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Chair

Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): We'll call the meeting to order.

We are continuing our deliberations today on our study on the quality of life for our Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

We've been anxiously awaiting this day to welcome our witnesses. It's good to see you all again. It was just a little over a year ago that we had the opportunity to bump into all three of you, I believe, in a faraway place. So it's good that you're here.

We have with us General Grant, deputy commander, Canadian Expeditionary Force Command. He was formerly commander of Joint Task Force Afghanistan.

We also have Colonel Lavoie, task force commander, Counter Improvised Explosives Task Force, former battle group commander, First Battalion, the Royal Canadian Regiment Battle Group.

We have Colonel Simon Hetherington, executive assistant, chief of the land staff, former commanding officer, provincial reconstruction team.

If anybody in Canada can tell us about the stresses our men and women in uniform are facing, I'm sure you three are able to.

I understand you all have opening statements.

General, are you going to start?

Major-General Tim Grant (Deputy Commander, Canadian Expeditionary Force Command, Former Commander, Joint Task Force, Afghanistan, Department of National Defence): I will, sir.

The Chair: Please, the floor is yours.

MGen Tim Grant: Mr. Chairman, honourable members, good afternoon.

I'm pleased to be here today with two of the commanding officers from Operation Athena, rotation 2—Colonel Omer Lavoie and Lieutenant-Colonel Simon Hetherington—to assist in your investigation into health services provided to CF personnel, with an emphasis on PTSD.

I had the honour and privilege to command Canada's military commitment in Afghanistan from November 1, 2006, until August 2007. I arrived in theatre halfway through rotation 2, shortly after the conclusion of Operation Medusa, an operation with which I know you are all very familiar. I stayed throughout the remainder of rotation 2 and all of rotation 3. This tour of nine months set the standard for future rotations of the joint task force headquarters. As you're likely aware, the units of the task force, such as the battle group, provincial reconstruction team, and the national support element, deploy for only six months.

During my time in theatre some soldiers under my command suffered physical injuries, others suffered mental injuries, and others paid the ultimate price, giving their lives for the mission and their country. Regardless of the injury sustained, I believe that each and every soldier received the best care possible. The medical services at every level, from forward operating bases through to the to the role 3 multinational medical unit at Kandahar Airfield, were focused on meeting the needs of soldiers operating in a combat environment.

Soldiers from all the units faced the prospect of physical injury. Whether it was an infantry soldier in close combat, a logistics soldier being ambushed in a resupply convoy, or a CIMIC operator interacting with Afghans, the vast majority of soldiers were in situations where they could have been injured. As a result, all those soldiers were under increased levels of stress during their deployment. How each soldier handled those stresses was, in my opinion, based on the training they received prior to deployment, the help they could expect from their buddies and the chain of command in theatre, as well as the assistance they could expect from the medical system. In hindsight, I believe we were successful in providing the support required by soldiers in this very harsh and demanding environment.

On leaving theatre each soldier participated in a decompression program. For the vast majority this was in Cyprus. At every opportunity, usually at medals parades, I stressed the importance of the decompression centre to the long-term health of returning soldiers. I spoke of the fact that many would not initially see the benefits of the stop in Cyprus, but the feedback that I had personally received from soldiers on rotation 1—that is the First Battalion, Princess Patricia's Canadian Light Infantry—was that the program was extremely valuable. I have to admit that in spite of my own words, as my chalk touched down in Cyprus I felt that it was the last place I wanted to be. However, in hindsight, the decompression did serve as a valuable service to me personally.

In summary, Canadian soldiers have operated and continue to operate in an exceptionally demanding and dangerous situation and environment in Kandahar. The chain of command and the Canadian Forces Medical Group have acknowledged the challenges faced by our soldiers. I believe that we're providing the assistance that soldiers need in order to deal with their wounds, be they mental or physical.

At this point I'll turn the floor over to Colonel Lavoie and to Lieutenant-Colonel Hetherington for their opening comments.

The Chair: Thank you, sir.

Go ahead.

Colonel Omer Lavoie (Task Force Commander, Counter Improvised Explosives Task Force, Former Battle Group Commander, First Battalion, The Royal Canadian Regiment Battle Group, Department of National Defence): Honourable committee members, good afternoon.

I am Colonel Omer Lavoie. Currently I am the commander for the Canadian Forces, Counter Improvised Explosives Task Force, based here in Ottawa.

Related to this appearance, ending at about this time last year I was the battle group commander for the Task Force Kandahar 3/06 rotation. I commanded the First Battalion, Royal Canadian Regiment Battle Group in Kandahar province from August 2006 until March 2007. The 1 RCR Battle Group was a Petawawa-based unit comprising approximately 1,200 soldiers. However, individual soldier augmentees and sub-units came from across Canada. The 1 RCR Battle Group had a full range of combat arms and combat service support. It included infantry, artillery, armour, combat engineers, reconnaissance, signals, intelligence, medical, and an unmanned aerial vehicle capability.

Training for our mission consisted of approximately ten months of individual, collective, and field training prior to the deployment. Most training consisted of live fire exercises using real ammunition in order to inoculate soldiers to the reality of the modern-day battlefield. Of note, the 1 RCR Battle Group was the first unit to receive training and be validated for operational readiness at the then newly created Canadian Manoeuvre Training Centre in Wainwright, Alberta.

My role as the battle group commander was to command the battalion and ensure that our battle group achieved its assigned missions while in theatre. The 1 RCR Battle Group's six-month deployment can be characterized in terms of intense offensive combat for the first third of the tour, defensive combat operations for the second third of the tour, and counter-insurgency operations for the last third of the tour.

Of note, the 1 RCR Battle Group was the lead unit during Operation Medusa, NATO's first ever ground offensive operation. The 1 RCR Battle Group was assigned a mission to defeat a concentrated enemy within the Panjwai-Zhari district. This operation was an intense offensive combat operation of a conventional nature that saw extensive close ground combat supported by significant offensive air support. The 1 RCR Battle Group achieved its mission, seizing ail assigned objectives and defeating a determined enemy.

Most of the combat casualties during our mission occurred during Operation Medusa. Overall, my battle group suffered approximately 140 soldiers wounded in action and 19 soldiers killed in action. Despite these significant losses, the battle group managed to force out and keep out concentrated enemy forces and successfully achieved its mission on subsequent major operations, including the construction of a combat road, Route Summit, and a brigade-directed operation, Operation Baaz Tsuka. I believe that part of the success of our mission can be partly attributed to the high standard of medical support available to our soldiers. I say this not only from the physical standpoint but, equally important, from a morale perspective. Our soldiers, me included, had great confidence that, despite our often being in harm's way, every effort possible was in place to take care of our wounded.

I am extremely proud of the accomplishments of the 1 RCR Battle Group, and in particular the resolve, courage, and professionalism of my troops.

With that, I would be happy to take your questions.

Thank you.

● (1540)

The Chair: Thank you very much.

Colonel Hetherington.

Lieutenant-Colonel Simon Hetherington (Executive Assistant, Chief of the Land Staff, Former Commanding Officer, Provincial Reconstruction Team, Department of National Defence): Mr. Chair and honourable members of the committee, good afternoon.

My name is Lieutenant-Colonel Simon Hetherington. I'm a field artillery officer by training. However, from June 2006 until late January of 2007, I deployed to Afghanistan as the commanding officer of the Kandahar Provincial Reconstruction Team, or the PRT.

The PRT, as you know, is an interdepartmental organization consisting of soldiers, diplomats from the Department of Foreign Affairs and International Trade, development workers from the Canadian International Development Agency, law enforcement personnel from the Royal Canadian Mounted Police and municipal law enforcement agencies and, more recently, corrections officers from Corrections Canada.

The mission of the PRT, as I saw it, was to extend the legitimacy of the central government of Afghanistan through assisting the government of Kandahar in building the capacity to govern and set the conditions for sustainable development. This was a lofty goal, which we soon learned would need to be approached in an incremental and measured manner.

While the mission's objectives and the tasks of the PRT are not the subject of this discussion, it's important to recognize that the type of work the PRT engaged in was not immediately intuitive to many of its members, me included. The bulk of its soldiers who formed the military component of the provincial reconstruction team came from combat arms backgrounds. Working with other government departments was also new to most of us, particularly in such close quarters.

The Canadian PRT had been established less than a year before I arrived in Kandahar and had been operating as part of the larger Canadian task force for only five months. Much of the early work the PRT engaged in during my tour was in concert with the 1 RCR Battle Group, conducting post-conflict battle damage mitigation. At the other end of the spectrum, DFAIT and CIDA staff worked with the provincial government and line ministries on longer-term reconstruction efforts.

Despite some initial uncertainties and growing pains, I can confidently say that at the end of our tour progress had been made, some important projects had been completed, and the members of the provincial reconstruction team had set the conditions for the success of the follow-on rotation.

In terms of discussing the relevance of my appearance before you here today, I will say that I was extremely fortunate that no member of the PRT was killed, and only one was seriously injured during our tour. This injury took place while this soldier was operating with the 1 RCR Battle Group.

I cannot be so certain about non-physical casualties. All members of the camp were witness to the effects of attacks on our convoys and the wounds they inflicted on innocent bystanders. Virtually every soldier in our camp had friends in the 1 RCR Battle Group about whom they worried constantly. Many members of the team were on the roads of Kandahar daily, some days without incident, others not.

You may know that the PRT works out of a small, self-contained camp just inside Kandahar City. Our team was relatively small, and its small size and the small camp we occupied meant that everyone knew each other. We worked together. We lived together. We ate together. We risked together. And we mourned together whenever a Canadian soldier was killed. We had a doctor and medical staff, as well as a chaplain, dedicated solely to the PRT. Through these professionals, we had access to additional help and spiritual care back at the main Kandahar airfield if we needed it.

Even though the PRT was composed of many different units from many different backgrounds and government departments, I believe the cohesion we formed during our period of training, coupled with the small size of the camp and the team itself, was instrumental in dealing with the stressors faced by everyone. I fully recognize that stress affects different people in different ways and that it would be naive of me to think that every member of the PRT returned home unscathed. But I can say that in theatre the resources and support of the chain of command were available to assist those who needed it.

I hope this has helped orient you to what I may be able to add to your consideration of this extremely important topic.

Thank you.

● (1545)

The Chair: Thank you.

We'll get into our opening seven-minute round of questions. We'll go over to the official opposition with Mr. Cannis.

Mr. John Cannis (Scarborough Centre, Lib.): Thank you, Chairman.

Welcome, gentlemen, and thank you very much for being here and giving us this briefing.

Today we are to do our study on services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder, if I'm not mistaken. Nevertheless, you're here, and we'd like to ask you some questions, if you'll permit us, as we've heard from other witnesses who have come before the committee, both military and former military people. Along the way, because you've gone into such an elaborate presentation, maybe you've enticed me to ask some other questions as well.

I'd like to open by saying that, first and foremost, all of us ask these questions with the intent of trying to do the best we can in this committee in the support that we've provided to our military as a whole. Sometimes the questions might seem rude, extreme, and obnoxious, but they're intended so that at the end of the day we can come forward with decent recommendations.

We've heard from former military service people who have found difficulty getting services after they've completed their missions. There are comments such as “Medically I know where I am; I've gone through this process. My commander or my superior is just not paving the way or is not giving permission or is not being cooperative”, etc. I don't know if you can elaborate on that or how true or not true it is. Everybody's innocent until proven guilty, as far as I'm concerned, but I find that unacceptable as an individual. It's like my going to the hospital, for example, and asking to be treated for whatever, and the doctor just doesn't want to see me.

Maybe you could just comment on that for me, because the concern here in this study is how do we address this need that former service people have or enrolled service people who have to be treated have? As we've all come to understand, they are treated adequately and then the green light is given for them to return to active duty, either here or abroad.

Have you experienced anything like that, gentlemen?

MGen Tim Grant: Sir, I could start by answering your question. First of all, I would say that I'm sure we won't have any rude or unpleasant questions, and I think we share your concerns about the quality of care our soldiers get. It's in everyone's best interest that the soldiers who serve this country do in fact get proper care while they're deployed, and more specifically when they get home.

My comments on this question would be very much based on my time as a brigade commander in Canada and as the commander of Land Force Western Area. In those cases it was exceptionally important for me that everyone had an opportunity to interface with a mental health professional when they returned from Canada.

I'm not sure if you're aware there is a program in place where between three and six months following redeployment everyone must go through—that is the aim of the program—a detailed interview with a mental health specialist.

The aim of that, in my mind, is twofold. One is it allows people to have that opportunity, after they've come home, after things have settled a bit, to be able to get some feedback from a mental health specialist. But perhaps even more important than that, because there has been in the past a stigma for people who are looking for mental health care, this in fact makes sure that every member who has deployed, regardless of rank or trade, is essentially forced to sit down with a mental health specialist.

I think in some ways that actually removes the stigma. People don't have to put up their hand any more and say “I'd like to go and speak to a psychiatrist”. In fact, we make sure that each one of those individuals does have an opportunity to go and speak to a psychiatrist. So there's no more stigma about going to the clinic. Everyone does that. What happens behind the door with that mental health specialist is clearly between the individual and that professional.

● (1550)

Mr. John Cannis: I appreciate your comments, and I sense the sincerity in responding to me, but just last week we had a mother here on behalf of her son. There are other examples; I'll just use that one. They are not criticizing the military as a whole, but elements of the system. It's not like they were isolating themselves with a so-called stigma, as you put it. They're saying that they were reaching out for help and somehow help just wasn't there for them.

We heard from family support organizations, and I was very pleased to hear that they're there and they're funded. Maybe they could be funded a bit more in the fundraising, etc., that's going on. They're there, but somehow—and I don't know the answer yet, but we hope to get to it—there's an element that's missing to connect them all together so that at the end of the day this young person doesn't have to go through this experience of saying “I'm frustrated, I know I need help”, and not getting that help. It causes them to become isolated maybe.

MGen Tim Grant: Sir, I couldn't agree more. The system is not perfect by any stretch of the imagination.

Mr. John Cannis: General, I didn't expect it to be perfect—

MGen Tim Grant: No, but—

Mr. John Cannis: —but with reference to where the bugs are, all of us are here to try to correct it.

MGen Tim Grant: Yes. And certainly my experience in western Canada—and I will suggest that Colonel Lavoie can talk about what happened with his soldiers when they came back—I was accountable to my boss literally in a nominal role to be able to say that every person who had deployed had been through the screening process. I believe we're getting better at it. Every person who falls through the cracks is a failure on our part. I'll be the first to admit that.

Mr. John Cannis: I've only got about 30 seconds, probably 40 seconds, for a quick question.

How much training does a person receive prior to their deployment abroad to Afghanistan, for example?

Col Omer Lavoie: How much training...?

Mr. John Cannis: How much training prior to their going on active duty abroad.

Col Omer Lavoie: As I mentioned in my opening remarks, in the case of our battle group, it was about ten months of comprehensive training from the time the battalion and battle group stood up as a fighting force integrating all the other subunits within the brigade to the time we actually deployed into theatre, sir.

Mr. John Cannis: Thank you.

The Chair: Thank you. Right on time.

Mr. Bachand, seven minutes.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you, Mr. Chairman.

I would like to welcome our friends from Kandahar. As it so happens, that is where I met them.

Our study is not focused solely on PTSD, but on the health of our soldiers as well. When soldiers set out on patrol from a forward operating base, different things can happen.

We are not only looking into the mental health of soldiers, but also into the overall health of the members of our military. What happens at a forward operating base when soldiers set out on patrol or leave to patrol villages?

Mr. Lavoie, you stated that 140 soldiers had been injured and 19 had died during Operation Medusa. How long did this operation last?

● (1555)

[*English*]

Col Omer Lavoie: My overall operation was approximately seven months in theatre. Operation Medusa was about a three-month intensive operation.

Mr. Claude Bachand: Was it in Panjwai?

Col Omer Lavoie: Panjwai and Zhari, sir.

[*Translation*]

Mr. Claude Bachand: What happens when soldiers set out on patrol from a forward operating base? If a soldier is injured, is he able to receive immediate care?

[*English*]

Col Omer Lavoie: Yes, sir. If I can just explain, the medical support in theatre for combat troops is really categorized. There are three hierarchies of medical support. At the very front, at the fighting edge, in your example, a patrol that would leave a forward operating base outside the wire is a company with at least one medic per platoon as well as a number of soldiers, at a ratio of one to ten, who have advanced tactical combat care training or advanced first aid.

The next level of support is our forward role, two-unit medical station, which would be, if you could envision, a mini MASH unit. These would be pushed forward enough—in the case of Medusa I had them pushed forward on my two axes of attack—so they were never more than three or four kilometres from the front line where the fighting was occurring. And this organization had either a doctor in it or a physician's assistant and a number of medics who could provide a fairly high degree of stabilization support for a casualty before they were put onto an air medevac system and flown back to Kandahar airfield, which is considered our role 3 facility, which has all the combat medical support you'd find in any hospital in Canada.

Mr. Claude Bachand: Yes, we've been there.

[*Translation*]

I read that when an injured soldier needs to be evacuated, the Americans provide the helicopter. What is the procedure followed? If a soldier has lost a leg, does help arrive immediately or two hours later?

[*English*]

Col Omer Lavoie: No, sir; and unfortunately I came across that situation a number of times during our combat operations.

The air medevac system is an ISAF provision, under Regional Command South, and it's multinational. The Americans provide some support, but I've had air medevac support from the British, and from the Dutch as well, in our case.

It is very transparent to a soldier at the front. I've been in a number of situations where I've had to request air medevac for, unfortunately, mass casualty incidents. It's very transparent; I as commander or anybody else get on the radio and put across what's called a "line 9" medevac request, which is a programmatic request for air medical support. It details the types of casualties, the numbers, and the degrees of seriousness. From there, helicopters are pushed forward almost immediately to air-medevac the casualties out. In my case, most times it happened within 20 to 30 minutes of the request.

[*Translation*]

Mr. Claude Bachand: Is it in fact true that part of the military operational planning process on a forward operating base involves ensuring that before an operation is undertaken, helicopters are available to evacuate soldiers? In other words, is this a deciding factor, for example, in sending soldiers out on patrol from an advanced base?

[*English*]

Col Omer Lavoie: Yes, sir, that's absolutely so. For Operation Medusa specifically, when we were going through the operational planning process for that, my medical officer, who's a doctor, made, with her staff, an integral part of our planning in terms of making sure we had sufficient medical capability going forward. Every mission that goes out, as part of the orders given, will have a paragraph dedicated to medical support.

The availability of air medevac is monitored by my operations cell back at Kandahar airfield. If we're told that sandstorm season is about this time of year, a sandstorm does move in, and word comes across that this would mean no air medevac support, then I would make the decision—I can say unequivocally that I have done so many times—to either reduce the type of operations we were doing or the proximity of the operations from Kandahar so that I could always guarantee it.

I think, sir, it speaks very much to what I call the "social contract" in my job. Part of my job, unfortunately, is to put troops in harm's way, but the other part is to make sure that every measure possible to, if necessary, get them out of harm's way is put in place beforehand.

● (1600)

MGen Tim Grant: Perhaps to give you a more complete picture, at Regional Command South it was the job of the commander and his staff to make sure that across all of the provinces in Regional Command South there were not so many operations ongoing that, if things went wrong, it would overwhelm the medevac system. There were often times when the commander of Regional Command South, my boss, would actually tell us to delay or push operations to the right to make sure that he could in fact respond to possible air medevac requirements across the region.

[*Translation*]

Mr. Claude Bachand: Earlier, you spoke about tours. As you know, the US government recently reduced the length of a soldier's tour from 15 months to 12 months. We have often heard it said that tours come up too frequently. Have Canadian Forces considered either shortening or extending tours of duty so that soldiers do not have to return as often to the theatre of operations?

[*English*]

MGen Tim Grant: Sir, my understanding is that the commander of the army, General Leslie, has been asked to look at the length of tours. At some point he will come back and present some options to the Chief of the Defence Staff.

The Chair: Ms. Black.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you very much.

It's a pleasure to see you all here in Canada. When we met the first time, it was in Kandahar. I just wanted to share with you that the visit we had as a defence committee to Kandahar had a very profound effect on me. I want to thank each of you for the role you played in ensuring that we had the briefings we did.

I might just mention that the person who was the close personal protector was terrific.

The Chair: You tried to take him home with you.

Voices: Oh, oh!

Ms. Dawn Black: Yes—he was just lovely.

Mr. Laurie Hawn (Edmonton Centre, CPC): This is not in camera.

Ms. Dawn Black: He was terrific, as was everyone who dealt with us there. I thought about all of you when I was home again, and I'm glad to see you home and safe in Canada. I'm sure everyone here feels that way.

The stories that have been shared with me about post-traumatic stress disorder all have the same ring to them. I've spoken to families and to some returning soldiers from Afghanistan who suffered through this. Each of them has told the same tale, and I found it very dramatic that the incidents replay through their minds over and over again. They can't switch channels. They can't turn it off.

Another common refrain is that in most instances they felt, while they were in theatre and had their military family—even when we heard testimony in camera—they had the support they needed there. But once they came home, they and their families certainly didn't feel—and families who testified here in camera didn't feel—the support was there to help them get through their disorders and get healthy again.

I want to ask you if you have any recommendations. How do you feel that part of the health system is working? What improvements could be made?

On a supplementary question to that, the ombudsman's report came out about reservists returning, and how the care, attention, and services they've been able to access have been dramatically less.

I wonder if you can comment on those two things.

MGen Tim Grant: I would start with the family support issue. I agree with you that in theatre, as Colonel Hetherington said, living very closely together, it's a very tight-knit community. Those bonds tend to break when you come back home and go back to your own life with your family. Single soldiers clearly have greater challenges, since they don't necessarily have families to go back to on the bases to which they're posted.

But the issue in my mind is not whether the medical system is able to support them. The medical system is there for them. The challenge we face is getting them connected with the medical system to identify them, or have them identifiy themselves, so we can get them the help they need. That's an ongoing challenge, and it really rolls into the reservist issue in very much the same way.

I speak again from my time in western Canada. The challenge I faced working with reserve unit commanding officers was keeping track of reservists who went back—making sure we kept an eye on them and that they went through the screening process. The hard part is when a reservist comes back and gets out of the military. He loses not only that peer support group he had in theatre, but whatever support his unit could give him. That does cause me concern—how we can continue to track them.

At the end of the day, I don't think it's because people are not concerned and not trying. The system's not perfect, and if there were an easy solution we would have put it in place by now.

● (1605)

Ms. Dawn Black: You said in your presentation that when you went to Cyprus for decompression you thought you'd rather be anywhere else, or obviously at home with your family. Then in hindsight you thought it was a valuable service for you personally. If you're comfortable telling us, what made you feel that way in hindsight?

MGen Tim Grant: I think in my experience there were two things. One was the battlemind program that was presented to us, and the chance we had to select a number of facilitated programs where we could discuss issues, whether it was command and leadership, or family relationships. It allowed us to go into a fairly benign environment and have access to some very qualified medical folks who could help us with some issues.

I found it therapeutic that I could just unwind, have a shower every day, eat some food, have a couple of beers, and socialize almost one last time with the team I had spent nine months with. But I have told the Surgeon General that I think we can make it better. We have great mental health folks there, but we don't necessarily have people there right now who can facilitate the discussions between soldiers and those mental health specialists. There are big groups, and sometimes we need people who are a little more gregarious to draw out the soldiers.

But it is a good program, and one that I know General Jaeger is looking to make better. The military side of the house, the chain of command, is looking to make it better, but even though I didn't go through nearly some of the challenges as soldiers in the PRT or the battle group, at the end of the day I found it useful.

Ms. Dawn Black: I'm wondering whether at the higher ranks you go through the same routine as the troops around the issues of operational stress injuries, as you call them, in terms of being prepared before an event. Is it different? Is the predeployment and time before you go out on patrol different for the higher levels than for the troops?

LCol Simon Hetherington: If I could start, I'd like to say that we, as officers and senior NCOs, spend our careers getting ready for that sort of position. It's called leadership. It's developing experience along the way, doing professional development, and learning to be a leader in understanding potential stressors and how to deal with them.

With regard to specific training, as Colonel Lavoie mentioned, part of that ten-month work-up cycle did involve professional development studies, not so much into post-traumatic stress, but in dealing with stressful situations. I wouldn't say that we had specific-to-rank training; the entire contingent has training in recognizing these things as part of command. It's part of what we do. And that's what I believe has contributed to my ability to deal with certain situations that I have faced.

The Chair: Thank you. Sorry, we have to move on.

Mr. Hawn.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

I thank you all for being here.

I'd actually like to follow up on that a bit, because that is one of the areas I was going to address as well.

In terms of the training, as you said, you are groomed through promotions and so on for that. Obviously the operational lessons learned from deployment to deployment come back on a daily basis. Do you get a chance to sit down, commander to commander, between rotations and pass on not just the operational lessons, but the lessons dealing with the human situations?

● (1610)

Col Omer Lavoie: Yes, sir. Absolutely.

It unfolds in two ways, from my experiences. One, as you're aware, I think, is that the commander of a unit that's about to deploy will go overseas at least twice—once on a strategic and once on a tactical reconnaissance. He is forward with the commanding officer, in our case, and we have an extensive opportunity to discuss everything from the operations to the more human aspects of dealing with combat. For most of us, as COs, it's really the first time we have experienced that kind of intense combat in our careers.

The second opportunity, though, is back in Canada. Not too long after returning from Canada, you go through a series of professional development opportunities with units that are about to deploy—it's a speaking tour almost—to pass on lessons learned. In our case it was with the 3 Van Doos battle group. Even further, most of my officers, including myself, deployed to Wainwright, Alberta, for about a three-week period. So while that battle group was going through its validation exercise, we were there as mentors. A large part of that was dealing with the operational side. But I certainly had a lot of evenings where it was heart-to-heart discussions with both the commanding officer of that battle group and his regimental sergeant major on the human aspects that you face in combat, up to and including, unfortunately, losing soldiers occasionally.

Mr. Laurie Hawn: I don't want to make this too personal, because I know you've been through a lot.

We talk about stress of the troops, and obviously stress knows no rank. Could I get a quick comment, particularly from you, Colonel Lavoie, about dealing with that kind of personal stress, when you are the battle group commander and people are looking to you not just for command leadership, but for fatherly leadership?

Col Omer Lavoie: I think it's the training you receive. You might take it for granted until the first time you actually get into those situations and bullets are flying, but I certainly found that when you do get into those hard situations—and I've been in a few myself—the training did kick in pretty automatically. Sometimes it's almost surreal. You see yourself doing exactly what you were trained to do throughout years of infantry training and company commander training and CO training. You see yourself doing it by the book, as if you're being evaluated.

I think the other aspect, though, that's ingrained into us as a culture in the Canadian Forces and in the army is this concept of leadership from the front and achieving your mission. I always found that when you did have dark hours, and I certainly had a degree of very close personal loss over there, you knew you still had 1,200 soldiers looking at your every move. In the end, your duty was to keep that ship on track and accomplish the next objective or the mission that you had been assigned. I think you get a lot of personal strength from that, and that does get you through from one bad day to the next.

Mr. Laurie Hawn: Thank you.

I'd like to look ahead a little bit. We're predicting changes to the mission, with more civilians, more DFAIT, more CIDA people, not just going to the PRT but going outside the wire to the projects, and so on.

Actually, I'd like to hear from Colonel Hetherington and Colonel Lavoie, from a PRT perspective and from a battle group commander perspective, about the challenges in getting more civilians in harm's way and how we're going to deal with that from the point of view of teaching them or looking after their stress levels, and so on.

LCol Simon Hetherington: You're asking me to speculate a bit, and obviously I'd rather not do that.

Mr. Laurie Hawn: Well, no. I'm not saying where we're going to put them in harm's way, but they will likely be in somewhat more harm's way. How are we going to deal with the training of those people, to equip them, as we train the uniformed people?

● (1615)

LCol Simon Hetherington: I completely understand your question, sir.

I stay in very close contact with my civilian counterparts with whom I served in the PRT. In fact, as recently as last night we were out discussing this. I think what needs to be considered, and I'm sure it will be, is being able to provide to those civilians the same degree of care and consideration for their mental health as we provide for our soldiers. That's not lost on anyone. How the training and preparation for that occurs, I'm not sure how that will work. As long as it's recognized that they are under similar stresses and we take measures to assist them, that's important.

Mr. Laurie Hawn: Obviously the CF is there to assist DFAIT, CIDA, and what not, in that kind of indoctrination.

MGen Tim Grant: Absolutely.

From the standpoint of CEFCOM, we work closely with the Department of Foreign Affairs and CIDA, offering them the opportunity to get their folks to training venues like Wainwright. Not only can they meet the people they will work with in theatre, but they will have some exposure to some of the challenges they'll have in that environment.

Mr. Laurie Hawn: Colonel Lavoie, as a battle commander, you've babysat, willingly or not, people like journalists who were embedded, who were obviously civilian. How did you find they handled that whole situation, as civilians?

Col Omer Lavoie: It often surprised me for the most part that they're certainly professionals as well and a lot of them have been in a lot of not-so-nice places in the world. It always struck me that, surprisingly, they handled some pretty tight situations as well as they did.

Just to build on what Colonel Hetherington said on the other aspects of civilians in the battle space, which is a term we use now, I do remember when PRT was training initially. As much as he won't admit it now, the PRT was initially part of 1 RCR Battle Group during the mounting phase. Certainly Colonel Hetherington orchestrated, as part of that, the preparation of the civilians who came from the other government departments. He brought them to Petawawa for a week or so, and they were exposed to some of the stressors that soldiers would experience in theatre, including seeing weapons being fired and artillery going off and receiving some degree of first aid and mine awareness. We do have the capacity to provide some of that training, which is general to everybody, whether you're going on a fighting patrol or you're part of a PRT in a reconstruction effort.

Mr. Laurie Hawn: We're obviously not going to intentionally put anybody in harm's way, soldier or civilian, but we have thought of that ahead of time.

The Chair: Thank you.

That ends the first round. We'll start into the second round. We'll start with the official opposition, back to the government, and then over to the Bloc.

We'll start with Mr. McGuire, for five minutes.

Hon. Joe McGuire (Egmont, Lib.): I'll repeat what Dawn said to you, that it's nice to see you back in a different.... You all look better, anyway, when you're back here. I know we had a chance to see Colonel Lavoie—he had just come in off the front when he gave us a briefing at that time. I think General Grant was back and forth.

The topic we're interested in is how the soldiers are treated, not only when they come off the battlefield, but also at home when they come into various situations in the family, whether there's family breakup, and how the family is treated versus how the soldier is treated, and how the reservist is treated differently from a regular soldier, and so on. When Colonel Lavoie was there he was very action oriented, period. He not only had people who were killed and wounded, but he probably had quite a few people who had post-traumatic syndrome at some point after those particular battles.

Now there's a different mental outlook there, I would think. I was wondering if any of you are in a position to judge whether it was any tougher when you were there in a more action-oriented arena than it is now, when you are worried about roadside bombs. Fewer people are getting killed, but are fewer people being affected? Is there less treatment required now from when you were there? Do you have any statistics to compare between the two situations?

● (1620)

MGen Tim Grant: From my understanding, the statistics, if they're there, have not been compiled yet from the rotation. The 3rd Battalion of the Van Doos battle group has just come back home, and I'm not aware that the statistics on the challenges faced by them have been compiled at this time.

I would say, as I mentioned earlier, there are stressors on everyone, and everyone handles those stresses in a different manner. There are some people who would suggest that there should be less of a result from combat action because you can take offensive action at the same time, as opposed to being in a more defensive routine, where you feel less capable of managing your environment. You can use the example of Bosnia in the early 1990s, when PTSD really started to come to the fore.

I'm not sure that at the end of the day, sir, those statistics are particularly important. I think the issue is that there continue to be stressors put on soldiers in the environment they're in today. As a result of that, we need to make sure that the medical system is still as robust as it was during the combat phase so that we can, in fact, make sure that if something comes up we can deal with it in a quick and timely manner.

Hon. Joe McGuire: Is there more stress seen now at the Kandahar hospital among medical doctors, psychiatrists, or people who deal with mental injury? Is there any difference in the numbers of people required there?

MGen Tim Grant: The numbers have remained the same. The numbers of psychiatrists who were there on rotation 2 and rotation 3 are the same as on rotation 4 and rotation 5. So those have not changed.

I had a discussion the other day with my senior medical officer from rotation 3. His belief, after looking at the statistics that he had for rotation 3, was that the complement of mental health specialists from psychiatrists to mental health nurses to social workers to padres was sufficient to handle the demand that was placed on them, not only by Canadian soldiers, but also by soldiers from other nations who were in Kandahar and could access that Canadian system as well.

Hon. Joe McGuire: We had another reservist in here a few weeks ago. He was there for a very short time, but he was on the front and he was associated with a roadside bombing incident. When he came home nobody would believe that he was actually injured. He wasn't injured physically, but he was certainly.... And what they went through, the reservist and the parents, was a particular hell. I'm just wondering how often that happens. The nurse in charge of his file basically accused him of lying, pretending he was injured and looking for a pension or something. All he wanted, and apparently wasn't getting, was his proper treatment. Those people are falling through the cracks. I don't know how many. You can't interview everybody who comes back, or their parents.

Are the reservists being treated any better now than they were? I understand they were treated differently for a while. Are they still treated differently? Is the medical response to them, at the time and when they get back, the same as to the regular soldier?

MGen Tim Grant: It is difficult for us to respond to cases of soldiers coming back. We don't have access, nor should we have access, to their medical documents to determine what has occurred. Those situations are best addressed by the medical world, which can investigate and determine where help is and what can be provided.

We're much better now at dealing with reservists who have deployed overseas, in part because there are greater numbers. We've learned through our mistakes in the past. Looking back at Bosnia, some of the reservists who came back from the Second Battalion of Princess Patricia's Canadian Light Infantry in the Medak pocket got off the plane and went home, never to be seen again. We don't do that any more. We have procedures for follow-up. It's not perfect, but we try to learn from our mistakes, and we try to make sure that nobody falls through the cracks.

● (1625)

The Chair: Ms. Gallant.

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

With regard to the soldiers who have been injured and are seeking compensation, we've been told about something called a CF 98 form. Maybe you could explain these forms to the committee. Apparently they are not all being completed as necessary, even though compensation hinges on whether or not these forms are submitted. Is it realistic to require that all the injuries and incidents requiring the submission of a CF 98 be done in theatre?

MGen Tim Grant: I'll give a general comment and then I'll turn it over to the COs, whose responsibility it is to fill out these forms. It is a document that Veterans Affairs reviews with respect to compensation and pensions. It records the incident and the circumstances to confirm that the individual was on duty at the time, and that the incident was the result of a service necessity. It has a place where a medical authority can sign off. In the current structure, it is required. Is it difficult to do? It can be, but I'll let the COs address that issue.

Col Omer Lavoie: It's a responsibility to ensure that the troops under your command, if they're injured, no matter how, have the injury documented and tracked. The system isn't perfect. But even if the soldier is injured playing hockey in CFB Petawawa, nothing to do with duty, there's an obligation for the chain of command to ensure that it's been documented.

I don't think it is very difficult, especially in this day and age. It's a simple form. When a soldier is injured, whether or not he's in an operating environment, the company clerks and medics all have this form and it's filled out. In the worst case, it can be done on a scrap of paper. If it's witnessed and annotated by chain of command, at least it serves as some source of documentation.

I don't think it's perfect. Do they sometimes not get filled out? Yes, unfortunately. I've been guilty of it myself. Sometimes you don't think it's a big deal, you don't fill it out, and then four or five years later you wish you had.

Mrs. Cheryl Gallant: Another problem that has been related to us has to do with the transfer of medical records. They're getting lost. Somebody hurt in theatre will go to the CAF hospital, perhaps be transferred to Lahr, then back home to a hospital, and finally, with luck, back to his base. So they'll be seeing the base doctor and they will be referred to a specialist eventually. With all these transfers of records, they're getting lost and causing delays in treatment and referrals.

Some have suggested that these records become electronic. You have been in theatre. Is this a realistic recommendation to put forward?

MGen Tim Grant: I would suggest that this is the wrong trio to answer that question. The medical documents are held by the medical community, and the challenge would be for someone in the medical community to look at the matter and decide the best way to deal with it. This is beyond our purview.

Mrs. Cheryl Gallant: Technically speaking, regarding communications, I know that there are certain parameters within which you have to transmit. From an operational standpoint, having that sort of data going through the air is not going to—

MGen Tim Grant: And that's an issue of not knowing what the scope of the problem is. I wouldn't be able to tell you whether there's enough bandwidth to pump those electrons through or not. So it really is, technically, trying to figure out what the problem is and find the technical solution. It's certainly beyond my ability as a liberal arts student.

Mrs. Cheryl Gallant: Lastly, I understand that in September 2007 we had a casualty support management detachment stand up in Petawawa. From what I know about it—and I know very little—it may address some of these issues we've heard about for soldiers who have been injured in theatre, instead of having the benefit of going through the decompression stage, as well as the month-long reintegration into home life.

Can you tell us how this works, if you're familiar with it, and what it's supposed to address?

● (1630)

Col Omer Lavoie: I was particularly happy to see that progress. When we came back from our tour, we had a number of visits from the director of casualty support here, out of Ottawa. It became apparent, through lessons I learned from our tour and certainly from the PPCLI Battle Group before us, that the directorate of casualty support needed to branch out and now start putting detachments forward at the bases where the troops would be returning.

So I was particularly happy after our series of discussions here in Ottawa that the idea was approved and that a detachment is now stood up in Petawawa. Among other things, it gives soldiers direct access now, rather than having to travel to Ottawa to deal with situations that require the directorate of casualty support to assist them.

The Chair: Thank you.

Mr. Vincent.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Thank you.

Good day and welcome.

I have looked at the positions you hold.

General Grant, you are with the Canadian Expeditionary Force and you are a veteran. You have come here today to speak to us about the health services provided to Canadian Forces members, specifically services to treat post traumatic stress disorder.

You have combat experience as well as experience in a theatre of operations. However, from a medical standpoint, what can you tell us about the treatment soldiers receive when they return to Canada and the medical follow up they receive if they suffer from PTSD? I am thinking about someone who may have lost a comrade in arms. What care will that soldier receive? Who can he turn to for help?

[*English*]

MGen Tim Grant: Sir, I would start by saying that in theatre the aim is to help every soldier, whether their injury is mental or physical. There have been occasions on which Colonel Lavoie and I have actually worked closely and monitored cases and tried everything with mental health specialists to ensure that individuals who were suffering got the care they needed and were brought back on the road to recovery.

Others have not been able to be given the help they needed to get over a severe trauma in theatre, and they've had to come back home.

I will tell you from my experience that there is nothing that we will not provide to a soldier in theatre or particularly back home if it will help them get better. The CDS has made that very clear to all of us. Regardless of the nature of the injury, we will get the support that the soldiers need.

I think that goes across the board. Rank is irrelevant when it comes to either mental health or physical injuries. As I said before, the challenge is linking the injured soldier with the medical specialists who will help the most.

[*Translation*]

Mr. Robert Vincent: How many mental health specialists does the Canadian Forces have and how many people avail themselves of their services? What is the ratio of mental health specialists to soldiers returning from a combat mission? Is the ratio one to ten, or one to one hundred?

[*English*]

MGen Tim Grant: Sir, I wish I could answer that question. I don't have the answer. I'm not sure if the Surgeon General had that information when she appeared before this panel, but if not, we will take that on notice and see if we can provide that.

The Chair: I think we already had it.

[*Translation*]

Mr. Robert Vincent: It is really important to the extent that soldiers must have the sense that they are being cared for. One soldier from my region committed suicide after he returned from Afghanistan where he had lost a foot. He may not have had a spouse, but he did have family. In my opinion, providing medical follow-up services is really not sufficient when a soldier returns from Afghanistan or from another mission. Earlier, you said that you had trouble providing medical follow up services to these individuals.

What do you think you can accomplish? You also said that you lacked the necessary expertise and did not know where to go and find it. Surely soldiers from other countries are experiencing the same thing and require medical expertise and psychological counselling.

● (1635)

[*English*]

MGen Tim Grant: Sir, there's no doubt that my discussions with the Surgeon General lead me to believe that they are exploring all options for services and trying to find the right treatment for soldiers.

The case you mentioned is one I'm familiar with. He was a soldier who was injured under my command in Afghanistan. He came back to Canada and had been under care for almost a year. His suicide was tragic, and it affected everyone who knew him. It affected his family, it affected his peers, it affected those who had served with him in Afghanistan.

Those are tragic events that, quite frankly, some of us don't know how to deal with. But I think we need to be very careful between saying the tragic results of a person not getting care and the results of a person who ends up taking his life, in spite of the care. There are cases where that happens, and that's all the more tragic. But as I say, I'm convinced in my own mind that the Surgeon General and her specialists are working to find the best care that can be provided to soldiers.

The Chair: Thank you.

Mr. Rota.

Mr. Anthony Rota (Nipissing—Timiskaming, Lib.): Thank you, Mr. Chair.

I've been listening to a lot and we've had some people on both ends. I guess when we look at it statistically and I look at the service you're giving, there's no question in my mind that the intention is very good and we want to see what's best for the individual soldier. I almost feel, though, when we ask questions, what I get is yes, this is what we mean. So the statistics are very good, and overall they seem to be in place and everything seems to be great, but I guess what we get in our office are the outliers, the data that doesn't fit in with the rest of the statistics. When a statistic is very distant, it sounds good, because you're talking 80%, 90%. But if you're part of that 10% of the population, all of a sudden it goes from being a statistic to being a personal problem, and I think that's what we see in our offices.

I have a question, and I'm not really sure how to put this. I don't want to sound insulting, but there seems to be a disconnect between some of the cases on the front line and what's going on up the ladder. Is there a review process in place to analyze just what's going on with the outliers, the people who are having troubles? Maybe you can describe to me how that would work.

Let's say somebody comes into my office and says “I've been getting terrible servic”. Now, granted, maybe some of the diseases that are existent are very hard to diagnose, they're not easy, and I'm not saying it's an easy problem to take care of, but how do you take care of that problem that is not as easy as...? Say you break a leg—you know it's there, the femur's cracked in two. You put it back together and you hope for the best, and at least you can monitor that. But when something goes on with the mind it's not exactly an easy one to take care of, and there's a lot of pain and suffering that goes with it. You're definitely not purposely leaving this person out in the cold, but they certainly feel like they are. How do you handle something like that? What would your role in something like that be?

MGen Tim Grant: I'll take a quick shot at it.

I would say that, even with the broken leg, the broken leg can't be repaired if the patient doesn't interface with the doctor. So if a person is coming to your office or anyone else's office, the aim is clearly to get them in connection with someone who can help them, and that someone, in my mind, would be the Canadian Forces medical health system. That is the issue. It's how you get them to the help they need.

I've been to two funerals for soldiers in my regiment in the last month. One was killed in action in Afghanistan and one took his life following a tour in Afghanistan. Both were tragic. The aim is to never let that happen. But at the same time, there will be people who...as you say, the outliers will fall through the cracks. The aim is, once they're identified, how do we get them back? I would suggest, sir, that you play a role in that, to identify that to the medical health system, so we can get them into the care they need.

LCol Simon Hetherington: I'd like to add, not so much from my role in Afghanistan, but as a commanding officer of a regiment in Petawawa before deploying and as a commissioned officer in the Canadian Forces, that I'd take action to look after the care of my subordinates when I hear there is an issue, and that's not just me; it's public knowledge, because it's in the newspapers, that General Hillier himself has entertained the families of those who may have fallen through the cracks. That's not meant to be taken pejoratively. He has taken it upon himself and he's led by example in that regard.

I know that within 2 Brigade I and every single one of the commanding officers I serve with, Colonel Lavoie being one of them, would take it to heart if we got a call from someone outside the military asking if we knew that soldier X had a problem. As General Grant said, we would engage the medical people to try to assist. It's the old adage of not being able to fix the problem if we don't know there is a problem.

● (1640)

Mr. Anthony Rota: If we had someone like that come to see us, would it be appropriate to ask who his commanding officer was? Would that be out of line?

MGen Tim Grant: Sir, I would say that's very appropriate. Phone the commander of that service, the nearest base commander, whether he's army, navy, or air force. That's the approach I would take. That will ensure it gets attention.

Mr. Anthony Rota: My concern, and the concern the individual soldiers often have, is about getting that attention and what it will mean for them. By the time they get to that point, their military career is usually pretty well over. They're not going back into theatre, and they're not getting any more work with the military. How will that affect them within the military?

The reason I ask is that I've had some come to me—and again, I'm taking individual situations and I know they're not the norm, but the outliers—who feel that if they say something, they'll be shunned, they'll be pushed aside, and maybe the attention they'll be getting won't be as positive as they might like.

Col Omer Lavoie: I could probably take that one on with a few examples.

The first part, sir—and I think we've gone a long way in the forces—is creating a command culture in which we don't differentiate between a physical wound and a mental wound.

It's easy to stand up in front of your troops and say that as part of your pre-deployment briefings. Certainly from what I saw.... I had soldiers in my own vehicles in a few-man crew, one of whom had to be sent back after a series of combat engagements, but I certainly never felt afterwards that the other soldiers in the crew or his fellow soldiers in that particular platoon ever cast any aspersions against him or treated him differently from any soldiers who went back with physical wounds. That's the first part.

The challenge is often that it comes to the point that you need to actually order the soldier, based on your professional determination, to get help. General Grant and I worked on a case in particular. You have to come down and sometimes order that soldier to come in and seek help, and if necessary to be repatriated back to Canada.

The segue to that was it would be the end of his career. That is not the case. In the one particular case that General Grant and I worked on for quite a bit of time after a traumatic circumstance, we sent that soldier back to Canada and after returning a few months later, followed up with him. I'm happy to say that I sat down with him and his wife back in Canada about two months after that occurred, and that soldier is now gainfully employed on our base and has received successful treatment, despite being a soldier who didn't want to come back but was ordered to come back, and in no way has his career been ended over that case. There may be limitations, perhaps, on his employment, but he'll still finish out his career and be gainfully employed within the CF.

The Chair: Thank you.

We'll get back. There's lots of time here.

We'll go over to Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Mr. Chair.

One of the challenges we're concerned about with post-traumatic stress disorder, especially with the long deployments, is the support network at home and the connections with home. I suppose in a sense we identify with that around the House here, because our members are removed from their families to a certain extent. They're not in the same kind, although you might call this place a combat.... You'd never know that from the way it's so peaceful around the table today, but it has been described as a combat zone in another way. I can certainly say that statistics tell us that casualties in relationships for members of Parliament have been recorded; we're away from our families, and it's a concern around here.

I'm wondering what happens in the theatre for soldiers on deployment. They're away from their families a long time. We know that when they go home, the support network is going to be so important for them. How do young couples maintain a relationship? Do they get to phone home once a week? What kind of infrastructure is available for people to try to maintain relationships and talk to their support network at home?

● (1645)

Col Omer Lavoie: I can probably take that, because the bulk of my troops were deployed forward, outside of the main airfield for almost the entire duration of our time there. There is a significant amount of infrastructure in place. I think you would be pleasantly surprised. Certainly the policy was in place when my tour was out. We had satellite phones, one down per section of soldiers, which was equivalent to a ratio of about one phone for ten. The soldiers were allowed to use that phone anytime. It wasn't required for operational reasons. They could call home, I would suggest, a few times a week if they wished to.

Although initially fairly austere when we first went in and seized that ground, the forward-operating bases were developed. Certainly in my time there satellite-based Internet was brought in. Again, when soldiers weren't out on a combat patrol or otherwise, they were able to go back and use the Internet and use it as a means to send e-mails back and forth to home.

It's a pretty stark difference from what I remember in Bosnia in 1992, where you went eight weeks, if you were lucky, waiting for a five-minute phone call, with a card, to call back home. I think that's gone a long way to keeping families connected. That's on top of the other services, like the hotline numbers and the services that are available on bases now so that spouses have access to getting things forwarded to theatre as well.

Mr. James Lunney: I certainly appreciate hearing that. It wouldn't be unusual for you to actually witness your soldiers calling home somehow or logging on for some computer time. One of the advantages of computer connectivity is that you can actually pretty cheaply communicate that way.

I certainly appreciate hearing that. It has to be a tough assignment when they are having such intense experiences, and that leads me to the second question, which would come back to the decompression. I am so glad to hear it has been implemented at that time, when they come out of theatre and after that intense military family experience that they've gone through together, and then they need a bit of time coming back to civilian life. It seems to me that's a very good idea.

We saw great images with the Stanley Cup showing up and some ball hockey going on. Are recreational opportunities available as well during the decompression time?

MGen Tim Grant: They are indeed. The program is five days. You arrive the first day and leave on the last day. On days two and three there are formal presentations in the morning that you have to attend. In the afternoons, and on the fourth day, there are subsidized recreational activities people can participate in. You can take advantage of those or you can lie around the pool and get a suntan if you'd like. The vast majority of people do get out and do some sort of social activity, some leisure activity that they are capable of going off and doing.

Mr. James Lunney: That's great. Maybe I missed something, as I thought decompression was only three days. I'm glad to hear it's five.

MGen Tim Grant: It's depending on when the flights arrive. There need to be three days of formal activities. For instance, we arrived on my flight at 10 o'clock on the first day. So we actually had an afternoon and an evening. The fifth day was a write-off because we went to the airport at about 4:30 in the morning. There are three days that are guaranteed to be set aside that folks can use.

Mr. James Lunney: I'm really glad to hear that. Are three days enough? Should it be a week? I know families are anxious to be reunited. They're out of that pressure cooker and they want to get home. There is pressure like that.

Maybe I'm asking the wrong three again here. Maybe you want to defer that to a psychologist, but I just throw that out. Is it enough, in your opinion?

Col Omer Lavoie: Certainly in my opinion I probably had the same sort of apprehensiveness that General Grant had mentioned about going there and thinking rather about just getting home. After the few days there I came to the same conclusion. It was a good and required buffer from going from a combat zone to meeting up with your family a few days later. Again, I'm sure there are a lot of medical health professionals who are looking at it to find the optimum timeframe, if it's not three days.

● (1650)

The Chair: Thank you, Mr. Lunney.

Mr. Cannis, and then back over to the government.

Mr. John Cannis: Thank you, Chair.

My question is predicated by something my colleague Mr. Rota said, and I just want you to elaborate on it. In trying to put some recommendations together to this inquiry, General Grant, if I may, in response to my colleague in terms of how they seek help, how they get resolution, how they get the proper service, you said "You play a role in that", referring to the member of Parliament, I presume. I just want to get this straight, only because it's very important.

As you know, part of our responsibility is to address the concerns our constituents have, whether they be revenue, disability application, or Veterans Affairs, for example. We speak with them directly.

To provide you with an example, I know our colleague here, Ms. Gallant, has CFB Petawawa in her riding. Please clarify for me. Are you telling us now that a person who has returned, who resides in the area, who has had these obstacles that we've heard of from individuals, mothers, and families, should call their member of Parliament—Ms. Gallant, for example—and say "You call so-and-so, Colonel such-and-such, or Major General such-and-such, and you talk to him"? Are you saying that we can have that access?

MGen Tim Grant: No, sir. Thank you for letting me clarify that point.

Mr. John Cannis: I just want a clarification on that.

MGen Tim Grant: The issue clearly is that in a perfect world the soldiers would have absolute faith in their chain of command and their chain of command would be able to deal with all those challenges that soldiers face and make sure they got the proper support.

My comment was specifically that if a soldier did come to an MP, did come to their representative, that the representative can then play a role in helping that individual.

Mr. John Cannis: How, sir? A representative came to my office, as an example—you know, a soldier who had just finished his duty and encountered some problems, and was running into some obstacles. How can I help him? Can I then pick up the phone and call the medical officer or regiment such-and-such? How can we help?

MGen Tim Grant: Not to be glib, but I would suggest you phone the parliamentary secretary, and he would help you to deal with the issue to get the right access.

Mr. John Cannis: Now we're narrowing it down.

MGen Tim Grant: That's how I would do it if I were you.

Mr. Laurie Hawn: Just to amplify that, if somebody has a problem or needs help—seriously—then let me know and I can pass it to the appropriate—

Mr. John Cannis: We know that. It's just that I was enticed, because we can play a role, and we're all more than receptive to see what kind of role we can play, not to step beyond what we can and cannot do. Sometimes we do get excited and do get attached to a certain file or a certain situation and we'll just pick up the phone and call somebody we're not supposed to call, and in essence we'll not get any result for the individual. We get in trouble, etc. So I just want to see how that venue works.

MGen Tim Grant: There's probably somebody sitting behind me from parliamentary affairs who's quite concerned with what I've just said, but that's what I would do.

LCol Simon Hetherington: If I may add something, my current position is one of record, and you can see it there. I'm the executive assistant to the army commander. I will say that I've lived through this, and this is how it works. I get calls from Minister MacKay's office, the military assistant's office, to say that someone has approached a member of Parliament and they have since gone to Mr. MacKay's office, potentially through Mr. Hawn, and this is the situation and can I deal with it. It could be something very innocuous, like he needs a contact number for X, and we get on it right away. We feed back that way, and then the loop is closed, either directly—I've made calls personally myself—or to the unit's commanding officer through the chain of command. It does work, and we are doing it, sir.

Mr. John Cannis: Thank you for that explanation.

The Chair: Thank you.

Over to Ms. Gallant.

Mrs. Cheryl Gallant: I just have a brief question for you, gentlemen.

Of course keeping on the ball in theatre, keeping your mind healthy also entails keeping your body healthy. Given the 24/7 nature of what you're doing there, how were each of you able to work through or maintain some type of physical fitness program for yourself—or were you?

Col Omer Lavoie: To be very frank, from my perspective, and I don't think it's changed, and also Colonel Hetherington's as a fellow CO, the time to try to get fit or even maintain fitness isn't when you're deployed into theatre and engaged in combat operations, as we were. The corollary to that is the absolute insistence on the high degree of physical fitness and preparation before going into theatre. So for that ten months I described, physical fitness was implicit, and doing hard physical training was implicit in all aspects of that ten-month training.

It depends really where you are. If you're back at Kandahar airfield, there are certainly a lot of opportunities to keep fit, if you're not in a front-line type of job. Weights are brought forward, and that sort of thing. But the reality of being deployed forward is a fairly limited ability to keep to a fitness program as you would do back in Canada. So it's imperative to be fit when you show up.

Having said that, walking around all day with 70 pounds of combat gear on assists your physical fitness level to some degree anyway.

● (1655)

MGen Tim Grant: I had a 25-year-old personal assistant who banged on my door at 5:30 every morning to make sure I went for a run, so that's how I dealt with it. I found that not only physically helpful, but mentally helpful.

Did you do anything, Simon?

LCol Simon Hetherington: Not at all, sir. You ate at the PRT. You know the food there.

Mrs. Cheryl Gallant: I'm sharing my time with Laurie.

Mr. Laurie Hawn: I believe I've seen the statistics. I can't quote them for you, but I believe the suicide rate in the Canadian Forces is lower than the suicide rate in society in general. If not, then it's no different, although maybe for different reasons.

We talk about people, the outliers, and the problems they have for whatever reason. Obviously, if anybody's having a problem it's their problem, it's very personal, and sometimes nothing is ever enough to fix the problem. That's totally understandable when somebody's having a severe case of PTSD.

I'm not sure whether Colonel Lavoie is the best one to answer this, but can you give some examples of the extra effort that you or the unit have gone to in bending over backwards to help folks who are having difficulty getting the problem resolved to their satisfaction?

Col Omer Lavoie: I think it was very fortunate that we deployed back to Canada between February and March, and I didn't change command until the following June. So I had those four or five months with my entire team to maintain the cohesion. But before I changed command and my team changed, my number one priority was to look after both the soldiers and the families of soldiers who were injured and the families who had lost soldiers there. That was where 99% of my energy was placed in those four months before I changed command.

A number of incidents there ranged from soldiers who had experienced combat stress reactions in theatre, to soldiers who had some pretty severe physical wounds. I engaged with the chain of command and my superior chain of command to make sure those soldiers were taken care of. From my perspective, in the ones we dealt with, I can't think of any who didn't get the treatment they either requested or required.

LCol Simon Hetherington: In my current position I can see some of the additional measures we've taken to assist those soldiers. For example, on providing assisting officers to the injured, if a family is uncomfortable with a certain assisting officer and they know of another military member they would like to be an assisting officer, we've been able to facilitate that.

We've assigned personal trainers to soldiers who are unable to interact in a public gym, to develop their fitness. There are those types of things, and the list goes on. Again, with leadership set from the top by General Hillier, there's nothing we won't do to try to assist our injured.

The Chair: Thank you.

That wraps up the second round. In the third round we have Mr. McGuire, the government, and then the Bloc.

Ms. Dawn Black: Will it ever come to me?

The Chair: It should get to you. I'm very hopeful.

Hon. Joe McGuire: In this age of sophisticated communications, and seeing there's such a relationship between yourselves and DVA, are there any advances being made between the two departments in servicing the returned men and their families now compared to before? Are you aware of any improved barriers?

The walls go down between the departments all the time—their territory and your territory—and never the twain shall meet. Are those walls coming down? Is there better communication between the two departments to better serve our servicemen?

● (1700)

MGen Tim Grant: In general, I think there is much better service than there was in the past. I know assisting officers dealing with the Department of Veterans Affairs get exceptionally speedy service. When there have been serious injuries or death in theatre, I haven't heard any complaints in western Canada that people haven't been getting an exceptional level of service.

I'll ask the COs if they have anything beyond that.

Col Omer Lavoie: The only thing I would add from my perspective is that it is similar. Now we have four detachments of casualty support people in Petawawa. We also have four detachments from DVA, which is something we hadn't seen years ago. Now there are DVA detachments on bases.

I've noticed a shift in perception in DVA. It's an organization that I think for a long time was focused on veterans of past wars, World War II and Korea, for instance. I think the shift is to the reality that we now have veterans who also need their assistance and who aren't in their sixties but in their twenties and they are returning from Afghanistan and other theatres. This is my perception in dealing on a very limited basis and from the feedback I've received from families.

Hon. Joe McGuire: Are you familiar or do you have any dealings with the family resource centres across the country? I know some provinces don't have one. P.E.I. doesn't have a military base or anything like that, and our veterans have to go to New Brunswick for support.

Is there any way to improve what they are delivering? I know a lot of this is voluntary, and they're undermanned and underfunded. Is there any way you can see that these organizations can be improved, from your point of view?

MGen Tim Grant: I know the chief of military personnel is looking at military family resource centres with the aim of improving them and making them even better than they are today.

I will acknowledgethat there are probably different levels of service across the country, depending on where you are. I would speak from an Edmonton standpoint and say I think the soldiers in Edmonton were very well served by the people and the programs in that service.

The challenge comes when you're trying to deal with families that are not close to a major base. I know in Edmonton the director of the MFRC spent a great deal of her time making sure that either other MFRCs across the country had taken ownership for a file, for a soldier's family, or they were on the phone or the Internet trying to make contact with folks wherever they were.

I think it's a good service. Like anything else, we can probably make it better.

Hon. Joe McGuire: Thanks.

The Chair: Thank you very much.

Mr. Lunney.

Mr. James Lunney: Thank you.

My first question would be about soldiers coming back, particularly the reservists, and the isolation once they get back. They're off the base, and they're back in their community sometimes quite a bit removed from a base. Where I am out in Nanaimo we have some reservists with the Canadian Scottish Regiment. Is there follow-up for reservists?

For example, if they're having trouble after the decompression time when they're back a month or a couple of months, is there any reuniting with other members they'd been in the combat zone with to decompress a little further or just talk about how they're reintegrating? Has that happened?

Col Omer Lavoie: Again, I can speak of my experience as CO of 1 RCR. Certainly when we came back after the leave period of a month to six weeks, depending on when you come back from theatre, we very purposely put together a series of activities. They consisted of a medals parade, a memorial service, and then what amounted to a battle group celebration over a period of three days. We are very insistent that reservists are told to come back to Petawawa on duty travel to participate in that. Part of it was to celebrate and honour sacrifices and achievements, but at the same time it was an opportunity for them to get back and have the chain of command they fought with, whether at a platoon or section level, and have a chance to talk with their buddies on the regular force side and others in one spot.

Colonel Hetherington may be best to answer from his position now as EACLS, but within that mechanism, at least for the army within the area structure, the area commanders and reserve brigade commanders have that duty as well to continue to track those soldiers who have come back from a deployment to make sure that if they require assistance it's put in place.

● (1705)

Mr. James Lunney: Okay, I'm surely glad to hear that, as I would think it would be very helpful.

Going back to the question of the provincial reconstruction team, Colonel Hetherington, this may have been answered somewhat before, but in your time there as head of the PRT, you had CIDA, DFAIT, RCMP, and the municipal police all part of it. Were you also responsible for overseeing the engineers or the people working at building bridges and roads? Were they soldiers who were doing most of that work?

LCol Simon Hetherington: I'm not sure who you mean by the engineers. We had engineers integrated with us who were military engineers.

Our modus operandi was not to do the work that we could engage Afghans to do, and that process is still continuing. You may have read of a road that's been constructed that could have been done a lot faster by hiring big pieces of machinery, but they chose to hire local Afghans to do it by hand to encourage economic development at the lowest level.

With locally engaged civilians, life, limb, and eyesight were the terms we would go by. If there was an Afghan working with us who suffered an injury in those three areas, we would certainly address it and treat him. But as for the Canadian civilians on the team, they were treated as any of our soldiers.

Mr. James Lunney: I'm certainly glad to hear that. I think it makes a lot of sense to employ the local people absolutely as much as possible. It leads to buy-in to the project, and they're certainly going to have an investment in wanting to protect it afterwards, so I certainly appreciate that.

Another question would be, with the other people who aren't military personnel there but are part of the PRTs, do you witness PTSD or operational stress injuries? Did you observe that in your time over there? Are these people experiencing these types of challenges as well?

LCol Simon Hetherington: In my time there I did not, but again, as is recognized and as is implied by the name, post-traumatic stress comes after the fact. I still keep in contact with the team I was with, and we look after ourselves.

General Grant, as many know, was close to his time to return home when his vehicle was attacked by a suicide bomber, and there was a CIDA representative in the vehicle with them. I can let General Grant address that.

I would like to say that we have a responsibility, I believe, for our civilian counterparts. While they were on the team, they were certainly part of the team in every respect—and that was in my little PRT, and I know it was the same with Joint Task Force Afghanistan, as well.

MGen Tim Grant: It was interesting that as a result of that suicide bombing attack, a young CIDA officer's first concern when she climbed out of the vehicle that had rolled over two and a half times was the impact it would have on CIDA's policy of letting her travel outside the wire.

The Chair: Very interesting.

All right, over to Mr. Bachand.

Your turn is getting close, Ms. Black.

Ms. Dawn Black: Am I after him?

Mr. Claude Bachand: Do you want to go right now?

The Chair: Go ahead if you want, Ms. Black.

Ms. Dawn Black: Thank you very much, Chair, and Claude.

I just have a quick question.

In the time you spent in Kandahar in operations, all of you were commanders and were dealing with these issues, so there was a lot of stress on you as well. I wonder if you noticed any particular trends or patterns in occupational stress injuries vis-à-vis the age groups of the people. Did that show up? Did rank seem to make any difference in that? Was it more difficult for some occupational groups than others? And I also wonder about gender, because when I was there I noticed there was quite a large number of women. Did gender play a role at all in the occupational stress injuries that you noticed or were reported to you?

● (1710)

MGen Tim Grant: Certainly from my standpoint I didn't see a trend in any of those discriminators. There wasn't a specific rank; there wasn't a specific trade; there wasn't a male or female pattern to it. It almost struck randomly, or it struck across all ranks and trades almost equally.

Ms. Dawn Black: Does anyone else want to address that, even if it's the same answer?

Col Omer Lavoie: I reinforce that. In our case, in our battle group, again it wasn't PTSD, but the combat stress reactions that we had in theatre ranged from the youngest soldier to seasoned senior NCOs and officers as well.

The thing I'd add, though, was that I was very satisfied—and I attributed it to our training as well—that given the significant amount of combat the battle group went through, we only had four combat stress reactions that required return to Canada. We had a few more that we were able to treat in theatre, and those soldiers returned to duty. But that is a pretty significant low rate compared with what some of the scientific and theoretical texts have out there.

Ms. Dawn Black: Yes, I would agree with you.

Thank you.

The Chair: Thanks, Ms. Black.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand: If a doctor diagnoses PTSD in theatre, is the platoon's commanding officer informed of the diagnosis?

[*English*]

MGen Tim Grant: The issue, sir, is one of doctor-patient confidentiality. The policy is that if a soldier were diagnosed with anything, quite frankly, physical or mental, the commanding officer, the chain of command, would be advised of the employment limitations. They would be advised of such things as that the soldier shouldn't carry a weapon or that they needed some time off or, back at home, that they needed to come into work for only half days, and those kinds of things. The chain of command is advised of those things, but they are not told what the diagnosis is, nor do I believe they need to be told.

[*Translation*]

Mr. Claude Bachand: As an employer, can the Canadian Forces challenge the doctor's report? For example, can they require the soldier to report for duty as usual? Can they do that? Does the commanding officer have the legal right to challenge the diagnosis and can he continue to order the soldier to report for duty as usual?

[*English*]

MGen Tim Grant: No, they can't at all.

[*Translation*]

Mr. Claude Bachand: They can't?

[*English*]

MGen Tim Grant: At the end of the day, it is the doctor who has the final say. In the medical chain of command there are certainly checks and balances, but at the end of the day it is a medical decision.

[*Translation*]

Mr. Claude Bachand: Personally, are you concerned about the use of drugs, specifically legal drugs, in theatre? I am not talking about persons who take illegal drugs. When a doctor recommends that a drug be prescribed to someone who is sent back to the theatre of operations, does that worry you, or does it come down to a purely medical decision?

[*English*]

LCol Simon Hetherington: I can start with this one just from a commanding officer's perspective, and it's exactly as General Grant has laid out. There's—again I'll use the term—a social contract, but it's more than that. It's laid out in regulations that the medical community or my medical officer is bound to give me the limitations of employment of the soldier under his or her care as well as potential return-to-duty dates. That's all. But all I need to know as a commanding officer is that.

So if a certain prescription has an effect that could affect a soldier's operational ability to do their job, my doctor has to tell me that. I don't need to know the drug or what the effects are.

[*Translation*]

Mr. Claude Bachand: In Canada or in Quebec, in the civilian world, when a person breaks a leg or an arm, as a rule, the employer does not challenge that obvious fact. However, a certain consolidation period applies, after which an administrative decision may be made to let that person go or to not take him back on.

I would imagine that this could also be done in the Canadian Forces. If a person breaks a leg in several places and cannot return to active duty, can he be discharged from the forces?

● (1715)

[*English*]

MGen Tim Grant: There is a policy called “universality of service”. In general terms, soldiers are expected to be at a minimum level of fitness and employability for operations. If a soldier does not meet that minimum standard, then there is the potential that they could be released at some point after that.

Mr. Claude Bachand: Is there a period of time for that?

MGen Tim Grant: No.

Mr. Claude Bachand: No.

MGen Tim Grant: I will say that the Canadian Forces is a selfless organization. We've invested a lot of time and effort in training soldiers and officers, and our aim is not to get rid of them. Our aim is to keep them and get them back to a healthy situation so we can employ them again. My experience is that we will often err on the side of the soldier more and more to make sure we give them absolutely every opportunity to get their health back so that we can get them back to work.

[*Translation*]

Mr. Claude Bachand: General, what you have just said also applies to PTSD. The individuals must be ready to resume active duty in less than six months, otherwise he is discharged.

In reality, the situation is quite different. You may be willing to have him back, but with certain limitations, provided he has achieved a minimum level of training and fitness. That is what you are looking for.

In case of PTSD, you try to reintegrate the soldier. If he cannot be reintegrated into a combat unit, for example, in the infantry, I gather you try to transfer him, perhaps to an administrative position. Is that in fact what happens?

MGen Tim Grant: Absolutely.

[*English*]

It's one of those things where we try to find where they can best be employed. And if they don't have the physical capability to be in the infantry, we can move them somewhere else. If their vision fails, it's the same issue. If they don't have the vision for a certain classification, we'll see if we can get them into a classification where their vision doesn't need to be as good.

It's across the board. Mental or physical, it's the same. The aim is to get them back to a healthy state so they can continue to contribute to the Canadian Forces.

The Chair: Thank you.

We've been through our pre-scheduled rounds here. I have just a couple of points before I ask if there's anything you'd like to add to wrap up.

I would imagine all three of you have been to Wainwright, the facility there. We're trying to get out there to have a look, just to see the value of that as it relates to preparing soldiers for what they will eventually see in reality.

Colonel Lavoie, you might want to comment on this. I think Laurie got into it a bit, about what actually happens on the ground and in battle, and the lessons learned there. Are they transferred back in a very quick manner to Wainwright to prepare the next people who will be going?

Col Omer Lavoie: Yes, sir, absolutely.

General Grant may be in a better position to answer, because he had a team of soldiers in Afghanistan as part of his task force who were often deployed forward with us and the other units. Their sole raison d'être was to be there to capture lessons learned and up-to-date changes in enemy tactics, techniques, and procedures, and to get those back to Canada and into the training system as fast as possible. So those experiences were learned and realized in Canada, and then subsequently incorporated into the training before deployment of the next set of soldiers coming over.

The Chair: General.

MGen Tim Grant: This is something that the army put in place. It was a team of three people: one who was technically qualified, an officer who could look at equipment; and an officer and an NCO who would look at tactics, techniques, and procedures—the way we did business in theatre.

They would look at every incident that transpired, or the vast majority of them—if there was a mine strike or if there was combat action—to see how we could get better, how we could learn from what we had done. The challenge was how quickly we could package those lessons up and get them back to the next unit that was going to deploy.

We're getting much better at that. We didn't used to do it; this is something that is new to Afghanistan. But it's paying huge dividends in getting the next rotation ready to go.

I look at my headquarters. It went in very quickly. I look at the headquarters that is currently there under General Laroche. It is much better than mine. And I look at the headquarters that will go in under General Thompson in about a month's time. His is even better still. So whether it's the headquarters or the soldiers down in the infantry companies, we are getting better because we're learning from our mistakes.

● (1720)

The Chair: Very good.

LCol Simon Hetherington: If I could add just one more thing to that, bringing it up one more level, in June of this year we're going to have the second annual army what we call after-action review, where the commanders from all levels—rifleman, tactics—are out in Wainwright, and the lessons learned.

We now bring it back to Kingston. So we're going to bring back the command teams from the missions in Afghanistan over the last year to come together in working groups and syndicates to take the greater lessons learned from their experience and again capture them to try to move them forward.

So this is an institutional process we've now taken on.

The Chair: Great. Thanks for that.

On a personal note, when we were in KAF we were briefed by a young man—I think Jim indicated he was a captain—who did the training on recognizing IEDs and a little bit of the disarming. How is that young man doing? Is he still active?

Hon. Joe McGuire: He was from Cape Breton.

The Chair: Oh, was he? Do you remember him at all?

MGen Tim Grant: I can see the face, but the name escapes me right now. If I can get the name, I can certainly look it up for you.

The Chair: He was a very intense young individual.

Mr. Claude Bachand: How about that young nurse?

The Chair: There was also a gunner in my Nyala. Her name was Tobi. I have a power point presentation that I put together after we came back. I've shown it to hundreds of people, and I always say she was cute but also dangerous, because she was a gunner.

Is there anything else you'd like to add before we conclude?

MGen Tim Grant: We appreciate talking about what is clearly an important subject to you and to us. Taking soldiers overseas into a combat mission is both an honour and a privilege. It is also a huge responsibility. Bringing those young men and women home is an equally big responsibility.

Do we have a perfect system to make sure no one falls through the cracks? We don't. Do we have a better system than we had in Bosnia? Absolutely. Our hope is that we will continue to make the system better, so that at the end of the day no one will fall through the cracks.

Some hon. members: Hear, hear!

The Chair: Thank you very much.

The meeting is adjourned.

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