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Chair

Mr. Neil Ellis

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● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good afternoon, everybody. I call the meeting to order. Pursuant to Standing Order 108(2) and the motion adopted on September 29, the committee resumes its study of mental health and suicide prevention among veterans.

Today, we have Colonel Jetly, senior psychiatrist, directorate of mental health, Canadian Forces health services group. We'll start our panel today with a 10-minute statement and then we will go into questions and answers.

Colonel, the floor is yours.

Colonel Rakesh Jetly (Senior Psychiatrist, Directorate of Mental Health, Canadian Forces Health Services Group, Department of National Defence): Mr. Chairman and members of the House committee on veterans affairs, thank you for this invitation.

I'm the senior psychiatrist in CAF. I have several key roles, including advising leadership on mental health issues, and leading our relatively newly minted centre of excellence, which is a cell within our directorate of mental health that is charged with a more strategic nature to forward thinking. I'll describe it in a little more detail in a moment.

To some extent, I also represent all of the clinicians who are working every day with those within CAF who are struggling with mental health issues. At the headquarters level, I am charged with innovation and clinical research. In the area of suicide, I've had the privilege of co-chairing our CAF 2009 international expert panel on suicide prevention, and our recently completed 2016 panel. I am just also returning from a NATO symposium on military suicide prevention in Riga, Latvia, in which Canadian clinicians and scientists played a key role. We also served on the planning committee and I served as technical evaluator of the same symposium, at which 27 countries were represented.

You heard a great deal already about the CAF, including the statistics of suicide, the way the CAF investigates and tracks each occurrence. You've heard of clinical programs and numbers of professionals available to treat members of CAF. You've heard of our other programs to aid in resilience and mental health literacy, such as R2MR, and various ways in which transition issues are being addressed. I will try to share some of my own observations and thoughts briefly without repeating too much, and of course will answer questions to the best of my abilities.

Suicide is a significant issue for both veterans and serving members. As a psychiatrist with an interest in population health and suicide, I would like to remind you that globally about 880,000 suicides occur each year. That means that about 200 people will die by their own hand during the two hours that you meet this afternoon. About 4,000 Canadians take their own lives each year. Mental illness and suicide are a global phenomena and leading causes of disability and death. The CAF and our veterans are not immune.

One of our esteemed speakers in Riga stated there are no “neat snippets or sound bites” to explain suicide or suicide prevention within militaries, and unfortunately not all suicides are preventable. We cannot predict which ones will and won't be preventable, and as such we need to continue to work to the best of our abilities to prevent each and every one of them. This is the basis for suicide prevention strategies that are being utilized and expanded within both CAF and Veterans Affairs Canada

First and foremost, we know more about suicide now than we ever did. There are excellent models for suicide. For example, the Mann model of suicide was adapted to military populations by our 2009 expert panel and has been the guide for most of our prevention strategies. The model describes that most suicides occur in individuals suffering from mental illness and facing a crisis. The crisis is usually interpersonal, legal, or financial, and that leads to somebody developing suicidal ideation. Other factors come into play, such as feelings of hopelessness, the impulsivity of the individual, and of course access to lethal means. These factors have provided obvious targets for suicide prevention.

There are other models, such as the interpersonal model of suicide proposed by Thomas Joiner, who spoke at Riga at our NATO symposium just last week. Joiner's model proposes that suicide is the result of “thwarted belongingness”, “increased burdensomeness”, and a diminished fear of violence and death, which can often occur in military and veterans.

These models are helpful; however, the need for research and a better understanding remains. For example, the clear majority of individuals in mental illness and crisis do not kill themselves. Likewise, many who may see themselves as a burden and isolated, again, do not commit suicide. In fact, the existing tools created to predict suicide are accurate, at best, 5% of the time. This is always the challenge in predicting rare events.

More research is needed. Suicide itself is complicated, as is suicidality. For example, those with suicidal ideation or desire are different from those who attempt suicide and those who complete suicide. We need to better unravel this and determine if there are predictors of transformation between the three groups. The “when” is also important, because there appear to be times of higher risk from various sources, such as early in one's career. Some of our NATO forces are facing increased suicide in recruits within the first year, soon after deployment, or when leaving the military. So transitions occur throughout one's career and we need to be mindful of that.

● (1535)

Further to this, our own review demonstrated that about half of our recent suicides are in care and half are not. For the latter group, we need to ensure that we remain committed to all of our efforts to reduce the stigma and barriers to care. These include our commitments to mental health education and training: for example, partnering with Bell Let's Talk and reaching people through social media and other technology.

Members in care who complete suicide remind us of the ongoing need to have mental health programs that are well resourced and staffed to allow the timely access to evidence-based care that's required, but also that current treatments of mental health conditions are simply not good enough. This is not a CAF or Veterans Affairs issue, but rather the state of the science in the treatment of mental health disorders. We need to develop treatments and study them to ensure that they work. We need to better understand who responds to which treatment in order to reduce the trial and error. Funding and other support are required, as we need to conduct military and veteran research, since some civilian research may not translate and we may have our own priorities, such as combat PTSD.

One of my roles has been to run our recently formed centre of excellence, and I am privileged to have been appointed the first Brigadier Meakins chair of military mental health at the Institute of Mental Health Research here in Ottawa. We have an ambitious research agenda that has three thrusts.

The first one is understanding the biological underpinnings of mental illness. We will use neuroimaging and establish the biomarkers of disease. It is only through a better understanding of the biology that we can develop tools to better diagnose and track illnesses like PTSD. Treatment can also be developed that targets specific areas or abnormalities, perhaps even identifying a biological profile for suicide.

The second major thrust is leveraging technology. We are committed to studying and expanding the use of technologies within mental health. This could include various things, such as web-based therapies, repetitive transcranial magnetic stimulation, neurofeedback, big data analytics, etc.

Personalized medicine, also called precision medicine, is the last thrust. Unfortunately, even for the most common mental illness, the trial-and-error procedure is the usual process for treatment, which can be frustrating for both clinicians and patients, and of course their families. We can conduct studies using technologies such as pharmacogenomics or even EEG to try to predict who is going to respond or not respond to treatment, and then use those technologies later on to avoid some of the trial and error.

Our centre of excellence is also studying new treatment approaches. We are exploring them, and if they are promising, we'll recommend implementation within CAF, and of course share our findings with our colleagues at Veterans Affairs Canada. Two current examples include CBT-S, which is a cognitive behavioural therapy specifically targeting suicidality, and approaches that formally teach our clinicians to establish safety plans for at-risk patients. These types of interventions represent a shift in my own thinking, but more importantly the field's thinking, regarding suicidality.

Traditionally, when a person suffering from an illness such as depression became suicidal, the conventional thinking was that the driver of suicidality was the illness and we ought to redouble our efforts to treat the illness. More recently, there has been a shift in thinking, and the idea is to address suicidality as an entity in itself and give it a specific focus within therapy, safety planning, etc. Of course, treating the underlying illness will remain crucial. I am happy to expand on this with specific questions, and I am quite excited that this will enhance our current approaches.

Another concept for consideration is the issue of contagion as it pertains to suicide. Suicide contagion occurs when vulnerable individuals relate to or identify with those who have completed suicide, and attempt or complete suicide themselves. The phenomenon exists in groups such as university students, and clearly can occur in military and veterans groups. Recently, a lot of focus has been placed on the responsible reporting of suicides. In fact, the World Health Organization, the Centers for Disease Control and Prevention, and the Canadian Psychiatric Association have all published responsible suicide reporting guidelines. It is strongly advised that we refrain from rationalizing, glorifying, or romanticizing suicide, as other vulnerable individuals may use that as a justification to take their own life. This is an important issue, as we must balance the honouring of those who die with the risk of others following. As a result, the Canadian Psychiatric Association is in the process of revising and publishing a new set of guidelines.

Thank you for your attention. I am happy to expand on my opening comments or answer any questions you may have.

● (1540)

The Chair: Thank you.

We'll begin with six minutes.

Mr. Kitchen, go ahead.

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

Colonel, it's good to see you again. Thank you for coming back, and thank you for your service. I appreciate your presentation. There is so much that I don't think I'll have enough time in my short questioning to ask you all the questions.

As you are aware, all research chairs require funding. Can you tell us where that funding is coming from and how much that might be?

Col Rakesh Jetly: I can't tell you the exact amount. The funding is basically joint funding. It really is our own CAF health services that are funding it. Some of it is in-kind funding in terms of my contribution and my salary and that kind of idea. It's not an endowed chair in the sense or the idea of $5 million sitting there and then us living off the interest. It's really about my contribution and the Royal Ottawa's contribution of space and of some of their scientists and scientific committees. If you want the exact number, I can try to find it for you, but I don't have one offhand.

Mr. Robert Kitchen: Thank you.

For the structure of how this will work, then, has that been devised at all?

Col Rakesh Jetly: There are two aspects around it. The chair is one thing, and the centre of excellence is a separate thing. We have clear terms of reference for the centre of excellence, which has the thrust of research, education, and training. That's staffed within the directorate of mental health. That works very closely with the chair, because it's the same person who runs both. We do have a structure and function in place, yes.

Mr. Robert Kitchen: Thank you.

We've heard from a number of witnesses who have talked about providing pretraining for our soldiers before they go into situations. I realize that we do an awful lot of pretraining in the sense that we're training our soldiers, troops, etc., in how they perform things, but I think they were referring more to issues of being exposed to what they might see in the battlefield.

In particular, we heard from one witness who was talking about dealing with creepy-crawly things, such as when you see somebody's who's had an issue, for example, an injury that might expose their abdomen, and how they're going to deal with it and respond to that. How do you see that fitting into your programming?

Col Rakesh Jetly: I think militaries have always had the adage of realistic training, of exposing people to stress. I think we are doing that to the best of our abilities. There's the road to mental readiness program. Also, all the stress awareness, coping, and performance psychology stuff starts in basic training and then is throughout one's career.

At the same time, once you know the mission, you can do mission-specific training. It's a very dynamic field. As we learned more about what was going on in Afghanistan, we were able to set up realistic scenarios in Wainwright and places like that. For IED scenarios that occurred in theatre, you adapted those immediately to the training. Nobody's going to argue with the adage of realistic training within human rights and within all of those things, but it's very hard to prepare somebody for the death of their best buddy. It's very hard for somebody to prepare for actually being blown up or having the head of your friend fly up and land in your lap. You can try your best. We're using more simulation, more talking about where we will end up going next, and we're getting as much as intelligence as we can from the other countries that are in there.

Absolutely, realistic training helps. It doesn't absolutely guarantee prevention, but as part of training, you do need to stress the body, stress the mind, and recover.

● (1545)

Mr. Robert Kitchen: Taking that to the next step, when our soldiers return and become our veterans, how do we decommission that? I guess I'm asking from a psychological point of view. How do we get to them so that they can express those fears and aren't forever dealing with them day in and day out?

Col Rakesh Jetly: I think it's very interesting. There will be a group who may be ill. With illness, you treat illness. You find them the appropriate evidence-based treatment and let them do it. As a group, I think transition is going to be adapting to a new identity—it may not be the old identity—and how we transition between. I think the challenge in transition becomes an “if I'm half there, half forward” kind of idea.

I think the idea of life after service can be meaningful. You can still contribute. If you choose to retire, you can still contribute to your community. It's a “thank you for your service” kind of idea. I think the emphasis on living day-to-day life is the piece. If they're stuck with trauma and there's an illness, of course we can treat the illness, but it really is about the whole determinants of life, such as shelter, food, social support, and all of those kinds of things.

Mr. Robert Kitchen: Do you see programming coming out of your centre of excellence that will fairly rapidly allow us to use those programs with our soldiers?

Col Rakesh Jetly: Our CAF centre of excellence is going to be much more focused on treating the ill and helping the ill. It will certainly help those people who are struggling with illness. The larger group that's still facing transition won't be specifically addressed by us.

Mr. Robert Kitchen: Okay.

I'm interested in the three points in your presentation here today. In particular, the issue of treatment in my life. When I go to seminars, when I go to meetings, I like to know what I can take home from that as the doctor. In your understanding of the biological underpinnings of mental illness, do you see being able to use that with GPs, with health care practitioners, so you can get that information to those practitioners? One of the things we hear from a lot of our veterans is the moment they've transitioned, they have no doctors to go to. If they have no doctors to go to who don't even have the understanding, it's an even greater challenge.

Col Rakesh Jetly: You've hit it on the head. It's a translation of that. The idea is that as we do more and more research, we're going to figure out promising things. We've made a concerted effort in the last decade or so to publish everything we find in the peer-reviewed literature. They're not military reports sitting on shelves. We take advantage every time we can present at a conference, the family practice associations. I'm presenting at the Atlantic Psychiatric Conference in Charlottetown. Disseminating is crucial, and we're working with the Canadian Psychiatric Association, family practice associations, all the different organizations, to get things out. It's absolutely essential that it reaches the people in the trenches who are looking after our soldiers and veterans.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, sir, for being here today.

In November the Public Health Agency of Canada released the “Federal Framework for Suicide Prevention”. Sections were dedicated to serving members of the Canadian Armed Forces and veterans. How much of an impact has this framework had, seeing it's not a national strategy? Has it had an impact on the prevention initiatives and treatment methods for serving individuals?

● (1550)

Col Rakesh Jetly: They've been consistent with what we've been working on. Outside of an affirmation that we're on the right track, we were consulted as they were coming up with the framework. We had some good discussions in the prevention, the pre-post. The whole idea of the framework is consistent with where we're headed as a path, as a population we're looking after.

Mrs. Alaina Lockhart: Okay. That framework concludes with the following statement:

> Ultimately, these actions will help reduce rates of suicide by breaking down the stigma and silence around suicide, encouraging people to have an open dialogue about suicide prevention, and promoting the development of suicide prevention initiatives throughout Canada using best practices that are informed by knowledge and research.

How has the conversation changed in the armed forces to include free and open discussion about mental health?

Col Rakesh Jetly: We are light years ahead of that statement. We've been on this journey for at least 15 to 20 years. There probably isn't an organization in Canada, or NATO writ large, that talks about mental health and suicide more openly than us, so again it affirms the direction we're on. We have colleagues, the Dutch, the Germans, and all of this, and they're just amazed at some of the programs we have.

We'll continue to do the same. We'll continue to talk about it. There's no shame in talking about it. The courageous thing to do is to put your hand up and let people know you're struggling. Canadian Forces members, by StatsCanada's own research, seek help more than the average Canadian when they're struggling with mental health issues, so we absolutely agree with that statement, and we've been on that journey for some time, and will continue.

Mrs. Alaina Lockhart: Okay, that's great.

I know too that General MacKay testified in the defence committee that a mental health education program was starting the second week of basic training, as well as communication plans and campaigns, like Bell Let's Talk and that sort of thing. Have you seen any changes in the pickup of mental health services because of the program?

Col Rakesh Jetly: Yes, that's a great question.

We've done so many things over the last 15 years, or close to 20 years now, to dismantle and ask which one is the one who has done it.... But our stigma rates are down. When you ask a battle group coming back from theatre if they would think less of someone else who had a mental health issue, it's about 7%. If you asked that for a bank or other corporation, it would be four or five times that, so we've seen a reduction in that.

We've seen an increase in help-seeking. Canadian Forces members sought help more in 2002 than average Canadians. The gap has widened in our last study, so we're seeing things moving in the right direction with higher utilization of our services, more people coming forward. You're never done, it's a journey, but whether that's because of the R2MR or because of leaders who have stood by and said, this is the way we're going to be, it's going to be very hard to tease out what's.... We have more mental health professionals than ever as well, so access has also increased, which is again one of the barriers to care.

Mrs. Alaina Lockhart: Very good. Thank you.

We've also heard a lot in the testimony about contributing factors to mental health and suicide, including alcoholism and drug abuse. We've talked about what leads to PTSD and suicidal tendencies. A couple of weeks ago, Dr. Heber, the chief of psychiatry for VAC, was here as a witness. She said, “It's important to remember that there are many factors leading that person onto that suicidal pathway. Deployment may be one of them, but not necessarily.”

In your experience at the Department of Defence, what's your opinion on that?

Col Rakesh Jetly: It's extremely complicated. That's not a cop-out, because there are many, many factors. Many people who don't deploy kill themselves. It's clearly not the single factor.

The common factors really are mental illness or a crisis. It can be a crisis with a big C or a little C, because when you're ill you can interpret different kinds of things. There's also the hopelessness and the impulsivity I mentioned, as well as other things.

For some, deployment could be the mediator toward getting mental illness. It's not binary in terms of whether you have deployed or not, it's what happens during that deployment. One person may be in a deployment where they're on the base camp, relatively safe and comfortable. Another person may be outside the wire, facing the bad guys every day. Clearly those two people haven't had the same experience. There are pre-enrolment factors as well—who you are, how you cope with stress and day-to-day things.

I think there are a fair number of things.

● (1555)

Mrs. Alaina Lockhart: I'd like to ask you a quick question about the pre-existing issues. Is that something you are able to identify or are looking at during recruitment?

Col Rakesh Jetly: It is, and all nations are facing it. You want your military to be representative of your population. If we say that 50% of our forces have adverse childhood events, and 30% of society has, you're not going to kick out 50% of people because some bad things happened in life. We've actually found that joining the CAF helps those people, because the link between suicidality and adverse childhood events is lower in the military than it is in civilian life. So there may be something good about the military taking in people.

For some of us as psychiatrists, who are sitting there doing psychiatry stuff, some elements that put people at risk for illness and self-harm may also make them good soldiers. Throughout history, many people who have been heroes, with medals of honour and all of these things, have also had PTSD and difficulties. There's risk-taking, running across the battlefield during enemy fire, and that type of thing. We have to balance that.

Right now in declared mental illness—you're actually ill at the time, excluding, of course, serious schizophrenia and those kinds of things—when you start to look at risk factors of taking an illness, which can happen in a 3% risk or up to a 5% risk, people can easily argue, "I think I'm part of that 95%". That's why the population-based approach of screening, education, and encouraging people to come forward is probably the logical way to go in a large organization.

The Chair: Thank you.

Ms. Sansoucy.

[*Translation*]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Thank you, Mr. Chair.

You chose to start by providing statistics on suicide in general. You noted that soldiers and veterans were at risk of suicide and that, like the general public, they were dealing with this issue.

I'm from Quebec. I started working in social services in the mid-1980s. After several decades of research, it was determined that we needed to work ahead of the clinicians. In Quebec, what is known as a sentinel program was developed. As I'm asking you the question, I realize that a military term was selected to name this program.

You said that soldiers are the most likely to seek help, which is good.

That said, does your centre of excellence also study the approaches developed on the civilian side? I'm thinking of a system that teaches families and people how to detect the suicidal thoughts of a family member.

Since veterans are no longer part of a military social network, how do you plan to teach the families to recognize the veterans' distress, when it emerges, and to encourage the veterans to consult clinicians who can help them?

[*English*]

Col Rakesh Jetly: I'll answer in English, if that's okay.

Ms. Brigitte Sansoucy: Yes.

Col Rakesh Jetly: Quebec has done wonderful things in terms of reducing its suicide rate, which was once one of the very high ones within Canada. Not everything is being done in our centre of excellence, but overall within our health services and within the CAF, we definitely do have programs such as peer support. The sentinel program itself is developing more and more in the army, training peers to reach out and get each other. The operational stress injury social support, OSISS, has been around since the early 2000s. We recognize that.

Within our road to mental readiness, we are teaching people to look for the signs within themselves when they're recruits. As they become older and have more experience, they start to become a bit responsible for other people around them, so they detect difficulties. We have leadership training specifically for leaders as well. For leaders, we talk about authentic, genuine leadership, knowing your people day to day, having coffee or tea with them, getting to know them and then you'll notice the subtle changes. You're not going to notice the subtle changes if you don't know them well.

That has been part of our prevailing access. With our road to mental readiness, we've just developed specific gatekeeper training for military police—for example, how they will deal with people if they encounter them when they're struggling.

You're 100% right. There's a clinical piece and a non-clinical piece. One helps people in crisis but also may get them into care. So we're very mindful of that and we have multiple programs.

With our last expert panel, we had a lot of civilians from all over. Absolutely, any lessons learned or anywhere there's some evidence, we will apply it.

I'm going to defer answering on what Veterans Affairs is doing as I'm not involved in direct implementation of things, but we have the things in place.

● (1600)

[*Translation*]

Ms. Brigitte Sansoucy: You referred to a recent consideration that really piqued my interest. You spoke of suicidality as an entity itself and of the importance of focusing on therapy, safety planning and treating the underlying illness. There appears to be a great deal of substance behind these words.

I want to know more about this subject.

[*English*]

Col Rakesh Jetly: Absolutely. At our last dinner in Latvia, I was talking to my colleague, my counterpart from the U.K. In a way, to understand as a physician, let's say you have somebody who has obesity, high cholesterol, and they smoke. They're coming into your office and you're going to give them the talk about watching their diet and stopping smoking, and then you'll give them a cholesterol medication. However, if they came in with chest pain and were sweating, you wouldn't keep talking to them about that. You'd probably switch and do an EKG and see if they're having a heart attack.

In the same way, you're working on prolonged exposure for PTSD or cognitive therapy for depression, but now they're declaring or you discover that suddenly this thing has happened. So let's shift. Let's talk about suicide. Let's talk about what it means. Let's develop ways, so when you're feeling hopeless, what can you do? Who can you call? It's that kind of idea.

Let's take some time to specifically work on suicidality. We're not going to ignore the underlying condition, because that's paramount, but in the meantime we're thinking about what we can do for people who are already in care who are contemplating, to keep them alive so we can actually treat the underlying condition.

In some ways, that sounds obvious, but it's only four or five years old. We have colleagues—I have a couple of teams—who are off to the U.S. to take some of the training, take part of it and consider whether we can bring it back here. One is the safety plan, which is specifically in Washington state; every primary care physician has to have this training. So when you have somebody who you're concerned about, it's not “Are you suicidal or not?” If they are, it's “What are you going to do if you feel that way?” It's a very concrete way of trying to focus on safety and then carry on with the treatment.

There are two different things: cognitive behavioural therapy specifically targeting suicidality as a thing, as an entity in itself; and this other safety plan. There are more and more different kinds of things, such as virtual hope boxes. Lots of different things are targeting suicidality itself. Just like if your cardiac risk patient is actually having a heart attack, let's save his life, resuscitate and fix him, so that then we can worry about the smoking and all those things.

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you for being here.

We have heard testimony from witnesses whose stress had a lot to do with their medical release from the armed forces. What would the decision-making process be that would lead to medical release as it relates to our topic?

Col Rakesh Jetly: Currently the medical folks themselves are advisers to the chain of command. Again, the psychiatrist would advise the family doctor that the general duty medical officer actually implements....

We have a medical category system with lots of different things—vision factor and all of that—but the important ones now are the geographic and the occupational factors. If any health condition, from knee pain to back pain to mental health conditions, has stabilized, then we will communicate in a way that's confidential, separate from disclosing the illness, the long-term prognosis and limitations that the person will have on a permanent basis.

If somebody needs to see a health professional once a month, if somebody can't walk on uneven ground, if somebody shouldn't be in stressful environments, shouldn't do shift work, shouldn't do this, you give those kinds of things. Then, the leadership makes a decision on whether that person can be retained or sometimes accommodated with those limitations—those kinds of ideas.

Universality of service comes into that, of course. I'm sure you folks have discussed that. The idea is that if I can't go overseas and put on a rucksack and drag an injured person out, I will violate universality of service, and the organization has to decide to keep me, keep me for a short time, or to medically release me. That's essentially the process.

We are looking at different ways within health services of better understanding the illness. It's not diagnosis-based, not based on “this illness means this”; it's the functionality. It often represents the risk to the individual themself, not necessarily the risk to the organization. If you go into theatre with an unstable C-spine or with significant mental health issues, nobody knows for sure how you will respond when you are exposed to those stressful situations, but it's the risk idea.

● (1605)

Mr. Bob Bratina: You made a comment about the improvement in suicide rates in Quebec. It has been stated that there was an increase in the suicide rates past the Quiet Revolution, when people became apart from their religion.

Is there any data at all on persons of faith and whether they are able to respond better to these kinds of stresses?

Col Rakesh Jetly: Yes, there's work on spirituality, in a sort of non-religious sense. There's a tendency that more spiritual people are less likely to harm themselves. It's extremely complicated when you read the studies. The definitions are all over the place. The idea that there's something beyond me is protective in many people, and it is helpful in chronic illness also.

Mr. Bob Bratina: You were appointed as the first chair.

What are your own hopes for accomplishment over the next couple of years?

Col Rakesh Jetly: I think it is to really push that research agenda, given those three thrusts. We have sat back with the whole trauma thing. We joined along, and for years we were happy to go along for the ride. Clearly right now, we're the leaders. We're leaders within this country, and other nations are looking to us. We need to start contributing to the dialogue, not just applying what is out there. That's the key.

There have been many, many large studies—meta-analysis they call it—where time and time again, the evidence-based treatments for PTSD seemed to work less in military people and veterans. In 1994, Bessel van der Kolk looked at Prozac. It works in car accidents, rapes, and not so much with vets.

There seems to be something unique that warrants study. We're not going to replicate all the civilian studies on depression and things. We need to do the knowledge translation to see things that are working out there, develop things, and see if things are working. Really, the emphasis is on those three thrusts.

There are a couple of NATO panels as well, on leveraging technology and things, which I'm involved with. I think psychiatry has been very slow in advancing in terms of adapting technology. We're still the pen and paper people, writing things down. There have been 20 to 30 years of incredible biological research that really hasn't translated into clinical practice. It's part of my hope to do that.

The Chair: You have 40 seconds.

Mr. Bob Bratina: In Riga, is there a general concurrence with the issue?

Col Rakesh Jetly: There is. Rates are different in different countries, the scope of the problem, so to speak. We need to continue with the idea of early education upstream as much as possible, as our colleague was saying. That's really going to be the key, as well as more mental health education, literacy. We're exposing our young men and women to incredibly stressful things and we need to be aware of that. I think overall, Canada, the U.S., and the U.K. were the three largest contingents there, which usually is the case. When I look at the tick boxes, I see we have a lot of the right things covered, and the things we're working on are very consistent with best practices.

● (1610)

The Chair: Thank you.

Mr. Eyolfson.

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

You talked about how it's a common thing that you have physicians out in the community, family doctors, the primary care providers who don't necessarily have the specific knowledge, and you're trying to get that out there.

Has there been any work on approaching the educational bodies and certification bodies to put this in the curriculum of the medical school and residency programs?

Col Rakesh Jetly: We have. The problem, in a way, is that population-wise in Canada, we're small. But there are universities... UBC, for example. For the last two or three years I've been going there to lecture to the graduating class, and this year I had breakfast with some of the kids to try to recruit them and I just chatted with them. My last couple of slides always say, if you see a veteran, realize that they have this whole suite of services; ask people if they've served. At one level, you produce documents, you get it out there, you educate people, but in the other way, you can get out to physicians early in their training and just have people realize they can just ask that one question. In medicine, you ask a question only if it leads to something you can do. In this case, there's the whole suite of services—vocational rehab, treatment, all of this stuff beyond the provincially funded system.

We're trying. At Dalhousie University, it's been either me or one of our military psychiatrists for the last 15 years who gives the lecture to the psychiatrists on PTSD. So it's every opportunity that we get at the large gatherings, and then more and more documents and publications. That's how we're working on things.

Mr. Doug Eyolfson: Great.

I'm a physician by training. For 17 years I practised emergency medicine. One of the things, of course, in the emergency medicine practice is that when your patients come in, you don't know them; they're not your patients, as it were. Has there been any outreach to emergency departments as to the local services available, particularly if you have nearby bases or training centres?

Col Rakesh Jetly: Yes, we were having that discussion.

Again, CAF is a little bit different from veterans.

One of the things that came out in Riga, which we've all sort of known, is how high the risk is—for the whole year, but certainly within the first few days, the first week—of somebody presenting to an emergency department with a suicide attempt. The risk is 30 times or 40 times higher in that first period. One of the evidence-based things that came out of the U.K. is an empathic assessment, with hope and all of this stuff, in that short period afterwards. What we risk, as a CAF—and we've had a couple of suicides where people have gone to emergency—is because we don't run our own emergencies and they go into the civilian system, is whether the emergency doctor will necessarily call the doctor on the base, and what if the person says, “No, I'm fine,” and this kind of idea.

In small bases, in small communities, for example in Fredericton, where there's one main hospital, the Chalmers, we can go there; we can establish that relationship. Our own people sometimes work in the emergency. In larger centres it's harder. But we do need to look at that transition as one of the riskiest transitions, and we need to reach out. I know there are a whole bunch of things in the emergency room, reminders, but we need to have one of those reminders. I think the British national health system struggled for years trying to get a tick box on their record asking whether the person has ever served. If we can get emergency rooms to think about that, that should tweak people to the fact that if they're still serving, there's a whole bunch of people who care about them, who will look after them, not just their health, and if they're a veteran, there's OSISS and different things.

We had that discussion just today about reaching out more to the emergencies, whether that means buying people coffee, visiting, putting posters up. That's one of our really important things.

Mr. Doug Eyolfson: That's good to know. One of the issues as well, from my experience and from the testimony we've had here, is that we've said very often when people are released, they're now in the provincial system, and it sometimes takes a long time to get a family doctor, and that's not just military people.

Col Rakesh Jetly: Absolutely.

Mr. Doug Eyolfson: In my practice, a large portion were people who couldn't find a family doctor and got all of their primary care from the emergency department.

● (1615)

Col Rakesh Jetly: Yes, that's a huge problem.

Mr. Doug Eyolfson: I think there's a tremendous potential for uptake through this initiative.

Col Rakesh Jetly: Absolutely.

The Chair: Thank you very much.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair.

Thank you very much for being here today.

I was reading the news release from December 2014 in regard to the announcement about the centre of excellence and your appointment. It indicated there are certain areas of focus that would be included, and I'll just quote it:

> Conducting research on unique aspects of military and veterans mental health; Collaborating with scientific experts in academia such as through the Canadian Institute for Military and Veterans Health Research, government agencies, private sector laboratories, research consortia, and with NATO and other allies....

I was really pleased to see that. Our discussion today is about preventing suicide and treating people.

I'm sure you're aware that there's been quite a conversation around mefloquine as of late, the very clear reactions to it such as inability to sleep, hallucinations, nightmares, heightened anger issues, suicide ideations, and a number of suicides at this point can be attributed to it. Health Canada has updated the warning label and indicated that these conditions can carry on past the use as an anti-malarial drug.

In that regard, Germany, Britain, Australia, and the U.S. in the last couple of years have come to very determined statements and decisions in regard to mefloquine. It sounds like you collaborate with, and have a lot of information in regard to suicide from, our allies. Are we any closer to identifying this as a brain stem injury in Canada? There's no diagnosis and therefore no treatment, and we're still using it. Have you collaborated with NATO and our allies on this issue, and where are we at with it?

Col Rakesh Jetly: Within our sort of headquarters, it's more of a force health protection issue, so—

Mrs. Cathay Wagantall: It's more of a...? Sorry?

Col Rakesh Jetly: Force health protection, sort of our preventative medicine. They're in the process, so I can't speak for.... We're in the process of revising our policies and things on that. It's exactly reaching out. It's not me doing it or my section, but our preventative medicine folks are reaching out to our allies and giving the surgeon general information. We're in the process of revising our policies, to the best of my knowledge.

Mrs. Cathay Wagantall: You're not part of that conversation with regard to suicide?

Col Rakesh Jetly: My opinion would be asked from time to time, but really, when you're giving people treatment to prevent another illness like malaria, it becomes part of force health protection. They have expertise, and they have epidemiologists and scientists within their section.

Mrs. Cathay Wagantall: Would you have an idea of a timeline on this decision coming?

Col Rakesh Jetly: The discussion is going on right now.

Mrs. Cathay Wagantall: Okay.

Col Rakesh Jetly: It's a pressing issue right now, which we're working on.

Mrs. Cathay Wagantall: A number of our witnesses have come forward who are still serving or have served, and they talk about the challenge with PTSD of those sudden crisis experiences that they have that we can't even imagine. It was brought up that they felt that they didn't get enough of that type of training in advance. There are some of those shows where you get to crawl amongst snakes—just things that I wouldn't do, but some people are capable of them—or even just, it was mentioned, having to crawl through pig guts—quite honestly I think was the term used—to get a sense of what you might experience. I wondered, I don't think we go to that extent when we try to prepare them—

Col Rakesh Jetly: You're hitting on one of the most difficult issues, historically, I think, because from speaking to many people who have developed PTSD, it's often your worst nightmare, and you don't know it's your worst nightmare necessarily.

So, clearly, let's work on sleep deprivation, let's work on getting shot at, let's work on crawling under barbed wire, let's work on people who speak a different tongue...the IED kind of scenario. But it's often something else. There's desensitization. There's training. There's stress inoculation. These have been used for many years, and the problem is PTSD has always been around. So back in the day, it was, let's go and watch animals being slaughtered, and let's do this. Around the Vietnam area that was popular. There was still an incredible amount of PTSD, and in fact, in 1980, the term PTSD was first coined to explain the phenomenon experienced by the Vietnam soldiers from the U.S. and Australia.

So, absolutely, let's stress inoculating people. Let's get them as desensitized as possible. But I still don't think that objectively exposing them to what you think is going to be stressful will help with what happens to the soul, the person with the moral injury, and the meaning of the actual trauma. We can set up all kinds of scenarios, and we should. We should exhaust people. We should wake them up in the middle of the night with flares. We should do all those kinds of things. I remember when General Leslie first brought the tanks to training, because he didn't want them to hear tanks firing for the first time once they were in Afghanistan, because we hadn't used them.

So, absolutely, I thought about what it would be like to have my best friend die, or to kill a child.

● (1620)

Mrs. Cathay Wagantall: Absolutely.

Col Rakesh Jetly: We're not going to get there.

Mrs. Cathay Wagantall: You're mentioning younger and younger, and I wonder about that whole training. At what point do you determine that too much would actually trigger potential PTSD —

Col Rakesh Jetly: There was something in the media today about some training in the eighties. I didn't read all of it, but there is a risk of harming people when you do certain types of conduct after capture and evasion training. You have to be careful about how far you take it, and not introduce illness, absolutely.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart: Thank you, Mr. Chair.

I want to go back to the mefloquine question for a second. I found a report here from the *Case Reports in Psychiatry*, from 2011. One of the statements says, “Prophylaxis against malaria still has benefits that frequently outweigh the risks, especially for deployed military medical personnel.” And it goes on. I know there are three drugs that we use.

Can you speak about how the transition has happened and what your feeling is on that statement?

Col Rakesh Jetly: I'm not a primary care physician prescribing this, but in my day, I took malaria, when I was in Rwanda, so I had a few nightmares, had a few things. For me, if I were to deploy again to Africa, I'd probably ask for mefloquine again, because I prefer the devil you know. Yes, I had a few side effects but the other medications.... Taking doxycycline for three months, six months, every day, doesn't appeal to me. There were the side effects.

So you're always balancing the risk to the individual of the medication versus the disease. Again, having been in Africa and having seen cerebral malaria, seeing people die from that, it's not a pretty sight. You want to stop malaria and then you want to give them the safest option for them to prevent the malaria, and then all of these agents are designed to kill an organism within your body, but not kill you. It's just like chemotherapy; it's this kind of idea.

Mefloquine is one of the options. Malarone is one of the options.

Mrs. Alaina Lockhart: Mefloquine is the third-line drug. Is that correct?

Col Rakesh Jetly: It depends on the guidelines. If you're a pregnant woman or breastfeeding, it's probably the first line still, based on the CDC guidelines from a little while ago. So it gets down to these individual kinds of ideas. Of course, there's a lot of literature and a lot of concern about mefloquine right now. Say, we go to a patient or soldier who's going to a malaria endemic area, who sits down with a physician and asks him what he thinks because they need to pick something. If the soldier says, “Doc, I don't want that one I hear about on TV”, then we'll go somewhere else.

But there are other factors. Doxycycline is an antibiotic in the tetracycline class. If you have an allergy to that, that's out. If you have a G6PD abnormality, you take the other one out. There are reasons for using these drugs, and the ultimate reason should really be to prevent malaria in the safest way possible.

Mrs. Alaina Lockhart: I referred a few minutes ago to Brigadier-General Hugh MacKay's testimony to the defence committee. At that time he said there was no evidence of the relationship between mefloquine and suicide. In fact, as the usage of mefloquine declined, suicide has increased. Has there been no research linkage between the two?

Col Rakesh Jetly: There really hasn't been. We can argue, our colleagues Greg Passey, Cam Ritchie ...there's certainly a split within the community. People I respect hold one view versus the other. It's a contentious issue within medicine.

Again, suicide is extremely complicated. With our Afghanistan cohort, if you were taking mefloquine, if you were taking anti-malarials that was during the summer, the fighting season. If you try to study the group that had mefloquine or anti-malarials or not, you've also got the confounders of trauma exposure. The winter season—if you look at casualties killed in action, PTSD rates were in April and May on, in 2006 and 2007. I was there, There's a shift in all the other confounding factors; there's also permethrin in the clothing. People who have permethrin in the clothing may have had a higher rate of PTSD, and PTSD can certainly mediate in the suicide. I don't think it's as clear.... It would be an incredibly difficult thing to study because of all the other confounding factors and the trauma exposure and things.

● (1625)

Mrs. Alaina Lockhart: That's very helpful.

Col Rakesh Jetly: The jury is still out to some extent, I think.

Mrs. Alaina Lockhart: What about your experience with individuals who are assigned to the JPSU and whose conditions worsened? What systems are in place to identify a worsening condition, and is there some intervention at that point?

Col Rakesh Jetly: The JPSU is an administrative unit; it's not a health care unit itself. The JPSU staff themselves who are responsible from a leadership chain of command point of view do have training in recognizing people, recognizing difficulties, and bringing them within care.

The health care system itself is going to have a treatment plan in place for the person. It's not as if it ends when they are posted to JPSU. There's a chronic medical condition that needs to be monitored. There's also an individual responsibility. That's sometimes the part that gets challenging because you know the system exists, you have things in place, and that's where this safety plan comes in. If you're having difficulties, let us know. I think things are in place. It's a difficult time for people. It's a transition period, and we recognize that more and more. For some people it's no problem. This is a natural part of life. For other people there's a really strong loss of identity. How do we keep them connected to their units? The ideal JPSU situation is they're technically in the JPSU but let's do some work back in their company lines, their ship, back with their thing in the meantime. That connectedness is really important.

From my experience it's extremely difficult. Where a unit might call somebody once a week to ask how they're doing, one person appreciates it, the other person sees it as harassment. It's very challenging.

The Chair: Thank you.

Ms. Wagantall, you have five minutes.

Mrs. Cathay Wagantall: Thank you.

This is very helpful to me in understanding the bigger picture from the medical perspective, specifically on mefloquine. There's a lot of static around mefloquine. Part of that, I think, is significant in the fact that, even as late as Afghanistan, with individuals who have testified, what they took wasn't an option. Even Lieutenant General Roméo Dallaire said he requested the opportunity to not take it any....

Col Rakesh Jetly: That was a long time ago.

Mrs. Cathay Wagantall: Exactly. That's what I'm trying to get at.

I think the concern around mefloquine is the recognition of what has happened in the past and the illnesses that have come from it, which very well might be a different dynamic. Now we know the use of it has gone down significantly over the last 10 years to 5%. I'm sensing from what you're saying they have the option as to which anti-malarial drug they choose.

Col Rakesh Jetly: That's right.

Mrs. Cathay Wagantall: When did that start happening?

Col Rakesh Jetly: I don't know exactly. I know what the current policies are.

In my day, I didn't have a choice, I don't think. I was a doctor, and this is what we were taking as an anti-malarial. It was before the Internet. It was before lots of things. It was not as if you could.... That's the medication we took because of where we were going. We were going to Rwanda. A few people had adverse reactions, and they were switched to other medications.

Mrs. Cathay Wagantall: Why wasn't the lieutenant general allowed to change when he was—

Col Rakesh Jetly: I have no idea. I didn't ask him.

Mrs. Cathay Wagantall: These are the questions that make you say, "What?"

Col Rakesh Jetly: I was there, and I don't know. I don't know who he asked. I don't know what he said. Certainly we had a few young soldiers in Petawawa prior to going and a few in theatre who were having difficulty tolerating it, and we switched them to the other agent. It wasn't like "you will take it no matter what." It wasn't that. I didn't sit down with a physician who said, "You're going into a malaria-infested zone. These are the choices. What are you going to take?" which is our current policy.

● (1630)

Mrs. Cathay Wagantall: Okay, great.

Col Rakesh Jetly: We didn't do it then. I don't know why we didn't do it then, because I wasn't the decision-maker; I was the patient.

Mrs. Cathay Wagantall: Okay, thanks. I appreciate that.

We're responsible, here in committee, for discussing issues with regard to veterans. It seems as though the mandate here is for the armed forces and veterans, but I'm hearing there's not a lot of follow-through on the veterans side.

Col Rakesh Jetly: For what? Sorry, I missed the—

Mrs. Cathay Wagantall: I mean in your studies and in what you're dealing with right now.

Col Rakesh Jetly: With regard to the studies, part of why we're at the Royal, at the Institute of Mental Health Research, is that there's an OSI clinic there. We're doing studies on neurofeedback, and the EEGs, the psychiatric electroencephalography evaluation registry, PEER, to predict antidepressant use. We're going to be recruiting subjects from our military clinics and from the Veterans Affairs clinics.

The magnetoencephalography, MEG research we did, the neuroimaging studies we've done so far in Toronto and London, have always looked at veterans. We're looking at combat veterans, people who have been exposed to combat, from both Veterans Affairs and the military.

Mrs. Cathay Wagantall: As far as CAF, DND, and Veterans working together goes, part of the challenge was to implement solutions to provide timely access for psychological and psychiatric assessments. That's something we hear a lot about on this committee too. As veterans, they're having trouble getting those assessments done. That's obviously not everyone, but there's a cohort.

Col Rakesh Jetly: Yes, absolutely.

Mrs. Cathay Wagantall: How do you plan to reduce the time required to transfer their records and to improve wait times for assessments?

Col Rakesh Jetly: Those are challenging, and it's case by case. There are several groups. Ideally, somebody is already on the books of Veterans Affairs long before they release, so the determination of eligibility and things have occurred. In that case, it's simply a matter of ensuring there's care available where they're going. That can start once the person decides their intended place of release. It's easy if they're releasing in a place where there's a Veterans Affairs OSI clinic. It's much more challenging if somebody goes to a more isolated location. That's the one group.

The second group are the people who are in the process of applying at release time. There is more and more being done to expedite the records and those kinds of things.

The third group, of course, are the people who leave and six years after leaving feel they're unwell and need to go in. You need to have solutions for all of them.

From a health services perspective, there are Veterans Affairs people who are working. It has become much easier with electronic health records and not paper records. There still needs to be some severing for privacy reasons and things. It's being worked on.

The Chair: For the last three minutes, we have Ms. Sansoucy.

[*Translation*]

Ms. Brigitte Sansoucy: You spoke of your collaboration with the Bell Let's Talk program. In addition to your participation in the program, how do your actions help reduce the stigma surrounding suicide? You touched on the matter in your presentation, but I want to hear more about the link between your work and the reduction in stigma surrounding suicide.

[*English*]

Col Rakesh Jetly: Stigma is a complicated thing, in the sense that there's social stigma, individual stigma, self-stigma, institutional stigma. It has to be addressed at all the different levels. I think there's an institutional stigma in provinces that don't cover psychotherapy. It's the most evidence-based treatment for mental illness, but they don't cover it.

In terms of how we are addressing stigma, there are many, many different ways. One of the interesting ways that we started teaching road to mental readiness was that we had a mental health professional, side by side with the soldier, teaching about mental health and mental health awareness. Soldiers respect the instructor. This is the boss, the person who is the expert. Then, somewhere along the way, they would maybe disclose that they've had a mental health condition themselves. They have PTSD.

The biggest thing for stigma reduction—evidence based—is to actually meet somebody with a mental illness and realize they are okay. They're competent. They're able to do things. It needs to challenge your image of what it is, as much as possible. That's a big part of it.

A few years ago, we put out a call—just a quick email—for people who were interested in talking about their experiences with mental illness. There were hundreds of people who responded. We had everyone, from privates up to admirals, saying that they got ill and the best thing they did was to talk to their boss. My boss got me into care, or my friend, my family—this kind of idea.

It's right down to that personal level kind of idea. It's not always about campaigns. It's not always about hearing the psychiatrist, a certain general, the CDS saying that we need to do this. Sometimes it's all of the different ways, from the personal....

You want to challenge people's beliefs, and then show them evidence that people who have mental illness stay in the forces. People who have mental illness can get promoted—all of these kinds of things.

It's many, many different levels. Bell Let's Talk, is just an example of us joining...but every opportunity we can get is—

● (1635)

[*Translation*]

Ms. Brigitte Sansoucy: Have you formalized this approach? In other words, among the people you've already helped, have you identified those who can speak and therefore help reduce stigma in this area?

[*English*]

Col Rakesh Jetly: Yes, it's—

The Chair: I'm sorry, the time is up. I'm going to have to ask for a short answer on that, please.

Col Rakesh Jetly: Okay.

Yes.

The Chair: Great, that's short. Thank you.

We'll have to suspend for a couple of minutes.

I'd like to thank Colonel Jetly for coming again in front of the committee, and for the work that you've done for the veterans and the men and women who have served.

We'll suspend for about three minutes and come back to our second panel.

Thank you.

Col Rakesh Jetly: Thanks very much.

● (1635)

——————————— (Pause) ———————————

● (1640)

The Chair: We'll call the meeting back to order.

We now have Marvin Westwood, counselling psychology, University of British Columbia, on video conference. Thank you for joining us today

Doctor, we will start with up to ten minutes of testimony, and then questions and answers.

Dr. Marvin Westwood (Professor Emeritus, Counselling Psychology, University of British Columbia, As an Individual): Good afternoon. It's good to be with you. Even though I'm 4,500 kilometres away from you, it feels as though I'm in the same room. It's a testament to the technology.

Also, I want to acknowledge first that I'm speaking to publicly elected officials, who are also in service for us. We often thank veterans for their service. To all the people there on the committee, who stood for election and are taking that role on, thank you for your service. We have multiple kinds of groups doing service in our country.

I am going to talk today, following Dr. Jetly's presentation, a little more upstream, for the treatment and not prevention of suicide. I don't talk a lot about prevention of suicide because I don't believe suicide can be prevented. It's ubiquitous, it's around, it's everywhere. It has always been and probably will be, but in general, what we can do, in my opinion, and with my colleagues out here, is reduce the risk of suicide. That's as far as I think we might be able to get, but that's a long way in saving lives of people. For me, then, the focus is on risk, rather than prevention.

When I think about the people I've worked with over the last 20 years in the Canadian military who are being released, both a usual release at end of tour of duty or medical release, I'm aware that, for veterans, we in the helping professions have to understand, first and foremost, that we're dealing with a unique population. I'm not the first witness to say this, but let's just remind ourselves about the military cultural socialization that takes place. The men, and also the women, who work in this particular career adopt this cultural socialization that demands of them to be high functioning and places a high value on competency, maintaining fitness for battle, frustration of weakness, self-sufficiency, and the universality of service.

Why is it important to recognize the social-cultural mapping here? It's because these very values that served them so well in their work and in doing their work for us make it almost difficult, or impossible for some of them, to seek or ask for help. We all know that an increased risk of suicide ideation is not necessarily mental illness. I prefer to use the term, and they use it in the military, of course, “operational stress injury”, because many people have operational stress injuries that do not progress to disorders. They do, however, handicap or prevent them from achieving their life goals.

The notion of a mental illness in this culture is stigmatized. We must remember that a post-traumatic stress experience, or even disorder, is a “normal experience to an abnormal event”. We do remind our veterans when we're working with them that what has happened to them is a normal experience in the face of an abnormal event.

What does that do if they use language such as, “I have an operational stress injury”? I'm less shamed, I'm less stigmatized, and I'm less likely to avoid going to a health professional to get help because that's a sign of failure. We learn from them very early on to change the language. To represent skills and help with injuries is more effective for them in making contact with services, whether it's in our clinics or in VAC, or wherever.

Dr. Jetly has referred to the medical interventions for those who have indeed full-blown mental health injuries, if they are untreated, and they do certainly exist. I'm talking about the majority of people leaving our service, who are leaving a culture that is really a very challenging one and having to let that go to adopt a new culture in the civilian world.

I think our focus should be primarily on the management of risk factors rather than prevention of suicide. I've said that. The goal in the management of risk factors related to suicide would be early detection, an intervention working from an upstream, rather than a downstream approach, long before they slide into isolation, depression, suicide ideations, and then, for a small percentage of them, acting on their desire to end their life.

● (1645)

The theoretical lens that I would like to refer to today, which Dr. Jetly referred to also, is the interpersonal theory of suicide. I think that is very helpful for us in working with our veteran group. Now, over 700 have gone through the program and have returned.

We endorse and work with the interpersonal theory by Joiner. The main constructs of this theory are really important for us to remember. The first thing to remember is that when someone leaves the service, they lose the primary group to which they belong. It's called thwarted belongingness.

In terms of attachments in the service, they have their other mates there who they work with, live with, connect with, and identify with. All of a sudden, one day you no longer belong because you're back in Canada, and you don't have the key group that you were with originally.

Another characteristic for many of the veterans after they return is that, because of what has happened to them, they can't function as well. There are limits in adjusting to the culture and dealing with the stress. They have a perceived sense of burdensomeness. As many of the veterans say to us, “That burdensomeness means I have to go quiet. I can't talk about what happened to me because, should I do that, it would distress, upset, and hurt members of my family and friends.”

The other thing that I think is important to remember is the acquired capacity for suicide, the capacity to actually take one's life. What I talk about there is that, for many of them, the injury could have been what I call a moral injury. They actually move to a place of feeling that they've failed the troops, that they've failed in a number of ways. They do know how to end their life and believe it may be the right thing to do. That's coming from a different place than most people in the civilian population. Those are the four points.

With a medical release versus a general release, everyone on this committee would know that it can trigger a downward spiral because of “loss of ability to serve due to injury, physical or psychological, stigmatization and feelings of incompetence, and a fragmented identity.” To prevent this chain reaction, special attention should be given to the following constructs, which I've referred to:

Again, “I've lost my primary group of attachment. I don't belong.”

They would say things like, “I'm not good enough,” “I feel rejected,” “I have a weakness,” and “My body is failing me,” and so they move into isolation.

You all know that moving into isolation and retreat from attachment to other groups of people can spiral down into depression. Depression, as we know, is correlated with higher levels of suicidal ideation.

The other one I refer to is burdensomeness, which is a heaviness or responsibility. From my point of view as a psychologist, what happens is that they go quiet. They keep all of their thoughts and emotions inside, and that is destructive to the person over time.

We all know many examples of people who return, and the way they cope is to live in their parents' basement in isolation for a number of years because they can't speak out. They've lost their group. That's a downward spiral and then the risk begins to increase.

Another thing I want to comment on is identified by John Whelan in his book. He is a psychologist of former serving military personnel with whom I have also worked in Halifax. This came back from the U.S. clinicians who are paying much more attention to what are called the moral traumatic injuries to the members.

Most Canadian citizens don't understand that when they come back, they not only have lost their group, feel they are a burden, and so on, but many of them are dealing with and are haunted by things that they have done and should probably not have done.

They see it as a violation of their own ethics and morality arising from the occupational requirements of being in the Canadian Forces. Moreover, these breaches of ethics are often not shared with others due to shame and self-muzzling. The term is, “I've done a terrible thing.”

● (1650)

As we begin to think upstream, when we meet people coming from the culture of the military back into civilian culture, we can begin to understand the interpersonal nature of the stresses that eventually could move them toward the health facilities, but that is early on. In my opinion, the most effective means for the decompression of soldiers returning from deployment includes those that are delivered. From talking to many veterans and our researchers, I would like to say it's a model so that when people come back, they come back into debriefing very soon after that.

What do we mean by debriefing? We don't mean an R and R session where people get a chance to just relax after combat, but a place where they are actually taken care of. It's facilitated in small groups, with several goals in mind.

The goal that I could see in the re-entry transition—and that's what we try to do with our program—is that, before problems develop, you shoot for a healthy transition, because re-entry is a normal kind of adjustment, and we can use knowledge and skills to help people navigate that. Also useful is sustaining connections with serving and former serving members. What I find most useful is to keep military personnel connected with one another and staying in touch when they're back. They will often say that those are the people who know, who have served, and who understand them, but in a country such as Canada, when people come back, they spread. They disperse all the way from the Maritimes to the west coast and everywhere in between, because they don't go back into their intact units, of course.

These small briefing and re-entry debriefing groups could focus on knowledge and skills for development toward civilian work and life and family. Of course, these groups would be staffed by paraprofessionals. Soldiers who have been through successful re-entry would be helping us as well. Also, a chance to have them come back into the small group format for debriefing and accessing knowledge for success would give us a chance to help with assessment for those who need different kinds of services as they move forward.

By promoting increased resiliency and reducing these mentioned risk factors of suicide, and while keeping the previously mentioned goals in mind to ensure that members are connected throughout transition, only then can we help retain capable and healthy members of our Canadian military.

That's my statement.

● (1655)

The Chair: Dr. Westwood, that is excellent testimony.

I have to apologize. The bells are ringing here. We're being called back to the House for a vote. We have to be there for the next 20 minutes.

Procedure-wise, we are at the end of our meeting here and at the end of our study. I think it's the consensus of the committee that we all have a lot of questions we'd like to ask you. We could get those questions to the clerk.

We have them in front of us now, but we won't have time for you to answer them. If we could ask our MPs here to get them to the clerk, the clerk will email them to you tomorrow. Would you be able to get those back to us by the end of the week? I know that's a lot to ask.

A voice: It can be later.

The Chair: It could be later, within two weeks, and then we could get them into our report.

Dr. Marvin Westwood: Yes.

The Chair: If that's fine with the committee, members, I'll ask you to try to do your questions so that he can answer them in seven minutes in a five-minute time frame.

Voices: Oh, oh!

The Chair: I'll make this quick. This is the end of our report. You are the last witness. We are trying to wrap things up. I know that we have a new study coming.

We are missing three members today who have missed the last two or three meetings due to travel and representing our men and women overseas. If there is anything that anybody has to add to the report or anything that you want, or any articles that anybody sees, could you get them to the clerk by Thursday at 3:30 p.m.? I'd like to have everything wrapped up by then. The clerk will distribute everything to the committee.

At our next meeting, we will start our next report. Then we travel.

Again, on behalf of the committee, thank you for everything you do for our men and women to make them better, and thank you for understanding that we have to go and cast a vote today.

Dr. Marvin Westwood: I just want to say goodbye to you and thank you for the opportunity to present. You guys are called to service now. I understand.

The Chair: Thank you for those comments.

We have a motion to adjourn from Mr. Bratina. All in favour?

(Motion agreed to)

The Chair: Thank you. The meeting is adjourned.

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