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## Thursday, February 23, 2017

Chair

**Mr. Stephen Fuhr**

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● (1530)

[*English*]

**The Chair (Mr. Stephen Fuhr (Kelowna—Lake Country, Lib.)):** I call the meeting to order.

Thank you very much for coming to the defence committee today.

I would like to introduce Brigadier-General Hugh MacKay and Colonel Andrew Downes. Thank you very much.

Before we start with your opening comments on the “2016 Report on Suicide Mortality in the Canadian Armed Forces” and the ensuing conversation, I want to let the committee know our agenda.

We'll go for about one hour and 45 minutes, and then we'll suspend and go in camera for 15 minutes for committee business.

This has been working for me, so if you ever see this piece of paper come up, you don't have to stop immediately, but you have about 30 seconds to wind down on your thought because then I'm going to have to give the floor to somebody else, and it just makes it a more smooth transition. This paper is the 30-second warning.

Gentlemen, thank you very much for appearing today.

General, you have the floor.

**Brigadier-General Hugh MacKay (Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence):** Thank you very much, Mr. Chairman.

Mr. Chairman and members of the Standing Committee on National Defence, thank you for the opportunity to present the results of the “2016 Report on Suicide and Mortality in the Canadian Armed Forces”.

[*Translation*]

Every suicide is a tragic premature loss of life which we all mourn; it has far-reaching negative repercussions on the lives of family, friends, the military community, and health care providers. This is an issue that is of great concern to the military leadership, and has been a particular focus of attention within the health services group for many years.

[*English*]

The Canadian Armed Forces has a strong and comprehensive suicide prevention program, as noted by the 2009 Canadian Forces expert panel on suicide prevention, and the implementation of recommendations from that panel have enhanced it even further.

We have a nationally and internationally recognized resiliency training program called “the road to mental readiness” and a suite of health promotion programs that include such topics as stress management, addictions awareness, mental fitness, and suicide awareness. Those who are suffering with mental illness are at risk of suicidality, so it is critical that we get them the support they need and get them into care.

We have accessible primary care clinics on bases across the country and several overseas, most of which have a multidisciplinary team of mental health clinicians. We also have our seven specialized operational trauma stress support centres distributed across the country at our larger centres. We have implemented telemental health within the system to improve access to care from more remote locations, to provide care in the language of choice, and to help improve access to care. We have also installed virtual reality systems in our larger clinics to help better treat people with operational stress injuries, and we have implemented a project to include direct entry mental health notes into our electronic medical records.

Military personnel have access to support from the Canadian Forces members assistance program 24-7, or they can access emergency medical care at civilian medical facilities after clinic hours.

[*Translation*]

Mental illness and suicide are complex problems and, unfortunately, there is still much that we have to learn. So we conduct research to better understand the health issues within our Canadian Armed Forces population, like the 2013 mental health survey that was conducted on our behalf by Statistics Canada. We are also exploring new ways to improve the quality of care available in our clinics.

[*English*]

The Canadian Forces health services group tracks all suspected suicides and sends out a clinician team to gather information related to each case in order to better understand the circumstances surrounding the event and to learn lessons that may prevent future suicides.

Information gathered from this process and other sources is collated and analyzed annually, and a report is produced. The report we are discussing today is one of these, and it includes data from 1995 to 2015.

It's important to know that the analysis is done on data from regular force male suicides, as the number of regular force female and reserve suicides is too low for proper statistical analysis, and reporting on them could actually breach privacy rules.

● (1535)

[*Translation*]

We know that suicide is a multidimensional event in which many factors contribute. These include biological, psychological, interpersonal, and social-cultural aspects, and this complexity can make it difficult to predict who is ultimately going to die by suicide. Most people who die by suicide have symptoms of mental illness, and typically experience one or more acute stressors such as marital breakdown, or legal or financial problems. People in crisis feel overwhelmed and hopeless, and have trouble seeing a better way out of their situation.

However, there are some who show no signs of distress even to their closest friends. Thinking about suicide is not uncommon in people with mental illness, but most people do not act on these thoughts and reach out for help. I am saddened every time I hear of another suicide death, knowing that help was just a call away and knowing that we have the resources that could have saved their life.

[*English*]

The overall suicide rate in the Canadian Armed Forces is largely unchanged over the past 20 years. However, over the past five years we have seen a significant increase in the suicide rate specifically among those serving in the army command as compared to other commands, such as the air force or navy. The reasons are not fully understood, especially given that all elements of the Canadian Armed Forces share the same recruiting, administrative, and disciplinary processes and have the same health care system.

At the same time, though, we have noted a small increased risk of suicide in people who have a history of deployment and also in combat arms occupations. It is reasonable to hypothesize that these groups are at higher risk for psychological trauma during operations, which would increase the risk of developing mental illness. However, there may be other explanations that we have not been able to accurately measure, such as adverse childhood experiences, which we know to be higher in military members than in the general Canadian population. It is known to be a risk factor for both mental illness and suicide.

In looking at specific, diagnosed mental health conditions in those who complete suicide, depression and substance use disorder are seen most frequently, followed by anxiety disorders, with post-traumatic stress disorder being the fourth most common. This is important because it highlights the need for a broadly focused mental health program.

Within the Canadian Forces population, the most common life stressor that likely triggered the suicide was a failed intimate partner relationship. Other stressors associated with the suicides were work-related, debt, and legal problems. These suggest that the opportunities for early suicide prevention go far beyond health care. The Canadian Armed Forces does have many programs and services to help address these types of stressors. As is the case in the civilian community, about half of those who complete suicide are in care, but the other half are not. While the care available within our health services is central, there are also suicide prevention opportunities for leaders and peers to assist members in distress and to encourage them to seek care. The Canadian Army's sentinels program is one such example.

In summary, through ongoing suicide surveillance as well as through rigorous reviews of suicides, the Canadian Forces continues to evaluate and improve policies and procedures to refine its suicide prevention activities.

I would also like to add that we recently convened a second expert panel on suicide prevention. We are still awaiting the report, however, following that review of our suicide prevention activities. We also have work under way now to develop a Canadian Forces-wide suicide prevention strategy.

Thank you for your attention, and we are happy to take any questions you may have.

● (1540)

**The Chair:** Thank you for your comments.

I'm going to turn to floor over to Ms. Alleslev.

You have the floor for seven minutes.

**Ms. Leona Alleslev (Aurora—Oak Ridges—Richmond Hill, Lib.):** Thank you very much for coming today to explore such a significant and, of course, disconcerting topic.

You mentioned that you compare to the Canadian general population. Could you tell me why that might be, because I wonder whether or not the military is actually a reflection of the general population when we have such stringent intake procedures and screening? We don't take the full spectrum of the Canadian population into uniform, and of course we have a significantly higher training element through which we can influence the culture and society within the department. What is your thinking on that, and how are you making that comparison to the Canadian population?

**BGen Hugh MacKay:** It's a good question, and we realize that the Canadian population is not a perfect match for us to use, for some of the reasons you mentioned, such as the mental health screening that we do or the medical screening we do before they enter.

However, we feel that it's important to make a comparison, so we do try to do the best we can to make sure that the comparison we conduct is as close as possible, as close as can be made. We do adjustments in looking at the suicide rates within the Canadian population and match them for age, because age is a very significant factor as we look at suicide and the risk for suicide in the Canadian population. It's not perfect, and I recognize that, but we think that it's the best population we can use to compare ourselves against.

We've had a little bit of a look at what would happen if we removed the aboriginal population from that general Canadian population, because as we know, unfortunately the aboriginal peoples do have a fairly high suicide rate. They're a small percentage of the general population, and we've identified that even taking that population with such a high suicide rate doesn't really change the comparison for us too much.

**Ms. Leona Alleslev:** Do you make any comparisons with other comparable militaries?

**BGen Hugh MacKay:** At the present time, we are not making comparisons with other militaries. There is such a difference across the various militaries that it would be, we think, a worse comparison than comparing us to the population from which we actually recruit.

When you look at the different experiences on operations and at the baseline rates of suicide in the various countries that they recruit from, there are considerable differences. Even across Canada, you see differences from province to province to province that we really can't explain very well.

**Ms. Leona Alleslev:** Okay.

You mentioned that there is a slight uptick in the trend, particularly in the army. Can you give us some sense of this? Obviously we would hope that these numbers would be going down, particularly with all the measures you've put in place. We have increased measures, yet the rate appears as though it might be increasing. How are you measuring, then, the success of the programs against the actual outcomes of the suicide rate?

**BGen Hugh MacKay:** It's very difficult to measure programs that are trying to prevent things. Measuring what you have prevented is a challenge across any health jurisdiction.

We have seen an uptick particularly in the army. In the air force and navy, there was a bit of a decline in the suicide rate, and then it came back up and stabilized. We saw the increase in suicide in the army starting to surface around 2011 and 2012, and it has more or less stabilized now. We think that's there because of the impact of Afghanistan, and the impact that Afghanistan has had on mental illness across the army.

**Ms. Leona Alleslev:** Can you tell us if RMC cadets are included in these numbers?

**BGen Hugh MacKay:** Yes, any suicide, including RMC cadets, will be included in these numbers.

● (1545)

**Ms. Leona Alleslev:** Are veterans, people who have taken their release, also included in this number?

**BGen Hugh MacKay:** These numbers do not include the veteran population. They're strictly based on serving members.

**Ms. Leona Alleslev:** Are you looking at some kind of joint study with veterans to be able to understand that bigger continuum? It's quite possible, I would presume, that some of the conditions that might have led to the suicide might have actually occurred while they were in uniform. Even if the outcome wasn't recognized while they remained in uniform, it might still inform and would also perhaps give us a different perspective on the statistical relevance of the sample size. Would that be something you have been considering?

**BGen Hugh MacKay:** We have been working with Veterans Affairs. The first time we did a report that included veteran population suicide rates was a Canadian Forces cancer and mortality study that we did. That was the study in which we identified that there was perhaps a 1.5 times greater risk of suicide in veterans.

We continue to work with Veterans Affairs to try to enable them, using a database we've built that includes everybody who joined the Canadian Armed Forces from 1972 to today, and we add to it every year for all the new recruits. We're building and helping them maintain that database, and then we use mortality data from Statistics Canada to see what's going on with rates of suicide in the veteran population.

We collaborate with them frequently, and we are collaborating with them in the development of a joint Canadian Armed Forces and Veterans Affairs suicide strategy. Part of that will be examining where we need to go next and examining what's going on with suicide in veterans—not us, but helping Veterans Affairs where possible in looking at what's going on with suicide in the veteran population.

**Ms. Leona Alleslev:** Thank you.

I think I'm out of time.

**The Chair:** You are.

Ms. Gallant, you have the floor.

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

What is the authority that the surgeon general has over military doctors? Is that a chain of command? Are they answerable to you for the different diagnoses? How does that work?

**BGen Hugh MacKay:** At the present time, there isn't a clear delineation of my authority over clinicians with respect to the work that they do, in fact. Primarily, my authority is through the chain of command at the present time.

**Mrs. Cheryl Gallant:** Okay, so the clinicians are not answerable to you.

**BGen Hugh MacKay:** The clinicians are answerable to me through the chain of command, yes.

**Mrs. Cheryl Gallant:** It's through the chain of command. Okay.

I noticed that when you were listing out the different causes and potential causes resulting in suicide, or the contributing factors, you didn't mention traumatic brain injuries or brain stem damage resulting from neurological toxicity that, in turn, arises from mefloquine. Has there been no evidence to that effect, that among the suicides there is an increase in the proportion of people who've taken this? Is there no positive correlation?

**BGen Hugh MacKay:** We have seen no evidence to date of mefloquine's relationship to suicide. In fact, if you look at our current data with respect to our mefloquine use and our data on suicide statistics, starting in 2003 the use of mefloquine in the Canadian Armed Forces started to decline from about 85% to where it is today, at about 5%. The curve on use of mefloquine was going this way. When you look at the curve for suicide in the Canadian Armed Forces, we started to see the rise in suicide in the army starting in 2006. You have a curve of mefloquine use going down this way, and suicide going up this way. I know it's a crude comparison, but if there really was a strong linkage between mefloquine and suicide, you might not have expected to see opposing angles on those curves.

**Mrs. Cheryl Gallant:** Unless there's a latent effect and it's more predominant the more it's taken, and with consecutive deployments.

What protocol is in place to ensure that forces members give informed consent for vaccinations when they're being “dagged” in preparation for deployment? Do soldiers know what they're being vaccinated with when they're preparing for deployment?

● (1550)

**BGen Hugh MacKay:** When soldiers are vaccinated for deployments, yes, they meet with a clinician and are advised on what the vaccines are. We do a screening for contraindications, allergies, and those kinds of things. They don't necessarily sign an informed consent, but the discussion is with their clinician as to whether or not they want to receive the vaccine.

**Mrs. Cheryl Gallant:** As of April 2014, 434 of the established 455 mental health professional spots had been filled in the Canadian Armed Forces, or about 95%. Has that number reached 100% yet, or has it gone down from the 95%?

**BGen Hugh MacKay:** The percentage of positions filled fluctuates. It is nearly impossible to reach 100% and sustain 100%, just because of the natural turnover of staff, which goes on in every organization. Right now I believe we're sitting at about an 8% vacancy rate, of which about 7% are clinical care providers.

**Mrs. Cheryl Gallant:** I know that locally, in Petawawa, a couple of months ago we were at the point where we had no psychiatrists available to treat the soldiers there. Has that situation improved?

**BGen Hugh MacKay:** I'll ask Colonel Downes.

**Colonel Andrew Downes (Director, Mental Health, Department of National Defence):** Perhaps I can just chime in on that. I'm not sure exactly of the circumstance you're speaking about, because we do have a full-time military psychiatrist there and she's still there now. There are also civilian psychiatrists who work in the clinic. I'm not sure if there was perhaps a gap while people were on leave or something like that, but there has not been a time when there were no psychiatrists in Petawawa.

**Mrs. Cheryl Gallant:** What number of people in JPSUs are being treated for OSIs now? I'd like a percentage, not an exact number, because you wouldn't have that. It changes from day to day.

**BGen Hugh MacKay:** I don't know if I have a percentage.

**Col Andrew Downes:** JPSUs, as I think you know, are not part of the health care system. These are organizations that exist to support members when they're ill or injured. We don't necessarily have visibility on who's posted there and what the specific diagnoses are. We continue to provide them with care, regardless of the reason that brings them to the JPSU.

**Mrs. Cheryl Gallant:** Across the forces, what number of psychiatrists and psychologists are available to the Canadian Forces members?

**Col Andrew Downes:** I don't have the exact number in my mind, but we have more psychiatrists per capita in the Canadian Forces in our clinics than there are in the civilian sector.

**Mrs. Cheryl Gallant:** From the political level, what could we be doing to lower the rate of suicides in the Canadian Armed Forces?

**BGen Hugh MacKay:** I'm not sure it's my place to advise you, from a political level, as to what you can or cannot do.

**Mrs. Cheryl Gallant:** Okay.

One of the recommendations the military ombudsman made was that:

> ...the Canadian Armed Forces retain medically releasing members until such time as all benefits and services from the Canadian Armed Forces, Veterans Affairs Canada, and Service Income Security Insurance Plan have been confirmed and are put in place.

Part of that would be to allow the findings of the clinicians. When they determine that somebody has to medically release and that the injury was as a consequence of service duty, he's recommending that this adjudication apply for their back pensions, their medical pensions. Right now, upon release, they have to apply to Veterans Affairs for the different benefits, so there's a gap.

In essence, they've been evaluated by a military doctor, but then upon their release or upon their trying to apply for veterans benefits, they have to go through another system and prove to a Veterans Affairs doctor that this injury was indeed as a consequence of service.

Do you see any reason that we couldn't use the evaluations of the military clinicians for the purposes of the pension adjudication?

**BGen Hugh MacKay:** It is not exactly as you have presented it, in that physicians in the military evaluate employment limitations. They don't make a decision as to whether or not it's going to result in somebody being released. It's the DMCA that makes that decision. Our physicians don't actually make a decision with respect to attributability to service at the present time. We diagnose, and we advise on employment limitations at the present time.

● (1555)

**The Chair:** That's your time, Ms. Gallant.

Mr. Garrison, you have the floor.

**Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP):** Thanks very much, Mr. Chair.

Thanks to our witnesses for being here today.

I'm going to start by saying something I know I've said before. I think the Canadian military is ahead of a lot of other sectors in our society in tackling some of the difficult questions, whether it's sexual misconduct or suicide, so I want to give credit to the Canadian Forces for doing that.

That said, then you get held to a higher standard. When others don't address these problems, they can throw up their hands and say they don't really know the nature of the problems. Now I'm about to hold you to the higher standard you established for yourself.

I want to go back to the question of health professionals. It seems, over the last couple of years, that the record on filling the vacancies has improved. If so, if that's true, can you tell me why that's so?

**BGen Hugh MacKay:** I think we went through a tremendous effort probably three years ago to try to create staff pools to fill the types of positions that we needed to fill. We had the approval authority for hiring delegated down, actually, to the individual who preceded Andrew in the position of director of mental health. We still need to have our contracted third party service provider provide us with some of the health care providers. We, quite frankly, have had very long discussions with that contractor to encourage the contractor to find innovative ways to find us the health care providers we need to fill those positions if we can't fill them with public servants.

**Mr. Randall Garrison:** That's what I was hoping you would say. That was my understanding, that there was a really concerted effort that had begun. For a long time there were a lot of underfilled positions, and from my understanding in talking to people in the mental health positions, there were people who were doing jobs that were beyond their formal qualifications. That's not to say they were doing a bad job, but I wonder whether that problem still exists.

**BGen Hugh MacKay:** I'm not aware that it ever happened.

**Col Andrew Downes:** I'm not aware of anybody who has been working beyond their scope of practice. If there have been cases where that has been identified, the leadership in the clinic would take care of that.

We have a very well-trained workforce. As we've discussed, within our clinics the staffing levels are good. Obviously we'd love to have 100% staffing, but that just is not a realistic thing in any organization, because as soon as you hire one person, somebody somewhere else leaves.

We demand a high standard and a high level of training and experience for the people working in our clinics.

**Mr. Randall Garrison:** I'll stand corrected on the question of the underfilled positions.

In terms of retention, I know that if you go back three or four years, there was a huge problem with retention of mental health professionals. There was a bit of turnover, which I think exacerbated the problems of filling vacancies. How are we doing on retention at this point?

**BGen Hugh MacKay:** With respect to our civilian workforce, I think we're doing not too badly with retention. We still have challenges with filling civilian psychologist positions and having them stay with us.

From a military uniform perspective, we have challenges with our uniformed physician cadre, in that attraction and retention have become an issue for us. We are working hard to look at ways that we might be able to improve both the attraction and, more importantly, the retention, because once we get them trained up and experienced, we want to keep them.

**Mr. Randall Garrison:** I'm asking all these questions leading up to one of the concerns I've heard locally, which is that for people with mental health problems, the relationship with the mental health professional is very important. In terms of stability and even in attracting people into treatment, you need that stability of personnel. I know the military has a challenge with that because of the rotation of service and deployments and all those kinds of things. What's being done to make sure there can be that consistency of treatment for those who need it?

● (1600)

**BGen Hugh MacKay:** One of the important initiatives we launched a couple of years ago was the actual creation of the electronic mental health notes. Up until just two years ago, notes were not necessarily available in the electronic health record. Now we know that if somebody goes from one location to another or is deployed for some reason, the caregivers who are there are able to access what has gone on before with the care of that individual. There may not be that same clinician in front of the individual, but they will at least know what has gone on before with his or her treatment.

**Mr. Randall Garrison:** I'm glad to hear that. From my understanding, that's a significant improvement.

My other question is, are you facing particular regional challenges in filling these jobs? I'm from British Columbia, and I know sometimes we've been told that it's harder to fill the positions there, where costs of living are higher and where there are more opportunities for people with the same skills.

**BGen Hugh MacKay:** When I last looked at the data for vacancies in positions, they're fairly evenly distributed across the country.

Is there an issue in Quebec City sometimes, perhaps?

**Col Andrew Downes:** Quebec City hasn't been a particular issue, although at every clinic from time to time we might run into a difficulty in finding individuals.

For example, at CFB Shilo we went a couple of years without having a psychiatrist on base. It was not for lack of trying, just for lack of availability, but we've since been successful in filling that position.

**Mr. Randall Garrison:** I'm getting the signal that I'm getting close to the end here, so I have one final question.

For those who may have been receiving treatment or were being monitored for mental illness and who then left the services, are we making sure that this information somehow gets passed along so they get the services they need as a veteran?

**BGen Hugh MacKay:** Everybody who leaves the service now gets a copy of their medical record so that they have that available to carry with them to their next health care provider. We do work very closely with Veterans Affairs now, so if they're going to be a Veterans Affairs client, that information will have been transferred through to Veterans Affairs as well.

**Mr. Randall Garrison:** Thanks very much.

**The Chair:** Thank you.

Mr. Robillard, you have the floor.

[*Translation*]

**Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.):** Thank you, Mr. Chair.

Welcome, Mr. MacKay, and thank you for your testimony.

I will ask my questions in French.

In recent months and years, a most pressing question has been about the difficulty that former members of the Canadian Armed Forces experience in making a smooth and effective transition from military life to civilian life. But it now also seems, in the light of the recent cases of suicide among new members of the armed forces, that the transition from civilian life to military life also presents our young recruits with significant challenges.

Can you tell me if any thought has been given to people making the transition from civilian life to military life? If so, can you tell me the precise aspects that you are currently exploring? In your view, what possible solutions could we look at to better prevent cases of suicide among our recruits?

**BGen Hugh MacKay:** Thank you for those questions. It is easier for me to answer them in English. My apologies.

**Mr. Yves Robillard:** No problem.

[*English*]

**BGen Hugh MacKay:** It's a good question. It is quite a transition that one undertakes, going from civilian to military life.

One of the things we have introduced into the recruit training—I believe it happens in week two—is that they undertake a program called road to mental readiness. In addition to their learning about the culture as they go through their basic training, we also address with them knowledge about mental illness and strategies to deal with stress.

I believe we are starting to see some success with the introduction of this program at the recruit schools, in that we seem to be seeing a bit of an increase in the success of recruits going through the school. We sensitize them to their own reactions to things and help them understand where that might place them on what we call the continuum of mental health. We have it colour-coded, so as they reach different stages, they can realize that perhaps it's time for them to go and seek some assistance to deal with the stresses they may be facing or the symptoms they're experiencing.

● (1605)

[*Translation*]

**Mr. Yves Robillard:** We know that funeral expenses for former CAF members are fully reimbursed, albeit with certain conditions, by the Last Post Fund. We also know that the military is looking to rectify omissions in awarding medals and other delays in cases of death by suicide.

What happens with suicides of members of the forces who have not been deployed? Without going into specific cases, what happens with new recruits to the forces?

[*English*]

**BGen Hugh MacKay:** The issue of funerals, honours, and awards is not a situation that I deal with as the surgeon general. I know that they are looking at reviewing those who have passed on by suicide. What we face is a very difficult issue. Because of the multifactorial causation of suicide, it is not easy to say, when somebody takes their own life, just what it is that has actually contributed to that decision. Sadly, there is much that we need to learn about suicide in order to understand what brings people to that decision.

[*Translation*]

**Mr. Yves Robillard:** As mentioned in the mandate letter for the Minister of Veterans Affairs, our government has promised to re-establish lifetime pensions as an option for our wounded veterans. The promise was repeated by the Prime Minister during his cross-Canada tour in January.

Where does the implementation of that policy stand today? Are you facing any obstacles with it?

[*English*]

**BGen Hugh MacKay:** Again, this is a question on a Veterans Affairs issue, so I am not in a position to comment on that. I am not involved in trying to create the policy.

[*Translation*]

**Mr. Yves Robillard:** Here is my last question.

What do you think about the first recommendations in the ombudsman's investigation into the cadets, which reads as follows:

> …that, in the event of an illness or injury arising out of an approved cadet activity, the Department of National Defence and the Canadian Armed Forces ensure that cadets are compensated and supported in a manner that is commensurate with the compensation and support available to members of the Canadian Armed Forces.

[*English*]

**BGen Hugh MacKay:** Again, my mandate is to provide health care for those who are ill and injured. We do provide health care for cadets who become ill or are injured while they are attending cadet camps. We also sustain that health care until the other programs are in place. This is an insurance program that is available to them to continue on with health care for their illness or injury. We provide the care and ensure that the transition to their civilian health care providers is smooth.

**Mr. Yves Robillard:** Thank you.

**The Chair:** Thank you.

We're going to go to five-minute questions.

Mr. Spengemann, you have the floor.

**Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.):** Thank you, Mr. Chair.

Thank you very much, General MacKay and Colonel Downes. Thank you for your service. Thank you for being here and for your important work.

I want to touch upon an issue that you addressed briefly in the written submissions, and that's our reserves.

This committee has received evidence from other witnesses on the state of our reserves. Mr. Robillard just made a comment in terms of the difficulties for people transitioning from civilian to military life. For reservists it can be even more challenging to do this repeatedly, especially for reservists who are employed in overseas combat operations. A significant percentage of folks who fought in Afghanistan were, I'm told, reservists.

Are there special considerations, special factors, for reservists with respect to mental health? What is the suicide risk? Is the transition to civilian life on an ongoing basis, on a repeated basis, a positive factor, or does it represent an additional challenge that has its own complexities?

● (1610)

**Col Andrew Downes:** Would you like me to answer that?

**BGen Hugh MacKay:** Sure, go ahead.

**Col Andrew Downes:** It's interesting to consider the situation of reservists. In many ways, reservists actually have an easier time because they're returning to communities where they have established support networks, where they have health care already set up, where their families are already well integrated. Regular force members may return from a deployment and be moved to another location, and so they face the upheaval of a move.

We know from our mental health survey that in many ways reservists have mental health concerns that are very similar to those of members of the regular force. We will offer programs and services to reservists for illness and injuries related to military service. If they are injured physically or mentally, we will provide care where we can, keeping in mind that some reservists live in communities where we don't have a base or a clinic.

Reservists also are entitled.... Because they have health cards, their primary health care needs are met through the civilian provincial health care systems. In a way, they have more choice and opportunity open to them. We certainly will provide and top up any care that they need that they aren't otherwise able to get through their normal system.

**Mr. Sven Spengemann:** That's very helpful. Thank you, Colonel.

I'll delegate the rest of my time to Ms. Romanado, Mr. Chair.

**Mrs. Sherry Romanado (Longueuil—Charles-LeMoyne, Lib.):** Thank you.

Thank you both for your service. It's a delight to be back at this table.

I'd like to talk a little bit about the mental first aid training that is provided, often through the military family service centres. Often serving members who are struggling are a little fearful about coming forward, especially with respect to mental illness out of a fear of stigma, universality of service issues, and so on and so forth.

What are you doing to work closely with the families who are seeing their loved ones struggling at home, self-medicating in the basement, and so on? What is it that you're doing to make sure that the families are equipped to be able to recognize, help treat, and get the help that our members need?

**BGen Hugh MacKay:** Most of that work is not the work that we do, but we do work with the military family resource centres to help them to understand the military member's life and what they might expect to be able to see.

The other thing that we do is try to have patients allow us to engage with their family members in their care because we view that as important. Unfortunately, as there are privacy regulations, should members not agree to have family members as part of their care, then it's difficult for us to engage directly with the family members. We're certainly always open if family members want to come forward and tell us what they're seeing so we can use that in our decisions about the clinical care of their loved ones.

**Col Andrew Downes:** If I may just add to that, our road to mental readiness program does have a module for family members through which they receive similar education and language around the mental health care that we provide to the service member.

**Mrs. Sherry Romanado:** My colleagues actually touched on this.

My son lost two classmates at RMC last year. Do you have statistics in terms of when, during their service, members are more likely to decide to take their own life? We're seeing it at the beginning of their service when they're transitioning from civilian. We see it after combat, according to your details. Are we seeing it after they've been ill or diagnosed as ill and injured? When is it happening in the career? Is it happening in theatre? Is it happening all over the place? We're just not sure when it's happening in the career so that we can identify some potential stressors there or make adjustments and make sure the supports are there. Do you have that information?

**BGen Hugh MacKay:** What we've seen from our medical professional technical suicide reviews doesn't really reveal that it happens in any particular place in a career. We're seeing that it happens broadly across the career timelines.

● (1615)

**The Chair:** I'll let us circle back on that, because we're out of time.

I'm going to have to yield the floor to Mr. Paul-Hus.

Go ahead, Mr. Paul-Hus.

[*Translation*]

**Mr. Pierre Paul-Hus (Charlesbourg—Haute-Saint-Charles, CPC):** Thank you, Mr. Chair.

My thanks to the brigadier general and the colonel for their remarks.

I would like to go back to the primary causes of suicide. In your presentation, you mentioned various causes. You said that the main cause is a breakup with an intimate partner.

Having served during two operational deployments, I know that we sometimes wondered who would be the first to be left by their spouse. Between 50% and 60% of the members of the battalion went through breakups during the mission. During missions, the pressure is enormous because of those domestic partnership issues.

It is easy to think that the deployment produces combat-related post-traumatic stress, but can the pressure that comes from one's personal life also have a devastating effect on forces during deployment?

Can the family centres on military bases really provide effective assistance in preventing suicides with support to spouses, so as to prevent, or help to prevent, breakup situations?

[*English*]

**BGen Hugh MacKay:** One of the results of the reports we've put together has led to a project within the Canadian Armed Forces called the journey. In the journey, we're trying to look at how we can address all of these items that we see as potential triggers. We do believe that if we can engage with the partners early on, we can help them to address the issues that are creating the stress in that relationship, help them to either stay together and work together or to find a way to separate in a way that is not so stressful and might otherwise cause one to undertake such a thing as committing suicide.

[*Translation*]

**Mr. Pierre Paul-Hus:** As Surgeon General of the Canadian Armed Forces, do you work with the family centres or are they completely independent entities? I am not talking about your chain of command. Do you have a direct involvement with family centres?

[*English*]

**BGen Hugh MacKay:** The military family resource centres are independent entities, but they report to my commander, Lieutenant-General Whitecross, commander of military personnel command, and they report to a colleague of mine, Commodore Sean Cantelon. We get together on a weekly basis. We talk about what's going on in the centres and we are able to collaborate and work together.

One of the perfect examples has been with the family violence prevention program. We have a very close relationship with them with respect to family violence.

[*Translation*]

**Mr. Pierre Paul-Hus:** Thank you.

My second question goes to you, Mr. MacKay, as Surgeon General of the Canadian Armed Forces.

Knowing that there are drug use problems in the Canadian Forces —it's a management problem involving various cases—what is your opinion about legalizing marijuana?

[*English*]

How do you see that?

**BGen Hugh MacKay:** We have done some studies—not us in the medical side, but the chain of command—to look at the use of marijuana in the Canadian Armed Forces. It is being used as a recreational medication, but it's a small percentage of military members who are using marijuana recreationally.

If you're asking me for my opinion with respect to it as a medication, at the present time I do not believe that there is enough clinical evidence to support us using marijuana to treat most of the types of illnesses that we are addressing in our military population. We do not prescribe marijuana in treatment. We look for alternative treatment methodologies.

[*Translation*]

**Mr. Pierre Paul-Hus:** In terms of potential legalization, which would allow members of the military to obtain marijuana, do you see that positively or do you believe that it is really not appropriate?

[*English*]

**BGen Hugh MacKay:** Once again, it's not a question for me. That's a question for the chief of the defence staff and the chain of command, because it really will be something that the chain of command is going to have to tackle. I think the use of any substance is something that you need to consider very carefully.

● (1620)

[*Translation*]

**Mr. Pierre Paul-Hus:** Thank you.

[*English*]

**The Chair:** Mr. Fisher, you have the floor.

**Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.):** Thank you very much, Mr. Chair, and thank you, gentlemen, for being here today with us to share your expertise.

I want to talk a little bit about mefloquine again. Ms. Gallant had some of the same questions I have.

You had talked about a decrease in use. Can you describe that decrease? Is that a minor decrease, or is it a massive decrease in use?

**BGen Hugh MacKay:** Yes, it's a very large decrease in use. In 2003, the medication called malarone became licensed. Starting in 2003, we started to see a decrease in mefloquine use. It had been sitting around 85% of prescriptions for anti-malarial medications, and it has decreased down to less than 5% today. Malarone use, which was maybe 5% or 10% at that time, has now increased to between 80% and 85% of the anti-malarial medication that we are prescribing.

**Mr. Darren Fisher:** Thank you.

Do soldiers know what they're taking? You touched on it with a couple of other questions. If they're still on mefloquine or if they're on a new drug, are they told about some of the potential side effects very clearly? Has that always been the case or is that something new, since they've seen what mefloquine can do?

**BGen Hugh MacKay:** I'm sorry, but I don't remember the date when we actually formalized the process. However, for many years now, before a member is given an anti-malarial medication and if there are a large number going out, they may receive a briefing on each of the anti-malarial medications, informing them about the potential side effects and the potential contraindications to using those medications.

They fill in a questionnaire that would help the clinician to identify whether they may have contraindications to the use of mefloquine and then they have a discussion with the clinician regarding which is the best anti-malarial medication for them.

**Mr. Darren Fisher:** You're doing a review on mefloquine right now, right? Are you finished it?

**BGen Hugh MacKay:** That's correct.

**Mr. Darren Fisher:** Will that report become public soon? Are you suggesting that it be banned?

**BGen Hugh MacKay:** I haven't made a formal policy recommendation yet. The report from the task force is under study right now. I anticipate that before the end of March I will be able to formulate a policy recommendation with respect to our anti-malarial use.

**Mr. Darren Fisher:** The one that's being used by 85% now, is it called malarone?

**BGen Hugh MacKay:** Yes, that's correct.

**Mr. Darren Fisher:** Do you foresee any future side effects? Has that been tested more extensively than mefloquine was? Are there any early signs of side effects?

I'm sure there's probably no chance of having a drug that has no side effects at all that would also take care of malaria.

**BGen Hugh MacKay:** To my knowledge, there are no medications that don't have any potential side effects. If you look at all three of the choices that we have for anti-malarials right now, you see that there is a long list of potential adverse effects from each of them. All of them have gone through the Health Canada licensure process and have met the Health Canada regulatory requirements for marketing within the country with respect to safety and effectiveness.

**Mr. Darren Fisher:** Thank you. I understand that mefloquine was convenient to take because it was a once-a-week pill as opposed to a pill that had to be taken every day. Has cost ever been a factor in mefloquine being the drug that the CF chooses or that they recommend the soldiers take?

**BGen Hugh MacKay:** The cost is—

**Mr. Darren Fisher:** It's considerably cheaper, right? My understanding is it's considerably cheaper than some of the alternatives. I don't know if that's....

**BGen Hugh MacKay:** Malarone is the most expensive medication of the three choices. I can't remember.... Mefloquine may be a little bit more expensive than doxycycline on a per-person basis, but cost has never been a factor in our recommendation.

**Mr. Darren Fisher:** Thank you.

Do I still have some time?

**The Chair:** You have about 30 seconds for a question and response.

**Mr. Darren Fisher:** Who can go to an OTS clinic? Is it uniformed soldiers, is it veterans, is it both?

**BGen Hugh MacKay:** You're speaking of our operational trauma stress support clinics. We have an MOU with Veterans Affairs that it is there for Canadian Forces members, but we can take veterans into our—

● (1625)

**Mr. Darren Fisher:** Do you? If someone is suffering from PTSD 10 years after leaving the forces, do they have the ability to go to the OTS?

**BGen Hugh MacKay:** They do, yes. We have had patients that come in.... We have benefited more from the MOU in that when we had a problem with psychiatry in Shilo, we were able to use the operational stress injury clinic that Veterans Affairs has in Winnipeg to get good care for our military members. It's a reciprocal agreement that we have with Veterans Affairs.

**Mr. Darren Fisher:** I look forward to March and your report on mefloquine.

Thank you very much. Thank you, Mr. Chair, for the extra few seconds.

**The Chair:** It was a pleasure.

Mr. Bezan is next.

**Mr. James Bezan (Selkirk—Interlake—Eastman, CPC):** Thank you, Mr. Chair.

We just witnessed the end of sunny ways.

**Some hon. members:** Oh, oh!

**Mr. James Bezan:** General, Colonel, thanks for joining us today.

I want to follow up on Mr. Fisher's question about mefloquine. We're about to send troops to Africa on a UN mission. Are they going to be given anti-malarial drugs? How do we determine which anti-malarial drug we will give them?

**BGen Hugh MacKay:** Every time we go on a deployment into a region, we will look at whether or not malaria is a threat. We don't know where we're going yet, so when that is determined, we'll do an evaluation. If malaria is a risk to our members, then we will recommend anti-malarial medications. At the present time, we are using the current recommendations, but as I said, I'm studying a report right now to look at what my policy recommendation is going to be.

**Mr. James Bezan:** In the past when we have had to deal with malaria, was mefloquine at any point in time given on the basis that it was easier to administer, since it's only once a week versus a daily dosage with other medications? Would the chain of command ever order that mefloquine be the chosen drug? Could it happen that the troops actually weren't given a choice?

**BGen Hugh MacKay:** To my knowledge, there has never been an order as to which medication needs to be taken for anti-malarials.

I'm sorry; the first part of your question was...?

**Mr. James Bezan:** It was whether the chain of command made the decision and if it was easier to administer.

**BGen Hugh MacKay:** We have, in the past, looked at mefloquine as having a benefit in that it is a once-a-week medication, and what we knew of its side effect profile compared favourably—before malarone was available—to the doxycycline, which has problems with sun sensitivity and people getting significant sunburns if they take it. When you looked at the side effect profiles known at the time, and the convenience....

There's an added protective factor because it's once a week. If you miss a pill of doxycycline one day and you are exposed to malaria, you can get malaria. If you miss your mefloquine pill and take it the next day, the likelihood of your getting malaria if you were bitten by a malaria-infected mosquito the day you forgot your pill is far lower, because the mefloquine is still in your system to protect you. That once-a-week protection factor was part of the consideration in recommending mefloquine.

**Mr. James Bezan:** I want to switch gears a bit and go back to the mental health side of this.

The road to mental readiness program is very well used, and the Canadian Armed Forces are a leader in it. Are we still actively doing road to mental readiness with all our troops, including those who are going to sea or in the air force?

You also talked about the continuation and the continuum of other programs. Is that a follow-on to the road to mental readiness program? How often do we reach out to the men and women in uniform to ensure that they're always doing the self-assessments, assessing their colleagues, and monitoring mental health in their brigade?

**BGen Hugh MacKay:** Colonel Downes may be better placed to answer the question of how often people are getting exposed to the road to mental readiness training right now.

**Col Andrew Downes:** Certainly, I'm happy to answer that.

Road to mental readiness is really a suite of about 36 different programs, I think. The first module, as General MacKay already mentioned, is given during basic training. There are other modules that are given at different stages in an individual's career as they move up in rank. There is a module for people when they're going on deployment, there's a module when people come back from deployment, and we've also recently started focusing on certain occupations. For instance, we've developed a road to mental readiness program for search and rescue technicians, for military police. We've incorporated very particular aspect stressors and so on that are unique to those particular groups.

Road to mental readiness training is something we've tried to infuse throughout somebody's career. We're continuing to extend the reach of it, and also the breadth of it in terms of getting people exposed to it as often as possible.

● (1630)

**Mr. James Bezan:** Okay.

**The Chair:** Thank you.

Mr. Ellis, welcome to the defence committee. You have the floor.

**Mr. Neil Ellis (Bay of Quinte, Lib.):** There was a question asked about comparisons with other military forces, and your answer was no. I just wondered when I looked at the statistics. You said, I think, that marriage and debt were the number one and number two contributing factors.

Have you even looked at what other countries do in order to try to alleviate those stressors through comparable programs? You're saying in your notes that the number one cause is marriage. The other one was debt, and I think the third one was prescription drugs or....

**BGen Hugh MacKay:** We haven't looked at this particularly from a health services perspective, but I know that within military personnel command they have close relationships with other military and look at the programs they have in place to help address the kinds of stressors that go on in military life.

**Col Andrew Downes:** Our 2009 expert panel specifically looked at the U.S. Air Force program, which is one of the few programs that actually showed a reduction in suicide rate. Even at that time, we had nearly all of the components of that program. We've included some of the others and done other things as well to enhance what we currently do for people.

**Mr. Neil Ellis:** Okay.

I'll go back to the mefloquine question.

You testified in the VAC committee, and I think you were asked about the percentage of the affected population it would have side effects on. I think the statistic was about 2%, off the top of my head. Does that number include the side effects for people who actually shouldn't take it? I don't know if I'm trying to pull that from your testimony.

I can just ask you that question, I guess. On the side effects, what's the percentage...?

**BGen Hugh MacKay:** There are different side effects.

One of the numbers that I spoke to was a number related to significant neuropsychiatric side effects and prolonged neuropsychiatric side effects. The number that we have is somewhere between one in 10,000 and one in 12,000 who may have that significant neuropsychiatric side effect.

We know a greater percentage of people have other, lesser side effects that are short-term types of side effects, whether it's some dreams associated with taking the medication or not. I don't have that number in my memory right now, but it is far more than the one in 10,000.

**Mr. Neil Ellis:** Okay.

An interesting part of the stressors had to do with legal aspects and debt. Do we offer any type of counselling or programs in that suite to families and to the men and women who do serve?

**BGen Hugh MacKay:** Yes, we've always had a program for those who get into financial difficulty to have the opportunity to seek financial counselling through our SISIP financial counselling program.

When it comes to legal problems, we've identified one thing that is really important. When we know someone has gotten into some legal difficulty, there is a handover of that person to their chain of command so that the chain of command is aware and they aren't able to go off on their own. Then, of course, they are able to seek assistance through assisting officers within their units.

● (1635)

**Mr. Neil Ellis:** I guess the other correlation is age. You have it in a graph here. Since you tracked that, I looked at the dates and I think it's more towards the younger end of our military. The numbers were higher in that range.

Is there anything geared towards prevention in that age group? If we're chasing something and it's more prevalent at the age of 21 or 22, as I think I read in your notes, are we targeting that area more than towards the age 40 range?

**Col Andrew Downes:** Suicide in 15- to 34-year-olds in Canada is the second leading cause of death in males. We're talking about the young military male population group of people. Suicide is a very common phenomenon in terms of cause of death.

We haven't specifically targeted them based on age, but as we've discussed, we do have mental health education programs right from the second week of basic training. We have a communications plan every year that includes messaging that we send out through tweets and email. We run campaigns. We have an annual addictions campaign. We participate in Bell Let's Talk. We participate in Mental Illness Awareness Week, World Suicide Prevention Day, and so on.

We have a suite of things that we provide to try to communicate down to all members of the Canadian Forces about mental health, the issue of suicide, care-seeking, and staying in care.

**Mr. Neil Ellis:** Did you mention apps?

**Col Andrew Downes:** Thank you, sir. I haven't mentioned apps.

We are working on a road to mental readiness app that we're hoping now will be ready for launch in May. We're hoping that appeals to young members of the Canadian Forces.

**The Chair:** You're out of time.

We're going to be able to go around the track one more time for sure. I'm going to give the last formal question to Mr. Garrison.

You have the floor.

**Mr. Randall Garrison:** I'll pass on this one, and we can go back.

**The Chair:** Do you want to pass it back to Mr. Ellis? He can continue for three minutes.

**Mr. Randall Garrison:** Sure. He's new.

**Mr. Neil Ellis:** Going back to your app, I know some of the municipalities and the provincial level are offering a wind-down or a chat after a traumatic incident, whether it's an ambulance driver or whether it's a firefighter. Some of these programs are actually homegrown in municipalities and counties.

After a deployment—it doesn't even necessarily have to be a deployment, but could be an accident at a base and somebody has to clean up the aftermath or see it—are we doing prevention that way and putting any resources or money or anything in the way of a program or a wind-down after these events?

I know a lot of fire and ambulance services are doing that on a regular basis. Have you explored that, or do you have that process?

**Col Andrew Downes:** We have that. We call it an “ad hoc incident review”. After a potentially traumatic incident there will be a discussion of the event led by the chain of command and an opportunity for people to speak about it, and information is shared with them about where to go for care should care be required. It's a formalized part of the road to mental readiness program.

**Mr. Neil Ellis:** Is it compulsory?

**Col Andrew Downes:** It's at the discretion of the leadership of the organization to decide when it's appropriate to do that. In some incidents it would be very obvious to do, but then there might be some incidents where the leadership and members of the unit would have a sense as to whether something such as that is necessary. However, at all times people are invited to come forward for care, because they might have been exposed to a traumatic incident outside the workplace.

Keeping the door open and encouraging people to seek care for any type of mental health problem is really the way to go, because we treat all mental health issues, not just those related to work.

● (1640)

**Mr. Neil Ellis:** Lastly, if it does happen, what's available to the family afterward? If there is a suicide of a member, what's the follow-up for the mental health of the whole gamut and the men and women who surround that person?

**Col Andrew Downes:** We call that "postvention". It's sort of an official part of what we do when there's been a suicide. We don't provide health care to the families, of course—they would need to see their own medical care providers for that—but we do offer some support programs.

Our CFMAP program, which is our equivalent to the EAP program, does offer a bereavement service to family members for whatever reason. There's also another program called the HOPE program, which also offers bereavement services. We also have chaplains that do bereavement care as well.

There are a number of things in place to help people who are going through the grief when there's been a suicide. Within the military community, we pay attention to people in units, to colleagues, and also to the care providers as well, because care providers can carry a lot of guilt. After there's been a suicide, they wonder what they could have done differently.

**The Chair:** That's the last of the time for the structured questions. I see there's still a will to carry on, so I'm going to go around the track one more time with five-minute questions.

I'm going to yield the floor first to the Liberals' Ms. Alleslev. Then I'll go over to Mr. Bezan, and then Mr. Garrison wants an opportunity. He can have the last five-minute question, but I'll re-evaluate as time permits.

Ms. Alleslev, you have the floor.

**Ms. Leona Alleslev:** Thank you.

I noticed from the document that 28% of the incidents of suicide have experienced legal or disciplinary procedures. Could you shed some light on what, perhaps, is being done to bridge that gap or link with the judicial system? Is the judicial system being educated on the issues around mental health and in using that as a defence? I noticed there wasn't a recommendation related to increased communication with the judicial system on these types of topics.

**BGen Hugh MacKay:** I don't believe we've had any engagement with the judicial system, although we have worked, and do work, with the military police with respect to the handoff policy that I referred to earlier.

Usually the incident or the stress that we're talking about isn't a result of a court appearance. It's the result of a charge that's been laid by the military police.

**Ms. Leona Alleslev:** It's also sometimes as a result of mental health issues, and therefore the defence of that individual through the judicial process might not necessarily be well versed in the mental health aspects that may have influenced that incident or that charge, such as AWOL, being laid. Someone with a bipolar disorder or depression or something might be AWOL and then charged with AWOL, and yet that person needs some help in the defence.

What's the connection between the mental health providers and the military structure in being able to provide advice in that defence?

**BGen Hugh MacKay:** I see what you're saying. Okay.

We are available to advise, and we do advise, assisting officers and the JAG officers as they consider cases against military members. Often, though, the types of triggers that we are talking about occur in the civilian legal system, so we're less able to influence what's going on there, although our military police do work closely with the civilian police forces in order to help us with that handoff process and with understanding what's going on.

Andrew, did you have—

**Col Andrew Downes:** I'll just add that in the last year we've rolled out a road to mental readiness program for military police, as I mentioned earlier. A significant part of that is how to deal with people with mental health issues and how to police people in crisis.

I'm not aware of a similar program in other police forces in Canada, so I feel that we are leading the way in that area because we do recognize that this can be an important issue.

**Ms. Leona Alleslev:** Brilliant. Thank you.

I'd like to give the rest of my time to Mr. Rioux.

[*Translation*]

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

Earlier, we talked about the transition from civilian life to military life. I am most interested in the recruits and those enrolling in military college. We hear about suicides and, often, we hear about the cases that get most media attention. Before people are admitted as recruits or officers, do they have to undergo tests in order to detect their state of mental health?

Mr. MacKay, I have two or three questions for you and I will ask them all together.

Once people have been admitted, is it possible to detect suicidal thoughts in any of them? Do you have a system that allows you to detect who those people are? Is it possible that the training is too demanding and there may be effects because of it? We have talked a lot about statistics on recruits and it seems that you do not have data about them. Would it be possible to get more precise statistics on the recruits and the people going into military college? Can more attention be given to this part of the military?

● (1645)

[*English*]

**BGen Hugh MacKay:** Recruits and personnel going to Royal Military College go through the same screening process before they come in. It helps us know whether they've had a history of mental illness.

Part of the reason we have undertaken this road to mental readiness training is to ensure that staff at Royal Military College and their colleagues would be in a position to recognize symptoms of mental illness. From a health services perspective it's very difficult for us to see people and identify that they have mental illness. We need them to come forward and reveal to us what they are suffering from and the symptoms they may have for us to be able to identify if they have mental illness.

With respect to statistics, the number of suicides in recruits is very small. It would be very difficult, based on the numbers we have for those recruits, to be able to make much in the way of conclusions from a statistical perspective.

**Col Andrew Downes:** Screening is not 100% accurate. It's based on a questionnaire. We ask people questions and how they respond isn't always 100% truthful. Sometimes they minimize things, and so on.

Another thing is that somebody could be fine today, but at the end of the week their relationship is falling apart and they've got into trouble, and things could happen. They're good one day, but a few days later they might not be.

We have to be very careful to understand the limitations of screening. We do it and we believe it's important, but we cannot rely on it as our only defence mechanism. This is why we spend so much time on education. It's so that people come forward for care when they need it, because we can't screen people every day.

**The Chair:** I'll give the floor to Ms. Gallant.

**Mrs. Cheryl Gallant:** Thank you.

In listening to the discussion, I understand that debt is one of the issues that causes suicide or can be a contributing factor. I see some people here from the veterans affairs committee. You had a Dr. Donald Passey, a psychiatrist, testify. He'd be the one who wrote a letter to the Somalia inquiry asking to testify, to inform the inquiry as well as members of the government and the Canadian Forces medical systems about the effects of mefloquine and his thoughts that it was affecting the Canadian Airborne Regiment members and their behaviour in Somalia up to and including the death of Shidane Arone. About a week later, the Somalia inquiry ended abruptly. An election was called. The Airborne Regiment was disbanded.

In any case, that's the background with Dr. Donald Passey, and he testified in committee that in addition to debt, the denial of claims has a huge impact and increases suicidal risk in veterans.

Earlier, Mr. Chairman, in answering my question about whether or not there would be anything preventing the clinicians from using the clinicians' reports to adjudicate a pension, the surgeon general said that clinicians do not attribute causal relationships to service. The military ombudsman also identified this, and he made a recommendation stating that he should be determining service attribution for medically releasing members. He recommended that the Canadian Armed Forces determine whether an illness or injury is caused or aggravated by that member's military service and that the Canadian Armed Forces determination be presumed by VAC to be sufficient evidence to support an application for benefits so that they don't have to go through everything in duplication and all the hardships that entails.

That being the case, on November 15 I tabled the motion that the Government of Canada immediately begin to take the measures necessary for the full implementation of all recommendations in the two reports of the National Defence and Canadian Forces Ombudsman that were tabled in 2016 and “that the Government implement all of [those] recommendations as the best way forward to support Canadian Armed Forces members and veterans, particularly those in transition” and that the office of the ombudsman provide a progress report to the committee on a monthly basis.

It would seem that everybody wants to do the right thing by our soldiers and veterans, so since we are on the topic, I would like to get the chair to call a vote to agree to that motion and push it forward so we can go forward. We learn in the news, sometimes on a weekly basis, of different suicides and suicide attempts. To stem these tragedies from happening, let's get on with this now so that the government can do its work and the surgeon general and his clinicians...and adjudications can be used to help them along their way in financial instances, so we'll resume debate of the motion.

● (1650)

**The Chair:** All right. Let me have a look really quickly at the motion you had originally.

**Ms. Leona Alleslev:** I think we should move to adjourn debate so we can continue with our witnesses.

**Mrs. Cheryl Gallant:** It won't take very long just to....

**The Chair:** Well, it's dilatory, so I'm going to have to call for a vote on it.

All in favour of adjourning debate on this?

**Mr. James Bezan:** Can we have a recorded vote, please?

**The Chair:** No problem.

**Mr. Randall Garrison:** Mr. Chair, I guess before I can vote on this, I need to be clear on the motion.

**Mr. Darren Fisher:** Yes. Nothing's been presented to us.

**Mr. Randall Garrison:** Well, the motion has been previously presented to the committee. The member has made reference to it.

**The Chair:** There have been lines changed before in the past.

**Mrs. Cheryl Gallant:** No, there's no change.

**A voice:** There was an amended one.

**Mr. Randall Garrison:** Before I can vote and we shut off debate and return to this, I need to know what we're voting on.

**The Chair:** Here's how we're going to handle it. I'll let you read it, Mr. Garrison, so you're clear.

There was a motion to resume the debate, and there was a motion to adjourn debate, so that's where we're at. There was a call for a recorded vote. When the clerk is ready, we will vote on adjourning debate on the issue.

(Motion agreed to: yeas 5; nays 4)

**The Chair:** Okay, we're going to debate this later. Basically, we've moved to adjourn debate.

● (1655)

**Mrs. Cheryl Gallant:** It has been three months.

**The Chair:** That's the will of the committee.

You have about a minute left. If you can get a question and an answer in within one minute, I'd happy to give you the floor. Otherwise, I'd like to give the floor to Mr. Garrison. It's up to you.

**Mrs. Cheryl Gallant:** I'll give it to Mr. Bezan.

**The Chair:** Okay. Go quickly, please.

**Mr. James Bezan:** Thank you, Mr. Chair. I'll be very quick.

We talked earlier about the stigma of mental health within the Canadian Armed Forces, and of course, there's the culture. If you're experiencing depression or anxiety, quite often you're called weak. Has the road to mental readiness suite of programs started to change that culture, especially with middle managers?

**BGen Hugh MacKay:** We believe that we are seeing the change in culture that's necessary. Part of the evidence to that is what we found in the recent survey with respect to the willingness of our members to come forward and ask for assistance. It wasn't just to the health system; it was to their bosses and supervisors. I think from 2002 to 2013 there has been a significant increase in the willingness of members to come forward and talk with family members, their bosses and supervisors, and the health system with respect to their issues with mental health. That's a very positive change.

**The Chair:** Thank you.

Go ahead, Mr. Garrison.

**Mr. Randall Garrison:** Thanks very much, Mr. Chair.

In your presentation you mentioned that the suicide rate had been largely unchanged, and then there was a spike or an increase in the rate—I won't call it a spike. Does that correspond with the ending of the mission in Afghanistan?

**BGen Hugh MacKay:** The start of the increase in the suicide rate in the Canadian army started in 2006. That's when we started to see it. Since the end of the mission, we've started to see it stabilize again.

**Mr. Randall Garrison:** It has stabilized.

**BGen Hugh MacKay:** Yes.

**Mr. Randall Garrison:** It went up during the mission. I'm not trying to say it's a cause, but it's of particular interest to me since I was in Afghanistan working for an international agency at the time. I think other international agencies didn't recognize this problem. Again, I'll give credit to the Canadian military: other agencies also had suicides and didn't recognize it at all. There seems to be some connection between that operation and the increase.

**BGen Hugh MacKay:** If you look at our study as well, what hadn't been present before was a potential linkage between risk of suicide and deployment. Although it's still not statistically significant, it's close enough to statistical significance that we believe we need to take a look at it. I think that this deployment is now starting to show as a risk factor for suicide.

**Mr. Randall Garrison:** That was going to be my question, then. Is there an investigation of that specific deployment? I know you said deployment is a factor, but is there an investigation of the circumstances of that specific deployment and a link to suicide?

**BGen Hugh MacKay:** We have not undertaken a specific investigation with respect to that. That certainly is the greatest deployment we had that is contributing to it.

Andrew, would you comment?

**Col Andrew Downes:** I was just going to add that it's not so much the deployment that counts; it's what happens. There are many people who went to Afghanistan and were not exposed to any significant psychological trauma, and there were some, obviously, who were. Even so, the majority of those who were did not sustain mental illness as a result.

Nonetheless, it's truly the exposure that counts, not the deployment per se.

**Mr. Randall Garrison:** That maybe explains your reference to the adverse childhood experiences. In other words, you're looking for underlying things that wouldn't be shared by all those on the deployment that might be the underlying causes.

**BGen Hugh MacKay:** It would be things that may contribute to the risk of developing mental illness with subsequent traumas in life.

**Mr. Randall Garrison:** If you can establish those kinds of correlations, might you be able to do better at predicting who would have problems and get more assistance to them earlier?

**Col Andrew Downes:** That's right, yes. Ideally, there would be a blood test or something that we could use to identify people at high risk, and then know exactly how we were going to manage that. Mental health conditions generally around the world are not that well understood to that level of sophistication.

In the future, we hope to get there. Perhaps things like machine learning are going to be able to help us identify some of these risk factors that we're not currently able to identify. I think the future is very bright in this area, but for now we still are very much limited by our knowledge and understanding of mental illness and suicide.

**Mr. Randall Garrison:** I have no more questions. Thank you very much.

● (1700)

**Mr. James Bezan:** Chair, could I share time with Mr. Kitchen? I have one question.

**The Chair:** Who else would like to ask another question?

Go ahead, Mr. Bezan.

**Mr. James Bezan:** Yes, and I'll share with Mr. Kitchen.

**Mr. Robert Kitchen (Souris—Moose Mountain, CPC):** Thank you, Mr. Chair. General and Colonel, it's nice to see you again.

I want to go back to your chart, in which you talk about suicides increasing and mefloquine dropping. That's a beautiful pictorial, but the reality is that you're making the assumption that if you take mefloquine, you're going to have suicide. That's a one on one.

When we're talking about mental illness and the potential of mefloquine being possibly toxic, the potential for long-term.... We actually see the increase, the spike of suicide later, and it might be a cause as we factor in all the other aspects, such as debt, family relationships, etc.

I don't see that same analogy that you might, where one going down and one going up is a reason to say it's not an issue. From a statistical point of view or a research point of view, you're sitting there saying that.... Is there not a potential that we should be looking at this and asking if there is a potential for that to happen, and can we rule it out?

**BGen Hugh MacKay:** As I said, it's a crude analysis. The difficulty is that the evidence to support the other side, to show that this is causing other long-term neuropsychiatric illnesses and suicide, is just not there for us to even be able to do an analysis about when you might expect to see an effect from the mefloquine. Therefore, to suggest that we need to wait for five years, 10 years, 20 years to see such an effect is not something that I can speculate on, because there is not good science to support that position to start with.

**Mr. Robert Kitchen:** True, but the actual science done on mefloquine to start off with was poor science, because the medication was given out initially without.... It was put in as an experiment, and the experimental procedures were not followed when it was sent out initially. It was not recognized as a medication when it was first given to our troops. Then, over time, the procedures that were supposed to be followed were not followed, so you couldn't perform a proper study on it because you didn't follow the protocols. Any researcher would have thrown that study out of the window.

**BGen Hugh MacKay:** Mefloquine, when it was used—I presume you're referring to the Somalia time frame—had been licensed and met the safety and effectiveness requirements of numerous regulatory bodies in many other countries, and in fact it was licensed shortly after the start of the Somalia deployment within Canada, meaning that it met the safety and effectiveness requirements of Canadian regulatory authorities.

**Mr. Robert Kitchen:** Sir, if we use the argument, then, that other countries used it and their studies were good and therefore we could use it, likewise surely we could use the studies from other countries that are now not using it to say that we shouldn't be using it with our troops.

**BGen Hugh MacKay:** I'm not aware of what studies, other than inquiries, are being used as evidence not to use it.

**Mr. Robert Kitchen:** Germany and the U.S. have stopped using it with their forces. We should be considering that, or at least looking at it to investigate the potential. Do you not agree?

**BGen Hugh MacKay:** I am in the process of reviewing the report that I received to make a policy recommendation. I will say, though, that I haven't been told by the U.S. which study they used to base their policy decision on, nor have I been told by the Germans which studies they used to base their policy decision on. I would be interested to know which studies they used to do that. I do have contact with those organizations and have had discussions with them.

**The Chair:** The last question is going to go to Mr. Fisher.

**Mr. Darren Fisher:** Thank you very much, Mr. Chair; and thanks again, gentlemen.

I'm going to go to a little happier topic. It's about some of the things you're trying to do to create some success.

You talked about telemental health and about virtual reality systems. It brought it back to my memory when you talked about apps.

Could you touch on your telemental health and virtual reality systems?

● (1705)

**BGen Hugh MacKay:** Telemental health is a system that we put in place a couple of years ago. It enables clinicians to remotely provide care to mental health patients.

We always have another health care provider on location with the patient who is receiving care so that should they develop some issues as a result of the therapy they undergo—because sometimes that kind of exposure therapy makes them relive some of the traumas they experienced that have caused their illness—we have somebody there with them. It provides a method of delivering care when we can't have a mental health care provider geographically located with the patient.

It's well received by patients. The clinicians have a little harder time doing it because they feel that they need to have that face-to-face contact, but once they've done it for a while, they enjoy it.

In terms of virtual reality, we have a couple of different programs that we're looking at. We have a small system, a headgear that helps replicate the kinds of things that people are exposed to when they're on operations, but we also have a larger system that we're using, and we're in collaboration with the Dutch on a study to look at a different way to use virtual reality to treat patients with post-traumatic stress disorder that is starting to show some success. We're anxiously awaiting further results from that study.

**Mr. Darren Fisher:** Both of these programs, including the apps, would be for uniformed members, not for veterans at the moment. Are some of those things being looked at for veterans as well, the virtual reality and telemental health?

I'll end with one final question: is there a text message component to the telemental health?

**Col Andrew Downes:** Just to be clear, the telemental health is a connection between clinics. An individual goes into a clinic at one base and then can be cared for—

**Mr. Darren Fisher:** I thought it was phone-based mental health?

**Col Andrew Downes:** No, it's not that.

Regarding your question about virtual reality, I'm not 100% sure if the Veterans Affairs OSI clinics have those in place, but there's no reason they couldn't. I think they, in fact, might.

We do communicate regularly with Veterans Affairs clinical personnel and we are looking for opportunities to do joint research with them. In fact, they would be certainly welcome to participate in our study at the rehab hospital where we have one of these virtual reality systems that General MacKay was talking about.

**Mr. Darren Fisher:** Thank you.

Is there a minute left?

**The Chair:** No, there's not.

Gentlemen, thank you for coming to talk to us about this very important topic, and thank you for your service.

I'm going to suspend so we can resume with committee business.

[*Proceedings continue in camera*]

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