HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 038 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, December 13, 2016

Chair

Mr. Neil Ellis

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● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I'd like to call the meeting to order.

Pursuant to Standing Order 108(2), and the motion adopted on September 29, the committee resumes its study on mental health and suicide prevention among veterans.

Today we have, from the Department of Veterans Affairs, Dr. David Pedlar, director of research, research directorate, who is on video conference from Charlottetown, Prince Edward Island. We also have, from the Parkwood Operational Stress Injury Clinic, Dr. Don Richardson, a psychiatrist at Western University in the department of psychiatry.

We'll start with a 10-minute time frame for the witnesses' statements.

We will start with Dr. Pedlar. Good afternoon, Dr. Pedlar.

Dr. David Pedlar (Director of Research, Research Directorate, Department of Veterans Affairs): Thank you for this opportunity.

First of all, I just want to mention to the committee that I'm losing my voice today, so please bear with me. Also, to help compensate for that, I've taken the unusual step of bringing a colleague with me, so if my voice dies on me, there will be someone. Dr. Linda Van Til, an epidemiologist, is with me, and she has the same expertise that I do. Our goal is to be able to fully and completely answer all your questions.

With that said, I will start my statement.

I'm Dr. David Pedlar, and I'm the director of research at Veterans Affairs Canada. This year I also held the university faculty post of the Fulbright visiting research chair in military social work at the University of Southern California, in Los Angeles.

I want to thank you for the opportunity to speak on this very important topic. My goal is to share with you what we know about the state of mental health and suicide in Canadian Armed Forces veterans, as well as my views on some conclusions to draw from these research findings. Underlying this presentation is an evidence base of research studies that include large population surveys, published research studies, research technical reports, literature reviews, and veteran file reviews.

Let's get to it. First I will speak about the state of the mental health of Canadian Armed Forces veterans. I thought that the simplest way to do this would be through three straightforward comparisons.

Comparison one: how does the mental health of the population of Canadian Armed Forces veterans compare to non-veteran Canadians? The answer is that while the majority of veterans in Canada have good mental health, the findings of two large Statistics Canada surveys report that, compared to the Canadian population, the prevalence of common mental health conditions, like mood disorders, anxiety disorders, and PTSD, was generally about two to three times higher among the population of Canadian Armed Forces personnel released since 1998. We looked back to 1998 because that's how far back our records will take us.

Comparison two: how does the mental health of the population of reserve force veterans compare to the Canadian population? The answer is that the population of reservists who served full time for a substantial period of time had a higher prevalence of common mental health conditions than the non-veteran Canadian population. Their level of mental health conditions was similar to the one I just mentioned for the regular force—you know, several times higher than non-veteran populations. However, the mental health of other reservists who did not serve full time for a substantial period of time looked a lot like non-veteran Canadians of the same age and gender.

Comparison three: how does the mental health of the Canadian Armed Forces veteran population fare in comparison to veterans internationally? The answer to this isn't completely clear because direct comparisons of rates between countries is not possible. However, overall, the direction or emerging trend in findings is that veterans in Canada, the United States, Australia, and the United Kingdom have at least the same or a higher prevalence of mental health problems than non-veteran populations. In other words, what we see in Canada isn't completely unlike what we see elsewhere.

I have a couple of concluding observations on mental health.

First, there's no single factor associated with higher mental health conditions in Canadian Armed Forces veterans. In fact, there are many factors at play: previous life experiences, military service, genetics, physical health, employment, finances, and social support.

Second, in understanding mental health in veterans, it's really important to appreciate the connection between mental and physical health in Canadian Armed Forces veterans. Canadian Armed Forces veterans have a higher prevalence of both chronic mental and physical health conditions. In fact, 90% of veterans with mental health conditions also have chronic physical health conditions. Often these are musculoskeletal conditions and chronic pain. These are about two to three times more prevalent than in civilian populations. Those who experience mental health and physical health problems and chronic pain at the same time are especially likely to experience quality of life challenges. Therefore, it's really critical not to silo mental and physical health when we talk about veteran needs. They really have to be treated together in this population if we want to treat, diagnose, and manage them well.

● (1535)

Now I'll change to the topic of suicide. I'll start again with a question: do Canadian Armed Forces veterans have a higher suicide rate than other Canadians? The answer is that there is evidence of a higher suicide rate in male Canadian Armed Forces veterans. A large-scale 2011 study of suicide mortality among Canadian Armed Forces personnel who enrolled between 1972 and 2006 found that, over this 35-year period, the rate of veteran suicide was 1.5 times higher—that's about 50% higher—than in the non-veteran Canadian male population.

As a next step, please note that Veterans Affairs Canada—and I'm responsible for this work—is committed to the release of annual Canadian Armed Forces veteran suicide statistics by December 2017. These will allow us to monitor veteran suicide in Canada and will contribute to suicide prevention efforts. This work is complex, and that's why it takes a long time to do.

In addition to these studies, to understand suicide statistics, we have also undertaken analyses of data and file reviews. Here are some of the important findings overall. Typically, suicide is the result of several factors operating at once, and not just one factor. While psychiatric disorders, particularly depression, contribute to suicide, multiple stressors come into play, such as, physical health problems as I mentioned previously, difficulty participating in life roles, employment, financial problems, social factors, relationship problems or feeling like a burden on others, housing challenges, addictions, and finally, some people have personal predispositions to suicide, like personality factors and problem-solving styles.

Another important finding of ours is that very elderly veterans had distinct suicidality profiles, including stresses from social isolation, housing transitions, and the presence of multiple chronic physical health conditions and frailty.

I have two observations on suicide. The first is to reiterate the point that in addition to psychiatric disorders, a number of well-being and personal factors contribute to death by suicide. Therefore, all the services that Veterans Affairs Canada and other organizations provide in mental health, physical health, employment rehab, social support, and economic benefits play an important role in preventing suicide.

Finally, in closing, I just want to mention that transition from military service to civilian life is a challenging time to some degree for all military members, and also a time of vulnerability for some. We are undertaking a large-scale study now to better understand how the transition from military service to civilian life can impact veterans' mental health, what supports work best, and how to mitigate the kinds of problems that can contribute to suicide vulnerability in veterans.

Thank you for the opportunity to make an opening statement.

● (1540)

The Chair: Thank you.

Go ahead, Dr. Richardson.

Dr. Don Richardson (Psychiatrist, Western University, Department of Psychiatry, Parkwood Operational Stress Injury Clinic): I'd like to thank everyone here for inviting me to speak on this very important topic of mental health and suicide prevention in veterans. I'm not going to speak for a long time, because it might be more interesting to have a question and answer presentation.

I'll give some information about my own background. I'm a consultant psychiatrist working at the Parkwood operational stress injury clinic. My academic affiliation is associate professor at Western University and assistant professor at McMaster University. For the past 20 years most of my clinical and research interest has been in still-serving members of the Canadian Forces and veterans.

In our topic today, as you probably already have heard from many other witnesses, mental health conditions are common in a significant minority of veterans. One of my colleagues, Dr. Jim Thompson, has published on this. Almost 25% of veterans in the Canadian population have a mental health condition, the most common being depression, followed by post-traumatic stress disorder, and then anxiety disorders.

Psychiatric disorders in general rarely occur in isolation, what we would typically call comorbidity, which is if you have one condition, what's the likelihood you have something else. When we talk about PTSD especially, it rarely will occur as one single condition. The most common conditions that co-occur with it would be major depressive disorder, other anxiety disorders, and also a whole host of addiction disorders.

When we looked at our treatment-seeking population, those who sought treatment at the Parkwood OSI clinic, almost 80% of those who had PTSD also met the criteria for probable major depressive disorder and about 40% had alcohol use disorder.

Suicidal behaviour, suicidal thoughts and attempts often co-exist with mental health conditions, especially major depressive disorder. In the general population—this was also research done by my colleague, Dr. Jim Thompson—the past year's suicidal ideations—these are thoughts—was found to be approximately 6.6% in veterans, while for those veterans in the community who were clients of Veterans Affairs Canada, their past year suicidal ideation prevalence was much higher at 12%.

When we looked at our treatment-seeking population, we found that 17% had endorsed having thoughts of suicide more than half the days or greater in the past two weeks. When you're looking at a treatment-seeking population, it's much higher.

I also want to point out some of the new research that's showing the association between sleep disturbances and suicidal ideation. Emerging evidence shows that sleep disturbance is a significant predictor of having suicidal ideation even in those without mental health conditions. However, when we look at the area of comorbidity—and we've examined this in our treatment-seeking population—once you have other mental health conditions, especially depression and the predictor of having problem sleeping is no longer significant.

In general, on the topic of suicide prevention, as you can probably imagine—and you've heard from other people already—this issue is very complex and there's probably no simple solution. You've probably already heard of the need for more research and statistics not only on suicidal ideations and thoughts, but also on suicide attempts and suicide deaths that would probably help in program development and public health strategies.

We also know that treating mental health conditions, especially depression, is an effective suicide prevention strategy. Therefore, it's important to stress timely care for veterans as well as a public awareness campaign for veterans to be aware that treatments are available.

● (1545)

At Western we are in the process of establishing a zero suicide strategy, where the fundamental belief is that suicide deaths for individuals under care within health and behavioural health systems are preventable. Adapting this strategy was one of the recommendations that was made by the Veterans Affairs Canada mental health advisory group.

My final comment would be in terms of treatment outcomes. There is much research that has been published on treatment outcomes and it's important to distinguish PTSD in the civilian population and PTSD in the veteran population, what we call military-related PTSD. In general, military-related PTSD has demonstrated a poor response not only to the psychotherapy, which is the talking therapy, but also to medication therapy or pharmacotherapy.

In general, when we look at the treatment outcomes, if an individual will participate in evidence-based care, approximately 40% to 60% will recover. We have been able to demonstrate that within our own treatment outcome studies at our clinic. However, this still means that a significant proportion of individuals, despite attending evidence-based treatment, are still suffering with significant symptoms of PTSD and depression.

Thank you.

The Chair: Thank you.

We'll start with a first round of six minutes. Go ahead, Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you both for coming here. It's great to have you provide us with information that will assist us in our study.

Dr. Richardson, I'm going to go to you first, because your numbers are still fresh in my head and I don't want to forget them. I'll go to Dr. Pedlar afterwards, if you'll bear with me.

Doctor, you said that about 40% to 60% will recover. You've mirrored that same finding with your studies at Parkwood. Can you explain that population base, 40% to 60% of how many, or 40% to 60% of what type? Can you expand on that for me, please?

Dr. Don Richardson: Some of this has been published in *The American Journal of Psychiatry*. In research that specifically looked at our treatment outcome data, for both one-year and two-year treatment outcomes, for those who are receiving psychiatric care, that's medication treatment in addition to psychotherapy, the talking therapy, these are individuals who, on average, would have suffered with chronic PTSD and the vast majority, almost 80%, had major depressive disorder.

By providing ongoing treatment, when I say they fully recover, they no longer would meet the criteria, if measured at that time, of having PTSD or depression.

Does that help you?

Mr. Robert Kitchen: That gives me a better idea.

When you talk about pharmacotherapy, what sort of medications are you talking about?

Dr. Don Richardson: In terms of medication treatment for PTSD, there's very little indicated other than the SSRIs, the selective serotonin reuptake inhibitors.

What we would tend to do, as clinicians, is we would try to treat the comorbidities aggressively, so including treating major depression, other anxiety disorders and using general protocols that have been established for treating depression. We would start first with an antidepressant and follow them over time. If they do not respond, we might increase the dose, and if they don't respond, we might add a different class of antidepressant. If they still do not respond, we could add an atypical antipsychotic or mood stabilizer.

Are those the types of details you're looking for?

● (1550)

Mr. Robert Kitchen: Yes. Thank you very much.

Dr. Pedlar, I wonder if you could expand on some of the challenges that you've found soldiers experience during that transition stage, as you discussed at the end of your presentation, from military life to civilian life and how you might equate that.

Dr. David Pedlar: I think the statement I made was that almost all veterans will experience some kind of a challenge, because for many during transition almost everything can be changing at once. That could be military culture, housing, where they're living, social networks, source of income, and they may have physical and mental health conditions upon release. Therefore, by definition, there's vulnerability built into that period of change.

Some veterans will encounter special problems during that period. Some of those can come from really the way they experience the change themselves, for example, if they hadn't planned in advance about what it would be like to take the uniform off. A number of veterans I've run into will talk about this issue, that they've lost their sense of purpose. In a sense, they've lost their sense of self. Some veterans are angry when they leave. They had planned on spending their whole career in the military, and their career was cut short unexpectedly, so sometimes veterans will have a feeling of anger or even betrayal upon leaving the forces.

There are so many factors coming together in transition all at one time that it has to be done well, especially for people who can get stuck, or they can get onto this trajectory that can lead to serious outcomes that perhaps exacerbate mental health problems, or even things like suicide.

I hope that's helpful.

Mr. Robert Kitchen: Thank you.

I think I have a very quick question here. I'm interested in the research you talked about in suicide statistics in Canada. We know that a lot of veterans, once they leave the military, if they don't want to be found, they can't be found. I'm interested in this. Could you indicate to us how you plan on making certain that when you do your epidemiology study on this you're going to actually have the complete veteran-based population? How are you going to find these soldiers who are hiding, who are homeless, etc?

Dr. David Pedlar: This is about completed suicides that we're counting, not people who have suicidal ideation. In terms of the suicide statistics, with completed suicides, it's done through data linkage with Statistics Canada. What we do is we get the record for as far back as we can go for everyone who was released from the Canadian Armed Forces, and we link that with the Statistics Canada mortality database, which is contributed to by the provinces and two territories. We use the same standard of measuring mortality, including suicide, that we would for all other Canadians. In fact, it's a very strong and reliable methodology where we don't actually have to find people.

The Chair: Thank you.

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you, all, for being with us today and sharing this important information. We really appreciate it.

Dr. Pedlar, you gave a comparison between Canadian Armed Forces and veterans and the regular population when it came to mental health statistics, saying that it was two to three times higher, and that was similar to international statistics on the same. Then you went into suicide rates and said that among Canadian Armed Forces and veterans, it's one and a half times higher among the male population, which I didn't hear anything about in the international comparison. I wonder if you have those numbers as well.

● (1555)

Dr. David Pedlar: No, I don't have those numbers with me. We could provide those numbers. It's hard to do direct comparisons, though, because the veteran populations are different across countries.

Mr. Colin Fraser: Fair enough.

Dr. David Pedlar: That's a challenge to actually do really true direct comparisons.

Mr. Colin Fraser: Okay.

One of the things that I think we understand and we've heard before is that identifying these mental health issues at an earlier stage would help us hopefully identify what treatment is needed and available for our Canadian Armed Forces members and veterans. How can we encourage people to self-identify earlier in the process, or to encourage them to address their mental health issues in an earlier step, so that we can find them adequate treatment and hopefully deal with these problems before they become even worse?

Dr. David Pedlar: I think that zone of expertise is probably stronger with Dr. Courchesne, who was here a week ago, who's responsible for the areas of mental health service delivery and suicide prevention. It's not in my zone of expertise, so I won't answer that if you don't mind.

Mr. Colin Fraser: I'll turn to Dr. Richardson then.

With regard to the OSI clinics, can you expand on what conditions there are other than PTSD that the OSI clinics deal with, and you would see on a regular basis? I think you mentioned a few other things, including alcohol addiction for example. What other things do you treat?

Dr. Don Richardson: I think not only at our clinic but in the network of OSI clinics, we don't have an exclusion criteria. As long as individuals have a mental health condition, we can assess and treat them.

When we look at our stats—and I don't have the exact stats but we can provide them for you in terms of the demographics—this is a treatment-seeking population referred by their VAC case manager or from National Defence from their medical officer. The number one condition is PTSD followed by major depressive disorder, and then generalized anxiety disorder, panic disorder, and alcohol use disorder.

Mr. Colin Fraser: With regard to the OSI clinics themselves, in your experience is there any difficulty in finding the appropriate staff with the requisite experience to deal with these situations? If so, do you have any recommendations on how we could perhaps solve that problem?

Dr. Don Richardson: I'm probably not aware of the entire network across Canada, the challenge in recruiting and retaining clinicians. However, we haven't had that much difficulty. We provide a lot of education and training for new staff, and we also, in collaboration with the Canadian Psychiatric Association and the Canadian Psychological Association, so my colleague psychologists, provide education and training to civilian clinicians.

Mr. Colin Fraser: Dr. Pedlar, we've heard this time and again that the transition is a challenging time. What makes this so difficult in particular for the mental health of the veteran or the transitioning member, and what can be done specifically regarding their mental well-being so we would be able to perhaps alleviate some of these problems? Could you comment on that?

Dr. David Pedlar: I think it's what you mentioned earlier, engagement as early as possible, and also ensuring members are encouraged to develop a realistic plan before they leave. We've found veterans who have a realistic plan of release almost always do better across most of the studies. Then things like transition interviews and other mechanisms where we have an opportunity to intervene with veterans and see how they are doing on their way through is critical. Once they are out, it would be to make sure there's a contact if needed, that the transition is smooth for those who are being followed, but also to encourage people to come forward and not have feelings of stigma if they need help.

● (1600)

Mr. Colin Fraser: Do you think proactively checking in with them on their mental health throughout this process would be valuable?

The Chair: If you could make that a quick answer, please, it would be appreciated.

Dr. David Pedlar: I don't know the answer to that. I think some of the group processes that veterans go through as well are also helpful. When veterans can share with each other and open up about their experiences, that's also helpful, and some programs do that as well.

Mr. Colin Fraser: Thank you very much.

The Chair: Thank you.

Ms. Mathyssen, you're next.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you to our witnesses. We truly appreciate your expertise and your taking time to be here. I'm hoping to get in lots of questions.

Dr. Pedlar, you said in your remarks that you had looked at the suicide rate among armed forces veterans, and you talked about male veterans and the fact that their suicide mortality was higher than the average population. Did you have occasion to look at suicide rates among female veterans, and if not, why not?

Dr. David Pedlar: We did, but the numbers were small. I think the difficulty was with the number of cases, which was small, and that made it more difficult to do analyses.

Dr. Linda Van Til (Epidemiologist, Research Directorate, Department of Veterans Affairs): There was an overall female rate that was similar.

Dr. David Pedlar: Yes, I'm sorry, there was an overall female rate that was similar to the male rate. Is that right?

Dr. Linda Van Til: No, it was similar to Canadians.

Dr. David Pedlar: Similar to Canadians, I apologize. There was an overall rate for females that was similar to Canadians. I was just corrected by my colleague.

Ms. Irene Mathyssen: Okay, thank you.

It's interesting and it makes one wonder what it is in terms of females managing their situation that is different from males, but maybe that's a different study or a question that doesn't really pertain here.

At any rate, I also want to ask about the drugs that are used in terms of treating individuals with depression, difficulties, panic disorders, or PTSD. In terms of these cocktails, I've heard there are some veterans who are taking as many as eight to 12 pills a day. Have you looked at that? By virtue of the fact that they're taking a significant number of drugs, would that not add to their inability to be socially interactive and to be more healthy in terms of their interactions with family and friends? If this has been looked at, I wonder what the cost is of all of these drugs, and how that compares to medical marijuana. Has this analysis been done?

Dr. David Pedlar: The answer is that, at least in my unit, we have not done large-scale studies of medication utilization, either of psychiatric medications or of medical marijuana. I don't have anything to report on that issue.

Ms. Irene Mathyssen: Would that be something that would make sense for VAC, Health Canada, or someone to entertain?

Dr. David Pedlar: Yes, a utilization study could be useful.

I actually did a medication utilization study on veterans many years ago now, and one of the problems we ran into is that we're not the full provider. We're often the supplementary provider, so it means that we don't have the complete medication record that would often be with health regions or provinces, so you start with a real limitation in what you can do if you're a co-payer or a second party payer of medication. That doesn't mean it can't be done, but there is that challenge that makes it more difficult to do on veterans than, for example, in a provincial environment.

● (1605)

Ms. Irene Mathyssen: Okay, thank you.

Thank you, Dr. Van Til, for your intervention.

Dr. Richardson, I would like to begin by saying how proud we are in London of the work at Parkwood and at Western for our veterans, so thank you for what you do.

I'm wondering about the role of mental health workers in terms of transition. Should they play a more central role? Would the stronger presence of mental health workers during the transition be of benefit?

Dr. Don Richardson: Just so I understand the question, are you talking about somebody transitioning out of the Canadian Forces into civilian life?

Ms. Irene Mathyssen: Yes, into civilian life, because we've heard, and it's been mentioned here today, that it's a loss of self, it's a loss of identity, and it's a loss of one's community. I wonder if mental health workers have a greater role to play in terms of making that less stressful, less painful, and less difficult.

Dr. Don Richardson: That's a fascinating and interesting question. First, I don't think I have the data to provide an answer to that, but I can give you what my opinion would be, just so I clarify that. Not everyone who transitions out of the Canadian Forces necessarily needs a mental health worker. If somebody has a medical condition, then it's probably that individual who is struggling more. I think if you're retiring from the military—and this is from my clinical experience—and you're retiring because you chose to retire, then I think that's a different situation from one where you are forced to retire because you have a medical condition.

In those cases, I think the biggest challenge I hear from many veterans and still-serving members is how to access and coordinate services. If you can imagine, when you're still serving, health care is provided for you and is directed to you. As civilians, because I'm not a military person, we are used to being self-directed in order to access services. For somebody in the military, that's a particular challenge. We've talked about, in other committees, the need of having a navigator, as somebody who could help them coordinate the services and learn how to access care. For a civilian, it's a challenge. If you can imagine somebody who has never done it before and who has a mental condition, it's a particular challenge.

Sorry for going over.

The Chair: It's no problem.

Thank you.

Ms. Irene Mathyssen: That's fine. I go over all the time.

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you both for coming.

Dr. Pedlar, I'm familiar with some of the issues with suicide. I practised medicine for 20 years. One of the things we found.... This may be difficult to answer, because you had said in regard to Ms. Mathyssen's question about women and suicide that your numbers were much smaller and it was more difficult to analyze.

One of the things that had become apparent over the years in the suicide stats we had looked at is that, when attempted, men are more likely to be successful than women. Usually that is because men will choose more instantly lethal means and women will choose means that are less lethal and more prone to recovery.

You said that you had tracked suicides. Is there any tracking of suicide attempts, and have you noticed any difference between men and women in that?

Dr. David Pedlar: We did a file review in 2014 that looked at 80 cases of suicidality, and they included ideation attempts and completed over a fairly long period of time, I think from 1960-something to 2013. We do have some data on the circumstances surrounding suicide, but I don't recall that women were analyzed in detail in those findings. The findings were very helpful in understanding the specific factors associated with suicide in personal cases around veterans.

● (1610)

Mr. Doug Eyolfson: All right, thank you.

You talked about reservists having a higher prevalence of mental health conditions than the Canadian population. It was a similar elevated level to regular force veterans. Do reservists who deploy get the same mental health services that regular force members are entitled to when they are veterans?

Dr. David Pedlar: First of all, I just want to go back to the record, which is that I had said that if you look at the reserve population as a whole, you could divide those into two groups. There are reservists who serve full time for a substantial period of time. That would be about three years or more. Once they serve three years or more full time, then they start to look a lot like regular force veterans in their mental health and other kinds of outcomes, whereas the rest would look a lot like other Canadians their age and gender.

I'm sorry, what was the rest of the question? I just lost it.

Mr. Doug Eyolfson: The question was, do they, as veterans, get the same mental health services as regular force members?

Dr. David Pedlar: You would have to ask the Canadian Forces that question. I'm not absolutely certain.

Mr. Doug Eyolfson: I mean when they are veterans, though. Do veterans of the reserves get the same mental health services as veterans of the regular forces?

Dr. David Pedlar: Yes, they would. Once they're a veteran, once they're released. Is that the question? Once they're released, they would have similar access, yes.

Mr. Doug Eyolfson: All right, thank you.

Dr. Richardson, regarding Canada's OSI clinics, would you say that they have all the resources, funding, staff levels, etc., that they need to assist veterans, or do you think they could do more on the resources that the OSI clinics, in general, have?

Dr. Don Richardson: Do we have enough money to do what we need to do? That's a good question. You'd have to ask my manager.

One of the challenges.... Probably what is needed is better statistics on where the veterans are currently living. My understanding is that's currently being done through the Canadian Institute for Military and Veteran Health Research. There's a veteran identifier, in Ontario, that is, on the OHIP card. That might provide some better statistics on where the veterans are, on whether the network of clinics and satellite clinics is appropriately located, and on whether they have sufficient staff to provide ready access to veterans. That's probably where I would go with that.

Across Canada? That's a good question.

Mr. Doug Eyolfson: Thank you.

Dr. Pedlar, this may be more appropriately directed to someone in the defence end, but you might see this in your treatment of veterans. You have said how there are rates of mental illness in veterans. In terms of career progression, would you be able to identify a stage where a Canadian Armed Forces member becomes most susceptible to mental health issues?

Dr. David Pedlar: I could speak a little about which veterans are more likely to have mental health issues. Would that help or not?

Mr. Doug Eyolfson: I'm wondering if they have identified if they started having issues when they were serving. Did they identify during their care when they first noticed their symptoms? At what point in their career progression—or does this actually show up...? Have they reported to you when they started having symptoms, or do they generally start having symptoms as veterans?

Dr. David Pedlar: It would depend. Some would have symptoms before they start in the Canadian Armed Forces and could have pre-existing mental health conditions. Some will develop conditions while serving, and some could develop conditions after they leave. It's really all of those. We have learned a little bit about who is more likely as a veteran to have mental health conditions, based on the analyses we've done. They tend to be people with chronic physical health conditions and pain, lower socio-economic status, etc. If they left in mid-career, say between 10 and 19 years, they could be at higher risk, as well. For those with lower education, they would have some of the same profiles as other Canadians who have higher mental health rates, but it would be in a military context.

● (1615)

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): The question that I have is for Dr. Pedlar, and perhaps Dr. Richardson.

The success of treatment can often depend on the attitude that the patient brings to bear. We've heard a lot of testimony from veterans who think that we should just disband our group. They feel that we don't know what we're doing, and so on. I'm wondering if you see push-back from the people you're treating, in terms of their openness to accepting the treatment.

Dr. David Pedlar: Dr. Richardson is a clinician, so he would see these people on a day-to-day basis. I'm more of a researcher. He would probably be able to clinically answer that better than I can. I might have a thought on it, but—

Mr. Bob Bratina: Okay. I was going to position it for both.

Dr. Richardson, could you comment on the way people approach the treatment that they're receiving?

Dr. Don Richardson: I'd have to do some of my specific research, but I think there is data out there that patient or client attitude regarding seeking treatment behaviour has an impact on recovery. There is some research that's been published on patient choice as a predictor of treatment outcome. As a clinician, being non-military, we have to look at patient attitude as something that's fluid. The vast majority of people I see do not necessarily trust me as a clinician. Trust is something that you have to build over time. That's something we take as a given at the beginning. The goal for most clinicians would be to get the patient to come for a second appointment, and then you have something that you have to work at.

I think attitudes are important. Also, as a clinician—and this is what we try to teach to other clinicians—it's important to have respect for the military member and the service that they did and not pretend that you know about the military culture, and if you have questions, to ask. These are things that we try to teach...also having a clinic that's successful across Canada at being veteran friendly, making people aware that we only treat veterans, that we only treat military members. In the veteran population, competence is very important, so having experience and treating people with respect are probably what I would recommend. Is that helpful?

Mr. Bob Bratina: Yes.

In our considerations, we've seen the problems. We've heard direct testimony from veterans, as I said, who just didn't like the system or didn't feel they were respected, as you suggested. Hopefully, we can come forward with recommendations that will enhance the profile of the work that VAC does and that integrates more the care providers, such as yourself, so that there's a better understanding that we're all here, and there's a new approach, a new energy, and so on.

We visited the OSI clinic in London and were very impressed. Regarding the work that you do, what are the debriefing sessions like? What sort of time do you spend consulting with each other on issues that were raised during the day or the week?

Dr. Don Richardson: In terms of a formal debrief, I'm not sure. Just to better understand, if we're looking at the clinical aspects, we have an interdisciplinary team meeting where we discuss the patients and the assessment and treatment plan.

● (1620)

Mr. Bob Bratina: Obviously, you must be constantly reviewing your processes, and you have a high reputation, so it's at a good level. How do you internally review and discuss?

Dr. Don Richardson: I'm not sure if you're asking in terms of the personal self-care of clinicians and staff. Is that what you mean?

Mr. Bob Bratina: That's another issue.

Let's go with that one, and then we'll get to the other one.

Dr. Don Richardson: Okay. I think for anybody who's in the clinical business of treating traumatized individuals—and this is not just in the military context, but in the civilian context as well—it's knowing yourself and knowing your limits. It's having a good clinical team and peers that you can rely on, and also having what I'd call just generic self-care, other interests outside of work. The work is difficult and challenging, but it's also very rewarding.

Mr. Bob Bratina: On the other side of the picture, would someone who's had a breakthrough with a patient share that with others saying what works and what doesn't work?

Dr. Don Richardson: On a regular basis within our team at Parkwood, and I'm assuming across the different clinics, we discuss good cases, those that are a success, and we also discuss those that are a very big challenge in order to learn from them.

Mr. Bob Bratina: Are there any impending—

The Chair: I'm sorry. We'll have to get you next round.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you very much, both of you, for being here.

Dr. Richardson, you mentioned new research. On this whole issue of individuals committing suicide, you're discovering that sleep disturbances have an impact on suicidal thought. You went on to talk about how with the treatment outcomes for the military, I believe you were saying, the talking and medication therapies for PTSD are 40% to 60% successful. Did I hear that right?

Dr. Don Richardson: Yes.

Mrs. Cathay Wagantall: If it's 40%, then 60% aren't successful. If it's 60%, then 40% aren't successful. It's in that number somewhere. I'm curious, in the diagnosing of PTSD.... You're probably also hearing right now about mefloquine toxicity and brain stem injuries. Is the diagnosis complete in that you look at the possibility of more than just PTSD? We're hearing that the two are very different. One is a physical illness and one is mental, and they're being treated without that recognition. With mefloquine right now, as you know, basically all of our allies have made it a last resort or blackboxed it. Germany has said no more, in any way, to armed forces or veterans or civilians. They all quote amnesia and suicidal behaviour. All these kinds of things can be outcomes of taking that drug.

Are we looking at this as a possibility that we need to study further, and consider that for these individuals who aren't succeeding in their treatments, it might be because we're diagnosing them incorrectly?

Dr. Don Richardson: I should have written those down. You asked multiple questions.

Mrs. Cathay Wagantall: I'm sorry. Pick one.

Dr. Don Richardson: I'll start with statistics. When I say 40% to 60%, it's based on different studies that have been published in terms of treatment outcomes. It's not necessarily 40% to 60% concerning those specific individuals, but multiple studies. I think one of the studies published in *The American Journal of Psychiatry* quoted that if individuals follow evidence-based treatment, about 50% will fully recover.

Speaking as a clinician, we tend to look at things as "thirds". With almost all mental health conditions, one-third will fully recover, one-third will get significantly better, and one-third will have a chronic course where they're continuing to have symptoms.

● (1625)

Mrs. Cathay Wagantall: In the diagnosis of PTSD, in light of what we're learning about and hearing around the world right now, do you see that there might be a possibility, even within research, or a need for us to consider another possible diagnosis? When they're looking at PTSD, do they look at the brain stem and that type of thing? I don't know.

Dr. Don Richardson: As a clinician and a psychiatrist—it's also done by psychologists when we're doing a diagnosis, but probably more so as a psychiatrist—we look at the entire person and do a complete medical history. Part of it would be looking at exposures. I'm not an expert in mefloquine; however, I've read about it. Obviously some of my patients have used it, or were prescribed it during their service, I should say.

In general, however, in medicine we try to find the most probable condition the person is suffering with as opposed to trying to find multiple probabilities. For example, somebody might have taken mefloquine, but they were also deployed to an area where they were exposed to significant traumatic events, and are reliving those events. Personally, as a clinician, I would approach it by saying, "It sounds to me like the symptoms you're presenting with are probably post-traumatic stress disorder. However, there are other things that might have contributed to it. Let's try the treatments that we know work well and see how you do." If they fully recover from the standard treatments, then most likely we have the correct diagnosis. If, however, somebody is not responding to treatment after six months, then I start getting concerned, i.e., is it the right treatment?

Mrs. Cathay Wagantall: Do you see in the future, in light of what we're learning now, that more of a focus on this as a potential condition should be considered?

Dr. Don Richardson: I would try to consider all potential issues, because we haven't touched here on the whole area of mild traumatic brain injury. As a clinician, you would also do a thyroid function test to make sure that has not been affected, because it will present as depression also.

Is that helpful?

Mrs. Cathay Wagantall: To some degree, yes.

Dr. Don Richardson: Okay.

I'm sorry.

Mrs. Cathay Wagantall: No, that's fine. It's complicated. I appreciate how challenging this is.

Dr. Pedlar, when you do your research and come up with your responses here, I appreciate how you're saying that there are a multitude of different factors that play into the conditions that these veterans face.

When I read the list of the various issues that can be impacting them, you talk about physical health problems, difficulties in life roles, employment, all of these different things, and addictions. Do you take into consideration at all what types of medications they are on and the side effects of those, and how that might also play into their sense of well-being?

The Chair: I have to apologize, Dr. Pedlar.

You'll have to get that in about a 30-second answer if you could, please.

Dr. David Pedlar: The answer is yes. I mean, medication can also impact well-being and can be a factor in physical and mental health. The answer would be yes.

The Chair: Thank you.

We're going to split time here.

I believe Mr. Rioux is first.

[*Translation*]

Mr. Jean Rioux (Saint-Jean, Lib.): Thank you, Mr. Chair.

I'd like to thank the witnesses for joining us today.

We've seen statistics on the transition of veterans from military service to civilian life, which, as we all know, is challenging. You told us that veterans were three times more likely to suffer from mental health issues and that the suicide rate was one and a half times higher among veterans. Do you have figures for the period when they were serving in the armed forces? Were the rates as high during those years? I'm inclined to think not. I suspect the transition to civilian life is the influencing factor. I'd also like to know whether the rates drop later on, in other words, four or five years after the return to civilian life?

● (1630)

[*English*]

Dr. David Pedlar: It's not exactly on that timetable, but we do find that levels of mental health problems are higher when they're veterans than when they're serving. That much we know.

We think that suicide is probably higher as well, although the Canadian Forces has noted, I think in their testimony, that there has been a trend to increasing suicide, especially among members of the army. That's a more recent trend.

[*Translation*]

Mr. Jean Rioux: Something you said during your presentation surprised me. You said there was a link between physical and mental health problems. I do find that somewhat surprising given that the members of our military are well-trained and supposed to be in good physical shape.

How is it that such a problem exists? They say a healthy body and a healthy mind go hand in hand. Does that mean members of the military should receive even more physical training?

[*English*]

Dr. David Pedlar: There is excellent training in the Canadian Armed Forces, and there's no question about that, but there's also no question that it's an occupation of wear and tear to a certain extent. The body isn't built to carry 125-pound packs for years on end without some kind of consequences. We see those consequences in our disability program. They are mostly musculoskeletal issues, which would be ankles, knees, backs, necks. In fact, by far the largest impacts from a pension point of view are the physical health issues.

That's why I underlined that point so much in my presentation. I see physical health and chronic pain as a very, very important pathway to mental health conditions in veterans, in addition to traumatic experiences that they might face as well. It's very important to look at physical health in veterans if we want to understand how to address mental health.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): I want to ask a couple of quick questions. We heard earlier from an American witness about cognitive behaviour therapy. I'm wondering whether this is part of the therapy we're using in Canada. Has there been any research done? They said they had noted positive results from it.

Dr. Don Richardson: I think the simple answer would be yes. Cognitive behavioural psychotherapy is one of the treatments provided across Canada, especially within the network of clinics.

Mrs. Alaina Lockhart: Great. Thank you very much.

Also in the testimony we've heard about delays during the transition period from military medical care to Veterans Affairs care. Is that an irritant in the treatment of mental health? If so, what is the impact of delayed treatment? For instance, if someone is not able to get a family doctor and a referral, what impact does that have?

Dr. Don Richardson: It's a good question: does delayed treatment affect overall treatment outcome? Put another way, does chronicity —how long you've had an illness—have an impact on treatment outcome? When we looked at our treatment outcome research, chronicity was not shown as a predictor of treatment outcome. My colleagues in the U.K. who have also examined it did not find chronicity as a significant predictor of treatment outcome.

This is looking at treatment outcome. That being said, however, there is a challenge that we often hear from our patients and clients. By the time I see them, they have a family doctor and things are set up, but to get there can be a challenge, especially if they move to an area in which there are no family physicians available. That becomes a barrier to seeking specialty care.

● (1635)

Mrs. Alaina Lockhart: Would it be fair to say, then, that there are some people you wish you had seen sooner?

Dr. Don Richardson: Yes, it would be for sure, and not just me: if they needed care and were waiting to seek treatment, for sure.

Mrs. Alaina Lockhart: Thank you.

The Chair: Thank you.

Mr. Brassard.

Mr. John Brassard (Barrie—Innisfil, CPC): First of all, Dr. Pedlar, it sounds as though you've been hanging around with Minister Dion. He has the same voice going today in the House of Commons.

One challenge, as I sit around this committee table, is going last, because oftentimes things have been covered, or we'll have a long list of witnesses who will have covered many of the things we're looking to answer.

This committee is charged with looking into mental health and suicide prevention among veterans, so I'm going to give my time to you. You have two minutes and 15 seconds each to provide this committee with your expert recommendations.

What would you suggest we do in order to prevent mental health and suicide issues among our veterans?

Now you have two minutes each.

Dr. Richardson.

Dr. Don Richardson: One thing I've already indicated is adopting, as we're trying to do within Western, a zero suicide strategy. There is an excellent website that you can get more information from, and I can provide it for the committee to review. It's really the general consensus that suicide is preventable, and the strategies whereby each person has access to an individual plays an important role.

The other area that I think is important is accessing care. Whether there are enough clinics and whether they are located in the right areas is something we still need to have a decision on. What is the waiting time in order to access services? Are veterans aware that treatment is available?

A public awareness campaign, then, much as you see in other countries, is needed: "If you are a veteran and you are reliving your experiences or having problems sleeping, there is help available. Contact this 1-800 number", and how to access services.

In the transition period, is it better coordinated? Is there a navigator? I'm calling it a navigator, but a person who would be able to assist in coordinating services.

Mr. John Brassard: We would call it a concierge, Doctor. Thank you for that.

Dr. Pedlar, in two minutes, what recommendations would you make to the committee that you would like to see us pursue?

Dr. David Pedlar: I'll just underline some of the things that I started with in my statement.

With respect to suicide, I think it's important.... I don't look at suicide as just a mental health problem. I consider it a well-being problem. When I say "well-being", I mean that, if you look at the individual stories through file reviews of veterans who die by suicide, you see that there are always a number of factors going on in their lives. You really have to take a comprehensive approach that maps out those factors and takes them into consideration when you move forward.

Mental health is a big deal in terms of addressing suicide, but you also want to look at social issues, financial problems, problems functioning in social roles, and also the issues I mentioned about pain and physical health.

When it comes to mental health, I'll go back to the point I made earlier, which is that, with veterans specifically, the pathway to mental health problems is often thought of particularly as trauma, and PTSD gets discussed the most. But when you do the work that I've done, what you typically see is that there is a real multiplier effect if somebody has a mental health problem, a physical health problem, and chronic pain. All those things come together more frequently in veterans than in other Canadians.

We need that kind of complexity if we want to do the best job possible.

● (1640)

Mr. John Brassard: Thank you, gentlemen.

The Chair: Ms. Mathyssen, go ahead.

Ms. Irene Mathyssen: Dr. Richardson, I would like to go back to the OSI clinic in London, because it is so very important in terms of recovery.

We've heard from some veterans that they need to feel they are in a place where they are in control, and very often they're bewildered. I wonder if you could comment on this in terms of the OSI clinic in London. How do you create that atmosphere where the veteran knows that they have control of the situation, that they're not vulnerable or at the mercy of someone?

Dr. Don Richardson: I never thought of it in that way, but that's a very interesting question and comment.

I think that, for a lot of veterans, a need to control their environment often has to do with their symptoms. One of the potential symptoms of PTSD is hypervigilance, constantly scanning for threats and not feeling safe. Providing an environment that is what we would call veteran friendly probably has to do with their own attitudes or experiences they've had in other mental health settings. Creating an environment where the waiting room is larger, or having either symbols or pictures that have to do with veterans or the military context....

I think we also have to keep in mind the power or the influence of peer support. If veterans have a positive experience, they will let other veterans know, in the same way that if they have a negative experience they will let other veterans know on social media and things like that. I think it's building a reputation in that type of context.

Also, like most organizations, we survey the veterans and ask them questions. When I refer patients for any treatment, I do ask them, when they come back, "How did they treat you?" in order to get feedback. I let them know that the reason I'm asking is that if I refer another veteran I'd like to know how they were treated, because that's helpful.

Ms. Irene Mathyssen: It's interesting. It's a very obvious thing, but it perhaps is something that has sometimes eluded those who take care of not just veterans but the general population.

We've heard a great deal about the importance of family support for the mental health of the veteran for that hope of recovery. What can we do better? Is there anything we can do better to support families caring for veterans with an OSI? In terms of that family member or the caregiver, we've heard from some who say they didn't have the training and they didn't know what to do. They couldn't support their loved one because it was just outside of their experience.

We heard from the ombudsman for the Department of National Defence that financial security is key. If we resolve those financial issues, and I think Dr. Pedlar made reference to this, we could go a long way to paving the way to a healthier outcome.

I wonder if you could shed some light on any or all of that.

Dr. Don Richardson: I'll comment on a few things, and I know I will have to do this very quickly.

In terms of family support, I think it's clear that not only with mental illness but if anybody has a significant medical problem, it affects not only them but those around them. What we identify as the family is different in the context of an older veteran, though not necessarily "older older"; it might be their spouse. For many younger veterans, it might be their parents or significant other. That's important when we're doing the assessment, and we would recommend seeing the individual and those they consider to be their family unit in order to provide the support.

The other thing we also try to emphasize is that we will treat the spouses and we will assess children and refer them to appropriate resources if necessary, but we will also provide education to the family members, adult children also, so they don't become the natural caregivers. Part of what we try to do in treatment is to let people know that their role is to be a spouse, not a caregiver or nurse. We take ownership of the treatment and of working together. Part of it is for someone as a spouse to become a spouse. That's their primary job.

● (1645)

The Chair: Thank you.

That ends today's meeting.

I will give each group a couple of minutes to wrap up if it wishes, starting with Dr. Pedlar.

Dr. David Pedlar: I just want to thank the committee for the opportunity to speak today. If there's any follow-up research material that we have, we'd be absolutely delighted to share it with the committee to support its deliberations and final report.

The Chair: Great, thank you.

Dr. Richardson.

Dr. Don Richardson: I'm not sure how much time I have, but if I can, I will just say that there were a lot of comments about the number of medications that patients are sometimes taking. I think it's important to focus not necessarily on the number of medications but really on the risks and benefits. If they need a lot of medication to fully recover, then the benefits might outweigh the risks. I think that's important to clarify. It's not looking at numbers and saying now it's too much or it's not enough.

Again, I thank you for inviting me to speak. If there are additional inquiries, the clinic or I will be able to provide you with some information or details.

Thank you.

The Chair: That's great.

I'll remind the witnesses again that if there's anything they want to elaborate on in questions or in their answers, they could send that to the clerk and the clerk will distribute those answers to the group here.

On behalf of the committee, I'd like to thank all three of you for testifying today and for all the help that you give to our men and women who have served.

We will suspend now for a few minutes and come back in camera.

Thank you.

[*Proceedings continue in camera*]