusp of making that decision, they have a lot of anxiety over their life after the military. We heard from a lot of them that they would like to stay involved in DND.

Ms. Rigg, could you talk to the fact that there is a desire among so many veterans and people who are currently serving members of the CAF to be still involved with DND? What types of opportunities would they have in coming back as civilian employees within DND? What policies does DND have concerning hiring veterans?

BGen Jean-Robert Bernier: It's not my area, but I know that releasing veterans are eligible to transfer to elements of DND that permit them to stay up to age 65 in the cadet instructor cadre and with the Canadian Rangers; there are limited positions there. There's legislation that was passed recently giving priority for public service hiring.

Ms. Jacqueline Rigg: Let me add that we have several programs in place on the civilian side to support and to look after ex-military folks who want to still stay working within the Department of National Defence.

On the civilian side, we have available to them the employee assistance program or EAP. We have a return to work program that is very useful. They have a worker who works with them to figure out how to get them back into the workplace. We also have a policy called duty to accommodate; we therefore have that in place. If there are any accommodation requirements, we have a duty to meet those, and we provide support that way. There are also leave provisions, provisions that are negotiated through our collective bargaining.

Those are several of the main ones that we have. But absolutely we encourage and support our ex-military in the civilian workforce.

Mr. James Bezan: Are there any barriers for ill and injured who are transitioned out? What barriers are there to actually being integrated within a DND context?

The Vice-Chair (Mr. Jack Harris): Could we have a very short answer, please?

Ms. Jacqueline Rigg: I wouldn't say there are any barriers, but we do have the Public Service Employment Act so we just have to follow that. They have to go through the process just as any other folks do. So that's not necessarily a barrier; it's just how we maintain fairness in our employment on the civilian side.

The Vice-Chair (Mr. Jack Harris): Thank you, Mr. Bezan.

We now have time for a third round. Each party has one questioner for five minutes starting with Madam Michaud.

[*Translation*]

Ms. Élaine Michaud: Thank you very much, Mr. Chair.

When Colonel Gerry Blais last appeared before this committee, on April 1, he told us about a full review of the joint personnel support unit network and the integrated personnel support centres. The results of this review contain recommendations about future staffing needs.

Could you give us a little more information about future staffing needs? What are the current initiatives to meet needs? What other recommendations have been made and what are the resulting initiatives?

BGen Jean-Robert Bernier: Thank you for your questions. However, I cannot answer them because those are two separate units. I am responsible for the health system and not the medical support system, which is Colonel Blais' responsibility.

Ms. Élaine Michaud: Nevertheless do they have some work elements in common?

BGen Jean-Robert Bernier: Yes. Case managers are part of this team. There is constant communication between the medical service and Colonel Blais' organization.

Ms. Élaine Michaud: Your responsibility is to inform them of the state of the situation and certain needs that you identify. Then, everything to do with staffing is done on his side of the organization. That is what I make of it.

BGen Jean-Robert Bernier: I look after staffing for health services. That involves the clinical services required to provide health care, education, training for mental health awareness and so forth. Colonel Blais is responsible for his unit, which looks after all the other elements that provide support.

Ms. Élaine Michaud: I want to get back to health-related topics.

On June 3, 2013, the committee heard from Heather Allison, who is the mother of a ill and injured soldier. Then, on June 5, 2013, we heard from Corporal Glen Kirkland. He told the committee that he was very worried about the fact that doctors seemed to be prescribing too many medications to soldiers who are ill or injured.

Have you heard similar concerns?

● (1230)

BGen Jean-Robert Bernier: That's always a concern. In medical school, they teach you to avoid medication as much as possible and to find other ways to treat a patient.

Everything we do is based on the best scientific data. We are always trying to determine the best ways to treat patients, based on new research. We always push doctors to consult all that information. We hold training sessions. All of our doctors take a minimum amount of training on news and updates in clinical science.

I can't speak to individual cases. However, we can always conduct clinical audits through the chief medical officers on the bases. We can also conduct central or national assessments. The director of mental health and his staff will conduct assessments of specific cases.

Our strategy is to ultimately create a clinical management and assessment system for each individual case that raises an alarm, for example, if something is not going well or does not correspond to scientific best practices.

Ms. Élaine Michaud: Could you give me an example of these best practices, without giving any details on individual cases? I understand those restrictions.

How does an assessment work if someone suspects an individual is abusing prescription drugs? What steps could be taken quickly to help a solder? Would it first go through the soldier's doctor? Would the doctor be the first person to note the problem? Are other staff members who are trained to intervene or detect potential problems able to note the problem as well?

BGen Jean-Robert Bernier: Our awareness program includes families, people in leadership roles, as well as the soldiers' peer support system. We are trying to rely not only on health care services, but also the entire community around the individual to speak up if their behaviour changes or there is something else that indicates a problem.

Ms. Élaine Michaud: If someone is prescribed psychotropic drugs, antidepressants or anything else to help them through a mental health issue, will they automatically receive mental health services from a psychologist, social worker or psychiatrist? Taking medications alone, without any consultation with a clinician is often ineffective. It is also a factor that can lead to prescription drug abuse.

[*English*]

The Vice-Chair (Mr. Jack Harris): I'm afraid you're over your time, but a very quick answer, General.

[*Translation*]

BGen Jean-Robert Bernier: That depends on the individual's specific condition. In Canada, in most cases, people will be treated only with medications prescribed by their family doctor, but in some cases they will need more than that.

Our group has an entire team. It is not only a doctor working independently. The entire mental health team and primary care team work together.

[*English*]

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Ms. Gallant.

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

To the surgeon general, you referenced the self-delay in seeking treatment...soldiers don't think they need help. What's been explained to me is that in some circumstances the individual doesn't recognize treatment is needed until they're ready to blow. They're a volcano about to erupt. That may not occur during the hours of operation of the mental health unit. Consequently, military police may be called in, but the option at that point is for the soldier who in crisis to go willingly into a psychiatric hospital.

For a soldier, willingly going and submitting for psychiatric help in a hospital is akin to surrendering. I'm sure you're with that military ethos. So the only way they can go in their minds is against their will. That action often has even greater consequences on the soldier's future in the military, and even civilian life. Civilian police can obtain a form from a physician ordering or allowing the police to take the individual to a hospital for psychiatric care. I understand a similar situation does not exist for the military police. So is it possible to get a similar measure in place so that the military police can force a soldier to a hospital for psychiatric treatment so that a crime does not have to be first committed before they're apprehended?

● (1235)

BGen Jean-Robert Bernier: Yes ma'am. All of our physicians have licenses that permit them to issue that form. Which arm of the police service, whether it be the civilian police or the military police, that exercises the requirement for a mandatory psychiatric assessment.... The civilian police could equally do it if the military police....

I can't comment on what the military police authority is, but we have had situations in various provinces where our military physicians issued a form and the civilian police collected the individual and took them to the nearest facility that had the competencies and capability necessary to conduct the psychiatric assessment for self-harm or harm to others.

Mrs. Cheryl Gallant: So then it's a provincial matter because—

BGen Jean-Robert Bernier: Yes, it's different in every province.

Mrs. Cheryl Gallant: —the military police in Ontario tell me they cannot do what a civilian police officer can, and consequentially the soldier in crisis has to commit a crime before they can forceably take them. So this isn't something that can be solved through the military. Does it have to be through the province?

BGen Jean-Robert Bernier: It's not necessary. If a family member, if any physician for any reason...whether the report of a military police officer.... The family member sees enough to be convinced that there's a need, that there's a sufficient risk of self-harm or harm to others, that requires a psychiatric evaluation.... Any physician can have whatever legislative authority in that province by completing a form—and it's a different form in each province—to mandatorily apprehending, and having that person be mandatorily assessed for psychiatric risk of self-harm.

Mrs. Cheryl Gallant: Does it have to be done in a very short length of time, or do there have to be symptoms that somebody observes in advance for that to occur?

BGen Jean-Robert Bernier: It can happen just based on symptoms. It doesn't necessarily mean it has to be an acute crisis with a criminal offence taking place.

Mrs. Cheryl Gallant: Okay.

On April 17, 2013, the Canadian Psychiatric Association recommended that the Canadian Armed Forces conduct periodic screening for PTSD and common comorbid conditions such as major depressive disorders, addictions, and suicide so as to enhance early detection and facilitate treatment.

How frequently do the Canadian Armed Forces conduct such periodic screening?

BGen Jean-Robert Bernier: The routine ones are at recruitment initially, with the routinely scheduled periodic health assessments that occur regularly, before every deployment overseas, after every deployment overseas with a very detailed evaluation, during subsequent periodic health assessments, and again at release.

In addition, for every routine assessment or during care for a runny nose or whatever brings someone in contact with the health system, there are also usually informal evaluations. All our clinicians are sensitized to do that, right down to the level of the medical technician.

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Your time is up.

Ms. Murray, you have five minutes.

Ms. Joyce Murray: Could you tell me how many suicides there have been in the forces and the reserves since September 1?

BGen Jean-Robert Bernier: Since September 1?

Ms. Joyce Murray: Yes.

BGen Jean-Robert Bernier: We keep the numbers by calendar year, so I'd have to look back. But since January 1, we've had three members of the reserve commit suicide. Those are still pending confirmation by coroner or police.

Ms. Joyce Murray: Would you be able to provide us the numbers since September 1?

BGen Jean-Robert Bernier: I could, from September 1 until now.

Ms. Joyce Murray: Okay. Thank you.

How many of the 37 hires to fill that gap were psychologists and psychiatrists, and how many of the remaining gap are psychologists and psychiatrists?

Ms. Jacqueline Rigg: I have that.

There are six positions required for psychologists. Two of those have been filled so there are four remaining.

I have numbers only for psychologists, social workers, mental health nurses, addictions.... I don't have a number for psychiatrists. I have the psychologist requirement as six; social worker as 21, of which we have 11; mental health nurse—

● (1240)

Ms. Joyce Murray: So the psychologists and psychiatrists are the hardest to fill, you were saying?

Ms. Jacqueline Rigg: They are.

Ms. Joyce Murray: And it's hardest to fill the spots at remote bases. Hence the advice to have uniformed clinical psychologists, because they can then be posted to these remote bases.

DND has contracted out a significant portion of the health care to a private company. Do you have numbers for average turnover for Calian-contracted doctors versus for those directly employed by DND or by the Canadian Armed Forces, so the comparison between turnover for contracted-out positions and for the hired positions?

Ms. Jacqueline Rigg: I apologize, but I don't have that statistic. I track only the positions that are public servants. I don't know about the Calian contractor turnover.

BGen Jean-Robert Bernier: I don't have objective data, ma'am, but we know that because the Calian contract permits Calian to readily respond to local market forces, they can modify the compensation to retain Calian contractors, so we have had many who tended to stay for a very long time.

Ms. Joyce Murray: So you have no statistics on what the relative turnover is. Okay, thank you.

You were saying, General Bernier, that your department is not responsible for care for spouses. My question is how often does the armed forces survey military spouses about their mental health needs and the quality of support services available to them?

BGen Jean-Robert Bernier: There is a separate organization called the director general for military personnel research that conducts research related to families of military personnel.

I'm not sure if there is a survey ongoing, but there was one done within the last few years. I believe there is one taking place right now to evaluate the kinds of services required for families.

Ms. Joyce Murray: Possibly every few years is the frequency.

BGen Jean-Robert Bernier: I couldn't answer accurately because it's not within my scope of responsibilities.

Ms. Joyce Murray: I understand that and I know that because you've been saying a number of times that you work as a team that you probably are aware of these matters as well and because how important it is to the physical and mental well-being of our armed forces members that their families are properly supported. So I'm sure it's an area of interest.

What were the results of the last survey? What did it indicate in terms of the mental health needs and the quality of support services available to spouses?

BGen Jean-Robert Bernier: Again, I'd have to defer that to the person responsible for that, support to families.

Ms. Joyce Murray: Are you ... well, okay ... are you ...

BGen Jean-Robert Bernier: But I can tell you that we did expand from 220-something mental health professionals to 447. Twenty-five percent of that increase was specifically to deal with the family involvement by mental health staff in the care of military personnel. We include them in our strengthening the forces health promotion social wellness programs, including anger management, stress management, addictions, various related factors that contribute to good or bad mental health...are open to families. The road to mental readiness program has a big family element to it that's offered to all family members.

In the evaluations pre- and post-deployment and in operational trauma and stress support centres, the family is involved in the assessment to ensure that everything is captured.

The Vice-Chair (Mr. Jack Harris): Thank you, General.

Sorry, Ms. Murray, your time is now up, in fact it exceeded by a fair bit.

Based on the time that we have left in our meeting, there appears not to be time for another round. We would go back to our first round which is four speakers. There not being time for that, I think we'll end the rounds. As is the tradition, there's a prerogative for the chair to ask a few questions. So I would seek to use some of that time to do that.

So Colonel Bernier, I was interested first of all in your assessment of the overall mental health expectations for members of the Canadian Armed Forces and you suggested that it was one in four, or one in five of the general population would have a mental health episode in their lifetime.

Can I suggest to you first of all, you don't really have people for their lifetime, you only have them from, say, 18 to 40 or 45? Secondly, you screen people presumably at the beginning of this period for any sign of mental health issues. You're not dealing obviously with the issues that relate to seniors and mental health as well. So your baseline for expectations would be lower than the general population to start with. Am I correct about that?

● (1245)

BGen Jean-Robert Bernier: That's correct.

The Vice-Chair (Mr. Jack Harris): Then, second, I was interested in your statement and I accept it, that individuals in the military would have mental health issues related to things other than their service and particularly other than their deployment.

But can you be more specific about what level or what percentage of the mental health issues that you're dealing with actually do relate to deployment? I'm not speaking specifically of Afghanistan. We've seen people with four or five deployments to Afghanistan who have also been to Bosnia or to other deployments, whether it be peacekeeping or peacemaking.

Do you have a statistic that would tell you what relates to actual deployment, operational? Let's call it operational factors.

BGen Jean-Robert Bernier: We only have specific numbers for the Afghanistan mission. The 2002 big study by Statistics Canada evaluated everybody and didn't attempt to determine whether it was related to the operations that had preceded that in Rwanda, Bosnia, etc. Statistics for mental health conditions attributable specifically to military operation, we only have for Afghanistan.

The Vice-Chair (Mr. Jack Harris): So you have a number for Afghanistan. What would that be? That's a number that keeps changing; I would suggest it will go up.

BGen Jean-Robert Bernier: For example, 13.5% of everybody deployed to Afghanistan, 40,000 troops, we anticipate based on a pretty good study to develop a mental health condition, an operational stress injury that's directly attributed to Afghanistan. That number over the course of nine years we extrapolate to increase to about 20% of everybody who deployed.

Eight percent at four and a half years for PTSD alone extrapolated to about 11.8% after about nine years post-deployment, compared to a lifetime prevalence of PTSD in the general population of anywhere from 7% to 9%. So it shows us that there's a very significant burden specifically resulting from the experience in Afghanistan.

The Vice-Chair (Mr. Jack Harris): Thank you. That clarifies it a bit more for me.

Ms. Rigg, perhaps you can help us on this one. I recognize that some of the issues you talked about, remoteness, etc., are factors here, but the concern I have is that the emphasis on trying to fill these positions seems to have only developed some 18 months after the funds were available to fill those positions.

It's been reported that there were internal factors that had nothing to do with the marketplace, etc., that have caused problems, such as restrictions on person-years, for example, adding person-years to DND or to the military, and specifically insisting that justification be given for particular positions.

Can you confirm that it wasn't simply the factors that you made available to us this morning?

Ms. Jacqueline Rigg: In terms of that, it did take a while to get the staffing up to speed, and yes, the factors I mentioned before are the primary reasons. Internally, as well, we realized that because this was such a unique workforce, we needed to stand up a tiger team, to be part of the CMP, and get this tiger team to be in more pointed actions on these hires.

Once we did that, we saw things pick up. Before that, because of the complications with the hiring of these folks, it was not going as quickly as we had wanted it to.

The Vice-Chair (Mr. Jack Harris): The ombudsman was complaining as late as November, for example, that almost nothing had happened at the lowest positions.

● (1250)

Ms. Jacqueline Rigg: I wouldn't say nothing had happened. It was not going to the speed we needed it to happen. Processes are run to hire folks, and they can take months. They were not expedited, but once we realized that the wait times were too long to staff these, we created a team that would make things move much quicker and take down some of the barriers.

So I wouldn't say “nothing”, but the speed was not to the speed that we'd wanted it.

The Vice-Chair (Mr. Jack Harris): Are you satisfied that whatever obstacles were there have been removed?

Ms. Jacqueline Rigg: I'm satisfied now that we have removed the main barriers and that we have given this the attention it requires to fill these positions expeditiously.

The Vice-Chair (Mr. Jack Harris): General Bernier, the numbers that were set in 2002 may or may not change as a result of further analysis. You referred to two reports, and you talked about the analysis of those reports. That suggests to me that there are reports in existence that are being analyzed.

Do you have any reports from either of those two studies, the lifestyle study and the Statistics Canada study that were mentioned?

BGen Jean-Robert Bernier: Not yet, sir. In terms of the Statistics Canada study, the analysis is being done by Statistics Canada.

The Vice-Chair (Mr. Jack Harris): Can I ask you specifically whether there is a report that you have access to?

BGen Jean-Robert Bernier: Not yet; I will, yes, but only after all the analysis is done. That one is being done independently.

The other one, the health and lifestyle information survey, is being done internally by the epidemiologists at the armed forces public health agency, the directorate of force health protection. That's ongoing now. All that data has been collected as well.

The Vice-Chair (Mr. Jack Harris): But neither of these studies has yet to produce a report of any kind.

BGen Jean-Robert Bernier: Correct.

The Vice-Chair (Mr. Jack Harris): So you don't have any preliminary results or anything like that.

BGen Jean-Robert Bernier: No, nothing like that.

Mr. Jack Harris: Okay.

As well, General Bernier, obviously we're all—everywhere, both inside and outside of government—concerned about suicides. You say in your closing remarks here that “...we recognize that much can be improved to give our colleagues and our own medical personnel the best possible care”.

Could you be a bit more specific about what improvements you see that need to be made? I know that other people have suggestions, but I'd like your suggestions as to what you think must be improved.

BGen Jean-Robert Bernier: We have a pretty robust program based on the 2009 expert panel, which included civil and military experts from academia, allies, etc. We have actioned all of their recommendations. There have been new data, new developments, including technological and so on, since then.

You can't divorce a suicide prevention program from the broader mental health system. Good mental health is what helps prevent suicide. Pretty much everything we think we need is thematically covered by the current strategy. The biggest problem is that we've done a....

We uniquely, certainly in Canada, have a psychiatrist and a physician do a detailed assessment of every single suicide. In a review of all of those so far, since 2010, half of the people are already in care who nevertheless commit suicide, and about half are not in care. But almost all have a mental health condition either treated or not treated.

Because it's half and half, that means we have to increase getting people into care and we have to increase the quality and the effectiveness of the treatments. We need continuous research to improve the treatments, better performance management to improve the treatments in individual cases for those who are in treatment, and continuous measures for reducing stigma and removing barriers to get people into care.

The Vice-Chair (Mr. Jack Harris): Here's one final question. Do you feel that you have sufficient access to residential treatment facilities for individuals in the military who have psychiatric situations that require that? We had one situation where there was a clear disagreement between the family of an individual and someone in the forces as to whether or not that person needed it. I've heard of several others. Is there sufficient access to residential treatment, and are you making full advantage of what's available?

BGen Jean-Robert Bernier: We are making full advantage. I can't comment on individual cases. What I can say, though, is that when expert external observers evaluate our handling of individual cases and our general policy and program, their findings and their opinions are typically that it's the model. There are individual cases where we can question whether or not the right in-patient care decisions were made, but in general, access—unlike for the rest of the population—is unlimited based on what the clinical judgment requires, so we will spend any amount of money.

Even back when we had about $38.6 million a year as our mental health budget, already it was six times what any other jurisdiction spent per capita for mental health in Canada, and that was before we got the extra $11.4 million. Access and expense are not restrictions based on clinical judgment. Whatever the best clinical judgment is in an individual case, which sometimes is not an agreement between the clinicians, the family, and the individual, we will resource.

● (1255)

The Vice-Chair (Mr. Jack Harris): Thank you, General.

I want to thank you, General Bernier and Ms. Rigg, for joining us today, giving your testimony, and answering questions.

With that, I will accept the motion for adjournment.

Mr. Rick Norlock: I so move.

The Vice-Chair (Mr. Jack Harris): The meeting is adjourned.