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Chair

Mr. Neil Ellis

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● (1540)

[*English*]

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

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

Today, our witnesses, from the Department of National Defence, are Brigadier-General Hugh MacKay, surgeon general, and Colonel Andrew Downes, director of mental health.

We'll start off with presentations for 10 minutes, and then we'll go into questions. I hope we can get through a couple of rounds. Without delay, we'll turn the floor over.

Brigadier-General Hugh MacKay (Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence): Mr. Chairman, and members of the House Standing Committee on Veterans Affairs, as surgeon general, I am responsible for the delivery of health services, the provision of deployable health services capabilities to support operations, and the provision of health advice to the Canadian Armed Forces.

I am very pleased to be back and to have the opportunity to speak with you about how we care for members of the Canadian Armed Forces who have mental illnesses and how we work with Veterans Affairs Canada to facilitate transition for those leaving the Canadian Armed Forces.

Members of the regular force are not covered under provincial health care plans. For this reason, the Canadian Armed Forces has its own comprehensive health system that addresses the health needs of members wherever they may be stationed in Canada or abroad. Health services are provided predominantly in our 37 health services centres and detachments across the country and in Europe. In addition to the care provided at the health services centres, we also purchase care from the civilian sector, particularly specialist services and hospital-based treatments that are not available internally.

On operations, Canadian Forces Health Services often deploy to provide health support, but there may be situations in which we work with our allies or a host nation to deliver health services.

[*Translation*]

Across the system, we have over 450 established mental health positions, including mental health nurses, social workers, psychiatrists and psychologists, within our clinics' mental health departments.

As of July 2016, 93% of these positions were filled. Staffing these positions is a dynamic process, one which is impacted by normal staff turn-over, competition with the civilian sector for mental health personnel, and challenges in recruiting personnel to some locations.

To ensure timely access to care, there is also a large network of over 5,000 civilian mental health professionals registered as external service providers to which patients can be referred.

[*English*]

As in the civilian health care sector, our primary care clinicians capably care for many patients with mental illness, and 31 of the 37 health services centres have some level of specialized mental health services to support the primary care clinicians and to deliver direct patient care by providing rapid access for urgent care needs, as necessary.

The seven largest clinics have operational trauma and stress support centres, or OTSSCs, which specialize in treating operational stress injuries, or OSIs. OSIs are those psychological problems that occur as a result of psychological trauma experienced during operations, which result in different diagnoses, including depression, PTSD, and substance-use disorders.

In cases of emergency after hours, Canadian Armed Forces members can contact the Canadian Forces member assistance program, or CFMAP, or a civilian crisis line. They can also go directly to a civilian emergency department or call 911. The seven OTSSCs are part of the joint network for operational stress injuries, which also includes the 11 Veterans Affairs Canada OSI clinics.

Through a tripartite MOU, this network allows for care of military members, veterans, and members or former members of the RCMP in either military or Veterans Affairs Canada facilities, when it is deemed appropriate for a given patient.

Technological advances have had a positive impact on the delivery of mental health services. In order to increase accessibility to mental health services, we have installed high definition, secure VTC systems in our clinics that are being used to provide telemental health services. These help us manage short-term health care demands in a given location and help reduce the need for some patients to travel to receive a higher level of care. They are also a way for us to ensure our ability to offer care in the language of choice, no matter where members serve.

We have also acquired a virtual reality system for use in our larger centres. This system simulates an operational environment, and it is used in exposure therapy.

● (1545)

[*Translation*]

The CAF is committed to ensuring that personnel suffering from mental illness have timely access to the medical care and support services necessary to either return them to duty or assist their transition to civilian life. We recognize the transition for our members as they release from the CAF can be difficult and stressful, particularly for those released for medical issues.

[*English*]

Canadian Armed Forces members with more complex medical needs benefit from the case management program. This program was established more than 10 years ago and offers services in all Canadian Armed Forces clinics located in Canada. Case managers are specialized nurses who are integral to the care-delivery team and who facilitate ongoing care for patients through complex periods of medical care. The intent of the case management program is to assist the CAF member in navigating the medical and administrative system. While the primary goal is to achieve a return to duty after a complex disease or injury where possible, for those members whose chronic medical conditions have led to permanent employment limitations and who do not meet universality of service, case managers assist with transition to civilian life.

Our case management program works closely with its counterparts in Veterans Affairs Canada. Moreover, analysis and work are currently being done to optimize the transition of the releasing member from the DND program to the VAC program. A working group under the VAC-CAF steering committee has been established to align programs and to analyze the elements associated with the continuum of care for members and their families in transition. The transition period around release is a critical time to ensure continuity of care for releasing members.

[*Translation*]

A standardized assessment of all transitioning CAF members is being done to determine the level of complexity involved in their transition from DND to civilian life in order to enable the handover of care to the civilian sector has taken place for those with ongoing needs.

Whenever a member is identified as having complex needs regarding transition, a multidisciplinary team works to proactively reduce or eliminate potential barriers to a smooth transition, either from a health, financial, occupational, academic or psychosocial perspective. In certain circumstances, additional transition time will be requested by the team in order to secure a safe transition. Each case is handled individually, on its own merit.

● (1550)

[*English*]

In addition to clinical care, we also have a nationally and internationally recognized mental health education and resiliency program, called road to mental readiness. There are now over 30 modules of this program, which are given at different points in a member's career, starting at basic training. We have recently expanded the program to include occupationally specific training for occupations like search and rescue technicians and military police.

Canadian Forces health services group also provides the strengthening the forces health promotion program. This important program includes education and skill development modules in areas such as suicide awareness, anger and stress management, healthy relationships, family violence, and addictions.

[*Translation*]

We continue to work with the strong support of leadership at all levels to reduce the stigma of mental illness and other barriers to care-seeking. This includes Forces-wide emails, newspaper articles, unit-level discussions and participation in events such as Bell Let's Talk. We also have produced a five-video series that addresses various topics such as stigma, transition and suicide.

[*English*]

Another key element of our mental health program is research. We have conducted a number of important epidemiological studies to better understand the impact of mental illness on CAF members. This includes the 2013 CF mental health survey, and the operational stress injury and outcome study.

The CAF is extremely interested in better understanding the biological underpinnings of mental illness and in exploring new treatments for PTSD and other conditions.

Much of this work is accomplished by the Canadian Military and Veterans Mental Health Centre of Excellence through collaboration with scientific experts, academia, government, private sector, and research consortia, and with NATO and our allies. Knowledge gained from leading-edge clinical research is then translated into clinical care.

My final comments will centre on suicide in the Canadian Armed Forces.

You will recall that in November 2015 we reported a trend of increased suicide rates over the preceding five years. This increase was among those serving in the army command in combat arms occupations, such as the infantry, as opposed to other commands. We've also reported that deployment is emerging as a risk factor for suicide, but it is important to stress that it is not so much the deployment itself but what some members experience during the deployment that might have an impact.

We conduct a medical review of each suicide to try to better understand the factors involved in each case and to look for opportunities to enhance our current programs. We find that about 50% of people who die by suicide have been diagnosed with one or more mental disorders, with major depressive disorder being the most prevalent condition. Typically, people also have one or more life stressors, with failing intimate partner relationships as the most common. Other factors often seen include work-related problems, debt, legal difficulties, and physical health problems.

The CAF suicide prevention program, guided by the 2009 suicide prevention expert panel, identifies three pillars of suicide prevention, namely, excellence in health care, effective leadership, and the awareness and engagement of members. We have a robust program that addresses these pillars, and we continue to make improvements.

In October 2016, we held another expert panel on suicide prevention to help guide future efforts, the results of which will be released once the report is finalized. My team will look carefully at all recommendations from this recent panel and ensure that the CAF has in place all elements of a robust suicide prevention program.

Thank you for your attention. We're happy to take any questions you may have.

The Chair: Thank you.

We'll start our six-minute round with Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you for attending. It's nice to see you again, General.

On mental health, which we talk about and are starting to see more and more issues on, I just want a comment or basically an idea from you.

As soldiers, CAF members would take a bullet for their buddy. They will stand up for these people, and they're trained to be there 24-7. When they now become veterans, they still have that ingrained in them, and they get extremely upset and annoyed when they see their comrades and buddies having to deal with issues like proving time and time again that they've lost a limb or that they've had an injury. We sit there with the military assessing these soldiers, and we understand that, and they have that diagnosis when they're ready to leave. Does it not make sense that this diagnosis would be transferred to VAC so that they don't have to repeat these same things time and time again?

● (1555)

BGen Hugh MacKay: The medical records of the Canadian Armed Forces personnel are in fact transferred over to Veterans Affairs Canada when we receive the request from Veterans Affairs Canada, and that includes any of the diagnoses we've made prior to their transition to Veterans Affairs Canada.

I am not in a position to comment on Veterans Affairs Canada's policy with respect to responding to the information that they ask for from those veterans.

Mr. Robert Kitchen: Do you think it would be wise that the transition of that information from DND to Veterans Affairs would be simple?

We talk about closing that seam, but that doesn't seem to be happening. From my understanding and from what I'm hearing, it takes months and years for that to happen, and in fact sometimes it gets delayed because their computers aren't even in sync.

I mean, it's a programming issue, and I'm not a computer guy, but the reality is, if there's a program that has it all recorded for our soldiers, then it should be easily transferable to Veterans Affairs so that they can access it the moment a member changes.

BGen Hugh MacKay: There has been an issue with respect to the timeline to transition the files. About two years ago we were at six to eight months, I believe, to transition a file. We put resources in place about two years ago to increase the number of people reviewing files to transition to Veteran Affairs Canada, and we're down to several weeks to two months, maybe, for transition of files.

There are issues that are not related to IT systems with respect to the transition of files; these have to do with the Privacy Act and our ability to share information from one department to another. I cannot transition the files from a military member to Veteran Affairs Canada until we've had the opportunity to go through that medical file to make sure there is no third party information in it. Once we screen the files, which is what this team does, to make sure there's no third party information present in them, we can then transition them to Veteran Affairs Canada in accordance with the Privacy Act.

Mr. Robert Kitchen: But if a soldier signs a document before deploying and the idea is that the soldier stays within the forces until such time as everything is in Veteran Affairs, the moment they sign that document that information should be passed on. When they give informed consent, they are basically saying that they are asking you to send that document to Veteran Affairs, and they put their signature on it. They should have the right to give it and they should also have right to take it away.

That process doesn't appear to be in place.

BGen Hugh MacKay: Members can sign informed consent for us to release the document, but it still doesn't remove my responsibility to review the file entirely for any third party information and to make sure that there is no third party information in the file when I transfer it to Veteran Affairs Canada. But I would have that member's informed consent.

It's important to remember that informed consent provided today does not necessarily mean I have their informed consent the next day. As you said, a member could remove informed consent, so we have to be careful. Signing a form as you leave on a deployment does not necessarily mean you consent when you come back from a deployment.

● (1600)

Mr. Robert Kitchen: That's correct, but you have that access and you know where the soldier is so they can update it from time to time, and you can ensure that the soldier is aware that they can do that, that they can manage that on their own, as well as with some guidance.

BGen Hugh MacKay: As soon as a soldier asks us to transfer the file, we'll start the process to transfer the file to Veterans Affairs Canada.

Mr. Robert Kitchen: Thank you.

The Chair: Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you.

Thank you, gentlemen, for your service. I appreciate it.

In testimony we had a few weeks ago, we heard that there weren't any formal mental health check-ins for soldiers in a theatre of war, and that those were on a voluntary basis.

Could you clarify for me whether we are performing regular mental health checks during service?

BGen Hugh MacKay: Are we doing them during service?

Mrs. Alaina Lockhart: Well, we talked about the theatre of war the last time, so what about during just regular service?

BGen Hugh MacKay: We do a mental health screening for anybody who is recruited as they are coming into the forces. Then, with each periodic health assessment, there is a small section that does a screen for mental illness.

Members under forty years of age have a periodic health assessment every five years; when they're over forty years of age, they have one every two years. We also do mental health screening as people are getting ready to go off on a deployment and we do the enhanced mental health screening within three to six months after a return from a deployment.

That is the formal mental health screening that we do within the Canadian Forces health services.

Mrs. Alaina Lockhart: What are the small unit commanders on the ground told with respect to reporting, when mental health issues are brought to them?

BGen Hugh MacKay: Our road to mental readiness program, which I referred to in my opening comments, is all about educating members of the Canadian Armed Forces and members of the chain of command about how to recognize when their soldiers or their battle buddies may be having difficulty with mental illness. They are taught to encourage them to seek help or to talk to the chain of command about getting assistance with mental illness.

Mrs. Alaina Lockhart: Are those conversations tracked in some manner?

BGen Hugh MacKay: I'm not aware that we're tracking those conversations.

Colonel Andrew Downes (Director, Mental Health, Department of National Defence): If I could just jump in, I think it's very important to appreciate the limits of screening and the logistical implications that screening during a theatre of operations would bring. For this reason, we really provide a lot of training to leaders at different levels as they move through their career on how to identify people who are showing signs that they may need help, how to speak to those people, and what resources are available.

During the deployment in Afghanistan, where both General MacKay and I were deployed, we did have a mental health team based in Kandahar, which included a psychiatrist, and people had direct access to that mental health team. In addition, we had medical teams present at all the forward operating bases, with physicians and physician assistants who people could present to should they feel the need. As well, we sent out mental health providers to visit the different forward operating bases.

We did have the services available in theatre, and people did have the opportunity to access them, and through our training we were able to help them identify when they should come forward for care.

Mrs. Alaina Lockhart: Okay. That was on a voluntary basis, though. There was no formal check-in that they went through, right?

Col Andrew Downes: That's correct.

Mrs. Alaina Lockhart: Okay.

I want to switch gears a little and talk about the JPSUs. I know they were originally created as places for healing. I know there certainly have been successes. I took a look at the numbers, and I think between July 2010 and January 2015, 1,614 people who went through the JPSUs returned to service. However, in the same time frame, over 2,000 were released. Do we have the capabilities for healing through these joint personnel support units, and do we have the resources we need? I've heard stories of just checking in once a week and appearing once a month. Are they functioning as they should, or as they were intended to function?

● (1605)

BGen Hugh MacKay: The JPSU isn't within my realm, really. I do have case managers who work within the JPSUs to help coordinate the health care of the patients who are in the JPSU. There is no health care delivered within the JPSU as such. The construct of the JPSU is really there to provide all the other kinds of supports necessary for the members and their families, looking at how they need to prepare for transition, looking at their financial arrangements, all those types of things.

The chief of the defence staff did order a review, and we're in the process of looking at JPSU renewal right now. I think Brigadier-General Corbould, who is the commander there now, really would be able to comment better on the functioning of the JPSU itself.

Mrs. Alaina Lockhart: I bring that up because when we hear stories of suicide, they're often related to the trigger of being transferred to the JPSU, even though their original—

Did you want to speak to that?

Col Andrew Downes: I'll happily speak about that, just to set the record straight. I don't have the numbers with me, and it is true that some members posted to the JPSU do die by suicide. There are people who are not posted to the JPSU who die by suicide as well. I think we just need to keep that in mind and not assume that this is the reason behind it.

Mrs. Alaina Lockhart: I think that's fair to say.

I think my time is up, but hopefully we will come back to that.

The Chair: I have a clarifying question. You talked about in theatre and outside of theatre, and I think you said it was every two years after 40, and before 40....

Is that a questionnaire? What type of screening is that? Are you talking about screening for those who are actually not in theatre?

BGen Hugh MacKay: With the periodic health assessment, there is a questionnaire screen that the individual goes through. It's every five years before 40 years of age, and every two years after age 40. Then they sit down with a physician, or a physician assistant or nurse practitioner, and they go through the answers to the questionnaire. There might be some additional questions that come up as a result of the encounter they have with the primary health care provider doing the periodic health assessment.

The Chair: Is that compulsory, for everybody?

BGen Hugh MacKay: It's required, yes.

The Chair: Okay.

BGen Hugh MacKay: Whether everybody is up to date all the time is a difficult question.

The Chair: Great. Thank you.

Ms. Mathyssen, go ahead.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair.

Thank you very much for being here, and thank you for your service. We appreciate the information you can bring to this committee, because we are grappling with recommendations and we want them to be the very best.

In listening to all this, it has occurred to me that your objective is to make sure that the men and women who are serving in the Canadian Armed Forces are supported in every way possible and are as healthy as they can be. Obviously, the strength of the Forces and of the nation depends on those individuals.

With that in mind, I'm wondering about something. In the presentation, you said that in terms of mental health providers, 93% of the available positions were filled by July 2016. This seems to be in conflict with some of the things we've heard here—that there were personnel members who knew they were in trouble but who couldn't get the help quickly enough. They had to wait six months, or sometimes more, on a waiting list, because the help wasn't there. Has that changed, or is there still a problem? Do we need that extra 7%?

You said there were challenges in recruiting personnel to some locations. Are those remote locations, the far north? Exactly where would that—

BGen Hugh MacKay: I'll start with the last question first. It is usually remote locations. We have had a challenge recently to fill our psychiatrist position in Shilo, Manitoba. We had some difficulty finding psychiatrists to go to Cold Lake, Alberta. In those situations, for example with Shilo, we used the Veterans Affairs Canada OSI clinic in Winnipeg to provide members with psychiatric service.

It's difficult for me to comment on individual stories about how members experienced access to the care. We have set a wait time goal of 30 days for non-urgent mental health care consultation within the Canadian Armed Forces, and that's in keeping with the Wait Time Alliance of Canada's goal for non-urgent care access.

Andrew, I believe, has the data on what our wait times are like at this point in time and what they have been over the last several years. I will ask Colonel Downes to answer that for you.

● (1610)

Col Andrew Downes: Certainly. We measure wait times at each of our clinics in the different parts of the mental health department. Just to add a little more precision to what General MacKay said, within our psychosocial services, the benchmark is two weeks. That is, again, for non-urgent, elective care. Obviously, more urgent cases will be seen sooner than that.

Within the general mental health department and the operational trauma and stress support centres, it's 28 days. Over the past year, the average across our system has been 25 days for general mental health and 32 days for the OTSSC.

I should point out that, when you have departments with individuals in them—perhaps in a small clinic, for example, where you have one or two psychologists—if one of them leaves or goes on holiday, it actually makes a big impact on the wait time. When you look across the year, the wait times at different clinics vary. As I said, overall the average is 25 days for general mental health and 32 days for the OTSSC.

Ms. Irene Mathyssen: We've talked about deployment and personnel who suffer from trauma because of combat and those experiences. Is it possible to have an OSI through training? One of the things I am particularly concerned about is the incidence of sexual assault. Have you looked at the situation of OSI outside of combat, and for men and women who have been victims of sexual trauma?

BGen Hugh MacKay: It is important to realize that it's not just deployments into combat zones that cause operational stress injuries. They can result from humanitarian assistance and disaster-response activities. We have found that exposure to dead people and disastrous situations can be as difficult for people to deal with as actual combat experience is. There is the potential for somebody in training to be part of, or witness to, an accident. A sexual trauma could very well also potentially lead not to what we would call an operational stress injury as such but to post-traumatic stress disorder. Of course, that doesn't make it an operational stress injury.

The Chair: Thank you.

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you, Chair.

Thank you, gentlemen, for appearing here today and thank you for your service to Canada.

I'd like to begin, General MacKay, with you. In your opening comments you talked about a working group under the VAC-CAF steering committee, which I think you said was established to align programs and to analyze the elements associated with the continuum of care. When was this working group set up, and what is the timeline for it to report back or to get its work completed?

BGen Hugh MacKay: This working group was established at the end of August, or in early September, I believe, and it was working very hard for several weeks to look at the situation. I believe the goal was for it to have recommendations put forward by mid-November. I haven't seen the final report out of the working group at this point.

● (1615)

Mr. Colin Fraser: That's going to be coming very shortly then. That's mid-November of this year.

BGen Hugh MacKay: That's correct. It should be.

Mr. Colin Fraser: Could the findings of the working group be shared with this committee or could you get back to us on that?

BGen Hugh MacKay: I'll have to get back to you on that. I guess it depends on where that information may go.

Mr. Colin Fraser: On that working group, are there veterans or former service members involved in the working group who are part of the discussion?

BGen Hugh MacKay: The working group involves staff from Veterans Affairs Canada and the Canadian Forces. However, the veterans groups have been advising the Veterans Affairs Canada staff as they've been working on their part of the working group.

Mr. Colin Fraser: Thank you.

With regard to the issue of mental health, can you give us a sense of how many members actually leave the armed forces with significant mental health issues? Do we know how many we're talking about?

BGen Hugh MacKay: It's interesting: we have had a little bit of a fluctuation in the number of people leaving the military for medical reasons. I believe last year we had about 2,000 leaving for medical reasons, and only 22% of those left for mental health reasons. The reason I say it's interesting is that in the previous several years, it was more on the order of 34% to 40% who were leaving for mental health issues, so I was a little surprised to see that the number had gone down.

Mr. Colin Fraser: Of the 2,000, 20% are—

BGen Hugh MacKay: It's 22%, I believe, who were—

Mr. Colin Fraser: That's around 400 to 450 people.

BGen Hugh MacKay: According to the numbers I was given, it is.

Mr. Colin Fraser: Is there any way to track how many of those may have had pre-existing mental health issues when they came into the forces? Are there any statistics on that?

BGen Hugh MacKay: I don't believe we do an analysis that looks at pre-existing conditions and whether they're related to being released for medical reasons from the forces at this time.

Mr. Colin Fraser: You mentioned that 31 of 37 health services centres have some level of specialized mental health services. For the six that don't, is there a reason why they wouldn't have those, or do you think it would be beneficial to look at having those at all of the health service centres?

BGen Hugh MacKay: They're just small clinics, so the patient population they are supporting doesn't really warrant having a full-time mental health professional. They certainly have access to local civilian mental health providers to whom they would be able to refer patients to meet the needs of the members who are there.

Mr. Colin Fraser: The outreach to communities across the country would then be serviced using technological means. I think there was talk of telecommunication.

BGen Hugh MacKay: We have internal telemental health within the Canadian Armed Forces, that can go clinic to clinic to be able to provide service. We also have a network of 5,000 mental health providers who work in the civilian community and who are registered to be providers for the Canadian Armed Forces if we need them. We simply send referrals to those health care providers, if we have a need based on the particular region, or a wait list, or something to that effect.

Mr. Colin Fraser: Do I have more time?

The Chair: You have one minute.

Mr. Colin Fraser: When someone presents in theatre with a mental health difficulty, what happens? Is there any case of somebody having been dealt with, or sent back home, for example, while in theatre, after having presented with a mental health issue that was identified and that would make it difficult for that person to remain in theatre? Do you have any examples of that?

BGen Hugh MacKay: I can only tell you what the policy would be. We would try to meet their needs as close to the front as possible. We've learned over time that treatment nearer to the operation and your buddies is better for you. But if we felt that retaining them in theatre wasn't going to be to their benefit, then we would arrange for them to be repatriated home to get more intensive care.

● (1620)

Mr. Colin Fraser: Thanks very much.

The Chair: I want to ask you for a clarification. Do you have any of those statistics for people who presented in theatre and whether they were sent home? When you get back, could you send them to us? Or do you have numbers for those who did present? Do you keep track of those?

Col Andrew Downes: I don't think we have numbers on how many people were sent back, or not, with mental illness. I'm not aware of any such statistics.

The Chair: You don't keep them, or was nobody sent back?

Col Andrew Downes: I know people were sent back, but I don't know that we have a list of who those people were.

The Chair: Mr. Bratina.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): What is the history of this, in terms of when it became apparent to the military that there was a unique situation with regard to suicide? Are we able to track a point at which somebody said “We're seeing things here that we haven't seen before”?

BGen Hugh MacKay: We've really been keeping suicide statistics and reporting on them since 1995. Our suicide statistics have said to us that the suicide rate in the Canadian Armed Forces has been at the same or about the same rate you would see in the Canadian population. It still is at about that rate.

We did a different analysis in 2014, in which we broke out the army, navy, and air force environments. In that analysis, we were able to see that at about the year 2006, there was a deviation or the start of an increase in the suicide rate in the army compared with that in the air force and the navy.

When you look at all of the statistics for the Canadian Armed Forces writ large, we're still at the same rate or about the same rate as in the Canadian general population, but that army rate started to rise as of about 2006. It has been sort of stabilized to the rate it is at now for the past couple of years.

Mr. Bob Bratina: The American experience—I looked the numbers up—seems to be that for the general population it is 13 per 100,000, and for the U.S. military it's 30 per 100,000. A lot of our missions and deployments have been somewhat similar, so would you stand by the figures that would indicate that non-army personnel experience suicide at a lower rate than do army personnel, if you're saying it balances out overall?

Col Andrew Downes: I'll answer that one: Absolutely.

What's important to understand about suicide is that the suicide rate changes over time and varies according to people's age. When you compare people of the same age, which is the analysis that we've done, that's where we get this observation that the rate is higher in the army than in age-matched males in the civilian sector.

Within the air force and the navy, the rate is slightly lower than in the civilian sector, but it's not a statistically significant difference. It is numerically a little lower.

Mr. Bob Bratina: Do the American numbers sound shocking at 13 per 100,000 versus 30 per 100,000?

Col Andrew Downes: Just remember that the 13 per 100,000 I think includes even children. I'm not sure what age it starts at, but as people move into middle age, that's when the suicide rate is actually the highest. That captures our serving population.

Mr. Bob Bratina: I think I'm getting what you're saying. If you're talking about people from 20 to 70, it would be a higher number obviously. I see.

What about the deployments themselves? I'm hearing that around 2006 we were seeing numbers that were disturbing. You can relate back to the Afghan deployment. You also began tracking in 1995, which would put you in the Bosnian, former Yugoslavia, deployment. In the Afghan one, has there been an evaluation of the operation and of how those stresses may have been manifested in extreme mental health incidents and suicide?

Col Andrew Downes: I'll go ahead first. We investigate each individual suicide to better understand what factors are at play, and we find that the majority of people do have mental illness or some mental distress. That is overlaid with what we call an acute trigger, so a stressor like a relationship issue, for example. We know that a mission like Afghanistan, in which there was a lot of psychological trauma, did end up causing a lot of mental illness. We think the mental illness that occurred during the operation is one of the factors behind the increase in rates in army personnel. It was primarily the army personnel who were exposed most to the combat-related stressors.

Mr. Bob Bratina: It's interesting to me, because in Kandahar our involvement was in the provincial reconstruction unit. We had people from Hamilton there, and I met a lot of these young veterans when they came back, and so on. It's certainly a lot different from a World War II battle, if you will. I wonder if the military needs to really investigate how troops are used, how they're deployed, and how they interact with the people around them, because something happened differently in these deployments than I think in what we traditionally saw in the past. Is it fair to say that there could be more to discover in this?

● (1625)

The Chair: Could we have a very short answer, please?

Col Andrew Downes: I would say that every mission has its risks. I think when we look at wars like World War I and World War II, there were significant mental illnesses that came from that. I think the Canadian Forces has looked at ways to interact as effectively as possible with the local population, but bearing in mind that there are still going to be circumstances in which soldiers are exposed to psychological trauma.

Mr. Bob Bratina: Thank you.

The Chair: Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you very much. I'm pleased to have both of you here.

Brigadier-General, I wasn't here last week so I've just been reading your notes from last week's statements.

I just want to quote:

> As you are likely aware, mefloquine remains an option for malaria prevention for many militaries around the world. We do, however, remain vigilant and open to assessing any new evidence related to mefloquine and other antimalarial medications.

Then you go on to say:

> We will, accordingly, update our approach to malaria prevention in a scientifically sound manner and with an emphasis on critical appraisal of the evidence.

I did some research, and of course, this would be in relation to our allies. That would be where we would go to see what else was being done with those other militaries around the world.

I have a statement here from September 15 of this year from the Minister of Veterans Affairs for Australia addressing mefloquine concerns:

> The Department of Veterans' Affairs has established a dedicated mefloquine support team for our serving and ex-serving community.... [and] additional support for current and former...members who have been administered mefloquine.
>
> The Government will:
>
> establish a formal community consultation mechanism to provide an open dialogue on issues concerning mefloquine between the Defence Links Committee and serving and ex-serving...;
>
> develop a more comprehensive online resource that will provide information on anti-malarial medications;
>
> establish a dedicated...mefloquine support team to assist...with...related claims, which will provide a specialised point of contact...and
>
> direct the inter-departmental [c]ommittee to examine the issues raised, consider existing relevant medical evidence and provide advice....
>
> Any former member who was administered Mefloquine...and is concerned about possible side effects...can lodge a claim for a condition that they think was caused by Mefloquine....
>
> Current and former...personnel can also access free mental health treatment....

They go on to list all the different areas of mental health that need treatment, and they indicate that those services are there.

In Britain also—this is from July 2016—the former head of the army has admitted that he would not take a controversial antimalarial drug as he revealed his son had suffered severe depression while prescribed Lariam. Lord Dannatt said that the side effects of the drug could be “pretty catastrophic” and he apologized to troops who had taken it while he was chief of the general staff.

He urged the Minister of Defence to show generosity when reaching compensation settlements with hundreds of personnel alleged to have suffered mental health problems after being given the drug during deployment to malaria hot spots.

He says here:

> We see no reason to disbelieve the very strong anecdotal evidence that such conditions have been ignored in dispensing it to large numbers of troops about to be deployed.... It is our firm conclusion that there is neither the need nor any justification for continuing to issue this medication to Service personnel except when the three conditions listed above have been met.

The conditions were as a last resort when they weren't able to tolerate the other alternatives.

Then of course, the U.S. has had witnesses here. Dr. Nevin has said it's been blackboxed in the States.

With this type of evidence from our strong allies, would it not be time for Canada, especially with the new definitions that Health Canada has come out with on side effects, to see that this is a mental health issue that we could deal with right now? These are people who think they have PTSD because that's what they were told, when it's clearly possible they have a brain injury. Is it not time for us to set up the same type of services for them whereby we can get this information from our veterans directly?

● (1630)

BGen Hugh MacKay: Mefloquine has been used in tens of millions of people over several decades. World experts and bodies like the World Health Organization, the Centers for Disease Control in the United States of America, the Committee to Advise on Tropical Medicine and Travel continue to look at all the evidence that is available with respect to mefloquine and recommend it as a first-line medication to prevent malaria.

Our conclusion from the statements, the assessment of what our allies have done, is that we should continue to offer mefloquine as an antimalaria medication, particularly to those who have used it in the past and were satisfied with the medication.

It's important to make sure that we consider all the available evidence and not rely on small bits of information, small groups of scientists who have opinions and theories, or jump to conclusions that might remove what has been recommended by the world experts as a useful antimalaria medication.

Mrs. Cathay Wagantall: While these other options have side effects, but not to the same degree as it would appear mefloquine has, why would we not make that choice to use what is less dangerous to our soldiers? It would appear that other countries have come to the conclusion to give them that other option. Why is it that in Canada this is still seen as a priority rather than a last resort?

BGen Hugh MacKay: It's important to remember that all antimalarial medications have side effects.

Mrs. Cathay Wagantall: Yes.

BGen Hugh MacKay: Some of those other medications have significant side effects.

When we discuss with patients what their choice will be with respect to their antimalaria use, we talk about all of the potential side effects, and we help them to come to a decision. We also screen them for any of the contraindications that are listed for any of the options for antimalarials, and we give them the opportunity to make a choice about which antimalarial they would like to use.

Malaria continues to be a dangerous disease that we need to be able to protect our soldiers, sailors, and air persons from. We think that it's important to be able to offer the options that are available and recommended by the world bodies.

● (1635)

The Chair: Thank you.

Mr. Eyolfson.

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

Thank you both for coming.

Colonel Downes, it's good to see you again.

Colonel Downes and I went to medical school together about 25 years ago.

A couple of people have asked about the data on suicide rates. To the greater question of mental health in the armed forces, what data is collected overall on mental health, which diagnoses, and what rates of mental illnesses?

Col Andrew Downes: We gather information from different sources. Perhaps the most important study we've done is the 2013 Canadian Forces mental health survey. The data was collected on our behalf by Stats Canada, and that actually showed a lot of important information, including the rates of several of the more prevalent mental illnesses like depression, PTSD, and so on.

That has really given us a very strong foundation for understanding what types of illnesses we have. There has been a fairly significant body of work going on to analyze this data in all sorts of ways, for example, understanding the rates of adverse childhood experiences in Canadian Forces members if we're looking at thoughts of suicide, suicidal ideation, etc.

We have published a number of papers and are working on more from that particular data set. We've also done chart reviews from which we have a good understanding of the impact of mental illness on people who have deployed in Afghanistan. We also examine the data from our enhanced post-deployment screening.

Those give some examples of some of the research we've done to understand this issue in our population.

Mr. Doug Eyolfson: Thank you.

Certainly, through all our work with veterans, we talk about the role of families and how, when someone enlists in the Armed Forces, their family enlists too. Does the Canadian Armed Forces offer mental health services to the family members of serving members?

BGen Hugh MacKay: The Canadian Forces health services don't offer mental health services to family members. Family members, though, may have access to some mental health services through the military family resource centres.

What we do recognize, though, is the importance of families as we're treating military members who have mental illness, and where we can and where the patient agrees, we'll try to involve the family members in the care of the military member.

Mr. Doug Eyolfson: Hypothetically, if you had a family member of an armed forces member living with the member in a reasonably isolated area, an outpost where there were very few resources other than what was available on base, if mental health issues were developing in that family member, what would be their resource, or where could they go?

Col Andrew Downes: In some of the very isolated communities, like Goose Bay, for example, military families are entitled to care by the Canadian Forces, but those are rather the exception. Otherwise, family members are provided health care through the provincial health systems.

Mr. Doug Eyolfson: Thank you.

BGen Hugh MacKay: I would just add, if I may, that there is a mechanism to help fund transportation for some if they need to travel to a different location to access health care.

Mr. Doug Eyolfson: Thank you.

Colonel Downes, you and I know from our common medical training and from the military that there is always a stigma around mental health and there are people who are reluctant to come forward because of mental health issues.

What is the Canadian Armed Forces doing to reduce the stigma around mental health issues to encourage members to come forward?

Col Andrew Downes: You're right. Mental health carries a stigma in Canadian society, as it does within the Canadian Forces. We've recognized that the stigma is one of the many barriers to seeking care that exist for our patients. But it turns out that it's not the most significant barrier to care. We have put a lot of energy into improving the mental health literacy of our members, because we know that when people better understand mental illness, the stigma is reduced. We've also participated in a number of activities designed to reduce stigma, such as discussions at the brigade level or the unit levels, and things like that. We participate annually in Bell's Let's Talk activities, again, with the goal of reducing stigma. We have actually found, from some of our research, that Canadian Forces members are much more likely to speak openly with their supervisors and their colleagues at work about their own mental illness than are civilians.

● (1640)

Mr. Doug Eyolfson: That's very useful to know. Thank you.

The Chair: Thank you.

Mr. Brassard.

Mr. John Brassard (Barrie—Innisfil, CPC): Thank you, Mr. Chair.

I want to focus on transition—and I know Mr. Fraser brought up this point earlier—and I want to speak more about the working group that's currently in existence. Obviously, they're going to come back with some recommendations.

Brigadier-General MacKay, and perhaps Mr. Downes, you might want to get in on this as well. What is your view of how a transition from being a member of our armed forces to being in VAC's care afterwards would ideally work? The working group is going to come down with a recommendation. I want to hear what Brigadier-General MacKay thinks should happen in that situation.

BGen Hugh MacKay: As we identify persons who are ill or injured and who no longer meet universality of service and are therefore going to be released for medical reasons, we want to be able to have the discussions between our case managers and VAC case managers to understand the treatment and support requirements of those individuals still in uniform as they're going to transition. We want to have the opportunity to have decisions from Veterans Affairs Canada with respect to what they will be entitled to from a benefits perspective, and we want to be able to identify health care providers in the civilian sector who are going to be able to pick up their care before they actually take off their uniform and go into the civilian sector.

That really is the goal we hope to be able to achieve for transitioning members and their families.

Mr. John Brassard: I was at Base Borden and there's a sense of frustration—I know Mr. Kitchen brought this up earlier—with the fact that VAC doesn't speak to DND on behalf of the soldiers with respect to the information that's available, and the reverse is also true; DND and VAC computers don't....

Brigadier-General MacKay, notwithstanding the privacy issues, do you think there's a way for us to overcome those issues? There's informed consent, and I know we talked about that, but is there a way we can integrate that information together to make it much more seamless?

BGen Hugh MacKay: I believe the key is at the case-manager level. If, with patient consent, we can have the case managers communicating effectively on what the treatment needs are and what the treatment plans need to be—and it doesn't necessarily have to be that full medical file but just having those discussions at that case-management level—that is really going to go a long way to facilitating that transition and helping that conversation to happen. That's one of the aspects we're working on, that coordination between the two case-management teams.

Mr. John Brassard: So in terms of roles, then, in that transition, should the emphasis be on DND, more on VAC, or should they be partnered equally as someone transitions out of the military?

BGen Hugh MacKay: I think we have to be in it as a team at that point. We want to be working on it together to get to the ultimate goal, to the benefit of the member and their family.

Mr. John Brassard: I want to focus on the issue of institutional fatigue. New missions will be evolving. There are going to be some new challenges, obviously. We talked about the difference between World War I, World War II, and Afghanistan. New troops are also going to be needed and new missions will require new assets. Are you concerned that as we deal with these new issues there is a risk of institutional fatigue? Do you see the potential of the military having to do more with less? Could this cause a greater problem in dealing with cases that these new sets of problems bring with them, or are we prepared to deal with them?

● (1645)

BGen Hugh MacKay: We're currently organized to deal with the current suite of options that the chief of the defence staff has to offer up, from a deployment perspective. I don't think I can speculate as to what these other unknowns may be and what the requirements of them will be for us.

Mr. John Brassard: Well, there has been direction that we are going to move more into a peacekeeping role. That brings a new dynamic to the situation. There may be a chance that the military will be expected to do more of that, with perhaps fewer resources. Do you think we're capable of dealing with some of these challenges going forward?

BGen Hugh MacKay: I'm not sure about the comment that there are going to be fewer resources. I am prepared to support the current Canadian Armed Forces as it is. Whenever there's a consideration for a mission to go out the door, we look at what we have for resources to support that mission.

The Chair: Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you, Chair.

The Canadian Forces Ombudsman made some recommendations in his report, and I know we've skirted around this a bit, but I want to come back to simplifying the service-delivery model. There were three very solid recommendations and I wonder if the changes he suggested could help the mental health of military members transitioning out. To what degree do you anticipate being guided by these recommendations?

Col Andrew Downes: Could you refresh our memory on which three recommendations these are?

Ms. Irene Mathyssen: They were that the Canadian Armed Forces retain medically releasing members until such time as all benefits and services are in place at VAC; that the Canadian Armed Forces establish a concierge service so that there is someone there who would be a liaison between DND and VAC; and that the forces lead, through a phased approach, the development of a secure web portal that would contain all of the information needed for a servicing-cum-security program and that would enable members to put their information in just once. This would allow them to automatically apply for services and benefits.

BGen Hugh MacKay: Those recommendations do not really fit within my mandate with respect to the provision of health care. My comment would be that we believe any effort to smooth the transition process is going to help our members as they prepare for that transition. We recognize that anything we can do to reduce the stress and time for that is going to be beneficial.

I would say, though, that there are times when members may want to leave more quickly, and it may be to their benefit to be able to leave more quickly. I would hate to hold people in the forces when they themselves want to leave before those services are all in place, as recommended by the Ombudsman.

Ms. Irene Mathyssen: It was also suggested in the course of our deliberations that the planning for civilian life begin right at the start of service, that it be something that doesn't just come up at some point, but is thought through right from the beginning.

Do you have any thoughts on that?

● (1650)

BGen Hugh MacKay: It's really an opinion that you're asking for, and I think everybody is going to be different with respect to what their needs and desires are with respect to planning their future going forward.

The Chair: Thank you.

Mr. Kitchen, go ahead for five minutes.

Mr. Robert Kitchen: Thank you, Mr. Chair.

Colonel, you indicated to one of my colleagues that the suicide rate is higher in the army than in the navy and the air force, mainly because they were the bigger contingent in Afghanistan.

Recognizing that fact, I wonder if you have looked at the prevalence of suicide in those soldiers—not the whole navy and air force, but those who deployed—and are the rates higher or lower than what you would see in the general population?

Col Andrew Downes: Yes, we have looked at that, not broken down by commands, but, overall, when you look at all the people who have deployed, they do have higher incidences of mental illness compared to military members who have not deployed. Those include depression and PTSD and general anxiety disorders, for example. We also know that, overall, the military has a higher level of mental illness than does the civilian sector.

Mr. Robert Kitchen: Do you think it would be a good epidemiological study to determine those cohorts?

Col Andrew Downes: I actually have the answer to your original question. I must have missed it then. We do know that people who deploy come home with higher levels of mental illness. We know that.

Again, it gets back to the original couple of comments. It's not so much the deployment; it's what happens to you on deployment that makes a difference in terms of risk for mental illness.

Mostly it was people working under the army command who were exposed to these more psychologically traumatizing events, but we certainly did have a few people from the navy and the air force who were exposed to similar things as well.

Mr. Robert Kitchen: Can you provide for this committee your reference list for the studies you have done?

Col Andrew Downes: I will do that, yes.

Mr. Robert Kitchen: Thank you very much.

If a soldier is deployed, and while in theatre exhibits signs of PTSD, what is the standard treatment for that soldier?

Col Andrew Downes: Do you mean when someone is in theatre?

Mr. Robert Kitchen: Yes.

Col Andrew Downes: An individual who is identified as having symptoms, perhaps related to PTSD or another mental illness, would typically be referred to a primary care physician for an initial assessment. Subsequently, there would be a referral made to the deployed mental health team, if there is one, such as we had in Afghanistan.

A decision would then need to be made as to whether the individual should be retained in theatre, perhaps returning to their unit to continue their mission, or perhaps doing another role, or be returned home for further care. That decision is made on an individual basis, based on the severity of the symptoms as well as the role that individual would play.

Mr. Robert Kitchen: Would any particular drugs be administered in such situations to keep them deployed?

Col Andrew Downes: If somebody required an antidepressant, for example, or medications that we would use to treat PTSD, they would not typically be retained in theatre. The symptoms would likely be significant enough that staying there could cause them to worsen.

Mr. Robert Kitchen: My questions earlier were about how to transition the medical information from DND to VAC.

If the doctors have filled out those forms for the soldier, could a military doctor fill out those forms for Veterans Affairs? If a soldier needs those forms filled out, could they have a military doctor fill out those forms for them?

Col Andrew Downes: Yes, and we do fill them out.

● (1655)

The Chair: You have twenty seconds.

Mr. Robert Kitchen: Okay. When a doctor fills out a form that indicates some sort of pensionable condition or non-pensionable condition, are there any repercussions for doing that sort of thing?

Col Andrew Downes: Are there any repercussions to the physician for doing that?

Mr. Robert Kitchen: That's correct, for a military doctor.

Col Andrew Downes: There are none that I am aware of. I see no reason why there would be.

I should point out that when we see patients, the forms we fill out are part of our own medical record. Veterans Affairs Canada has its own forms, which look for very particular information to help determine whether the injury or illness was related to service. Those forms are sent to us, and we fill them out.

The Chair: Thank you.

I just want to clarify. You mentioned that if they had issues, they could be sent home. Who makes that decision? Is it the doctor, the person, or the chain of command?

Col Andrew Downes: It is typically the physician, with input from the individual and potentially the chain of command. We make a recommendation to the chain of command that a particular person should be repatriated for medical reasons. The chain of command would likely not know what the reason was.

The Chair: Okay. Are those decisions always followed? Are doctors orders always followed? Can the chain of command overrule the physician?

Col Andrew Downes: The chain of command can, at its peril.

The Chair: Okay.

BGen Hugh MacKay: I would clarify that the chief of the defence staff put out a directive that medical employment limitations assigned by physicians are to be followed by the chain of command. If we gave a direction that the individual needed to be sent back, then the chain of command would follow that.

The Chair: Okay. Thank you.

Mr. Rioux.

[*Translation*]

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

I will continue along similar lines.

Some of the witnesses we've heard from said that, when CAF members leave for medical or other reasons, they had difficulty in getting their records. They explained that they had to wait a long time before getting them and often didn't receive them at all. The same was true for the historical records.

What is your experience? Do you think people can get their historical records and the final diagnosis quickly?

[*English*]

Col Andrew Downes: I'm going to answer in English if you don't mind.

[*Translation*]

Are you talking about medical records or other documents?

Mr. Jean Rioux: I'm talking about the medical record.

[*English*]

Col Andrew Downes: Certain documents from the medical record can very easily be provided to an individual, but to provide the complete medical record requires us, under the Privacy Act, to go through each page and remove information that's considered third party information. That takes some time to do as you can imagine. Nonetheless, as General MacKay has mentioned, we have a higher number of additional people to complete this task, and the time it takes is significantly shorter now than it was in the past.

[*Translation*]

Mr. Jean Rioux: Unless I'm mistaken, this is in line with the ombudsman's recommendation.

[*English*]

Col Andrew Downes: Yes.

[*Translation*]

Mr. Jean Rioux: In addition, General Roméo Dallaire said that National Defence should be more involved in suicide prevention.

Have any improvements or efforts been made toward prevention?

[*English*]

Col Andrew Downes: We have done many things to improve suicide prevention within the Canadian Forces. As I mentioned earlier, mental illness is one of the key elements of suicide, so we have done a lot to improve the programs and services that we offer clinically to decrease the impact of mental illness. For example, in the past 10 years or so, we've doubled the number of mental health clinicians working in our clinics. We have increased the number of operational stress support centres. We have brought on line a resiliency program that helps people to better manage their own levels of stress, as well as to identify when they themselves need to come forward for care. Outside of health services, the army, for example, knowing that its suicide rate is higher, has recently implemented what it calls the "sentinels program", which is a peer-based program in which certain members of a unit get special training so that they can more easily identify their colleagues who are having difficulties and encourage them to come forward for care.

The army has also implemented a program that they call CAIPS. I can't remember what the acronym stands for right now, but basically it is another form of resiliency program that deals with different aspects of people's lives, from family to spiritual, to medical, to physical fitness, and so on. A lot of things have been put in place to tackle the problem of mental illness, and therefore, suicide as well.

● (1700)

[*Translation*]

Mr. Jean Rioux: In the Saint-Jean riding, which I represent, some people who attended the two military colleges took their own lives. There seems to have been an increase in these cases recently. You would be more familiar with the statistics than I would be.

Have any additional steps been taken with this group?

[*English*]

Col Andrew Downes: Regarding the road to mental readiness program that we spoke of earlier, one of the new modules we've recently developed is specifically intended for military colleges. We've just implemented this for the first years at the Royal Military College. Depending on how that goes, we might roll it out to other places as well. Road to mental readiness training is also provided to new recruits when they go to Saint-Jean Garrison and start their basic training for the military. All members, once they've joined the forces, have access to the full suite of programs that we offer to our members, including the clinic-based care and mental health, education, and training programs, as well as our CFMAP. It's a member assistance program. There's a 1-800 number people can phone if they're having stresses or issues going on in their lives, to get some advice and assistance over the phone and potentially some additional counselling as well.

The Chair: Thank you.

Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you, Mr. Chair.

I want to go back to earlier questions from Ms. Wagantall and get a better sense of the concerns that I'm sure the medical personnel of DND have with regard to the current concern about antimalarials.

In light of the reports of side effects of long-term concern, are you doing any follow-up with personnel who have taken antimalarials once they return home or are released?

Col Andrew Downes: Everybody who returns home from a mission undergoes enhanced post-deployment screening three to six months afterwards. At that time, their mental health conditions in particular are reviewed, but they also have a chance to bring up physical health conditions. These could include side effects of medications or other concerns that individuals might have. That gives an opportunity to review those things. In addition, at any other time afterwards when they're having medical appointments and follow-up, people can bring up their concerns as well.

Ms. Irene Mathyssen: That's three to six months.

Has there been any thought about going beyond that? The discussion that's been out there in the last little while is that these side effects go on for many years.

Col Andrew Downes: Typically, though, if people are having side effects, they would have them early on either in the course of taking the medication or shortly after. You'd expect the person to have experienced them by the three-month to six-month window.

● (1705)

Ms. Irene Mathyssen: You said that at the time of deployment, or just before deployment, troops are advised about the potential side effects, and they are given a choice about which antimalarial drug they want to take. What if they weren't willing to take anything at all? What if they were so concerned about being one of those people profoundly adversely affected that they didn't want to even try the drugs? What happens then?

BGen Hugh MacKay: If we are going to be sending troops into areas where malaria is a significant risk and an individual chooses not to take an antimalarial medication, then we would make a recommendation that the individual not deploy into that particular area or mission. Malaria is a very significant disease, and we would not want them to have that risk.

Ms. Irene Mathyssen: Would there be any negative consequences of that decision for the individual?

BGen Hugh MacKay: A decision not to take the antimalarial medications and therefore not deploy may result in an administrative review process, where they would look at whether or not the individual would be able to continue to serve.

Ms. Irene Mathyssen: It could have very negative consequences on a career.

BGen Hugh MacKay: The administrative review process could result in significant consequences, yes.

Ms. Irene Mathyssen: In the theatre, in the field, you said that if someone is experiencing a mental difficulty, then the primary care physician gets involved. I wonder if they are mental health specialists or if they are general practitioners. What kind of skill set do they bring to that diagnosis? It's a significant decision in terms of what happens to the individual CF member.

BGen Hugh MacKay: The primary care clinicians who would normally deploy would usually be physician assistants, general practitioners, or family physicians who have experience and knowledge to be able to assess an individual's medical condition and to make a decision as to whether they should have employment limitations applied or stay in a mission.

Ms. Irene Mathyssen: That would include the mental health piece of it. I know that there are specialties in medicine, and I wondered about that particular area of expertise.

BGen Hugh MacKay: There is a broad spectrum of symptoms that somebody might present with, and a physician assistant or family physician might seek assistance from a medical health professional to help them make the decision, if that was necessary.

The Chair: Thank you.

Mr. Eyolfson.

Mr. Doug Eyolfson: Thank you.

You talked about someone having a mental health issue coming up when they are serving in theatre, whether it turns out they're diagnosed with depression or PTSD, and then a determination being made as to whether it's suitable for them to remain in theatre or to be removed from the theatre to another sort of deployment. Does this have implications for their universality of service?

BGen Hugh MacKay: A decision to repatriate an individual for an acute medical condition would not usually result in an assessment of their universality of service.

It's not the medical service that looks at universality of service; it's the personnel world, but usually that occurs after we've applied permanent employment limitations. It's usually a year or more after a condition has started before we would give them permanent types of medical employment limitations based on what we can see as the prognosis for the individual. At that point in time, somebody might start to make a decision, or the file might go for consideration with respect to their universality of service.

● (1710)

Mr. Doug Eyolfson: Okay.

In order for them to maintain their universal status, would they at some point have to be deemed able to serve in active theatre again?

BGen Hugh MacKay: Yes. Typically one could continue to serve even with some minor medical employment limitations. The general result is that we're looking for people who can deploy.

Mr. Doug Eyolfson: All right. Thank you.

In earlier sessions we had on health care delivery, we talked about possibly giving feedback data from Veterans Affairs to DND with a view to informing DND about some of the causes contributing to health.

One of the examples we brought up a few months ago came from a veteran's physician who noticed that this person, who had been a paratrooper and had done his thousand jumps, needed knee replacements five years after discharge because his knees were blown. There might be ways to inform DND that this is happening with regard to all of your personnel who perform this task. Could you review how this is done to see if you could prevent...?

Is there any sort of feedback in the direction of DND regarding mental health? Is there any mechanism whereby the physicians of veterans can inform DND of what factors are contributing to mental health issues, with a view to improving things?

Col Andrew Downes: There's no formal mechanism that I know about, to speak to your point, when a civilian physician notices something. There's not a 1-800 number that they could phone to provide that feedback, but we are in regular contact with Veterans Affairs physicians who work within their system, including researchers who are looking at things like the health of people after service. They've conducted a life-after-service study, for example, that includes a lot of health-related information on people who have left the forces.

Mr. Doug Eyolfson: Great.

This might be premature, but are there any plans to perhaps use this data as a sort of, for lack of better word, quality assurance mechanism, again to inform DND on its practices and to maybe improve the health and safety of personnel to prevent injury and illness before they happen?

Col Andrew Downes: I would say we're always interested in knowing about ways to prevent illness and injury. That's one of the things we pay particular attention to, because we know that preventing illness or injury in the first place favours long-term health. The challenge, though, is that some of these things are difficult to prevent. Given the nature of the work, there really are limited opportunities to modify how people do parachuting, for example, in order to protect somebody's knees.

The same thing happens with other illnesses and injuries as well, but when we find something of importance that we can intervene on, we are certainly very interested in that.

The Chair: Thank you.

Mr. Bob Bratina: How does the sentinel program work? Volunteers come forward. These are obviously professional soldiers, but not mental health professionals.

What's the recruitment? How does that work?

Col Andrew Downes: I can't speak to exactly how it works, but I do know that it's volunteer-based. We want people who are interested in this role; we don't want to assign this to somebody. We want them to want to do this. Then they undergo training. I think it's a day long, but I'm not 100% sure of the duration. In that training they are taught about the resources available. They're taught about how to engage people as well as what signs and symptoms to look out for in people who might be struggling.

Mr. Bob Bratina: Would it typically be peer to peer in terms of ranks?

Col Andrew Downes: I can't speak to how they decide this, but ideally you would want to have people at different ranks within a unit, I'd say. Rank does matter in the Canadian Forces. If somebody more junior were to approach a senior person, it might not be taken the same way as if a peer of the same rank did so.

● (1715)

Mr. Bob Bratina: In that the basis of it is peer-to-peer, are you aware of a debrief or information that's drawn from the sentinels with regard to the conversations they have with their peers?

Col Andrew Downes: There is not, as far as I know, a formal mechanism to get feedback. These aren't designed to be clinical interventions. We don't want to encumber the process or make it such that someone would be scared to come forward to ask these people for help, knowing that the commanding officer might find out, for example. It's not done for that reason.

Mr. Bob Bratina: Probably, historically, there was often an individual in a group who you knew you could go and speak to. This is a little more formalized. They do get some training. It might be valuable to consider expanding that or, as I suggested, talking to them about what guys are talking about. Maybe that would destroy the confidential nature of a soldier talking to a soldier—"You're not going to tell anybody, are you?"—but they must have valuable insights into how someone's mental health deteriorates through a deployment or something.

Col Andrew Downes: I imagine they would have some insights on that. I think the role, though, is really to facilitate the access to care. As clinicians, we then have a chance to talk to those people as well and to find out what's going on. In fact, they're more likely to really open up to us about that, because they're protected by confidentiality. They know they can tell us things, and we won't....

Mr. Bob Bratina: The way I see it working is that I will say "Why don't you go see somebody?" if I'm the sentinel and I'm talking to my peer. Because the stigma issue is so huge, I'm not sure how you get around that, especially in terms of combat. They're all going ahead, and they're not sure they can make it, but it affects their career, so they don't say anything, etc.

Col Andrew Downes: Stigma is a big issue, but we really believe we've made significant headway in stigma reduction. I think people are coming forward for care. We have evidence that people are coming forward for care in numbers higher than in the civilian sector. We feel that the willingness of people to talk to peers and supervisors about their mental illness is another sign that we've cracked through a little bit. There's still work to be done, but we've made a difference in that regard.

Mr. Bob Bratina: We know about General Dallaire. I just read that a two-star general in the United States very recently took his own life. Does the data show anything with regard to ranks?

Col Andrew Downes: Do you mean the suicide data?

Mr. Bob Bratina: I mean that or the mental health data and so on.

Col Andrew Downes: Generally, people of lower rank are more likely affected by mental illness.

Mr. Bob Bratina: Can you show that statistically?

Col Andrew Downes: Yes.

Mr. Bob Bratina: Thank you.

The Chair: Ms. Wagantall.

Mrs. Cathay Wagantall: Thank you, Mr. Chair.

In reference to our previous conversation, I want to make note that you indicated that we can't rely on these studies and things unless they're significant. I think it's important to note that the one in the U. S. was done by the FDA, and a significant portion of the U.S. military participated. The other two were done by the British House of Commons and by the Australian Department of Veterans' Affairs. These would be very credible studies that I think would be important for Canada to take a look at in discussing mefloquine.

I have three very quick questions for very short answers.

In 1999, Brigadier-General Claude Auger, surgeon general and commander of the Canadian Forces Medical Group of the Department of National Defence, was asked some questions by the Standing Committee on Public Accounts. He was answering the question on what we have done since Somalia to better control distribution of unlicensed drugs, and he said, "We are also in the process of developing an adverse effect monitoring and reporting database".

Are you aware of whether that database exists? Is that something this committee could have some feedback from or access to?

● (1720)

BGen Hugh MacKay: Since General Auger presented, we did create a medical regulatory affairs group within the Directorate of Health Services Operations. For unlicensed medications, they do track anybody who has been provided those unlicensed medications —this is since they've been put in place—and whether or not there were any reported adverse events as a result of the use of those medications.

Mrs. Cathay Wagantall: That would apply to mefloquine as well, then?

BGen Hugh MacKay: Mefloquine is not an unlicensed medication in Canada. It became licensed in 1993, I believe.

Mrs. Cathay Wagantall: This was after, so there was no going back and studying the effects of the unlicensed drug mefloquine?

BGen Hugh MacKay: To my knowledge, there was no study looking at the use of the unlicensed drug.

Mrs. Cathay Wagantall: Okay. Can you tell me how many options are given to our soldiers when they go into an area where they need to use an antimalarial drug? How many options do they have as far as the drug they could choose is concerned?

BGen Hugh MacKay: In chloroquine-resistant areas, we would usually offer three medications. The first one is Malarone; the second one is doxycycline; and the third one is mefloquine.

Mrs. Cathay Wagantall: Can you tell me, or could you find for us, the cost per soldier for each of those three?

BGen Hugh MacKay: We could find that for you. Malarone is our most-used medication at this point in time, and I believe it's the most expensive. For doxycycline, I'm sorry, I'll have to get you the data.

Mrs. Cathay Wagantall: That would be great. Thank you. I would appreciate that.

That's all I have.

The Chair: You have one minute and 40 seconds.

Mr. John Brassard: Thank you, Mr. Chair.

Mr. Downes, you spoke about the incidence of mental health in the lesser ranks. Quite often within the military, pay and benefits are tied to rank, so you may find in fact that some of those in higher command positions may not necessarily come forward with issues of mental health because doing so could potentially impact their pay and benefits, or more importantly it could impact their potential for promotion. Are you suggesting that it's just in the lower ranks that we're seeing those issues of mental health? A lot of these commanders who are in positions of command were deployed at some point, perhaps in Afghanistan, and perhaps they're masking or not coming forward with any mental health issues because of that fear of a lack of promotion.

I'd like your comments on that, because it's something I picked up on when you said it earlier.

Col Andrew Downes: I think you've touched on a few important facts, including the fact that mental illness is more common in people of lower socio-economic status and lower levels of education. That is typically what we see in younger members of the Canadian Forces. Many of them are still studying at school. They're maybe not earning much income.

As people get promoted, they get more education, and they get more insight. They have more tools to develop for the stresses and strains of the job as well.

We have people of all ranks of the Canadian Forces, from privates to generals, coming forward for care in our clinics. Each one of them makes an individual decision to come forward, certainly, and we encourage them to do so because we know that the best option for continuing their career is to come forward for care early, because they have the best chance of recovery if they come forward early.

But another interesting point is that currently there is a rule in place such that people have to be medically fit to be promoted, and this rule is a barrier to care. People often, when they know they're potentially getting close to promotion, may decide to wait until afterward. This particular policy is one that is under review as well.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart: Thank you.

One of the things we haven't discussed is addiction, and we know that it's quite often tied to suicide rates. What services are we offering for addiction?

BGen Hugh MacKay: Addiction or substance-use disorders are a concern of mine, certainly. One of the things we do see is that mental illness combined with substance-use disorder makes it very complicated to treat patients. We have in-house treatment available. We have addictions counsellors available and all of our mental-health providers can deal with addictions. But when we have really complicated, difficult cases, and sometimes when there's the co-morbidity of mental illness, we refer people out to civilian medical treatment facilities that can do in-patient care.

● (1725)

Mrs. Alaina Lockhart: Do you feel that referring them to outside civilian services is optimal, or is it a reflection of resources?

BGen Hugh MacKay: I believe that when we refer them to those civilian in-patient facilities it's because there's a need for that kind of intense substance-use-disorder care. That is a valuable resource available to us to provide the care to our service members.

Mrs. Alaina Lockhart: I just find it curious that we're referring people to outside civilian services given that we talk an awful lot about the value of camaraderie when we're talking about treatment. Again, is it ideal that we're referring outside? Are in-house services something we should be working towards? Are they something we had in the past and lost?

BGen Hugh MacKay: We did have in-house services in the past, and I think we closed them down in the nineties. It's important to remember that they go away for a period of time when they're in-patients to get that intense care, and then they come back to us. There's a next phase of care where they're at home and they're working with our health care providers. They have an opportunity to have that camaraderie but also to work on issues that may have arisen at home as a result of the substance-use issues. I think we have a very good mix of services to meet the needs of the members.

Mrs. Alaina Lockhart: I appreciate that the success stories happen when they do come back. I guess I'm concerned with those who are, for lack of a better term, falling between the cracks, and who aren't successful. We're looking for ways to improve this and lower suicide rates. Can either one of you give us some insight on things that we can improve upon to try to broaden the net?

Col Andrew Downes: Specifically related to addictions, we have recently convened a working group to look at the addictions issues with an addictions treatment process within the Canadian Forces. We have just recently hired an addictions specialist to help give us some advice on all of this. We're aiming to personalize the care to match the needs of the individual with the services that we can offer them. There will always be a need for the intensive in-patient care in one of these private centres to which we can send people, but we do want to have access to intensive out-patient treatments closer to people's homes.

There are factors to keep in mind, including where people live. Is it reasonable for us to have our own intensive out-patient centre at a small base where we would not have the clientele to justify having such a program? Perhaps at a larger base.... We're looking at different options, but I would just like to reassure you that this is something we are actively looking at.

Mrs. Alaina Lockhart: Thank you very much.

The Chair: That ends our meeting today.

On behalf of the committee I would like to thank both of you for what you've done for our country and our men and women.

Also, I would like to remind you again that if there's any information that the committee has asked for or anything that you would like to add, please email it to the clerk, and the clerk will distribute it.

The meeting is adjourned.