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MENTAL HEALTH OF CANADIAN VETERANS: A FAMILY PURPOSE

Report of the Standing Committee on Veterans Affairs

Neil R. Ellis
Chair

JUNE 2017

42nd PARLIAMENT, 1st SESSION

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THE STANDING COMMITTEE ON VETERANS AFFAIRS

has the honour to present its

SIXTH REPORT

Pursuant to its mandate under Standing Order 108(2) and the motion adopted by the Committee on Thursday, September 29, 2016, the Committee has studied mental health and suicide prevention among veterans and has agreed to report the following:

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MENTAL HEALTH OF CANADIAN VETERANS: A FAMILY PURPOSE

INTRODUCTION

> *[P]eople who are contemplating suicide … feel like there are no other options. Families share that despair; they often bear the brunt of the anger and witness the fear. Families often experience and feel hopelessness and helplessness. …*
>
> *Families that are well supported, functioning, and healthy can be a significant protective factor for those contemplating suicide. … They can be the centre or foundation of the system of support for people in distress: we've heard some people who have lived through distress—who have come out of the darkness to the other side—report that this was the result of somebody being in their lives who didn't give up.*[1]

At its meeting of 29 September 2016, the House of Commons Standing Committee on Veterans Affairs (the Committee) passed a motion to undertake "a study on mental health focused on improving the transitional support (closing the seam) between Canadian Forces and Veterans Affairs, and including recommendations which can ultimately be used in the development of a coordinated Suicide Prevention Program."[2]

This resolution results from an observation made during the Committee's previous study:

> A great many military members manage a fairly smooth transition to civilian life. The challenge is greater, however, for those who leave military life not at their choosing, including those who are medically released – the vast majority of VAC clients. …
>
> The overall impression from the testimony heard … is that the needs of many medically released veterans are not met, and they feel isolated as a result.[3]

A successful transition seems to be a key factor in veterans' long-term well-being. Conversely, a difficult transition can have a lasting negative effect on their lives and the lives of all their family members. Given the mental health risks involved in a military career, it is even more important not to increase them during the transition to civilian life.

Suicide is frequently the tragic outcome of a deteriorated state of mental health and, for many veterans, the origin of this deterioration could often be traced back to a difficult transition. As we will see later in the report, although the suicide rate among members of the Canadian Armed Forces (CAF) is about the same as for other Canadians of the same age, it is alarming, since the military population is already a pre-selected group that is in better health than the general population. However, the suicide rate for

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1 ACVA, Ms. Nora Spinks (Chief Executive Officer, Vanier Institute of the Family), *Evidence*, 15 February 2017, 1540.

2 ACVA, *Minutes of Proceedings*, 29 September 2016.

3 ACVA, *Reaching Out: Improving Service Delivery to Canadian Veterans*, December 2016, section 4.6.

veterans is nearly 50% higher than that of serving members. This statistic indicates that simply becoming a veteran is a risk factor for suicide.

While there are some distinctions, these statistics are also valid for most mental health disorders grouped under operational stress injuries. This non-clinical term refers to "psychological problems that occur as a result of psychological trauma experienced during operations, which result in different diagnoses, including depression, [Post-Traumatic Stress Disorder] (PTSD), and substance-use disorders."[4]

In the case of veterans, a successful transition is a key part of any strategy focusing on well-being, mental health and suicide prevention. In this study, the Committee has tried to identify ways to support these objectives and to recommend their implementation by the Government of Canada.

The Committee heard from 71 witnesses over the 19 meetings that it devoted to this study. Two common themes emerged: the support of family and loved ones, and a sense of purpose. Their presence seems to be the greatest protective factor, while their absence seems to be a significant risk factor during the transition from a military career.

The loss of military identity during the transition to veteran status is difficult for many of the CAF members who were released involuntarily, and for their friends and family. The Committee hopes that its proposals will help to improve the quality of life of veterans and their families.

1. MENTAL HEALTH AND SUICIDE AMONG MILITARY PERSONNEL

1.1. Mental health of Canadian Armed Forces members

The state of mental health in the CAF is closely linked to Canada's increased participation in military operations starting with the Balkan conflict in the early 1990s. The risks increased throughout that decade during operations in Somalia, Rwanda and the former Yugoslavia, and later in Afghanistan.

Overall, close to 40,000 CAF members were deployed to Afghanistan. In terms of personnel, that effort exceeds Canada's participation in the Korean War between 1950 and 1953, and was therefore Canada's largest military operation since the Second World War. Combat operations ended in Afghanistan on 7 July 2011, but Canada maintained a contingent of close to 1,000 members until March 2014 to help train Afghan security forces. During the country's involvement in Afghanistan, 158 CAF members were killed and more than 2,000 were injured; four Canadian civilians were killed.

The human face of the Afghanistan mission has often been seen in the moving and tragic stories of some members of this new generation of the military, whose wartime experiences have cost them their mental health in some cases. According to Dr. Heber

4 ACVA, *Evidence*, 15 November 2016, 1540 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

from Veterans Affairs Canada (VAC), an increase in the number of suicides, particularly among land forces, coincided with participation in this mission.[5]

PTSD is the medical term usually applied to the possible psychological effects of participating in military operations. Another common term in the military and police services, "operational stress injury" (OSI), is also used. These effects are harder to foresee than the effects of physical injuries because they are less visible, the people affected are reluctant to talk about them, and the symptoms may not appear until years after the traumatic event. As a result, our knowledge of this disorder is incomplete and little about it is certain, except the suffering of those affected.

The war in Afghanistan is thought to have affected the mental health of CAF members. According to Brigadier-General MacKay, CAF Surgeon General, the number of cases of post-traumatic stress did indeed increase:

> Through [a survey], we were able to see that the 12-month prevalence of PTSD had changed from 2.7% in 2002 to 5.4% in 2013. We did see, though, that there was no real change in the percentage of CAF personnel suffering from depression – which is still our number one cause of mental illness in the military – which was around 8% in 2002 and still the same in 2013.[6]

"On average, over 10,000 regular and reserve force members transition out of the Canadian Armed Forces every year. Of that number, approximately 16% on average are medically released."[7] Statistics show a decline in the percentage of people who have been medically released and who suffer from mental health issues.

> [W]e have had a little bit of a fluctuation in the number of people leaving the military for medical reasons. I believe last year we had about 2,000 leaving for medical reasons, and only 22% of those left for mental health reasons. The reason I say it's interesting is that in the previous several years, it was more on the order of 34% to 40% who were leaving for mental health issues, so I was a little surprised to see that the number had gone down.[8]

These figures are encouraging, and it is hoped that this trend will continue in the coming years as the 40,000 CAF members who participated in Canada's mission in Afghanistan retire or start their transition to civilian life.

1.2. Suicide among Canadian Armed Forces members

In November 2016, the Department of National Defence (DND) released its most recent *Report of Suicide Mortality in the CAF*. The report covers a 21-year period (1995 to

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5 ACVA, *Evidence*, 20 March 2017, 1630 (Dr. Alexandra Heber, Chief of Psychiatry, Health Professionals Division, Department of Veterans Affairs).

6 ACVA, *Evidence*, 3 November 2016, 1640 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

7 ACVA, *Evidence*, 22 February 2017, 1540 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

8 ACVA, *Evidence*, 15 November 2016, 1615 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

2015) and focuses solely on suicide among men in the Regular Force. Dr. Elizabeth Rolland-Harris, one of the study's co-authors, explained why female suicide numbers were not included:

> The reason is that reserve force and female suicide numbers are too small for us to release detailed information about the cases without running the risk of identifying the individuals and compromising their privacy. Although their experiences are included in the evidence used to drive mental health policies and suicide prevention endeavours within the CAF, the information is not presented in the annual reports.[9]

Trends in the Reserve Force are difficult to analyze because "Reserve Force records may be incomplete for both suicide events and information on the size and characteristics of the Reserve Force, both of which are needed to calculate reliable suicide rates. There is a high turnover for Class A Reservists and suicides among this group may not be brought to the attention of Department of National Defence."[10] The statistical limitations regarding suicide among reservists are even more applicable to the analysis of veterans' suicide rates.

When the CAF believes that a member of the Regular Force or the Reserve Force likely died by suicide, the CAF seeks confirmation from the coroner in the province where the death occurred and orders a medical professional technical suicide review (MPTSR).

> The investigation is conducted by a team consisting of a mental health professional and a general duty medical officer. This team reviews all pertinent health records and conducts interviews with medical personnel, unit members, family members and other individuals who may be knowledgeable about the circumstances of the suicide in question.[11]

The Report of Suicide Mortality in the CAF is based on data collected as part of the MPTSRs.

In 2015, 14 men in the Regular Forces committed suicide. They suffered from the following mental health disorders (some may have had more than one):

- documented depressive disorder – 6 individuals;
- substance use disorder – 6 individuals;
- anxiety disorder – 4 individuals;
- traumatic brain injury – 3 individuals;
- PTSD – 3 individuals;

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9 ACVA, *Evidence*, 20 March 2017, 1535 (Dr. Elizabeth Rolland-Harris, Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, Department of National Defence).

10 DND, *2016 Report of Suicide Mortality in the Canadian Armed Forces*, p. 1.

11 ACVA, *Evidence*, 20 March 2017, 1535 (Dr. Elizabeth Rolland-Harris, Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, Department of National Defence).

- trauma and stress-related disorders (other than PTSD) – 2 individuals;

- personality disorder – 2 individuals.

More than 85% had access to some form of health care in the CAF during the three months preceding their suicide.

Over the 21 years covered by the report, 239 men in the Regular Force committed suicide, an average of 11.4 suicides per year. In 2011, there were 21 suicides, an atypically high figure that increased the short-term trend for the period covering 2011. The fewest suicides occurred in 2006, when there were only seven cases.

After converting this data into a suicide rate based on age and sex, it can be compared with the corresponding Canadian rate. The highlights of this comparison are as follows:

- From 1995 to 1999, the male suicide rate for the Regular Force was 28% lower than the suicide rate for the male population of the same age, and this difference is statistically significant.[12]

- From 2000 to 2004, the rate was 20% lower, but the difference is not statistically different.

- From 2005 to 2009, the rate was 13% lower, but the difference is not statistically significant.

- From 2010 to 2012 (only three years), the rate was 20% higher. This rate is close to being statistically significant but it includes the atypically high number of suicides (21) in 2011.

The main reason why suicide trends in the military should be analyzed carefully is that there may be a causal relationship between exposure to traumatic events during deployment and the suicide rate. From 1995 to 2004, there was no notable difference between the suicide rates for CAF members who had been deployed and those who had not. However, when age is taken into greater account, the difference for the period from 2005 to 2014 is close to being statistically significant:

- From 2005 to 2014, the suicide rate for men in the Regular Force who had been deployed represented 148% of the rate for those who had not been deployed (in other words, it was 48% higher);

12 The term “statistically significant” refers to the degree of confidence in a given interval. To be statistically significant, the degree of confidence must usually be above 95%. For example, for the period from 1995 to 1999, we can state with a degree of confidence of at least a 95% that the suicide rate for men in the Regular Force was below the suicide rate for the general population by a minimum of 6% and a maximum of 45% or, in other words, a confidence interval with limits of 94% and 55%. When the interval limits are both either above or below 100%, the difference is considered statistically significant.

- This figure of 148% has a confidence interval (see footnote 12) of 98% to 222%.

- If the lower limit for the confident interval had been above 100% rather than being 98%, the difference would have been statistically significant. In other words, a very slight increase in the number of suicides in a given year between 2005 and 2014 would have made the difference of 48% statistically significant.

Another hypothesis supporting the possible causal relationship between deployment and suicide is that members of the Army may have a greater risk of exposure to traumatic events during deployment than members of the Navy and Air Force, and are therefore far more likely to commit suicide. The difference between the suicide rate for Army command and the other two commands seems to support this idea:

- From 2002 to 2015, "the Army command crude suicide rate among Regular Force males was nearly 2.6 times that of non-Army command Regular Force males."[13]

- During the same period, the Army command crude suicide rate for males aged 20 to 24 was 40/100,000, but was 13/100,000 for males of the same age from non-Army command.

It is therefore possible to claim, as Dr. Rolland-Harris stated, that "Canadian Army personnel, more specifically those in the combat arms trades, are at a greater risk of suicide than the Royal Canadian Navy and Royal Canadian Air Force members."[14]

Colonel Andrew Downes, Director, Mental Health, DND, went a little farther in his estimation of the factors that may have contributed to the increase in the suicide rate for the Canadian Army:

> [T]he majority of people do have mental illness or some mental distress. That is overlaid with what we call an acute trigger, so a stressor like a relationship issue, for example. We know that a mission like Afghanistan, in which there was a lot of psychological trauma, did end up causing a lot of mental illness. We think the mental illness that occurred during the operation is one of the factors behind the increase in rates in army personnel. It was primarily the army personnel who were exposed most to the combat-related stressors.[15]

In other words, the stress factors related to ground operations in Afghanistan may have compounded the effect of other risk factors involving a member's family, work

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13 DND, *2016 Report of Suicide Mortality in the Canadian Armed Forces*, p. 25.

14 ACVA, *Evidence*, 20 March 2017, 1535 (Dr. Elizabeth Rolland-Harris, Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, Department of National Defence); see also ACVA, *Evidence*, 15 November 2016, 1550 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

15 ACVA, *Evidence*, 15 November 2016, 1620 (Colonel Andrew Downes, Director, Mental Health, Department of National Defence).

and medical history. The stress factors related to military operations alone would not be enough to trigger mental health issues, but when added to the others, they could help to explain the high suicide rate among CAF members who have seen combat.

2. MENTAL HEALTH AND SUICIDE AMONG VETERANS

> *When you come back, they do not understand when you tell them 'Well, I have nightmares every day. I can't cope with day-to-day living. I don't like being in crowds.'*[16]

2.1. Mental health of veterans

Veterans suffer more from mental health disorders than serving military members and the Canadian population of the same age and sex, and they have higher suicide rates. Dr. David Pedlar, Director of Research at VAC, stated that "compared to the Canadian population, the prevalence of common mental health conditions, like mood disorders, anxiety disorders, and PTSD, was generally about two to three times higher among the population of CAF personnel released since 1998."[17] These statistics apply to Regular Force veterans and Reserve Force veterans who served full time for an extended period. Dr. Pedlar went on to say that "the mental health of other reservists who did not serve full time for a substantial period of time looked a lot like non-veteran Canadians of the same age and gender."[18] As for international comparisons with the United States, Australia and the United Kingdom, "what we see in Canada isn't completely unlike what we see elsewhere."[19]

Dr. Pedlar also highlighted an issue that is essential to understanding veterans' mental health: the link between mental and physical health. He suggested that the two are considered separately far too often and that the statistics on this subject speak volumes:

> 90% of veterans with mental health conditions also have chronic physical health conditions. Often these are musculoskeletal conditions and chronic pain. These are about two to three times more prevalent than in civilian populations. Those who experience mental health and physical health problems and chronic pain at the same time are especially likely to experience quality of life challenges. Therefore, it's really critical not to silo mental and physical health when we talk about veteran needs. They really have to be treated together in this population if we want to treat, diagnose, and manage them well.[20]

In other words, one of the most characteristic features of veterans with mental health problems is that almost all of them also suffer from a chronic physical health

16 ACVA, *Evidence*, 29 November 2016, 1640 (Mr. John Kelley McLeod, As an Individual).

17 ACVA, *Evidence*, 13 December 2016, 1530 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

18 ACVA, *Evidence*, 13 December 2016, 1530 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

19 ACVA, *Evidence*, 13 December 2016, 1530 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

20 ACVA, *Evidence*, 13 December 2016, 1530 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

disorder: “The body isn't built to carry 125-pound packs for years on end without some kind of consequences. We see those consequences in our disability program.”[21]

The physical wear and tear that is part of military life can therefore be seen as a risk factor in developing mental health disorders. As Dr. Pedlar stated, it is important to “see physical health and chronic pain as a very, very important pathway to mental health conditions in veterans, in addition to traumatic experiences that they might face as well.”[22]

It follows that the treatment offered to veterans must take into account their physical and mental states. If mental health issues are not treated at the same time as physical ailments and pain, it will be difficult to improve veterans’ quality of life.

Dr. Pedlar made the same observation in the case of suicide prevention: “[T]here is a real multiplier effect if somebody has a mental health problem, a physical health problem, and chronic pain. All those things come together more frequently in veterans than in other Canadians.”[23]

2.2. Suicide among veterans

In Canada, the suicide rate is determined by dividing the number of recorded suicides in a given year by the total population of Canada, all ages considered.

In 2012, the Canadian suicide rate was 11.3/100,000 (17.3/100,000 for men and 5.4/100,000 for women).

There is no equivalent calculation for Canada’s total veteran population, estimated at 685,000. However, in a 2011 study entitled *Canadian Forces Cancer and Mortality Study: Causes of Death*, researchers looked at the causes of death of a sub-population of 112,225 veterans who served in the Regular Force between 1972 and 2008. The study resulted in the following findings:

- suicide was the only cause of death that had a significantly higher incidence among veterans than in the general population;
- the risk of death by suicide was 46% higher among male veterans compared with corresponding age groups in the general male population;
- in the case of male veterans released when they were between the ages of 16 and 24, the risk of death by suicide is twice that of the same age group in the general male population;

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21 ACVA, *Evidence*, 13 December 2016, 1630 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

22 ACVA, *Evidence*, 13 December 2016, 1630 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

23 ACVA, *Evidence*, 13 December 2016, 1635 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

- the risk of death by suicide was 32% higher among female veterans compared with corresponding age groups in the general female population;

- the risk of death by suicide among female veterans aged 40 to 44 was 2.5 times higher compared with the corresponding age group in the general female population.

According to the same report:

> Of the 112,225 veterans in the sub-population studied, 96,786 men and 15,439 women enrolled in the Regular Force after 1972 and were released before 31 December 2007.
>
> Of the 2,620 men who died, **696 (26.6%) committed suicide**. By extrapolating, we arrive at a cumulative suicide rate of 719/100,000 (1/139) for this cohort over a 36-year period. By comparison, the cumulative suicide rate for the corresponding age group in the general male population is about 551/100,000 (1/181) for the same period.

Of the 204 women who died, **29 (14%) committed suicide**, which represents a cumulative suicide rate of 187/100,000 (1/535) for this cohort over a 36-year period. By comparison, the cumulative suicide rate for the corresponding age group in the general male population is about 146/100,000 (1/685) for the same period.

Given the lack of reliable data for veterans released from the CAF after 2007, VAC has announced that a second edition of the study will focus on Regular Force and Reserve Force Class C veterans released in 2015 or before.[24]

This data on the total veteran population corresponds to that of VAC's Parkwood Clinic in London, Ontario. As Dr. Don Richardson, a psychiatrist at the clinic, told the Committee:

> When we looked at our treatment-seeking population, those who sought treatment at the Parkwood OSI clinic, almost 80% of those who had PTSD also met the criteria for probable major depressive disorder and about 40% had alcohol use disorder.
>
> Suicidal behaviour, suicidal thoughts and attempts often co-exist with mental health conditions, especially major depressive disorder. … [T]he past year's suicidal ideations – these are thoughts – was found to be approximately 6.6% in veterans, while for those veterans in the community who were clients of Veterans Affairs Canada, their past year suicidal ideation prevalence was much higher at 12%.[25]

In the opinion of Dr. Richardson, and of most experts who appeared before the Committee, the best suicide prevention strategy lies in treating mental health disorders,

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24 ACVA, *Evidence*, 20 March 2017, 1535 (Dr. Elizabeth Rolland-Harris, Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, Department of National Defence).

25 ACVA, *Evidence*, 13 December 2016, 1540 (Dr. Don Richardson, Psychiatrist, Western University, Department of Psychiatry, Parkwood Operational Stress Injury Clinic).

particularly depression. “Therefore, it's important to stress timely care for veterans as well as a public awareness campaign for veterans to be aware that treatments are available.”[26]

3. RISK FACTORS

A military career gives people greater exposure to a number of risk factors for developing mental health disorders. As Dr. Jitender Sareen, professor of psychiatry at the University of Manitoba explained:

> [T]he strongest risk factors for mental health problems and suicide are childhood and adult stressful life events. Those occur very commonly in the military population. Early adverse events as well as stressful life events, physical assaults, as well as losses, can occur. Other common factors are also a family history of mental health issues. Physical injuries and physical health issues are also very important. Specifically, financial difficulties and legal problems have also been shown to increase the risk of mental health difficulties and suicidal behaviour. Those are very common.[27]

Dr. Pedlar, Director of Research at VAC, presented a similar list of risk factors likely to affect veterans’ mental health: “previous life experiences, military service, genetics, physical health, employment, finances, and social support.”[28]

However, protective factors are also part of military life and can reduce the risk of developing mental health issues.

> Things that are known to be protective around mental health difficulties and suicide prevention are community supports, workplace mental health programs, leadership within units, organizational structures. Social supports and peer supports are really important, as are, of course, families, and the understanding of the family of what the member is going through.[29]

During their study, Committee members learned that risk factors are common to both serving members and veterans, but the protective factors present in military life tend to disappear when people become veterans. For members who are released voluntarily, this transition seems to play less of a role in their future health, but the loss of support poses an increased risk for members who are involuntarily released.

> Suicidal ideation is there in about 4% of the population in the Canadian Forces, so approximately four out of every hundred active military personnel have serious thoughts about suicide. Less than 1% attempt per year. As was mentioned by the previous speakers, veterans, especially during that first year or two, have a slightly higher rate of

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26 ACVA, *Evidence*, 13 December 2016, 1540 (Dr. Don Richardson, Psychiatrist, Western University, Department of Psychiatry, Parkwood Operational Stress Injury Clinic).

27 ACVA, *Evidence*, 17 November 2016, 1545 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

28 ACVA, *Evidence*, 13 December 2016, 1530 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

29 ACVA, *Evidence*, 17 November 2016, 1545 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

> suicidal ideation. Dr. Thompson did a study of over 3,000 Canadian veterans and showed that the prevalence was around 6%.[30]

Without the support structure of military life, veterans whose problems could be controlled while they were in the service are suddenly left to their own devices. They often have little experience dealing with the stresses of civilian life and can find it difficult.

It is therefore no surprise that more veterans have mental health problems and commit suicide than active members. If veterans do not find the organizational structure that Dr. Sareen mentioned in their new work environment, then the support of family members, peers and their social circle constitute their only protective factor.

3.1. Deployment

There is some disagreement within the scientific community about whether military deployment itself should be considered a risk factor for mental health disorders and suicide. A consensus seems to have emerged that it is not being deployed in itself that is a risk factor, but what service members are exposed to during deployment. Exposure to stressors adds to the other risk factors. As a result, it is important not to try to explain a complex phenomenon by just one cause. As Dr. Sareen explained:

> [I]f there are high levels of traumatic exposure during a deployment, that can increase the risk of post-traumatic stress, depression, and suicide. … When we look at suicide, the example that I would use is someone who has asthma. Asthma alone is not deadly. But if you have asthma plus someone who has a lot of other physical health issues, that together can lead to mortality.
>
> Similarly in suicide, when we think about suicide, … [i]t's the combination of a number of different factors coming together, usually a stressful life event, depression, alcohol, difficulties in the military and transitions, potentially legal difficulties. All those things coming together puts people at much higher risk of making an attempt at suicide or dying by suicide.[31]

The intensity and stress of military deployment makes it difficult to assess the mental health risks facing specific individuals on the ground. For most CAF members, this operational stress will disappear quickly, whereas for others, this will be the start of a more lasting problem that will require treatment. It is almost impossible to determine on the spot who will develop long-term problems. Consequently, members returning from deployment must be made aware that they may experience symptoms indicative of disorders that could become more serious if not treated as soon as possible.

3.2. Transition to civilian life

> *A release from the Canadian Forces is not the end of a job; it's an identity crisis. What am I now? Even our family members introduce us to other people as soldiers. They'll say*

30 ACVA, *Evidence*, 17 November 2016, 1545 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

31 ACVA, *Evidence*, 17 November 2016, 1550 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

> *their brother's in the army, or their sister's in the navy. They'll say their dad was air force – not "was in"; they'll say "was". It's a thing you actually are. It's a culture. A 25-year-old Canadian Afghan vet will have more in common with a Vietnam vet from North Carolina than he will with his next door neighbour, same age, same gender. It's a culture.*[32]

The critical period of transition to civilian life can be one of the most significant risk factors for veterans in developing a mental health disorder.[33] For many service members, transition means losing the social and organizational support of the CAF, and so the transition period is vital to creating an environment that supports their long-term well-being.

It is often thought that medically released veterans find the transition particularly hard because many of them did not want to be released. VAC representative Michel Doiron presented statistics that challenge this view. According to the data, of the close to 10,000 people who are released from the CAF each year, about 27% have difficulty making the transition. It would be easy to assume that this 27% was composed mainly of medically released veterans. However, this does not seem to be the case:

> We just realized, because our researchers had done some work on it, that of that 27%, 60% are actually non-medically released people who are having a hard time. We've been concentrating on the medically releasing, and now we have to make sure we're taking care of the non-medically.
>
> Most of them want to be released with their head high, no stigma, but then they realize when they get into the Canadian population, it's a little different.[34]

VAC has traditionally focused its efforts on medically released members and so they most often become its clients, while members who were not medically released are more likely to think that they do not need VAC's services: "[F]or the people who medically release they come to us right away. … After that when we look at the trends of when people come to us for services it's anywhere from two years after release to 40 years after release."[35]

Since July 2015, VAC has had the authority to work with serving members, develop a rehabilitation plan, encourage them to apply for benefits, etc. However, this early intervention was based on the idea that people being medically released would be the main beneficiaries. It is hard enough for VAC to make contact with medically released veterans if they do not identify themselves. It is harder still to make contact with non-medically released veterans if they have not been approached while still serving.

Dr. Heidi Cramm of the Canadian Institute for Military and Veteran Health Research (CIMVHR) recommended establishing a veterans' registry that would include anonymized

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32 ACVA, Evidence, 29 November 2016, 1545 (Mr. Brian McKenna, As an Individual).

33 ACVA, *Evidence*, 6 March 2017, 1550 (Brigadier-General, Retired, Joe Sharpe, As an Individual).

34 ACVA, *Evidence*, 8 December 2016, 1535 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

35 ACVA, *Evidence*, 8 December 2016, 1605 (Dr. Cyd Courchesne, Director General, Health Professionals Division, and Chief Medical Officer, Department of Veterans Affairs).

health data and help researchers learn more about the little-known role transition plays in veterans' long-term mental health.[36]

Mr. Doiron's testimony showed that VAC is aware of the difficulty in identifying veterans and better understanding their needs during transition. The Committee wishes to support the department's efforts and therefore makes the following recommendation:

Recommendation 1

That Veterans Affairs Canada take steps to systematically register all releasing Canadian Armed Forces members for a My VAC Account, whether they are being medically released or not, so that it is easier to establish contact between them and the department should the need arise.

A number of witnesses spoke of the loss of identity and sense of purpose they felt when making the transition to civilian life – a way of life that they have often experienced only sporadically:

> People sign up for the military because they believe in something. They have an identity that's recognizable. People can look at you in uniform, and that means something to them about who you are and what you're bringing to bear in your day to day. But if you're just in your civilian clothes, you could be involved in any number of different kinds of jobs or contributions to society. You don't have that same kind of face value recognition around what your identity brings. You potentially have a compromised sense of your meaning, identity, and purpose. You have some difficulties potentially in how you're structuring your time, and then your sense of belonging gets quite disrupted as well. …
>
> So that sense of identity is quite a real issue. We know that if we can support people through the transition so that they continue to be living lives worth living, as we say in occupational therapy, then that can really support people's mental health transition and general quality of life.[37]

According to Dr. Pedlar of VAC, the transition to civilian life involves such significant changes that most veterans will experience some type of difficulty as their lives become restructured:

> Almost all veterans will experience some kind of a challenge, because for many during transition almost everything can be changing at once. That could be military culture, housing, where they're living, social networks, source of income, and they may have physical and mental health conditions upon release. … Some veterans will encounter special problems during that period. Some of those can come from really the way they experience the change themselves, for example, if they hadn't planned in advance about what it would be like to take the uniform off. A number of veterans I've run into will talk about this issue, that they've lost their sense of purpose. In a sense, they've lost their sense of self. Some veterans are angry when they leave. They had planned on spending their whole career in the military, and their career was cut short unexpectedly, so

36 ACVA, *Evidence*, 17 November 2016, 1635 (Dr. Heidi Cramm, Interim Co-Scientific Director, Canadian Institute for Military and Veteran Health Research).

37 ACVA, *Evidence*, 17 November 2016, 1615, (Dr. Heidi Cramm, Interim Co-Scientific Director, Canadian Institute for Military and Veteran Health Research).

> sometimes veterans will have a feeling of anger or even betrayal upon leaving the forces.[38]

Sometimes, this lost sense of purpose emerges as soon as service members learn that they will be released, as described by Hélène Le Scelleur:

> We are slowly moved aside, or even transferred to the Joint Personnel Support Team. … In a way, we are isolated from and forgotten by the system that shaped us. We feel the burden of our suffering in addition to the burden of this rejection. …
>
> We wear our equipment, an important symbol of identity, and our identity cards, with no thanks, no honours, and no acknowledgement of what we have given. We have to beg to leave with dignity; there are no parades to recognize our service and our sacrifice. … Believe you me, that is enough to lead a person who is suffering to suicide.[39]

Ms. Le Scelleur suggested that a type of retirement ceremony be introduced that would allow people to "experience a form of grief, but in a group."[40] The ceremony would also let the transition take place in an atmosphere of military solidarity and allow for public recognition of the sacrifices made during military service. "Why not have one last parade to mark our service? We could receive our pin then, in front of family and friends. All service members who retire or are injured could take small steps like this, together, the same as when they started their career."[41]

While the CAF's Depart with Dignity program offers a similar recognition ceremony,[42] it appears to be carried out on an ad hoc basis within units and lacks the formality of a larger event. The Committee members wish to support the idea of a symbolically significant ceremony in which releasing CAF members could mark the transition to civilian life together and with members of the public. Therefore, the Committee recommends:

Recommendation 2

That the Canadian Armed Forces, in collaboration with its public and private partners, examine how to better recognize the contribution of releasing members through a public event in which the members could participate voluntarily.

During this study, the Committee heard from a number of witnesses about the challenges that DND and VAC encounter when they try to better integrate their services to ensure the best possible transition. Far too often, the move from the CAF to VAC is still

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38 ACVA, *Evidence*, 13 December 2016, 1550 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

39 ACVA, *Evidence*, 30 January 2017, 1545 (Ms. Hélène Le Scelleur, As an Individual).

40 ACVA, *Evidence*, 30 January 2017, 1620 (Ms. Hélène Le Scelleur, As an Individual).

41 ACVA, *Evidence*, 30 January 2017, 1625 (Ms. Hélène Le Scelleur, As an Individual).

42 ACVA, *Evidence*, 22 February 2017, 1640 (Captain (N) Marie-France Langlois, Director, Casualty Support Management, Department of National Defence).

seen as a loss of identity and something to be mourned. A number of people leaving the military must deal with the details of everyday life for the first time and they find it difficult:

> A lot of guys get in when they're 17, 18, 19. … They go into an environment where a lot of things are structured for them, provided for them. … [B]eing a member of the military is a core part of your identity, and most of your life revolves around that. When someone unexpectedly finds himself now needing to emerge into the civilian world, in some cases they – and I'm not trying to sound condescending in saying this – may have a lack of basic life skills. There's nobody to tell them they have a medical appointment coming up, to make sure they take care of this, that, or the other thing.[43]

Like many witnesses, Colonel Russ Mann of the Vanier Institute of the Family described how the gap between the two departments impedes a smooth transition:

> Right now, the government has structured transition to break the circle of support. DND and Veterans Affairs do not act as a continuum in the transition spectrum. They act as two separate entities, with separate frameworks and separate operating methods. To the family and the veteran in transition, that feels like it is breaking their circle of support.[44]

Given that the two departments have been dealing with this difficulty for so long, retired General the Honourable Roméo Dallaire and others have suggested a radical approach: “I think it is time to look at those countries that have moved their veterans departments over to their national defence departments. … The client is not handed over to somebody else. The client is still in the family.”[45]

In the Hon. Roméo Dallaire’s view, this is the only approach to convince people considering a military career to make the leap. There must be no doubt in their minds that

> there's a cradle-to-grave responsibility, not to the age of 65, not with a reduced way of life, but an actual covenant that they have committed themselves to unlimited liability, recognizing that they've come back injured, that their families are being affected, and that some of them are dead and their families are obviously affected, and then you've got them for life. If you don't sell that, then you will not gain their trust.[46]

Integrating the two departments would facilitate another recommendation that the Committee has heard repeatedly: establish a care team that would follow CAF members while they are still in active service and beginning their transition, and would continue to provide them with the necessary services when they become veterans. This is the approach advocated by Kim Basque of the Association québécoise de prevention du suicide:

> We suggest that the same health care team follow the veteran, whether he is an active member of the military or a veteran released from the Canadian Forces because of the

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43 *Evidence*, 6 February 2017, 1550 (Mr. Brian Harding, As an Individual).

44 ACVA, *Evidence*, 15 February 2017, 1530 (Colonel Russ Mann, Special Advisor, Vanier Institute of the Family).

45 ACVA, *Evidence*, 6 March 2017, 1620 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

46 ACVA, *Evidence*, 6 March 2017, 1600 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

> state of his or her health. Of course that would help the transition. Ultimately, it would in a way eliminate that transition. The same health care team would take care of the same member, whose needs would evolve. Since the request for assistance continues to be fragile among male military members, it is important that it be received with an eye to its particularities. You have to continue to build the trust that was created, rather than changing the caregivers.[47]

General Dallaire emphasized the strong commitment reflected in the CAF suicide prevention strategy.[48] VAC is also working on its strategy, and both departments are working on a joint DND-VAC suicide-prevention strategy that has not yet been released.[49]

The Mental Health Commission of Canada has indicated that it is ready to work with VAC to introduce its national suicide prevention model, which could target communities with a higher veteran population.[50]

3.3. Career transition

A significant part of the identity and sense of purpose of CAF members is determined by their work. This aspect of their lives must undergo a complete overhaul during their transition to civilian life. Members receive a good deal of information in the months preceding their release from such sources as the Second Career Assistance Network.[51] Spouses are encouraged to attend these optional workshops, which last two days, or three in the case of a medical release. CAF members can attend the workshops more than once if they wish.[52]

In the case of CAF members who are medically released, DND's Service Income Security Insurance Plan (SISIP) guarantees 75% of their income prior to release and offers a vocational rehabilitation program. However, members do not have an opportunity prior to release to test their skills in areas where they might want to pursue a career. They must enter civilian life, take training and then secure employment, at a time when every aspect of their life is changing. VAC offers a similar program, but it cannot begin until after the two-year period for SISIP has elapsed. The two departments have been trying to harmonize these two programs for a number of years, but no solution has been found yet.

The Canadian Armed Forces Transition Assistance Program also helps veterans find work with close to 200 registered employers who recognize the value of their skills

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47 ACVA, *Evidence*, 6 March 2017, 1715 (Ms. Kim Basque, Training Coordinator, Association québécoise de prévention du suicide).

48 ACVA, *Evidence*, 6 March 2017, 1540 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

49 ACVA, *Evidence*, 8 December 2016, 1535 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

50 ACVA, *Evidence*, 13 February 2017, 1600 (Mr. Ed Mantler, Vice-président, Programs and Priorities, Mental Health Commission of Canada).

51 ACVA, *Evidence*, 22 February 2017, 1540 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

52 ACVA, *Evidence*, 22 February 2017, 1555 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

acquired in the military. Some 1,200 veterans have found employment through the program, and it has a target of 10,000 jobs in 10 years.[53] Efforts to establish equivalencies between military competencies and civilian ones should be noted, but they do not go as far as enabling transitioning CAF members to apply their competencies directly in a civilian context before release.[54]

The Joint Personnel Support Unit (JPSU) coordinates most of the transition services but it does not enable releasing members to apply their skills in a job that could continue after the transition process has begun. Barry Westholm emphasized this point during his testimony:

> This is one of the things where the JPSU can play a big part. When you're in the transition outstream, you are leaving the Canadian Armed Forces. You are going to be a civilian. That's where you should be able to try out different jobs, professions, what it's like to be in civilian communities, and working within a framework other than the military framework. It's letting go of the military, and the military should be letting go of you. However, it doesn't work that way. As it is right now, you could be standing at attention by a desk the day before you get out of the military. The transition part is totally broken, and it has been since this thing stood up.[55]

Witnesses suggested that the CAF, DND, VAC and the entire federal government should work together to lead the way and find places for service members who can no longer serve in their unit. The Hon. Roméo Dallaire strongly recommended that medically released members be integrated into civilian positions with the CAF. “Why try to convert a person completely when you can build on a person? Why not find gainful employment in, around, surrounding, contractually or otherwise, what veterans have grown up with, what they have given their loyalty to, namely, the armed forces?”[56]

Brian McKenna suggested taking the same approach throughout the federal public service:

> If someone in the Department of Fisheries can no longer serve, they get offered jobs in Immigration or Canadian Heritage before they're released from the civil service. Why not for our vets? … If the military has decided it has broken you and you have to go, it would be a good idea if they could scour the civil service jobs before they release you. The government shouldn't look at these people as a resource to pull from in the future, but rather, people they shouldn't have let go in the first place, even if there's no role for them still in the military.[57]

In order to address the career transition needs, the Committee recommends:

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53 ACVA, *Evidence*, 22 February 2017, 1545 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

54 ACVA, *Evidence*, 22 February 2017, 1600 (Captain (N), Marie-France Langlois, Director, Casualty Support Management, Joint Personnel Support Unit, Department of National Defence).

55 ACVA, Evidence, 29 November 2016, 1640 (Mr. Barry Westholm, As an Individual).

56 ACVA, *Evidence*, 6 March 2017, 1540 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

57 ACVA, *Evidence*, 29 November 2016, 1545 (Mr. Brian McKenna, As an Individual).

Recommendation 3

That the Department of National Defence and Veterans Affairs Canada harmonize their transition programs and services, and launch an initiative to:

- **ensure that releasing members and veterans have access to dedicated career transition services;**

- **examine and look to improve access for releasing members and veterans to priority hiring in the public service.**

3.4. Mental health problems and the risk of suicide

All of the factors identified previously can contribute to mental health disorders among military members and veterans. Moreover, these disorders constitute the biggest risk factor for suicide. As General MacKay noted:

> We find that about 50% of people who die by suicide have been diagnosed with one or more mental disorders, with major depressive disorder being the most prevalent condition. Typically, people also have one or more life stressors, with failing intimate partner relationships as the most common. Other factors often seen include work-related problems, debt, legal difficulties, and physical health problems.[58]

In other words, the risk factors for suicide are the same as those for mental health disorders, and situational stress factors contribute as well. Dr. Alexandra Heber of VAC expressed the same idea:

> The first thing I'll say is that the factors that lead to what I call that "suicide pathway" are similar for veterans and for any member of the general Canadian population. The first factor is that almost all people – 90% or more – likely have a mental health problem at the time they commit suicide. … The other factor that is usually present right before the suicide is some stressful life event. Often it is something like a relationship breakup, or perhaps the person has run into trouble with the law or has lost their job. … That sets them off starting to think about suicide. … Often people do this impulsively. Often, if people can be stopped from committing suicide today, and especially if help is provided, they will not go on to commit suicide.[59]

Dr. Sareen presented the act of suicide as the end result of a continuum that can be affected unpredictably by additional stressors:

> I think there's usually a suicide attempt before, and often there's suffering for a period before someone attempts. Sometimes, if there's alcohol involved, there can be impulsive events. The strongest evidence around suicide prevention is around restricting lethal means – for example, access to firearms like hunting rifles, and access to large quantities of medications. Those are two, really, that have been shown to have quite a bit of evidence.

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58 ACVA, *Evidence*, 15 November 2016, 1550 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

59 ACVA, *Evidence*, 20 March 2017, 1605 (Dr. Alexandra Heber Chief of Psychiatry, Health Professionals Division, Department of Veterans Affairs).

> I think most people suffer for a long time, but if there is alcohol involved, sometimes it's quite impulsive when that event occurs.[60]

Representatives from the Association québécoise de prévention du suicide provided insight into the aspects of military life that could increase the risk of suicide:

> When a man conforms to the traditional male role, he is five times more likely to attempt suicide than a member of the general population. In the armed forces, a medical release is a failure of the system, but it is also a failure for the man who finds himself in a vulnerable situation. As that perception is generalized within himself and within his unit, he feels shame and has difficulty seeking help, as we were saying. Therefore, going from active military service to civilian life and becoming a veteran is a critical moment when the vulnerable soldier loses the strong and unified network with which he identified and participated in. So that will be an extremely difficult moment that must be anticipated and monitored.[61]

The spirit of mutual support, often associated with a male culture, is vital to the cohesiveness of the armed forces, and a way must be found to maintain the strength of this solidarity after military release.

3.5. Glorification of suicide

> *I heard a story when I was at base Gagetown of how another soldier had killed himself by hanging from the stairs in the basement, so I took some paracord to the basement one day while my ex had the kids out shopping. I tied a rope to the stairs and around my neck. I never hung myself, but that was enough for me. I broke down, and I knew I needed help. My desire to have a stable family life was disintegrating before my eyes. Like a house that been engulfed by fire, I just had to watch it burn from the side, never having the mental ability to do anything about it.*[62]

Participation by the Association québécoise de prévention du suicide (AQPS) opened up a difficult discussion on the social acceptability of suicide. They questioned how to reconcile the willingness to view the suicide of a service member or veteran as the result of a service-related injury with the risk of presenting suicide as a heroic act of self-sacrifice and a courageous release from suffering.

AQPS representative Catherine Rioux explained that every effort must be made to make suicide less socially acceptable, particularly among men:

> That acceptability appears to be stronger among men who conform to the traditional male role. … As part of education, society should avoid glorifying individuals who have died by suicide, since that involves a risk of contagion. To avoid that, the media must

60 ACVA, *Evidence*, 17 November 2016, 1620 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

61 ACVA, *Evidence*, 6 March 2017, 1650 (Ms. Kim Basque Training Coordinator, Association québécoise de prévention du suicide).

62 ACVA, *Evidence*, 27 octobre 2016, 1625 (Mr. Brandon Kett, Veteran, As an Individual).

> be educated. I know that is being done already, but the message must constantly be repeated, as newsrooms and journalists are always changing.[63]

This approach presents an additional difficulty in a military context, given the symbols and rituals involved when a service member or veteran dies:

> We must also educate people in charge of ceremonies when a death by suicide occurs, as well as grieving families. That is a very delicate thing to do, but we must pay attention to that if we want to save the lives of suffering veterans. Some practices can have consequences, such as the erection of monuments honouring military members who died by suicide. We see them as a real risk to veterans who are suffering, who are vulnerable to suicide and who have lost a tremendous amount of recognition and value. Those veterans could see suicide as a way to regain some honour and recognition. Let us be clear: appropriate funeral services must be provided for military members who have taken their lives, just like for military members who died of other causes, but attention must be paid to the potential glorification and contagion aspect.[64]

Kim Basque, also from the AQPS, emphasized the need to ensure that, by honouring the person, we do not "send the message that we are also paying tribute to the way in which he or she ended his suffering.[65]

The Hon. Roméo Dallaire stated that it is important to first recognize the mental health disorder that may have led to suicide. A balance must be found between recognizing an honourable injury while not honouring the way in which the person died:

> Before they commit suicide, the option is to have a system of recognizing them as being injured honourably. If you have a solid way of showing that they've been honourably injured, just like we take care of the guy or girl who has lost an arm or a leg, and they feel that they've been honourably recognized in that way, then you have an equilibrium with those who simply have gone the other route. If you only try to recognize them because they've committed suicide, I agree entirely with them. The onus is on the prior recognition of an honourable injury that they've received and that we've treated them honourably and that their regiments and so on have done the same. Then you have established a balance.[66]

4. MEFLOQUINE AND ITS IMPACT ON THE MENTAL HEALTH OF CANADIAN MILITARY PERSONNEL AND VETERANS

In September and early October of 2016, veterans of Canada's 1992−1993 mission to Somalia, as well as veterans from other deployments, including Afghanistan, made representations to the Canadian government stating that they believed they were suffering from health problems due to mefloquine, an antimalarial drug they were required to take

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63 ACVA, *Evidence*, 6 March 2017, 1645 (Ms. Catherine Rioux, Communications coordinator, Association québécoise de prévention du suicide).

64 ACVA, *Evidence*, 6 March 2017, 1650 (Ms. Catherine Rioux, Communications coordinator, Association québécoise de prévention du suicide).

65 ACVA, *Evidence*, 6 March 2017, 1710 (Ms. Kim Basque, Training Coordinator, Association québécoise de prévention du suicide).

66 ACVA, *Evidence*, 6 March 2017, 1715 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

during their missions. The matter was referred to the Committee by the government. As it had just begun its study of mental health and suicide prevention, the Committee decided to address the issue of mefloquine.

During its hearings, the Committee examined three inter-related aspects of this issue:

- current knowledge about the risk of short- and long-term psychiatric effects associated with the use of mefloquine;
- the appropriateness of continuing to offer this drug to CAF members sent to at-risk areas;
- the risk of diagnostic confusion regarding the possible symptoms of mefloquine and the symptoms of PTSD, as well as the treatment of these symptoms.

4.1. Current knowledge about the psychiatric effects of mefloquine

Mefloquine was discovered as part of an ambitious research program initiated by the United States military in the late 1960s, in response to the high incidence of malaria. At its worst, malaria was claiming 1% of the soldiers deployed to Vietnam each day.[67] The drug was first marketed by Hoffmann-La Roche under the name Lariam in the late 1980s and was approved by Health Canada in January 1993.[68] After becoming commercially available on 31 December 1993, the drug became popular among travellers to at-risk areas because it was slow to be eliminated by the body. The slow release meant that the drug could be taken once a week, unlike the alternative doxycycline, which has to be taken daily. Close to 30,000 Western travellers contract malaria annually, and between 300 and 1,000 of them die from it.[69]

Until the mid-2000s, the recognized side effects of mefloquine were gastro-intestinal problems and minor neuropsychiatric events such as dizziness and sleep disruption. Gradually, the widespread use of the drug revealed a few rare but serious episodes of anxiety, depression, hallucination and psychosis. However, these episodes were too few to establish a causal relationship with the drug. The CAF Surgeon General stated that, "writ large, for those who have received mefloquine … one in 11,000 or one in 13,000 persons may experience a severe reaction."[70] This ratio is similar to the findings of reliable studies that showed the risk of serious adverse events to be approximately

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67 Ashley M. Croft, "A lesson learnt: the rise and fall of Lariam and Halfan," *Journal of the Royal Society of Medicine*, Vol. 100, No. 4, April 2007, pp. 170–174.

68 Ms. Maria Barrados, Assistant Auditor General, Standing Committee on Public Accounts, 18 November 1999, 1535.

69 Patricia Schlagenhauf et al., "The position of mefloquine as a 21st century malaria chemoprophylaxis," *Malaria Journal*, Vol. 9, No. 357, 2010.

70 ACVA, *Evidence*, 3 November 2016, 1640 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

1 in 10,000.[71] The risk is greater for persons taking the drug for therapeutic rather than prophylactic use.[72] It must be noted that prophylactic use of doxycycline and Malarone has side effects including but not limited to gastro-intestinal problems, photosensitivity, dizziness, anemia, severe liver problems and other infections. Both of these medications are taken daily, or twice daily, and must be started prior to deployment, and for a period after completion.

Witnesses challenged these estimates, including Dr. Remington Nevin and Dr. Elspeth Ritchie, who stated that the statistics on serious mefloquine-related events should not conceal the high incidence of events that are less serious but still very significant: "[M]ost estimates are 25% to 50% of people on mefloquine have neuropsychiatric side effects depending on how we define the effects such as bad dreams or nightmares."[73]

The World Health Organization recommended that mefloquine be contraindicated for persons with a personal or family history of psychiatric disorders.[74] In 2014, the European Medicines Agency recommended that a warning be added regarding possible long-term neuropsychiatric reactions: "In a small number of patients it has been reported that neuropsychiatric reactions (e.g. depression, dizziness or vertigo and loss of balance) may persist for months or longer, even after discontinuation of the drug."[75]

Lariam has not been sold in Canada since 2 May 2013, and its monograph has not been updated since 2011. AA Pharma Inc. continues to produce and market generic mefloquine[76], and its monograph, dated August 2016, was posted on the Health Canada website during the last week of October 2016. A recent study, co-authored by Dr. Nevin, made the conclusion that the warnings produced in Canada are not as strongly worded as those issued in other countries.[77]

In light of this information, the Committee notes that:

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71 Patricia Schlagenhauf et al., "The position of mefloquine as a 21st century malaria chemoprophylaxis," *Malaria Journal*, Vol. 9, No. 357, 2010. See also ACVA, Dr. Elspeth Ritchie (As an Individual), *Evidence*, 25 October 2016, 1545.

72 Tuan M. Tran et al., "Psychosis with paranoid delusions after a therapeutic dose of mefloquine: a case report," *Malaria Journal*, Vol. 5, No. 74, 2006.

73 ACVA, *Evidence*, 25 October 2016, 1545 (Dr. Elspeth Ritchie, As an Individual). This statement is supported by a Danish study: Ringqvist, A., et al., "Acute and long-term psychiatric side effects of mefloquine: A follow-up on Danish adverse event reports," *Travel Medicine and Infectious Disease*, 2014, XX, pp. 1−9.

74 Patricia Schlagenhauf et al., "The position of mefloquine as a 21st century malaria chemoprophylaxis," *Malaria Journal*, Vol. 9, No. 357, 2010.

75 European Medicines Agency, Pharmacovigilance Risk Assessment Committee, "PRAC recommendations on signals," *EMA/PRAC/65788/2014*, 24 February 2014.

76 Health Canada, *Drug Product Database*, "Mefloquine."

77 Remington L. Nevin and Aricia M. Byrd, "Neuropsychiatric Adverse Reactions to Mefloquine: a Systematic Comparison of Prescribing and Patient Safety Guidance in the US, UK, Ireland, Australia, New Zealand, and Canada," *Neurology and Therapy*, Vol. 5, 2016, pp. 69−83.

- the risks of short-term psychiatric events, of varying intensity and severity, associated with the prophylactic use of mefloquine, although rare, are recognized by the scientific community; and

- the risks of long-term psychiatric effects are sufficiently recognized by the scientific community that they should be added to the drug's medication guide.

4.2. Use of mefloquine by Canadian military personnel deployed to Somalia

Despite the problems with the clinical trial protocol, all of the military officials believed at the time that "[W]hen used properly, Lariam is a drug that is safe and effective. While there are risks associated with even the proper use of Lariam, these are far outweighed by the benefits of being protected against a potentially fatal infection."[78] As Dr. Ritchie told the Committee during the current study:

> Back then, in 1993, we did not know that much about the neuropsychiatric side effects of mefloquine, and we sat in the circles with the preventive medicine officers and debated the risks and benefits of getting malaria versus using mefloquine, and we thought compliance would be enhanced by taking a medication that was once a week, rather than daily, as are Malarone and doxycycline. So mefloquine was widely accepted.[79]

The view expressed in this quote was shared by the then Assistant Auditor General: "[W]e don't question whether the drug should have been given to the soldiers – they had to be protected from malaria."[80]

Among these statements, in October 1993, Major Barry Armstrong said: "I believe that the UN's failures in Somalia are rather exceptional, considering previous peacekeeping successes. I believe that a simple reason may exist. Canadian and American troops may have been impaired by the use of mefloquine." Shortly thereafter, Major Armstrong made the following comment concerning Master Corporal Clayton Matchee: "The suicide attempt in theatre may also be mefloquine related."

In a reply to Member of Parliament John Cummins on 11 December 1994, the Honourable David Collenette, then-Minister of National Defence, pointed out that the adverse effects of mefloquine allegedly experienced in Somalia had not been reported during a deployment to Rwanda the following year. Minister Collenette believed that mefloquine could not have been behind the problems in Somalia since the same drug caused no difficulties in Rwanda:

> A close review of the relevant scientific literature does not indicate that mefloquine, when used to prevent malaria, impairs thinking or judgment. … On specific questioning, CF

78 Mr. Dann Michols, Director General, Therapeutic Products Directorate, Health Protection Branch, Health Canada, Standing Committee on Public Accounts, 18 November 1999, 1545.

79 ACVA, *Evidence*, 25 October 2016, 1540 (Dr. Elspeth Ritchie, As an Individual), (army psychiatrist until my retirement in 2010. I now work for the Washington, D.C., Veterans Health Administration, in its hospital).

80 Ms. Maria Barrados, Assistant Auditor General, Standing Committee on Public Accounts, 18 November 1999, 1535.

> medical authorities in Rwanda have not expressed any particular concern about mefloquine-related effects on thinking or behaviour among the CF units deployed in Rwanda; further, their operational commanders have not expressed any such concerns.[81]

During his appearance before the Committee, the Hon. Roméo Dallaire confirmed that he had clearly expressed his concerns after experiencing the drug's effects:

> I was on mefloquine for a year. About five months into it, I wrote the National Defence Headquarters, and I said this thing is affecting my ability to think. This thing is blowing my stomach apart. This thing is affecting my memory, and I want to get rid of it. … I then got a message back, which was one of the fastest ones I have ever got back, which essentially ordered me to continue, and if not, I would then be court-martialled for a self-inflicted wound because that was the only tool they had. Mefloquine is old-think, and it does affect our ability to operate.[82]

Many witnesses described how mefloquine affected behaviour. Dave Bona, a veteran who was deployed to Somalia and to Rwanda, described his perceived symptoms to Committee members:

> The first day I took mefloquine for Somalia, in 1992, I almost immediately felt sick. […]My vision would go black and I would see stars, I would feel disoriented and dizzy after. This would happen initially only on mefloquine days, eventually they would occur randomly the rest of the time – lying down, standing in line at super market, sitting at the supper table. … The dreams I suffered from were quite horrific. They involved the violent death by my hand of my loved ones and my section members. They were just like they were happening. I would wake up. I stopped sleeping. The day I took the pill, from then on, early in the tour, I didn't sleep, and that continued all the way through to Rwanda. … Throughout deployment [to Rwanda], there were daily trauma incidents, two, three, four or more some days. Not sure what to say about that. It sucked. To this day I am haunted by blown up little black kids. ... I did not sleep for first two weeks in Rwanda. … Every time I closed my eyes, all I would see was the image of dogs walking off carrying dead babies, and friends shot and blown up. The only thing that I could control that with, while I was deployed, was alcohol. … The depression started to take over – I would bounce between anger and being so depressed that I would sometimes catch myself holding my rifle in my hands, just thinking how easy it would be. … To this day I'm plagued with balance and dizziness issues. I can't even go on the waterslide with my kids. I can't go on roller coasters.[83]

Dr. Donald Passey told the Committee of his attempts to warn military officials and the Commission of Inquiry into Somalia:

> In 1996, January I believe, I forwarded a letter to the committee members. I wrote a letter to the Somalia Inquiry wishing to testify and inform the inquiry, as well as members of government and the Canadian Forces medical system, about the effects of mefloquine,

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81 Quoted in *Dishonoured Legacy: The Lessons of the Somalia Affair*, Report of the Commission of Inquiry into the Deployment of Canadian Forces to Somalia, 1997, Volume 5, Chapter 41, "The Mefloquine Issue," p. 1387.

82 ACVA, *Evidence*, 6 March 2017, 1615 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

83 ACVA, *Evidence*, 27 October 2016, 1615–20 (Mr. Dave Bona, Veteran, As an Individual).

> and my thoughts that it was affecting the Canadian Airborne Regiment members and their behaviour in Somalia, up to and including the death of Shidane Arone.[84]

Some witnesses experienced a sense of unfairness after the Airborne Regiment was disbanded. Claude Lalancette, a veteran of the Somalia mission, stated the following:

> I am a Canadian veteran paratrooper. I proudly served my country for over 10 years. I'm a member of the Royal 22nd Regiment and proudly served with the Canadian Airborne Regiment. On December 26, 1992, I was ordered by my government to deploy to Somalia for ops deliverance. Mefloquine was issued as an anti-malarial drug. This is where I can retrace the root of my mental health issues.[85]

Some Committee members found surprising that subsequent research was not conducted to determine the link between mefloquine and the behaviour of military personnel. As Dr. Nevin explained to the Committee:

> [W]ith the information we have available today, with the literature, with the science, with the recent acknowledgements by drug regulators of this drug's effects, I think many of the points of confusion that dominated this discussion in previous decades no longer apply.[86]

The information connecting mefloquine to the behaviour of some military personnel is too anecdotal to call into question the judgment of military officials, given the level of knowledge at the time. However, once the drug's effects started to raise doubts and were more thoroughly documented, some Committee members believe that a more thorough study should have been conducted to better identify the possible adverse effects of mefloquine.

Therefore, the Committee recommends:

Recommendation 4

That Veterans Affairs Canada reach out to members of the Canadian Armed Forces who served in Somalia, Rwanda, or other deployments in that time period, to ensure each is receiving the mental and physical health services and support, as well as Veterans Affairs Canada's benefits and programs to which they are entitled for their service.

4.3. Continued use of mefloquine as a prophylaxis against malaria

Possible long-term effects are still not well documented enough to establish a direct causal relationship, but the risk is pertinent enough for many regulatory agencies to request that a warning be included in the product information provided with the drug.

Dr. John Patrick Stewart of Health Canada supported this position during his testimony: "Some of the reports of adverse events with neuropsychiatric symptoms said

84 ACVA, *Evidence*, 25 October 2016, 1600–05 (Dr. Donald Passey, Psychiatrist, As an Individual).

85 ACVA, *Evidence*, 27 October 2016, 1540 (Mr. Claude Lalancette, Veteran, As an Individual).

86 ACVA, *Evidence*, 25 October 2016, 1720 (Dr. Remington Nevin, As an Individual).

that the symptoms persisted afterwards. It's not clear whether that's been caused by the medication, but it's there, so it's in the monograph to alert practitioners that this is something to consider when they're thinking of prescribing the drug."[87]

Dr. Nevin emphasized the importance of proper labelling to inform the public about all the risks identified by the scientific community.[88] Health Canada could justifiably be criticized for not updating the documentation promptly, but it has taken corrective action since. The Committee felt that this was a public health issue and made its concerns about labelling known in a letter to the Minister of Health.[89]

Dr. Nevin presented data from a scientific study supporting the use of a stronger warning that could influence prescribing practices:

> For example, in one recent study of Danish travellers who had previously reported adverse effects while using mefloquine, 21% of those reporting nightmares and 33% of those reporting cognitive dysfunction while taking the drug identified that these adverse reactions as still persisting over three years after use of the drug.[90]

According to the manufacturer's brochure, the drug's possible long-term effects include "anxiety, unreasonable feeling that people are trying to harm you, do not like you, etc., (paranoia), depression, seeing and hearing things, hallucinations, thoughts of suicide or harming yourself or someone else, feeling restless, feeling confused, and unusual behavior."[91] Dr. Stewart told the Committee that the possible connection between mefloquine and suicidal thoughts was added to the product monograph in 1999.[92]

These risks have led some scientists, military personnel and veterans to recommend that mefloquine simply be removed from the choices available to service personnel when they are deployed to a region where there is a risk of contracting malaria[93] or at least that it be a drug of last resort and that all necessary precautions be taken.[94] The Surgeon General of the CAF told the Committee that mefloquine has rarely been prescribed during deployments over the past 15 years:

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87 ACVA, *Evidence*, 3 November 2016, 1630 (Dr. John Patrick Stewart, Director General, Marketed Health Products Directorate, Health Products and Food Branch, Department of Health).

88 ACVA, *Evidence*, 25 October 2016, 1555 (Dr. Remington Nevin, As an Individual).

89 ACVA, Letter from Neil R. Ellis, Chair of the House of Commons Standing Committee on Veterans Affairs, to the Honourable Jane Philpott, 18 November 2016, http://www.parl.gc.ca/Content/HOC/Committee/421/ACVA/WebDoc/WD8608734/421_ACVA_reldoc_PDF/ACVA_LetterToMinister-e.pdf.

90 ACVA, *Evidence*, 25 October 2016, 1555 (Dr. Remington Nevin, As an Individual). The study is by A. Ringqvist et al., "Acute and long-term psychiatric side effects of mefloquine: A follow-up on Danish adverse event reports", Travel Medicine and Infectious Disease (2014).

91 AA Pharma Inc., *Product Monograph Including Patient Medication Information. Mefloquine*, p. 30. Monograph not available in French.

92 ACVA, *Evidence*, 3 November 2016, 1540 (Dr. John Patrick Stewart, Director General, Marketed Health Products Directorate, Health Products and Food Branch, Department of Health).

93 See, for example, ACVA, *Evidence*, 25 October 2016, 1655 (Dr. Elspeth Ritchie, As an Individual); see also *Evidence*, 6 March 2017, 1620 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

94 ACVA, *Evidence*, 25 October 2016, 1620 (Dr. Remington Nevin, As an Individual).

> In the early 2000s, mefloquine was the most often used antimalarial. This started changing in the mid-2000s, and now mefloquine is our least often selected medication. It accounts for about 5% of our current antimalarial prescriptions, whereas atovaquone/proguanil, first licensed in 2002, now accounts for about 80%. The remainder of prescriptions are for doxycycline.[95]

General MacKay maintained that mefloquine should continue to be offered along with the other antimalarials, and he emphasized that the rare instances of serious cases should not prevent all military personnel from benefiting from the drug. He was also critical of the negative publicity the drug has received:

> It's important to make sure that we consider all the available evidence and not rely on small bits of information, small groups of scientists who have opinions and theories, or jump to conclusions that might remove what has been recommended by the world experts as a useful antimalaria medication.
>
> More than 17,000 Canadian Armed Forces personnel and tens of millions of people worldwide have received mefloquine since it was first licensed to prevent and treat malarial infection. We are aware of the potential short-term side effects of mefloquine; however, even given this extensive use of mefloquine, severe neuropsychiatric adverse effects have very rarely been associated with its use.
>
> We are also aware of the assertions of some regarding their theories that mefloquine might cause long-standing neurological damage and mental health issues, which they themselves suggest requires more research to support. Our assessment of their assertions, at this time, is that they are not sufficiently supported through direct scientific evidence for us to remove mefloquine as an option for patients to protect themselves from malarial infection, particularly if they have used it safely in the past.[96]

This statement by the Surgeon General is consistent with the views expressed by the European Medicines Agency in a 2014 document, stating that mefloquine could be responsible for "very rare cases of long lasting and/or persistent neuropsychiatric adverse reactions."[97]

Service members deployed to at-risk areas have a choice of medications and their informed consent is now clearly required if they choose mefloquine. Few choose to take it and those who do must test its effects before they are deployed. Therefore, it is difficult to see why there should be a total ban on mefloquine, as it is recognized to be effective. Only a minority of users experience serious enough effects that they need to replace mefloquine with a different drug and, although a warning about the long-term effects is merited, there are still too few cases to outweigh the benefits of the drug.

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95 ACVA, *Evidence*, 3 November 2016, 1535 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

96 ACVA, *Evidence*, 3 November 2016, 1535 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

97 European Medicines Agency, Pharmacovigilance Risk Assessment Committee, Minutes of the meeting of 3-6 February 2014, EMA/158631/2014, 6 February 2014, p. 21. See also Brief by Remington Nevin, published 16 January 2017.

As the Committee emphasized in its letter to the Minister of Health, work is still needed to address the "paucity of empirical and peer reviewed scientific evidence concerning neurotoxicity and difficulties in finding potential treatment plans for those that may have persistent and lasting adverse symptomology that could potentially be linked to the use of mefloquine."[98] Although a clear diagnosis is not yet possible, the Australian Department of Veterans Affairs "recognises mefloquine as being associated with several health conditions under the Statement of Principles system that applies to treatment and compensation claims."[99]

4.4. Mefloquine and Post-Traumatic Stress Disorder

During their appearance, Dr. Nevin and Dr. Passey gave their opinion that, given the perceived similarity between symptoms of PTSD and those associated with potential neuropsychiatric effects of mefloquine, veterans could have been misdiagnosed as suffering from post-traumatic stress and received inappropriate treatment.[100] Dr. Nevin went so far as to offer his opinion that the symptoms caused by mefloquine were distinctive enough to be recognized, but he speculated that few doctors know them well enough to identify them correctly:

> I think that during brief diagnosis, brief encounters, if a clinician is not thoroughly familiar with the many symptoms caused by mefloquine, it may be tempting to assign certain combinations of symptoms caused by the drug to PTSD. … For example, dizziness caused by mefloquine is unlikely to be explained by PTSD. Amnesia, extreme severe dissociation and psychosis are symptoms commonly caused by mefloquine in certain circumstances but are not associated with PTSD.[101]

Dr. Ritchie noted that this is an interesting area of research and the U.S. Department of Veterans' Affairs is studying it carefully, but there is still much work to be done to be able to diagnose the effects of mefloquine:

> [T]here is an overlap in symptoms but some we think are unique to mefloquine. Those are the effects of damage to the vestibular part of the brain, that's the brain stem, so that's a dizziness, nystagmus, your eyes fluctuate back and forth, and then looking at all the other symptoms as well.
>
> We are now beginning a study at the veterans administration where we are trying to categorize the symptoms[…]. We're not there yet, but we think that we may find a combination of neurological and psychological problems. Of course, they're not mutually exclusive, and that's part of the challenge. You've served in Somalia, you've served in

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98 ACVA, Letter from Neil R. Ellis, Chair of the House of Commons Standing Committee on Veterans Affairs, to the Honourable Jane Philpott, 18 November 2016, http://www.parl.gc.ca/Content/HOC/Committee/421/ACVA/WebDoc/WD8608734/421_ACVA_reldoc_PDF/ACVA_LetterToMinister-e.pdf.

99 Australia, Department of Veterans Affairs, "Mefloquine Information", https://www.dva.gov.au/health-and-wellbeing/medical-services-and-conditions/mefloquine-information.

100 ACVA, *Evidence*, 25 October 2016, 1555 (Dr. Remington Nevin, As an Individual); ACVA, *Evidence*, 25 October 2016, 1600 (Dr. Donald Passey, Psychiatrist, As an Individual).

101 ACVA, *Evidence*, 25 October 2016, 1615 (Dr. Remington Nevin, As an Individual).

> Afghanistan, you've been exposed to the blast of combat, so you may have TBI and PTSD.[102]

Despite the similarities and the fact that "there is a great deal of overlap,"[103] the experts appearing before the Committee all agreed that "we should recognize there is yet no accepted medical diagnosis of mefloquine toxicity syndrome."[104]

The Committee believes some veterans have difficulty accepting a diagnosis of post-traumatic stress or some other mental health disorder. PTSD has been recognized for decades, while the long-term adverse effects of mefloquine have yet to be determined. While in some cases one may have been misdiagnosed as the other, it should not lead to a sound, empirically-based diagnosis being set aside because an alternative one would be more easily accepted. Dr. Don Richardson advocated the following approach:

> In general, however, in medicine we try to find the most probable condition the person is suffering with as opposed to trying to find multiple probabilities. For example, somebody might have taken mefloquine, but they were also deployed to an area where they were exposed to significant traumatic events, and are reliving those events. Personally, as a clinician, I would approach it by saying, "It sounds to me like the symptoms you're presenting with are probably PTSD. However, there are other things that might have contributed to it. Let's try the treatments that we know work well and see how you do." If they fully recover from the standard treatments, then most likely we have the correct diagnosis. If, however, somebody is not responding to treatment after six months, then I start getting concerned, i.e., is it the right treatment ?[105]

During his testimony, veteran Dave Bona read a letter from his wife describing the positive effects of changing his treatment in a manner that reflects the careful, results-based approach discussed by Dr. Richardson:

> Three years ago, Dave's psychologist changed his treatment plan to include the protocol of someone with a traumatic brain injury, a new therapy, one that retrains the brain around injured areas utilizing a type of electronically monitored neurofeedback. Results didn't happen overnight, and there were times that things seemed to get worse, but it finally settled in. The time span between rages lengthened, his ability to settle down eventually quickened from a week, to a few days, and eventually a few hours.

Advances such as this must be promoted, and every effort must be made to ensure that any treatment veterans receive meets their specific needs. In addition, research must be encouraged.

It is important not to over-extrapolate and question the diagnosis of post-traumatic stress itself, or to attribute a large number of ongoing mental health problems to mefloquine, when in all likelihood these are exceptional cases. As General MacKay, CAF Surgeon General, stated:

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102 ACVA, *Evidence*, 25 October 2016, 1615 (Dr. Elspeth Ritchie, As an Individual).

103 ACVA, *Evidence*, 25 October 2016, 1615 (Dr. Donald Passey, Psychiatrist, As an Individual).

104 ACVA, *Evidence*, 25 October 2016, 1720 (Dr. Remington Nevin, As an Individual).

105 ACVA, *Evidence*, 13 December 2016, 1625 (Dr. Don Richardson, Psychiatrist, Western University, Department of Psychiatry, Parkwood Operational Stress Injury Clinic).

> [F]or our deployment to Bosnia there were no antimalarial medications, and we certainly have seen mental illness as a result of the deployment to Bosnia. Our use of antimalarials in Afghanistan was limited. … Although the American forces were almost all on antimalarials, we gave them only to those who were going out into small regions on foot patrols in areas in which we thought they would potentially see malaria. Even given the limited use of antimalarials, which were primarily Malarone or doxycycline, we are still seeing a fairly significant amount of mental illness as a result of our efforts in Afghanistan.[106]

In light of the lack of solid evidence that would allow for a better differentiation between symptoms used in the diagnosis of PTSD and symptoms potentially associated with the long-term effects of mefloquine, the Committee recommends:

Recommendation 5

That Veterans Affairs Canada cooperate with any institution concerned in any research program that would study the effects of mefloquine.

5. PROTECTIVE FACTORS

5.1. Family members

> *[K]ids watch dad or mom go away, and they're so happy. There are pictures in the paper and big kisses at the navy wharf or wherever, and dad or mom goes off. Then dad or mom comes home, and there's a celebration, and the kids are proud of their parents, proud of their dad and mom. They talk about it in school. ...*
>
> *All of a sudden, six months later, out of the blue – mom may have seen a little bit but the kid hasn't – dad beats the tar out of mom. Holy mackerel, what a trauma. And nothing happens. Mom has heard a little bit about military issues and decides to do some checking, and then it happens again. Then all of a sudden, dad is charged. He goes to jail. There's a divorce. All this stuff happens. That is a trauma that will drag that kid for 60 more years after dad comes home from Afghanistan. We frequently forget that that happens and the impact of that trauma, which goes untreated and unrecognized. Forty years later that kid may have a real problem, and they'll never be able to track it back to that incredible trauma.*[107]

Often throughout this report, mention is made of how important it is for CAF members and veterans to maintain a solid support network, which constitutes one of the most effective factors offering protection against the development of mental health problems and the risk of developing suicidal thoughts. Family members are the first line in this support network. According to the Hon. Roméo Dallaire, this network must be incorporated into operational life within the CAF, to ensure that veterans, once they have left the military, do not lose the support they received while they were in the military as well as the support of family members outside the circle of military life.

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106 ACVA, *Evidence*, 3 November 2016, 1620 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence); for the testimony of veterans who state they have suffered mefloquine side effects during their deployment to Afghanistan, see John Buckle, *Brief*, published 23 January 2017; see also Dan K. Jones, *Brief*, published 8 February 2017.

107 ACVA, *Evidence*, 15 February 2017, 1630 (Mr. Philip Upshall, National Executive Director, Mood Disorders Society of Canada).

> For a reservist who's single, it would be his parents. They're part of the forces. And if he's married, it's his intimate family or close family and so on, his children. Bring the human side back to these individuals so they can build on that, and then work from there. We've lost a lot of people because they lost their families and there was nothing left. It was not just losing a job. They lost their families because of that, and they killed themselves because of that.
>
> Try to keep that fundamental element of our society with them, and help them go through the years of difficulty of living with a person like that.[108]

The solution advocated by the Hon. Roméo Dallaire would be to integrate family members into the operational life of the CAF through the Military Family Resource Centres (MFRCs). Such an approach would support implementation of the recommendation to extend MFRC access to veterans' family members.

For spouses of veterans dealing with mental health problems during their transition to civilian life, the adaptation can be especially difficult if this link with military life is completely severed. In a letter from Teresa Bona, the Committee heard about the shocking effect this transition had on her husband:

> Dave would accuse me of impossible things, create an alternative reality with details that were exaggerated or didn't exist to begin with. When I look into his eyes during these situations, and they still occur, it's as though the Dave I know and love has ceased to exist. His colour is off. His eyes are darker and look so mean, without humanity. It is truly very frightening to experience.[109]

Indeed, the Committee heard numerous disturbing accounts from family members, including the following from Stephanie Thomas: "he was so heavily medicated he would just sleep all day, shuffle to the bathroom, back to bed, to the table, and back to bed. And when I expressed my concern, I was told, 'Well, he's not hurting anyone.'"[110]

CAF Surgeon General, Brigadier-General MacKay, explained to Committee members that "[t]he Canadian Forces health services don't offer mental health services to family members."[111] Thus there is a gap in the continuum of services if family members experiencing difficulties during the military service of a loved one cannot receive support for themselves. This is another instance where the MFRCs can bridge the gap and provide assistance services to the families of military personnel.

While it is often said that severe PTSD symptoms can arise long after the events that triggered them, the warning signs of such symptoms are usually present well before an individual leaves the CAF or is given a medical release. Hence, from a strictly operational standpoint, in order to optimize the mental preparedness of military personnel,

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108 ACVA, *Evidence*, 6 March 2017, 1635 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

109 ACVA, *Evidence*, 27 October 2016, 1610 "Letter from Teresa Bona," (read by Mr. Dave Bona, Veteran, As an Individual).

110 ACVA, *Evidence*, 8 February 2017, 1645 (Ms. Stephanie Thomas, As an Individual).

111 ACVA, *Evidence*, 15 November 2016, 1635 (Brigadier-General Hugh MacKay, Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence).

the assistance offered to family members should be a central concern. In the words of the Hon. Roméo Dallaire:

> [T]he families must be integrated into that support structure. It's not about co-operating with the families or assisting the families, but about integrating them into the operational effectiveness of the forces. Why? It is because the families live the missions with us. In my case, I came back injured. I was thrown out of the forces injured. My family was injured. It wasn't the same family that I had left behind because the media make them live the missions with us.[112]

Along those same lines, Dr. Heidi Cramm of the Canadian Institute for Military and Veteran Health Research told the Committee that "[s]ocial support is one of the biggest predictors of people doing well in the context of living with mental health issues, so the idea that we would provide a service to someone who has something like PTSD, without supporting the family to support the person who has PTSD, is counterintuitive."[113]

Even when considered strictly in terms of the well-being of veterans, it seemed clear to the Committee members that such support for family members during military service constituted one of the best possible preventive measures when it came to the mental health of veterans. Therefore, the Committee recommends:

Recommendation 6

That the Canadian Armed Forces further integrate family members into their mental health and suicide prevention programs.

This approach focusing on the complete integration of family members must continue after CAF members leave the military and become veterans. What is at issue in this particular case is not just the well-being of veterans, but also the well-being of their spouses and children. With the one fortunate exception of the VAC Assistance Service, which will be discussed later in this report, VAC's capacity to intervene when it comes to family members remains limited. The VAC services to which veterans are entitled after contacting the department are still unavailable to family members. Despite the best intentions expressed by the VAC representatives who appeared before the Committee, it was quite evident that they were limited by their legislated mandate:

> [U]nder the various acts, Veterans Affairs is for the veteran. Most of our services, ... are aimed at the veteran. That said, we strongly encourage family members to attend the [operational stress injury] sessions, peer support, and various other programs. …
>
> However, that being said, there is a full range of services that we provide to the family, without going through the veteran. As an example, the 1-800 phone number is 24/7. …

112 ACVA, *Evidence*, 6 March 2017, 1535 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

113 ACVA, *Evidence*, 17 November 2016, 1655 (Dr. Heidi Cramm, Interim Co-Scientific Director, Canadian Institute for Military and Veteran Health Research).

> As we're advancing in our program, we are looking at how to have better programs for families. We have the family caregiver program, but again that is through the members themselves to help the caregiving side.[114]

The problem is similar for VAC clinics. Despite the best intentions of the individuals who work in those clinics, their ability to provide services to family members is restricted and, unless the veteran requires it, will be limited to referral, orientation and information:

> [W]e will treat the spouses and we will assess children and refer them to appropriate resources if necessary, but we will also provide education to the family members, adult children also, so they don't become the natural caregivers. Part of what we try to do in treatment is to let people know that their role is to be a spouse, not a caregiver or nurse. We take ownership of the treatment and of working together. Part of it is for someone as a spouse to become a spouse. That's their primary job.[115]

Improved integration of family members into the operational life of the CAF must therefore be pursued and extended to the families of veterans. Following the same logic:

> If the family is intrinsic to the operational effectiveness of the forces, they should have access to the same level of care. That means, yes, more money into VAC and more money into DND to take care of the families. We're already transferring a whack of money to the provinces. We're telling the provinces that we're going to clean up our own mess. We created these injured people and we're going to take care of them. We'll buy the resources from you instead of simply dumping them and having that very serious disconnect.[116]

At present, the death of a veteran is the only way for family members to become full-fledged VAC clients. Otherwise, the department can recommend services, can integrate family members into the services a veteran receives, and can offer up to 20 hours of mental health counselling through the Assistance Service, but family members remain dependent on the will of the veterans for all actions undertaken by VAC in their regard. Therefore, the Committee recommends:

Recommendation 7

That a veteran's family members have the opportunity to become Veterans Affairs Canada clients as soon as the veteran enrols in a Veterans Affairs Canada rehabilitation program.

5.2. Peer support

For members of the military and veterans dealing with mental health issues, peer support is an essential component of treatment and recovery. Dave Gallson of the Mood Disorders Society of Canada explained its importance as follows:

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114 ACVA, *Evidence*, 8 December 2016, 1540 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

115 ACVA, *Evidence*, 13 December 2016, 1640 (Dr. Don Richardson, Psychiatrist, Western University, Department of Psychiatry, Parkwood Operational Stress Injury Clinic).

116 ACVA, *Evidence*, 6 March 2017, 1610 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

> While professional help is very necessary, it's not always available at eight o'clock at night or midnight, when veterans need someone to talk to about their stresses or thoughts of suicide. With peer support programs, people have a network of peers who understand what they're going through, because they've experienced the same things and can relate on an equal level. Funding more programs like these, as well as effective research, would go a long way to supporting the mental health needs of veterans.[117]

The Operational Stress Injuries Social Support (OSISS) program is a peer-support initiative managed jointly by DND and VAC. Established some 15 years ago by Lieutenant-Colonel Stéphane Grenier, this program sometimes makes it possible to overcome veterans' reluctance to seek assistance.

The program comprises approximately 125 volunteers, and its services are organized by some 40 coordinators at DND and about 10 VAC employees. VAC's OSI clinics make use of the peers in the OSISS network, nearly all of whom have a history of mental health problems themselves. In a 2015 report, the House of Commons Standing Committee on National Defence estimated at approximately 2,000 the number of individuals who made use of OSISS services.[118]

Without denying the great usefulness of the program, Ms. Marie-Claude Gagnon, from It's Just 700, was concerned that the OSISS program, in its current design, was not well adapted for veterans with an OSI related to military sexual trauma:

> Our group therapy is with the OSISS program, which is mostly men who were in a combat role. If we think that it's good to send men who were in combat in Afghanistan to talk together and find support, then sure, that will be fair. I'm just saying that people who are in a combat-related role think there's a difference between them and, let's say, a policeman. They feel there's a different need. However, for us it's good enough: we need to go to the civilians, and we don't need our own group. By doing this, we're making sure that we can't regroup, we can't talk to each other. We can't bond and find our common issues. That's kind of a way to ensure that we can't connect with each other and find our strength together.[119]

Committee members share these concerns, and recommend:

Recommendation 8

That Veterans Affairs Canada and the Department of National Defence examine and make available programs, including peer support, for those veterans that have an operational stress injury related to military sexual trauma.

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117 ACVA, *Evidence*, 15 February 2017, 1555 (Mr. Dave Gallson, Associate National Executive Director, Mood Disorders Society of Canada). See also Mr. Michael McKean, as an individual, 3 April 2017, 1540.

118 House of Commons, Standing Committee on National Defence, *Caring for Canada's Ill and Injured Military Personnel*, June 2015, p. 43.

119 ACVA, *Evidence*, 6 February 2017, 1645 (Ms. Marie-Claude Gagnon, Founder, It's Just 700).

5.3. Chaplains

The medicalization of mental health problems and the general decline in religious sentiment may have detracted somewhat from the key role played by chaplains. Scott Maxwell of Wounded Warriors described the comfort that their presence brought and continues to bring:

> It was almost, within the regimental family, a place to go if you didn't want to go up the chain of command or tell any of your superiors anything about anything, because you just weren't sure how significant the problem was, or if it was even worth mentioning. It was a safe place within the regimental family to go and at least have that first point of discussion with someone you weren't fearful of, and you didn't fear any repercussions for saying something or asking a certain question.[120]

Although little of the testimony heard by the Committee mentioned the role played by chaplains, the Committee members suspect that their commitment to the well-being of CAF members is more greatly appreciated than the understated acknowledgements they receive would tend to indicate. They are asked to shoulder the suffering of a great many individuals and often do not receive the credit they deserve. Retired General Joe Sharpe made note of their contribution as follows:

> I visited a major army base to interview the padres about their role in dealing with [PTSD] and [operational stress injuries]. Fourteen of the 16 padres on that base had been diagnosed with PTSD.
>
> So if we're going to use padres – and we need to, as they're a critical part – we have to take care of the padres as well.[121]

Committee members consider that the contribution of chaplains to the mental health of military personnel has not been sufficiently recognized, and that, given the specific non-clinical nature of their listening and counseling, they are exposed to a heightened risk of developing mental health problems. The Committee therefore recommends:

> **Recommendation 9**
>
> **That the Department of National Defence better recognize the contribution of chaplains to the mental health of military personnel, and ensure the chaplains receive the mental health support they require.**

6. BARRIERS TO CARE

6.1. Career progression

Given the invisible nature of mental health problems, there is a reluctance to seek care that goes well beyond concern of stigma. Some believe that seeking mental health

120 ACVA, *Evidence*, 6 March 2017, 1625 (Mr. Scott Maxwell, As an Individual).

121 ACVA, *Evidence*, 6 March 2017, 1625 (Brigadier-General (Retired) Joe Sharpe, As an Individual).

care could be harmful to their career advancement. According to Colonel Downes, the CAF Director of Mental Health:

> We have people of all ranks of the Canadian Forces, from privates to generals, coming forward for care in our clinics. Each one of them makes an individual decision to come forward, certainly, and we encourage them to do so because we know that the best option for continuing their career is to come forward for care early, because they have the best chance of recovery if they come forward early.
>
> But another interesting point is that currently there is a rule in place such that people have to be medically fit to be promoted, and this rule is a barrier to care. People often, when they know they're potentially getting close to promotion, may decide to wait until afterward. This particular policy is one that is under review as well.[122]

Several witnesses reported feeling very reluctant to express their concerns about their mental health when they were transferred to the JPSU. Kurt Grant shared his experience with the Committee members in these words:

> If I admit I have a problem, I'm going to be punted over to the JPSU. That stops my career progression right away. If I admit I have a problem, that I can't do the job, people are going to start looking at me differently. They will decide to pass me over and go to the next guy who doesn't have a problem. …
>
> Because of that, nobody's willing to admit they have an issue. Besides, let's be clear here. We're guys, okay? … Rather than face that demon, they would just as soon plow ahead and say they're okay.[123]

Ms. Céline Paris, a psychologist, pointed out that too little attention was paid to treatments that work:

> What I propose is that we communicate that PTSD is treatable and you can resolve it through treatment. If it stops being a life sentence the way the media has been portraying it lately, and the way patient groups have been portraying it, I think the stigma might then change. If it means that you go into treatment for a few months or maybe a year shortly after the time you've experienced the difficult events, then the whole face of this problem changes.[124]

Even though there is still a long way to go, CAF representatives, including Commodore Sean Cantelon, stated with conviction that the entire CAF culture was changing on this issue, and that this was reflected within the JPSU: “We are also bringing about a complete culture shift towards the ongoing care of those who are ill and injured, so that the fragility to the [JPSU] that you and others have spoken about won't be there. That culture shift is ongoing right now.”[125]

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122 ACVA, *Evidence*, 15 November 2016, 1720 (Colonel Andrew Downes, Director, Mental Health, Department of National Defence).

123 ACVA, *Evidence*, 29 November 2016, 1700 (Mr. Kurt Grant, As an Individual).

124 ACVA, *Evidence*, 5 April 2017, 1720 (Ms. Céline Paris, Psychologist, As an Individual).

125 ACVA, *Evidence*, 22 February 2017, 1550 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

6.2. Wait times for mental health care

The control which the CAF exercises over its health system gives CAF members a real advantage over veterans in terms of the availability of care. The wait times required to obtain services are clearly shorter for members of the military than they are for other Canadians:

> [W]ithin our psychosocial services, the benchmark is two weeks. That is, again, for non-urgent, elective care. Obviously, more urgent cases will be seen sooner than that.
>
> Within the general mental health department and the operational trauma and stress support centres [OTSSC], it's 28 days. Over the past year, the average across our system has been 25 days for general mental health and 32 days for the OTSSC.[126]

This relatively fast access to care also applies to cases involving the risk of suicide: [M] ilitary members have much greater access to mental health services if they are suicidal than the civilian population."[127]

As far as veterans are concerned, Michel Doiron of VAC described some of the progress made by his department in terms of the speed with which requests involving service-related mental health problems were being processed:

> 94% of people coming to us with mental health issues are being approved on first application, and a lot of them are within the 16-week standard. ... When you hear it's a bit longer than 16 weeks on the mental health side, we typically are lower. The only thing is that we need to have the diagnosis and that sometimes can be an issue.[128]

The issue alluded to by Mr. Doiron is related to the fact that veterans, unlike members of the military, have to rely on provincial services. That being said, the shortage of mental health professionals across Canada means that veterans and other members of Canada's population must face substantial wait times before they can obtain treatment. It is for this reason that VAC decided to set up a network of clinics.

For veterans, the first barrier to care is therefore the same as that faced by Canadians in general, namely the shortage of mental health specialists in provincial health care systems.[129] However, this barrier can easily be overcome if veterans contact VAC or are already VAC clients, at which point access to VAC clinics and to the network of VAC-authorized specialists allows veterans to receive treatment services faster than the general population.

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126 ACVA, *Evidence*, 15 November 2016, 1610 (Colonel Andrew Downes, Director, Mental Health, Department of National Defence).

127 ACVA, *Evidence*, 17 November 2016, 1550 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

128 ACVA, *Evidence*, 8 December 2016, 1605 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

129 ACVA, Evidence, 3 April 2017, 1555 (Mr. Philip MacKinnon, As an Individual).

This Committee, the Veterans Ombudsman and the National Defence and CAF Ombudsman, have all recommended on numerous occasions that for military personnel who are released for medical reasons, all benefits should be adjudicated, and all services put in place before the member is officially released. Committee members want to emphasize that position once more for releasing members who suffer from a mental health condition, and therefore recommend:

Recommendation 10

That the Department of National Defence and Veterans Affairs Canada ensure that all medically releasing members diagnosed with a mental health condition have their mental health care in place as close as possible to where they will reside, at an Operational Stress Injury clinic or with other mental health care providers, before they are released from their military service.

For veterans who are released for reasons other than medical, the initial contact with VAC constitutes a barrier in and of itself. Veterans who are not already VAC clients, who were released from the military for medical reasons or for any other reason, and who experience mental health issues several years after leaving the CAF will not necessarily have the instinct to contact VAC. Often, they do not think of themselves as veterans and are not familiar with the services available to them through VAC.[130] To overcome this barrier, Shelley Hale of the VAC clinic at the Royal Ottawa suggested launching a national public awareness campaign directed at front-line workers in the provincial health systems:

> What we would love to see adopted and tried is a national public awareness campaign that would cue veterans as they enter into any avenue of the health care system whether it's the emergency room, their family physician's office, or a walk-in clinic. If we could teach all health care providers to ask someone if they have served, that would open up a whole avenue for clients who aren't attached to Veterans Affairs Canada. Having all service providers educated to ask that one simple question would mean more veterans could access services that have already been established for them.[131]

The Vanier Institute of the Family's Leadership Circle is already contributing to a similar initiative. In her appearance before the Committee, the Institute's CEO, Nora Spinks, described her organization's activities to make front-line workers more aware of the importance of identifying the specific needs of veterans:

> The circle has four purposes: to build awareness, so that's public awareness information; to build capacity, which is organizational capacity, enhancing what's already there; to build competency, which is the professional competency and making sure that every family physician has basic military literacy, and we were able to get 35,000 family physicians some material on military literacy in the last month; and then finally, to build community, so that if somebody comes to the Distress Centre or to Mood Disorders or to a child care centre and is reaching out, whoever they reach out to will know how to get them to the right place.

130 See for example ACVA, Evidence, 3 April 2017, 1610 (Mr. Joseph Brindle, As an Individual).

131 ACVA, *Evidence*, 13 February 2017, 1540 (Ms. Shelley Hale, Director, Operational Stress Injury Clinic, Royal Ottawa Health Care Group).

> Now if you call 911, you may get patched over to the Distress Centre. If the Distress Centre has military literacy, then it will be able to do its job even better than it's already doing, and it's doing an amazing job. Those are the four purposes.[132]

Breanna Pizzuto, representing the Distress Centre of Ottawa and Region, described a follow-up service that could supplement the proposed campaign to better identify veterans:

> If a patient presents to an emergency department at a specific hospital and consents to a call from us, they will receive a call within 24 to 72 hours after their discharge. If they're admitted to the hospital, we'll give them a call after their discharge, however long that may be. We'll check in with them and see if the hospital left them with a discharge plan, if they're following their medication regimens, and if they're seeing who they're supposed to be seeing. That's something that could be done with veterans, following up after the fact, because these people have said that PTSD doesn't necessarily show up right away. You can do a psych assessment the minute they're discharged, and they'll say they're fine. Then six months or a year down the road, the PTSD starts to crop up.[133]

VAC has already expressed interest in such approaches directed at health care professionals in the provincial networks.[134] In light of the low cost of such an initiative and the substantial potential benefits for veterans, the Committee recommends:

Recommendation 11

That Veterans Affairs Canada, in partnership with the provincial and territorial authorities concerned, launch an awareness campaign directed at front-line workers and healthcare professionals to help them identify veterans experiencing mental health problems, establish a system to follow up on the progress of such veterans, and refer them to Veterans Affairs Canada services.

6.3. Stigmatization

The stigma associated with mental health issues and suicide is a problem affecting all Canadians. Catherine Rioux of the Association québécoise de prévention du suicide indicated to the Committee that significant progress has been made in this area within the general population:

> Thanks to repeated awareness-raising campaigns, mentalities have started to change on the issues of suicide and mental health. Taboos are less entrenched and are starting to fade. Unlike 10, 15 or 20 years ago, suicide is no longer seen – or is less so – as inevitable and as an individual problem. People are more aware that it is a collective problem and that prevention is possible.

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132 ACVA, *Evidence*, 15 February 2016, 1610 (Ms. Nora Spinks, Chief Executive Officer, Vanier Institute of the Family).

133 ACVA, *Evidence*, 15 February 2017, 1635 (Ms. Breanna Pizzuto, Acting Community Relations Coordinator, Distress Centre of Ottawa and Region).

134 ACVA, *Evidence*, 20 March 2017, 1625 (Dr. Alexandra Heber, Chief of Psychiatry, Health Professionals Division, Department of Veterans Affairs).

> People talk more about their mental health issues and asking for help is more valued. We have come a long way in this area, but there is still much work to be done.[135]

However, members of the military are particularly affected by stigmatization because the predominantly male-oriented culture in the armed forces may lead members to put forward an image of strength and control that is incompatible with the initial acceptance that one may have a mental issue and the subsequent decision to seek assistance.

CAF representatives who appeared before the Committee, such as Commodore Cantelon, emphasized the progress made in recent decades:

> [P]reviously those were private conversations involving only two or three people, and now they're becoming more open. I think that's the best thing we can do. As the leaders of today's Canadian Forces, we're taking our leadership responsibilities and trying to change that culture so we don't get to that sense of alienation and loss of identity.[136]

Commodore Cantelon contradicted the widespread perception that admitting to a mental health issue would almost automatically lead to the medical release of a member:

> A mental health illness does not automatically mean a release from the Canadian Armed Forces. We've had other generals who have spoken and other chief warrant officers who have spoken about their own individual.... You manage and move forward. That's the key, so I want to break that assumption that, just because you go to see the psychologist or social worker with a problem, that automatically leads to release. I think the more we have those cases, the more we talk about the fact that you can move forward in your life and you can be a functioning member, and there's no restriction in regard to promotion, etc., the better off.... That's the culture piece I talked about earlier.[137]

He even went so far as to state that, within the upper echelons of the organization, few barriers remained when it came to gaining access to mental health care, but that in some cases individual sufferers might still believe the resulting stigmatization would be detrimental to their career. According to Commodore Cantelon:

> There's no one saying you can't go [to the hospital]. All you need to say is, 'Sergeant, PO, Commodore, I need to drop into the hospital tomorrow.' That's it. No one asks why. If you have a close work relationship, someone might ask that, but at the end of the day, it's up to the individual. ... That goes back to us, as a leadership team and as the Canadian Forces, to work hard on this culture, just as we're doing throughout the nation through the idea that a bandage that's invisible around your head is equal to a bandage around a broken arm from tobogganing on the weekend.[138]

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135 ACVA, *Evidence*, 6 March 2017, 1645 (Ms. Catherine Rioux, Communications Coordinator, Association québécoise de prévention du suicide).

136 ACVA, *Evidence*, 22 February 2017, 1605 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

137 ACVA, *Evidence*, 22 February 2017, 1630 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

138 ACVA, *Evidence*, 22 February 2017, 1630 (Commodore Sean Cantelon, Director General, Canadian Forces Morale and Welfare Services, Department of National Defence).

General MacKay also made it a point to dispel the perception that the military chain of command took precedence over medical personnel in decisions leading to the reintegration of members who had suffered mental health problems. CAF medical personnel determine whether a member is fit to rejoin his or her unit: "[T]he chief of the defence staff put out a directive that medical employment limitations assigned by physicians are to be followed by the chain of command. If we gave a direction that the individual needed to be sent back, then the chain of command would follow that."[139]

This openness demonstrated by current military personnel stands in contrast to the perception reported by others, such as retired general Joe Sharpe, who related situations in which the prospect of stigmatization prevents some members from seeking help:

> [A] young corporal, ... was telling me very candidly that he suffers from PTSD and is being cared for, but he said, 'Sir, you're hearing all the right words from the senior leadership in the organization.' It's an honest commitment coming from the senior leadership of the Canadian Armed Forces. This young lad is an infantry soldier in the process of being released. He said, 'On the ground, the sergeants and the warrant officers do not believe a word of that. To them, it's purely BS. If you come forward in your platoon or in your company and ask for help, you are a weak link, and they don't want you there.' That's Thursday of last week that this was described.
>
> Is the stigma gone? Absolutely not. The stigma is still there, but it's because we focus very, very strongly on changing that immediate behaviour. If we caught you, from a leadership perspective, badmouthing these guys, we're all over you. We're worried about behaviour, and we didn't really focus at the belief level.[140]

Thus, it would appear that some resistance still persists at the intermediate levels in the hierarchy, namely among those who interact most directly with members who might be willing to risk asking for help.

That being said, the culture of an organization such as the CAF cannot be transformed in the space of a single generation. Beliefs persist and still lead individuals to wait too long before seeking support and assistance. In the treatment of mental health issues, as is the case with other types of health problems, fast action is a key factor contributing to success. As the Hon. Roméo Dallaire noted, the beliefs underlying this reluctance to seek help are deep-seated:

> If you lose an arm, you know that you've lost it, so the aim is to try to build a prosthesis that will be as effective as possible. If you don't intervene with the same sense of urgency an operational stress injury by recognizing it first and then providing for it, it gets deeper and more difficult to get at and to resolve.

139 ACVA, *Evidence*, 15 November 2016, 1655 (Brigadier-General Hugh MacKay, Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence).

140 ACVA, *Evidence*, 6 March 2017, 1605 (Brigadier-General (Retired) Joe Sharpe, As an Individual).

> It took four years before I crashed. I lost one of my officers 15 years afterwards and having been treated. So there is a vacuum of how to get at them so that they don't continue to walk around as if they're not injured, without there being a stigma there.[141]

According to Scott Maxwell of Wounded Warriors, veterans are in a much more favourable situation because they are no longer afraid of being stigmatized. Thus they are far less reluctant to seek help, but this puts added pressure on a health care system that is unable to cope with the resulting increased demand for services., Mr. Maxwell indicated that in the experience of Wounded Warriors, there was a two-year waiting list in some cases:

> [The veterans are] obviously already out so there's a lot less risk, but there's more comfort in talking about their situation. They're comfortable to put themselves out there in a very, very vulnerable position, often among their own peers. It's happening all across the country. As I mentioned earlier, our problem is expanding access to programs, not trying to find ill and injured people to come into our programs. I think that certainly highlights that there is some progress being made for those who have released and for the veterans on the civilian side of the world to come forward, put their hands up, and seek help. There's a little bit of optimism there. The downside, of course, is we've have to make sure we can help them when they come forward.[142]

7. TREATMENT OF MENTAL HEALTH PROBLEMS

Numerous promising treatment options were presented during the course of this study. Some are in the exploratory phase, while others have already proven their viability. When institutional treatment is involved, the preferred option is to keep members of the military and veterans together amongst themselves. The esprit de corps that tends to be lost when members transition to civilian life seems to constitute one of the best protective factors against the development of mental health problems.

In the field of suicide prevention, Dr. Zul Merali of the Royal Ottawa Health Care Group presented some very encouraging preliminary research results on the use of ketamine for the treatment of depression. Normally an anaesthetic, his findings suggest that ketamine halts the onset of suicidal ideation much more quickly than traditionally prescribed anti-depressants.[143]

The care offered to individuals with suicidal ideation is essentially limited to psychological therapy, but increasing efforts are being made to add some innovative elements to the more traditional therapeutic psychological interventions. Dr. Sareen outlined the principal approaches that have yielded positive results:

> There are specific psychological interventions that can be done, cognitive behaviour therapy that specifically focuses in on suicidal behaviour, and then another type of therapy, called dialectical behaviour therapy, that has also been shown to help people

141 ACVA, *Evidence*, 6 March 2017, 1555 (Hon. Roméo Dallaire, Founder, Roméo Dallaire Child Soldiers Initiative).

142 ACVA, *Evidence*, 6 March 2017, 1605 (Mr. Scott Maxwell, As an Individual).

143 ACVA, *Evidence*, 13 February 2017, 1545–1550 (Dr. Zul Merali, President and Chief Executive Officer, The Royal's Institute of Mental Health Research, Royal Ottawa Health Care Group).

> who have made multiple suicide attempts to learn to manage those symptoms. Those are two therapies that are suicide-specific that both the military and veterans systems need to look at and ask how they can implement those.[144]

7.1. Screening

All of the studies on factors that can predispose some individuals more than others to developing mental health problems might suggest the possibility of predicting the probability that an individual will develop mental health problems if he or she is exposed to the stressors associated with military life. In other words, could the onset of mental health problems be prevented through improved screening for risk factors at the time of recruitment?

According to the CAF Surgeon General, Brigadier-General MacKay, such screening does in fact take place, and periodic follow-ups occur according to the age of members:

> We do a mental health screening for anybody who is recruited as they are coming into the forces. Then, with each periodic health assessment, there is a small section that does a screen for mental illness.
>
> Members under forty years of age have a periodic health assessment every five years; when they're over forty years of age, they have one every two years. We also do mental health screening as people are getting ready to go off on a deployment and we do the enhanced mental health screening within three to six months after a return from a deployment.[145]

It remains impossible to predict with any degree of confidence, however, whether a particular individual will have mental health problems while another will not. Since statistics on mental illness are compiled from large data sets, it is possible to predict approximately how many people in all will develop problems over a specified period of time, but it is not possible to identify those individuals. What can in fact be done with such preventive measures therefore remains extremely limited. According to Dr. Jitender Sareen, a psychiatrist at the University of Manitoba who specializes in veterans' mental health, "[R]ight now there is no screening process that is suggested around the world, that I'm aware of, to say people aren't eligible to be part of the military, unless they have a very serious psychotic illness."[146]

According to Dr. Merali, studies are being conducted elsewhere in the world to identify these risk factors and possibly determine that a particular individual might be too vulnerable for deployment:

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144 ACVA, *Evidence*, 17 November 2016, 1555 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

145 ACVA, *Evidence*, 15 November 2016, 1600 (Brigadier-General Hugh MacKay, Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence).

146 ACVA, *Evidence*, 17 November 2016, 1615 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

> That's happening in Netherlands right now. It is starting to happen here in Canada, but we are behind in taking measures pre-deployment. There are a lot of concerns about that, because, if you see indicators of vulnerability to PTSD, does that mean that we do not deploy someone? The debate is, do you want people who are hypervigilant, ready to go, are able to grab somebody from a disastrous situation and carry them to safety, and things like that, or do we weed them out with early predictors?[147]

A distinction also needs to be made between screening at the time of recruitment, screening at the time of deployment and post-deployment screening. Given the intense level of activity during a deployment, it is very difficult, strictly from an operational standpoint, to imagine having a systematic screening process. As General MacKay indicated: "I think it's very important to appreciate the limits of screening and the logistical implications that screening during a theatre of operations would bring."[148]

Obviously, some situations may arise that would require a member to interrupt his or her deployment: "If somebody required an antidepressant, for example, or medications that we would use to treat PTSD, they would not typically be retained in theatre. The symptoms would likely be significant enough that staying there could cause them to worsen."[149]

In order to get a fairly accurate picture of the long-term effects that a difficult deployment may have had on a particular member, a certain amount of time has to elapse, the stress level must be scaled back to a more routine level and the pace of the individual's day-to-day life must return to normal. This is why post-deployment assessments are important.

In the case of suicide, it is just about impossible to predict on an individual basis who will progress from suicidal behaviours to the actual act of committing suicide. According to Dr. Sareen: "If you have someone sitting in front of you, it's very hard to predict at an individual level who is going to make a suicide attempt in the future. ... Most of the instruments that have been tested so far do not predict, do not help a clinician at the individual level."[150]

7.2. Mental health care available to Canadian Armed Forces members

The CAF has its own health care system, particularly when it comes to primary care. It operates 37 centres and detachments in Canada and Europe. For specialized and ultraspecialized care, the CAF relies on the provincial health care systems, but the responsibility for treatment remains under the authority of the CAF. CAF Surgeon General,

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147 ACVA, *Evidence*, 13 February 2017, 1635 (Dr. Zul Merali, President and Chief Executive Officer, The Royal's Institute of Mental Health Research, Royal Ottawa Health Care Group).

148 ACVA, *Evidence*, 15 November 2016, 1600 (Colonel Andrew Downes, Director, Mental Health, Department of National Defence).

149 ACVA, *Evidence*, 15 November 2016, 1650 (Colonel Andrew Downes, Director, Mental Health, Department of National Defence).

150 ACVA, *Evidence*, 17 November 2016, 1555 (Dr. Jitender Sareen, Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba).

Brigadier-General MacKay, provided the Committee with a thumbnail sketch of the main components of mental health care:

> [W]e have over 450 established mental health positions, including mental health nurses, social workers, psychiatrists and psychologists, within our clinics' mental health departments.
>
> As of July 2016, 93% of these positions were filled. ...
>
> The seven largest clinics have operational trauma and stress support centres, or OTSSCs, which specialize in treating operational stress injuries, or OSIs. ...
>
> In cases of emergency after hours, Canadian Armed Forces members can contact the Canadian Forces member assistance program, or CFMAP, or a civilian crisis line. They can also go directly to a civilian emergency department or call 911. The seven OTSSCs are part of the joint network for operational stress injuries, which also includes the 11 Veterans Affairs Canada OSI clinics.[151]

With regard to awareness and education, the CAF has established the Road to Mental Readiness program:

> [W]e also have a nationally and internationally recognized mental health education and resiliency program, called Road to Mental Readiness. There are now over 30 modules of this program, which are given at different points in a member's career, starting at basic training. We have recently expanded the program to include occupationally specific training for occupations like search and rescue technicians and military police.
>
> Canadian Forces health services group also provides the strengthening the forces health promotion program. This important program includes education and skill development modules in areas such as suicide awareness, anger and stress management, healthy relationships, family violence, and addictions.[152]

Mental health problems are frequently combined with other disorders, particularly addiction issues, which add to the complexity of organizing proper treatment:

> [M]ental illness combined with substance-use disorder makes it very complicated to treat patients. We have in-house treatment available. We have addictions counsellors available and all of our mental-health providers can deal with addictions. But when we have really complicated, difficult cases, and sometimes when there's the co-morbidity of mental illness, we refer people out to civilian medical treatment facilities that can do in-patient care.[153]

According to Colonel Downes, the progress made by the CAF in developing services to mitigate the impact of mental illness should not be overlooked. In addition to doubling the number of clinical practitioners in its Operational Trauma and Stress Support

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151 ACVA, *Evidence*, 15 November 2016, 1540 (Brigadier-General Hugh MacKay, Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence).

152 ACVA, *Evidence*, 15 November 2016, 1550 (Brigadier-General Hugh MacKay, Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence).

153 ACVA, *Evidence*, 15 November 2016, 1720 (Brigadier-General Hugh MacKay, Surgeon General, Commander, Canadian Forces Health Services Group, Department of National Defence).

Centres (OTSSCs), the CAF has set up programs specifically for land force members, who are at greater risk of developing mental health issues that might lead to suicide. These programs, including the Sentinels Program and the Canadian Army Integrated Performance Strategy (CAIPS), were described by Colonel Downes:

> [T]he army, for example, knowing that its suicide rate is higher, has recently implemented what it calls the 'sentinels program,' which is a peer-based program in which certain members of a unit get special training so that they can more easily identify their colleagues who are having difficulties and encourage them to come forward for care.
>
> The army has also implemented a program that they call CAIPS ... another form of resiliency program that deals with different aspects of people's lives, from family to spiritual, to medical, to physical fitness, and so on. A lot of things have been put in place to tackle the problem of mental illness, and therefore, suicide as well.[154]

7.3. Veterans Affairs Canada services

Regular Force members are excluded from the *Canada Health Act*, and the Department of National Defence is fully responsible for the health care services extended to them. Upon their release from the CAF, however, members of the military become veterans and the responsibility for their health care services falls to the provinces, in accordance with the division of powers under the Canadian Constitution. As Dr. Cyd Courchesne of VAC explained to the Committee:

> Because veterans receive their health care in their communities, under their own provincial health authorities, we don't have access. We have no right to have access to that type of information unless it's shared with us. Our review and analysis is only based on what we know of the veteran, but it's an incomplete picture, unlike for our colleagues in the Canadian Forces, who have the entire medical record and can go more in depth.[155]

VAC's responsibility for the delivery of health services is therefore limited. It covers health services (including mental health services) that are not covered under provincial health care plans, in cases where the department determines that such services will support the well-being of veterans and ensure their independence and self-sufficiency. In most cases, veterans must demonstrate that the services they require are related to a health problem resulting directly or indirectly from their military service.

In the case of mental health services, most of the provinces do not cover specialized psychological services, certain residential treatments and certain drugs. VAC will cover the cost of such services if they contribute to the well-being of a veteran experiencing mental health problems related to military service.

According to the *2014 Fall Report of the Auditor General of Canada*, veterans with mental health conditions represent an increasing proportion of VAC clients: up from less than 2% in 2002 to almost 12% in 2012 (i.e., 16,000 of the 135,000 veterans who are VAC

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154 ACVA, *Evidence*, 15 November 2016, 1655 (Colonel Andrew Downes, Director, Mental Health, Department of National Defence).

155 ACVA, *Evidence*, 8 December 2016, 1555 (Dr. Cyd Courchesne, Director General, Health Professionals Division, and Chief Medical Officer, Department of Veterans Affairs).

clients).[156] Dr. Cyd Courchesne of VAC told the Committee that this proportion had in fact been underestimated: "Of our clients, 23% have a mental health disorder diagnosis."[157]

7.3.1. Veterans Affairs Canada's network of Operational Stress Injury clinics

VAC funds a network of 10 OSI outpatient clinics across the country, plus one 10-bed in-patient clinic located at Sainte Anne's Hospital in the province of Quebec. Eight smaller satellite clinics have also been established to serve certain less-populated regions.

The vast majority of patients receiving treatment at these clinics are veterans referred by VAC case managers. The outpatient clinics each handle between 100 and 300 open case files. Their primary mission is to provide treatment to veterans; they do not actively offer services to family members, but will provide such services at the request of a veteran. According to Michel Doiron, VAC's Assistant Deputy Minister of Service Delivery:

> Each OSI clinic has a team of psychiatrists, psychologists, social workers, mental health nurses, and other specialized clinicians who understand the experience and unique needs of veterans. To further improve accessibility, each OSI clinic provides services through telehealth, or distance health services, to support those living in remote areas.[158]

These clinics are separate from the seven OTSSCs established by the DND. The OTSSCs are located on CAF bases and primarily serve active military personnel. Under a tripartite agreement, however, both the CAF and VAC clinics may provide treatment to serving CAF members, veterans and current and former members of the Royal Canadian Mounted Police (RCMP). In her appearance before the Committee, Shelly Hale of the VAC clinic at the Royal Ottawa described the vital needs that have been met by this occupational stress injury clinic since it first opened eight years ago:

> [W]e've worked with over 1,700 clients. ... We are one of 11 clinics and the only one situated in a specialized mental health facility. Veterans Affairs, the Department of National Defence, and the Royal Canadian Mounted Police are the only agencies that can make referrals to our clinics, and we provide comprehensive assessments back to them about each referral that comes through our doors. Our clinic in Ottawa is responsible for half of the province of Ontario and western Quebec. We collaborate with seven area offices, three active bases, five integrated personnel support centres, and two RCMP divisions.[159]

For those individuals who, for one reason or another, receive services outside of these clinics, VAC maintains a list of approximately 4,000 approved mental health service providers to whom veterans may be referred as necessary.

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156 Office of the Auditor General of Canada, *2014 Fall Report of the Auditor General of Canada,* para. 3.6.

157 ACVA, *Evidence*, 8 December 2016, 1645 (Dr. Cyd Courchesne, Director General, Health Professionals Division, and Chief Medical Officer, Department of Veterans Affairs).

158 ACVA, *Evidence*, 8 December 2016, 1535 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

159 ACVA, *Evidence*, 13 February 2017, 1540 (Ms. Shelley Hale, Director, Operational Stress Injury Clinic, Royal Ottawa Health Care Group).

While acknowledging all these efforts, barriers to access to mental health care still remain for veterans, especially those who do not live in urban areas, or close to a military base or wing. The Committee therefore recommends:

Recommendation 12

That Veterans Affairs Canada, in collaboration with provincial and territorial partners, continue to find ways to improve access to mental health care for veterans through technological innovations or other means, including but not limited to the possibility of expanding the network of Operational Stress Injury satellite clinics, and investigating, in partnership with provinces and territories, incentives for professionals to work in rural, remote, and/or underserviced areas.

The establishment of these clinics is certainly one of the Department's most important contributions to the treatment of Veterans' mental health, and very little criticism has been made of them. An area that could deserve consideration was nevertheless raised by Dr. Ken Lee, a specialist on substance abuse and mental health issues. According to him :

> The mental health care provided in OSI clinics has always been focused on PTSD. Significant time and resources are spent in those clinics to filter out the diagnosis of PTSD as distinct from other mental health conditions that are not necessarily treated in OSI clinics.
>
> If we're going to make an impact on reducing veterans' suicide and improving their mental health, I think it's important that these OSI clinics broaden their scope and treat other mental health conditions. Depression is a large component of what we see, but the veterans do not necessarily qualify for treatment within these clinics unless there's an identified service-related PTSD condition. We make the diagnosis of sub-threshold PTSD to allow people to be qualified for treatment.[160]

In other words, according to Dr. Lee, attention to PTSD in VAC clinics may prevent some veterans from obtaining care for other mental health problems, particularly depression and substance addiction. Committee members do not wish to make any recommendations in this regard at this time, but wish to alert those responsible that there may be a selection of patients according to the type of problem, which appears to be incompatible with the spirit of openness of the clinics.

7.3.2. Veterans Affairs Canada Assistance Service

Johanne Isabel of VAC and Chantal Mallette of Health Canada gave a presentation to the Committee on the VAC Assistance Service, which is relatively unknown, although it has been in existence for some 15 years. It is a toll-free telephone service, available 24 hours a day 7 days a week, that allows CAF and RCMP veterans and their family members to receive immediate mental health counselling and referral services. The VAC

160 ACVA, *Evidence*, 5 April 2017, 1640 (Dr. Ken Lee (Medical Consultant, Parkwood Institute's Operational Stress Injury Clinic, Canadian Mental Health Association, Middlesex-London Branch, As an Individual).

Assistance Service is similar to the services offered under employee assistance programs in the public service. Veterans and their family members need not be VAC clients to avail themselves of these services, which are entirely confidential and offered in both official languages. The health professionals who answer these telephone calls are among those registered on VAC's list of approved mental health service providers; each of these qualified professionals holds a master's degree or a doctorate, and callers gain immediate access to their services.

Further to the recommendations contained in the Committee's April 2014 report, the number of hours of individual counselling provided free of charge by a mental health care professional was increased from 8 to 20.[161]

Interest in the VAC Assistance Service grew following this increase to 20 hours, and the number of users doubled since 2012, reaching a total of 1,143 in 2016. Of these:

> 68% are veterans, 28% are veterans' family members and 2% are retired RCMP members. The people who use the services are, on average, in their late forties or early fifties. People use the Veterans Affairs Canada assistance service mainly for psychological issues not related to military service or for couples counselling.[162]

It is interesting to note that the reasons individuals contact the Assistance Service primarily fall into the category of so-called stressors, namely factors that add to already existing mental and physical issues and that may have an exacerbating effect on these problems or lead to suicidal behaviour.

There are no eligibility criteria for this service, which is available to both veterans and their family members.[163] To gain immediate access to services, a person can simply call and mention that he or she is a veteran, the spouse or common-law partner of a veteran, or the child of a veteran. The person will be placed in contact with a mental health professional within one to five days, depending on the urgency of the case. If the professional feels that an individual might benefit from certain programs offered by VAC, the individual may be referred to a VAC official or case manager.[164] The number of sessions necessary will be determined by the professional according to the needs identified by the caller. On rare occasions, the maximum number of sessions may be increased to more than 20.[165]

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161 ACVA, *Evidence*, 20 March 2017, 1640 (Ms. Johanne Isabel, National Manager, Mental Health Services Unit, Directorate of Mental Health, Department of Veterans Affairs).

162 ACVA, *Evidence*, 20 March 2017, 1650 (Ms. Chantale Malette, National Manager, Business and Customer Relations, Employee Assistance Services, Department of Health).

163 ACVA, *Evidence*, 20 March 2017, 1715 (Ms. Johanne Isabel, National Manager, Mental Health Services Unit, Directorate of Mental Health, Department of Veterans Affairs).

164 ACVA, *Evidence*, 20 March 2017, 1700 (Dr. Cyd Courchesne, Director General, Health Professionals Division, and Chief Medical Officer, Department of Veterans Affairs).

165 ACVA, *Evidence*, 20 March 2017, 1710 (Ms. Johanne Isabel, National Manager, Mental Health Services Unit, Directorate of Mental Health, Department of Veterans Affairs).

At present, services are accessible only by telephone, which can pose an obstacle.[166] Most similar employee assistance programs offer online services that make it possible to reach a younger clientele. The greater anonymity of online services also sometimes helps to overcome the shyness that can arise during a personal discussion over the telephone. The representatives of the Association québécoise de prévention du suicide also recommended the integration of services.[167] Therefore, the Committee recommends:

Recommendation 13

That Veterans Affairs Canada and Health Canada work together to make the Veterans Affairs Canada Assistance Service available through online chatting, and accessible through multiple platforms.

The members of the Committee appreciate VAC's focus on professionalism within the context of its Assistance Service. However, some comments by the representative of the Distress Centre of Ottawa indicate that professional counselling must not be the only option considered, since contact with professionals rather than peers or volunteers can, in and of itself, constitute a barrier to care for some individuals:

> [A] study reported on by Distress and Crisis Ontario has shown that volunteer-based support outperforms paid professional support on suicide phone lines. When compared, volunteers conducted more risk assessments, had more empathy, and were more respectful of callers, which in turn produced significantly better call outcome ratings than paid professionals on phone lines. It makes sense then that perhaps a partnership between Veterans Affairs and some or all of these Canada-wide distress centres would be a good idea, in the interest of saving money and building on an existing, proven, and effective source of help.[168]

In order to offer the widest possible range of options that might assist veterans facing difficulties, the Committee recommends:

Recommendation 14

That Veterans Affairs Canada approach all its partners in mental health to establish a mutual cooperation strategy in order to better assist veterans in crisis situations.

7.3.3. Partnerships

VAC has developed other awareness or training tools in partnership with organizations known for their expertise in the field of mental health. Mr. Doiron of VAC described a few of these to the Committee members. For example, a basic learning

166 ACVA, *Evidence*, 20 March 2017, 1715 (Ms. Johanne Isabel, National Manager, Mental Health Services Unit, Directorate of Mental Health, Department of Veterans Affairs).

167 ACVA, *Evidence*, 6 March 2017, 1650–1655 (Ms. Kim Basque, Training Coordinator, Association québécoise de prévention du suicide).

168 ACVA, *Evidence*, 15 February 2017, 1550 (Ms. Breanna Pizzuto, Acting Community Relations Coordinator, Distress Centre of Ottawa and Region).

program called Mental Health First Aid for Veterans, adapted from a program developed by the Mental Health Commission of Canada, is offered to veterans and those around them free of charge. Ed Mantler of the Mental Health Commission of Canada presented the program to the Committee:

> The program ... improves knowledge about mental health and builds skills for recognizing and responding to mental health issues at the community level. ... The program improves the capacity of members of the veterans community and empowers them to address mental health problems and illnesses ... until professional help can be engaged.[169]

Debbie Lowther, representing Veterans Emergency Transition Services, an agency providing support to homeless veterans, participated in the final phase of the development of this program and recommended that the instructors providing the training be veterans themselves.[170]

The Government of Canada is also partnering with the Mood Disorders Society of Canada on a program to offer training to unemployed veterans suffering from mental disorders. Speaking on behalf of the Mood Disorders Society of Canada, Dave Gallson presented the highlights of this program:

> [O]ur goal is to assist nearly 450 veterans over three years who are experiencing obstacles within their communities. The program aims to provide the direct supports needed to address the emotional and coping strategy challenges of veterans, with a focus on employability skills, mental well-being, and peer support.[171]

VAC and Saint Elizabeth Health Care will soon be launching an online caregiver training program to support informal caregivers of veterans with mental health issues.[172]

Lastly, VAC contributed to the development of various IT applications that will be offered to veterans and their family members free of charge. Mr. Doiron discussed some the partnerships that led to the development of these applications:

> PTSD Coach Canada and OSI Connect are mobile apps that provide valuable information to CAF members, veterans, and their families impacted by an OSI. The operational stress injury resource for caregivers is a self-directed online tool for caregivers and families of CAF members and veterans living with an OSI. It provides self-care, problem-solving, and stress management techniques for managing the challenges of being a caregiver. 'Veterans and Mental Health' is an online tutorial

169 ACVA, *Evidence*, 13 February 2017, 1600 (Mr. Ed Mantler, Vice-President, Programs and Priorities, Mental Health Commission of Canada).

170 ACVA, *Evidence*, 30 January 2017, 1620 (Ms. Debbie Lowther, Co-founder, Veterans Emergency Transition Services).

171 ACVA, *Evidence*, 15 February 2017, 1555 (Mr. Dave Gallson, Associate National Executive Director, Mood Disorders Society of Canada).

172 ACVA, *Evidence*, 8 December 2016, 1535 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

> designed for anyone who is wanting to learn about service-related veteran mental health issues or who is supporting a loved one with a service-related mental illness.[173]

7.3.4. Family resource centres

The Veteran Family Program is a pilot project allowing medically released veterans to have access to 7 of the 32 MFRCs, to the Family Information Line (FIL), which offers services similar to those available under the VAC Assistance Service, and to CAFconnection.ca (which provides information and links to resources for military personnel, veterans and their families).

The MFRCs were established 25 years ago under the Military Family Services Program. The program's director, Laurie Ogilvie, explained that it "exists to support families in mitigating the challenges associated with service life, such as geographical relocation, operational deployments, and the inherent risk of military operations."[174]

Ms. Ogilvie told the Committee that the MFRCs are funded by the CAF under the Military Family Services Program, which provides them with $27 million annually; however, they are provincially incorporated non-profit organizations administrated by the families themselves. Each MFRC is an independent entity and can therefore adapt its services to the specific needs of the community it serves. This enables MFRCs to be:

> local community ambassadors or navigators for military families. Their governance construct and mandate provide the operational flexibility to meet the unique needs of the Canadian Armed Forces' community, and adjust quickly as demographic and operational landscapes change. Though they may have many services in common, no two resource centres are exactly alike.[175]

The VAC-funded pilot project, which extends from 2015 to 2019, gives veterans and their families access to seven MFRCs for two years following their medical release. According to Ms. Ogilvie, the veterans' families participating in the pilot project are better "able to transition from military to civilian life" and the "children and youth of ... medically released members [are receiving] the services they hadn't been receiving before."[176]

Based on Ms. Ogilvie's assessment that "veterans and families themselves are very encouraged and very supportive of the program,"[177] the Committee recommends:

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173 ACVA, *Evidence*, 8 December 2016, 1535 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

174 ACVA, *Evidence*, 8 February 2017, 1540 (Ms. Laurie Ogilvie, Director, Family Services, Military Family Services, Department of National Defence).

175 ACVA, *Evidence*, 8 February 2017, 1540 (Ms. Laurie Ogilvie, Director, Family Services, Military Family Services, Department of National Defence).

176 ACVA, *Evidence*, 8 February 2017, 1555 (Ms. Laurie Ogilvie, Director, Family Services, Military Family Services, Department of National Defence).

177 ACVA, *Evidence*, 8 February 2017, 1620 (Ms. Laurie Ogilvie, Director, Family Services, Military Family Services, Department of National Defence).

Recommendation 15

That Veterans Affairs Canada expand the Veteran Family Program, in cooperation with the Canadian Armed Forces and the Military Family Resource Centres.

7.3.5. Centres of excellence

In December 2014, the CAF established a Canadian Military and Veterans Mental Health Centre of Excellence and created a Chair in Military Mental Health, both in partnership with The Royal Ottawa Health Care Group. This centre is under the authority of the CAF Health Services Group, in collaboration with VAC.

In March 2017, pursuant to the federal budget, VAC announced the creation of a Centre of Excellence in Veterans' Care, specializing in mental health, PTSD and related issues for veterans and first responders. The link between these two centres has not been specified. However, key aspects of the VAC centre were presented by Dr. Cyd Courchesne of VAC:

> For the centre of excellence on mental health and PTSD, we've been consulting with the minister's mental health advisory group as to what they see being needed in that centre. …
>
> We want to be able to develop innovative practices and best practices, advance and build on what we're doing already, and provide education, and not just education internally for our own OSI network. This will generate knowledge that any care provider in the country who's looking after a veteran or someone dealing with PTSD can come to as a resource.[178]

These initiatives were well received, but Brian Harding pointed out the ambiguity of the term "centre of excellence":

> That, in my opinion, is a weasel word. What was actually demanded by veterans' advocates was specifically a treatment facility, yet that's what it turned into in the mandate.
>
> On the mental health advisory group that I'm a part of within VAC, we are pushing very hard for that to be a brick-and-mortar facility. We need something in a therapeutic environment filled with safe people who veterans can open up to. I'm not denigrating other people who have suffered from mental health disorders or trauma, but certain people are not compatible with each other. Vets also include former RCMP members. We need brick-and-mortar facilities that are unique to the VAC client population and have a constant ability, on a demand-driven basis, to get vets into full-time treatment. …
>
> [T]he main effort has to be something for treatments of 30 days or more.[179]

178 ACVA, *Evidence*, 8 December 2016, 1545 (Dr. Cyd Courchesne, Director General, Health Professionals Division, and Chief Medical Officer, Department of Veterans Affairs).

179 ACVA, *Evidence*, 6 February 2017, 1615 (Mr. Brian Harding, As an Individual).

Mr. Harding seems to argue that the activities of these centres of excellence should go beyond research and beyond the outpatient treatment that is currently available from VAC clinics. The VAC clinic at Sainte Anne's Hospital does offer in-patient treatment, but only for short stays.

Given the lack of options for veterans with mental health problems who would need in-patient care, the Committee recommends:

Recommendation 16

That Veterans Affairs Canada work with provinces, territories, and related service providers to ensure that veterans with an operational stress injury have all options available for treatment, while ensuring that the provincial and territorial jurisdiction for healthcare is recognized and respected.

7.4. Services offered by third parties

7.4.1. Dog therapy

The effectiveness of dog therapy to assist veterans dealing with mental health issues is currently a subject of considerable debate. Within VAC, there appears to be resistance stemming from the inconclusive results of available research regarding the quality of dog training. "We recognize dogs," Mr. Doiron of VAC told the Committee, "but that dog must be well trained and trained for what it is supposed to do."[180] While the Committee members appreciate the caution shown by government officials, the burden of providing a service that can be clearly beneficial to the well-being of veterans should not fall onto the shoulders of often less well-equipped community organizations.[181]

Ms. Liane Weber, from Companion Paws Canada, told the Committee that "medical studies have shown that companion animals significantly improve mental and physical health, including by reducing stress, depression, and anxiety symptoms."[182]

According to Philip Upshall of the Mood Disorders Society of Canada: "They work. ... The research proved what we knew worked. Common sense told us it worked. A hundred veterans told us it worked."[183]

Given the accumulated evidence supporting the efficiency of dog therapy, the Committee recommends:

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180 ACVA, *Evidence*, 8 December 2016, 1615 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

181 ACVA, Evidence, 3 April 2017, 1610 (Mr. Joseph Brindle, As an Individual).

182 ACVA, Evidence, 13 February 2017, 1530 (Ms. Liane Weber, Companion Paws Canada, The Lifeline Foundation).

183 ACVA, *Evidence*, 15 February 2017, 1645 (Mr. Philip Upshall, National Executive Director, Mood Disorders Society of Canada).

Recommendation 17

That Veterans Affairs Canada incorporate international research on service standards and efficacy studies on dog therapy.

7.4.2. Marijuana

In his appearance before the Committee, Dr. David Pedlar of VAC stated that nearly all veterans with mental health conditions also suffered from physical health conditions
that often involved chronic pain.[184] Since marijuana is now frequently prescribed for the treatment of chronic pain, a debate has now opened up on what approach VAC should favour regarding such medical use of marijuana by veterans.

The department is preparing a study that will guide its policies in the years to come. As Mr. Doiron of VAC explained to the Committee: “Our first step will be to do the research on marijuana. We're partnering with our colleagues at CAF to do proper research on the benefits of cannabis for medical purposes. ... Right now we just want to know if marijuana works and what the long-term effects are, whether it is addictive or not.”[185]

Dr. Merali cautioned against making any premature extrapolation of the research results without taking into account the specific dosage of the active ingredients in marijuana:

> THC and CBD are the two active ingredients with different properties, and we don't really understand exactly the advantages and disadvantages of the different components. It would be very interesting to get studies that look at the different kinds of mixes in a known amount so that you would know what you were dealing with. ... Therefore, it's very important to initially do a study in which you're looking at the actual components in a titrated way just as you would give a drug treatment, so that you would know what you're dealing with. Once you have clear answers, you can match up the strains of marijuana with the specific kind of profile that you want.[186]

7.4.3. Other initiatives

The Committee heard from several witnesses about promising and innovative initiatives that demonstrate the importance of informal mutual aid groups offering appropriate support measures which veterans greatly appreciate, but that would be more difficult to implement at the government level. Veterans Emergency Transition Services, for instance, which is primarily known for the support it provides to homeless veterans, launched a very simple program that has yielded significant results:

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184 ACVA, *Evidence*, 13 December 2016, 1630 (Dr. David Pedlar, Director of Research, Research Directorate, Department of Veterans Affairs).

185 ACVA, Evidence, 8 December 2016, 1630 (Mr. Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

186 ACVA, *Evidence*, 13 February 2017, 1710 (Dr. Zul Merali, President and Chief Executive Officer, The Royal's Institute of Mental Health Research, Royal Ottawa Health Care Group).

> The idea behind that came from when my husband was struggling with PTSD. He decided to pick up his guitar, which had been sitting in the corner for a long time, and it was very helpful for him. Back in late 2013 and early 2014 we saw a string of veteran suicides, and at that point in time he decided that something should be done, so we launched Guitars for Vets. Basically, we use donated guitars, and the veteran or RCMP member is provided with 10 free lessons with a volunteer guitar instructor. I have to say that we get more response from that program, with people saying, “You saved my life,” than we do with people whom we've taken off the streets. It's amazing.[187]

Several community agencies that may or may not be affiliated with the CAF or VAC provide invaluable assistance to veterans who may be experiencing difficulties. Soldier On, for example, is an agency affiliated with the CAF that allows individuals to regain a sense of military comradeship through the practice of sports and recreation activities. The manager of this program, Major Jason Feyko, outlined its highlights to the Committee:

> The objectives of the program include to facilitate, support, and integrate resources and opportunities for ill and injured members to fully and actively participate in physical, recreational, or sporting activities.[188]

In her appearance before the Committee, Stephanie Thomas described the benefits she and the members of her family derived from their participation in three programs that were the result of individual initiatives funded and encouraged by veteran support agencies: Can Praxis, which provides equine therapy, the Veterans Transition Program and the COPE program.

> The first I will speak about is Can Praxis.
>
> [W]hen it came to doing [an] exercise with my husband, the ... horse sensed the tension between us, and it wouldn't move. That was very eye-opening. We had been in couples therapy since 2009 and we took Can Praxis phase one in 2015, and we finally had something we needed to work on.
>
> The second program that came into our lives was in the winter of 2016 was the veterans transition program. The VTP changed our lives for the better. It was 100 hours of therapy over 10 days, and this was the first time Marc got to work on his trauma within a therapeutic circle of all men. ...
>
> Out of the VTP came COPE, Couples Overcoming PTSD Everyday.
>
> Wounded Warriors Canada pays for these programs. The level of connectedness, understanding, and compassion from other couples has helped build lifelong friends and bring back that sense of community that gets shattered when you're released from the military.[189]

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187 ACVA, *Evidence*, 30 January 2017, 1700 (Ms. Debbie Lowther, Co-founder, Veterans Emergency Transition Services).

188 ACVA, *Evidence*, 8 February 2017, 1535 (Major Jason Feyko, Senior Manager, Soldier On, Director, Casualty Support Management, Department of National Defence).

189 ACVA, *Evidence*, 8 February 2017, 1650 (Ms. Stephanie Thomas, As an Individual).

Such examples demonstrate that, quite often, the most promising initiatives germinate at the grassroots level and that it is subsequently up to the government to recognize the merits of such initiatives and support their continued growth. The creation of the Send Up the Count mutual assistance network is a typical example of the possibilities and flexibility that social media can offer in terms of peer support to veterans in distress. Brian Harding described the genesis of this group in 2013 following several military suicides:

> Our intent was just to push out a message to other soldiers to re-establish contact with those they had served with, try to maybe find some members who had fallen through the cracks, and drag them out with some friendly human contact. ...
>
> Our first suicide intervention involved a veteran who [had been] badly hurt, sidelined and forgotten at work, medically released. ...
>
> One day he made several suicidal comments on Facebook and made reference to being armed. Several of us saw it, confirmed through family that he had access to a gun, and were able to contact police in time to intercept him. He was safely arrested in possession of a loaded handgun before he was able to carry out a plan to publicly shoot himself.
>
> Social media let this veteran reach out to a support network that previously didn't exist and give enough warning signs for us to act. Those of us involved in the call were spread from Yukon and British Columbia to Ontario.[190]

Many more examples exist all across Canada of similar initiatives born out of the desire of other veterans to preserve or rekindle the vital link of close comradeship that bound all of these people together when they were still in uniform.

7.5. Sexual assault

The male culture within the armed forces, the low participation rate by women (about 15% in the CAF), extended absences and the stress of deployments create conditions in which the risk of sexual assault is higher than in civilian life. Sexual assault can leave serious and lasting psychological impacts. The reluctance to ask for help is complicated by the possible sense of guilt in accusing a fellow CAF member, and the risk that the CAF's overall reputation could be tarnished if the incident becomes public. In addition, sexual assault does not usually occur during deployments, and its possible psychological effects are considered less important or legitimate than those brought on by combat operations, for example.

Veteran Brian Harding explained the mentality that impedes the reporting of sexual assault:

> It's an environment often dominated by alpha male mentalities. The military, of course, revolves around the ability to kill people and break their stuff in defence of the national interest. There is a certain mentality that comes around toughness, around self-resilience, and I have seen this too many damn times. If you were not outside the

190 ACVA, *Evidence*, 6 February 2017, 1535 (Mr. Brian Harding, As an Individual).

> wire, on the ground and inflicting violence on the enemy personally, there is no way that your trauma can possibly be as legitimate as my trauma.[191]

Certain remarks to the Committee by CAF Surgeon General Brigadier-General MacKay may suggest that he supports this distinction between operational stress injuries resulting from combat operations and those that are simply psychological injuries.

> It is important to realize that it's not just deployments into combat zones that cause operational stress injuries. They can result from humanitarian assistance and disaster-response activities. We have found that exposure to dead people and disastrous situations can be as difficult for people to deal with as actual combat experience is. There is the potential for somebody in training to be part of, or witness to, an accident. A sexual trauma could very well also potentially lead not to what we would call an operational stress injury as such but to PTSD. Of course, that doesn't make it an operational stress injury.[192]

This distinction seems to stem from the fact that the incidents would have occurred in an environment different from that of deployment to a combat zone. The distinction could have negative effects, such as downplaying the relative importance of psychological injuries that are not the specific result of combat deployment.

The other danger concerns the treatment available in such circumstances. DND and VAC have established mental health clinics for operational stress injuries. The exclusion of mental health problems related to sexual trauma from the definition of an OSI could cause a suspicion that CAF members suffering from PTSD following a sexual assault during training on a military base could not be admitted to one of these clinics.

The CAF is responsible for providing its members with health care, regardless of the causes or circumstances involved. If a service member injured his leg, the CAF would provide care whether the injury occurred during leave or in a combat situation. Therefore, CAF members suffering from mental health issues following a sexual assault should receive the same care, whether the incident took place during a deployment, an exercise on base or while on vacation.

However, this distinction could be important for VAC when compensation must be paid under the law for a service-related injury. There may be no compensation for the effects of a sexual assault that took place on leave. But in this case as well, the distinction would lie in the difference between a service-related injury and a non-service-related injury, not in whether the injury occurred in combat or during on-base training. However it leaves open the question as to whether or not a veteran suffering from PTSD after being sexually assaulted at night on a military base would have access to VAC's OSI clinics if the injury was deemed to be service-related.

Marie-Claude Gagnon of the organization It's Just 700 is very pleased by the VAC's progress in handling claims for compensation related to sexual trauma:

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191 *Evidence*, 6 February 2017, 1555 (Mr. Brian Harding, As an Individual).

192 ACVA, *Evidence*, 15 November 2016, 1610 (Brigadier-General Hugh MacKay, Surgeon General and Commander, Canadian Forces Medical Group, Department of National Defence).

> [The department is] starting to accept the fact that military sexual trauma can be a case. Also, if the act happened, let's say, after work, but you get repercussions at work and you have proof of that, these cases can also be considered. Before, if the act happened, say, at a mess dinner, then you were not covered. Now they are starting to look into whether they should cover people in mandatory mess dinners at night and people who got assaulted in the barracks. Right now they aren't. Those things are being reviewed.[193]

This progress deserves recognition, but the ongoing reluctance to accept that an injury resulting from off-hours social events is service-related should be examined in light of similar events that did or did not result in compensation for health problems other than mental health issues.

Given the lack of programs and training specifically addressing military sexual trauma, the Committee recommends:

Recommendation 18

That Veterans Affairs Canada conduct an evaluation of the response process and support services available to victims of military sexual trauma, and make available any training necessary in military sexual trauma.

8. MENTAL HEALTH IN THE ROYAL CANADIAN MOUNTED POLICE

Integrating the concerns of serving and former members of the RCMP into VAC programs has long been a difficult issue. VAC administers the compensation programs set out in *Royal Canadian Mounted Police Superannuation Act*, and this legislation stipulates that the compensation programs for members injured while serving are those set out in the *Pension Act,* which has not applied to CAF veterans since 2006. Consequently, there is a disconnect between the services VAC offers to former RCMP members and the services it offers to CAF veterans.

With regard to mental health, active and former members of the RCMP have access to VAC's clinics for the treatment of occupational stress injuries; because they are not covered by the New Veterans Charter, however, they do not have access to VAC's Rehabilitation Program. In addition, as federal government employees, they do not have access to the provincial workers' compensation plans that offer such mental and physical health rehabilitation programs.

Other federal public service employees have access to these provincial programs through the *Government Employees Compensation Act.* However, RCMP members and members of the Regular Force are specifically excluded from the programs offered under this legislation.

Since 29 June 2012, members of the RCMP are no longer excluded from the *Canada Health* Act; consequently, the provinces and territories are responsible for their health care while they are active members. This means that they have the same status as

193 ACVA, *Evidence*, 6 February 2017, 1605 (Ms. Marie-Claude Gagnon, Founder, It's Just 700).

any other member of the Canadian public service in this regard. The exclusion of RCMP members from the *Government Employees Compensation Act* is therefore difficult to understand, since the federal government is no longer responsible for their health care and Reserve members, for example, continue to have access to provincial workers' compensation plans. As Sebastien Anderson of the Mounted Police Professional Association of Canada argued, this leaves few alternatives for RCMP members suffering from service-related mental health problems:

> Unlike the Canadian Armed Forces or the provincial workers' compensation regimes, the RCMP does not have a vocational rehabilitation program. However, a vocational rehabilitation program is absolutely necessary to accommodate sworn RCMP members suffering from a properly diagnosed mental or physical disability such as PTSD. ...
>
> Vocational rehabilitation benefits and programs ought to be available to current and former RCMP members prior to the RCMP initiating a medical discharge, similar to the vocational rehabilitation benefits and programs available through the various workers' compensation regimes available to municipal and provincial police officers and most other employees in the federal, provincial, and private sectors.[194]

From the outset, Committee members recognize the merits of providing a complete rehabilitation program to RCMP members whose mental or physical health has been affected by their service. Therefore, the Committee recommends:

Recommendation 19

That the Government of Canada weigh the merits of continuing to exclude members of the Royal Canadian Mounted Police from the workers' compensation plans provided under the *Government Employees Compensation Act.*

The witnesses from the Mounted Police Professional Association of Canada also expressed additional concerns regarding the decision-making process through which RCMP members can access mental health care services:

> It is the RCMP health service that decides which medical doctors, psychologists, and other specialists are approved. These doctors participate with the affected member, while agreeing to follow the rules and direction of RCMP management. They accept this knowing that they will receive other referrals and become the doctor of choice.
>
> This control by the RCMP has escalated to the point where doctors are told what to do, what the desired outcomes are, what they can say about the treatments, and how the treatments are done. In some cases, the member never knows what is happening.[195]

Such testimony implies that, although the RCMP no longer has any legislative authority over the health care services available to members, it continues to exercise

194 ACVA, *Evidence*, 30 January 2017, 1600 (Mr. Sebastien Anderson, Employment, Human Rights and Labour Lawyer, Mounted Police Professional Association of Canada).

195 ACVA, *Evidence*, 30 January 2017, 1555 (Mr. David Reichert, Officer, Retired Members Alliance, Mounted Police Professional Association of Canada).

control over the services received by members, but without providing a structured rehabilitation program.

The Committee cannot readily make an informed judgment on these allegations, which seem disturbing at first glance, because it has not had any opportunity to hear the views of RCMP representatives on the subject. However, the Committee will make sure to pass on the concerns it now has in the wake of this evidence.

CONCLUSION

Mental health and suicide prevention are complex issues that affect all Canadians to varying degrees. However, given the nature of their role, military personnel are at greater risk of being exposed to events likely to trigger mental health issues or aggravate predispositions that, until then, had not had significant negative consequences.

Since military members are in better health than other Canadians of the same age, they could be expected to have fewer mental health problems than the rest of the population and have lower rates of suicide. However, the prevalence of mental health disorders and suicide rates for military members is similar to what is seen in the general population. The most supported explanation for this is that frequent exposure to traumatic events for military members, especially members of the Army, cancels out any favourable conditions related to their better health.

This means that the risk of exposure to traumatic events, which is a part of life in the military, is in itself the key risk factor. Since it is obviously impossible to eliminate it, the primary objective of mental health care for members is to mitigate the possible impact of this exposure on mental health. This could be done by preparing members prior to deployments for the possibility that they will be faced with traumatic events, by conducting short- and medium-term screening of symptoms for members returning from a deployment, and by providing the best possible treatment to those showing these symptoms.

Veterans experience mental health problems more frequently than do military members and have rates of suicide almost 50% higher. This significant difference between these two populations, made up of the same individuals during and after military service, suggests that simply becoming a veteran is a significant risk factor for developing mental health disorders.

According to the extensive evidence we heard throughout the study, veterans feel that losing their military identity and the accompanying spirit of mutual support and comradeship is like having the thing that gave meaning to their career ripped from them. They frequently feel that they are no longer able to “serve” and are no longer useful, as if leaving the military behind also cut off their sense of purpose in life.

In contrast, this highlighted the fact that belonging to the military community is the main protective factor against the risk of developing mental health problems and potentially suicidal thoughts. When the dimension of collective duty inherent in military life

disappears, many veterans are left facing the individualistic isolation of modern life that promotes competition, for which new veterans are often ill prepared.

The strength of this solidarity in military life stems in part from the risk faced by members of the Canadian Armed Forces in their interdependence towards the danger to which they are exposed. Since it is difficult to find the same degree of operational necessity for this mutual trust in the civilian world, the key recommendations in this report are aimed at strengthening what can support this sense of mission and duty and at better preparing military members to deal with it once they become veterans.

Almost all of the veterans who courageously spoke about the difficulties they faced, once they had to leave behind what many of them considered a fundamental component of their identity, connected the beginning of their mental health problems to this loss of a sense that they were contributing to an important mission through their military service.

Fortunately, three quarters of veterans make the transition successfully. Even so, over a quarter of them struggle with the transition to civilian life, and over half of them who face such challenges were not medically released, meaning that they were not suffering from mental health problems at the time they became veterans. The success of this transition therefore depends less on the reason for release than what might have previously been thought.

What we do know, however, is that most of the veterans who overcome obstacles and successfully transition to civilian life have been able to rely on a solid support network, and their families are at the heart of this network. Many veterans told the Committee how difficult, if not impossible, it would have been to overcome the difficulties of the transition process, mental health issues and suicidal thoughts without the unwavering support of their spouse and the desire to get well and be there for their children.

Informal peer support networks, whether they consist of military chaplains, online groups or veterans' associations, also play a vital role in maintaining an environment of solidarity that evokes the same environment present during military service.

Some barriers persist, and the first is a perception still shared by many service personnel that admitting to a mental health problem ends a military career. Officials from the Canadian Armed Forces provided the Committee with many reassurances on this point, and Committee members hope the many examples of serving members who were able to get help with a mental health problem and carry on with their career will provide a positive example for others struggling with mental health. It is critical that Canadian Armed Forces remain vigilant and regularly assess the strategies in place to assist serving members who have disclosed their struggle with mental health.

The second barrier concerns wait times for mental health care. This problem is not exclusive to military personnel or veterans and is mainly due to the fact that provincial health systems face an increase in demand and a shortage of mental health professionals. Over the past 20 years, Veterans Affairs Canada and the Canadian Armed Forces have worked hard to develop a network of clinics to alleviate the difficulty in accessing provincial

resources. Veterans Affairs Canada has also introduced a round-the-clock assistance service to help veterans and their families contact mental help professionals quickly and receive up to 20 hours of counselling. Various partnerships have also been developed, including an arrangement for medically released veterans and their family members to use the Military Family Resource Centres.

Generally speaking, most veterans have access to a higher level of service than other Canadians. However, three important exceptions were noted during the Committee's study.

First, many veterans of the deployments in Somalia and other areas at risk of contracting malaria suspect that their difficulties may be related to a medication they had to take while in theatre. The publication of research suggesting a rare but possible causal link between the drug and certain persistent neuropsychiatric symptoms created a doubt in their minds. One can understand the feeling, of both hope and frustration, that some of them may have experienced by believing that the difficulty in treating their mental health problems could be explained by the side effects of the drug. Unless there is a dramatic scientific breakthrough, it will be years before research can establish or permanently invalidate the link between mefloquine and the persistence of these neuropsychiatric symptoms. Meanwhile, veterans experiencing difficulties must receive all the support they deserve, and Canada must continue to collaborate in all research projects that would help to dispel any remaining doubt.

Second, the growing number of women joining the Canadian Armed Forces has not led to the introduction of services tailored to their needs. For example, veterans who have experienced military sexual trauma can have physical and mental health problems that last beyond their release. While acknowledging improvements, many of them still struggle to access benefits from Veterans Affairs Canada due to issues with proving relation to service that do not take into account the unique circumstances that surround military sexual trauma. When veterans do qualify for benefits, they often struggle to find appropriate treatments through Veterans Affairs Canada services.

Third, testimony revealed that veterans of the Royal Canadian Mounted Police do not receive the level of service they should expect, particularly with regard to psychosocial rehabilitation.

Overall, it can be said that the services introduced to help active members and veterans deal with mental health problems have produced noteworthy results and this progress should be acknowledged. There is still much work to be done, of course, and the recommendations in this report seek to highlight the gaps that persist. They also attempt to address the enormous challenges involved in transitioning from military to civilian life, and the vital role that families and peer support networks can play.

The military is more than just a job to the members of the Canadian Armed Forces. It is a calling that demands everything they have got. For many, the military becomes their culture and their identity. When active members become veterans, the federal government

must do everything in its power to help them transition to civilian life and redefine their identity as successfully as possible.

LIST OF RECOMMENDATIONS

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
As Individuals	2016/10/25	27
Claude Lalancette		
Remington Nevin		
Donald Gregory Passey, Psychiatrist		
Elspeth Cameron Ritchie		
International Mefloquine Veterans' Alliance	2016/10/27	28
John Dowe, Advocate		
As Individuals		
Dave Bona		
Brandon Kett		
Claude Lalancette		
Department of Health	2016/11/03	29
John Patrick Stewart, Director Genera Marketed Health Products Directorate, Health Products and Food Branch		
Department of National Defence		
Andrew Currie, Section Head Communicable Disease Control Program, Directorate of Force Health Protection		
Hugh MacKay, Surgeon General Commander, Canadian Forces Health Services Group		
Public Health Agency of Canada		
Barbara Raymond, Interim Director General Health Security Integration, Health Security Infrastructure Branch		
Department of National Defence	2016/11/15	30
Andrew Downes, Director Mental Health		
Hugh MacKay, Surgeon General Commander, Canadian Forces Health Services Group		
Canadian Institute for Military and Veteran Health Research	2016/11/17	31
Stéphanie Bélanger, Interim Co-Scientific Director		
Heidi Cramm, Interim Co-Scientific Director		

Organizations and Individuals	Date	Meeting
University of Manitoba	2016/11/17	31
Jitender Sareen, Professor Psychiatry, Rady Faculty of Health Sciences		
As Individuals	2016/11/29	34
Kurt Grant		
Brian McKenna		
Jeanette McLeod		
John Kelley McLeod		
Barry Westholm		
Department of Veterans Affairs	2016/12/08	37
Cyd Courchesne, Director General Health Professionals Division, Chief Medical Officer		
Michel Doiron, Assistant Deputy Minister Service Delivery		
Department of Veterans Affairs	2016/12/13	38
David Pedlar, Director of Research Research Directorate		
Linda Van Til, Epidemiologist Research Directorate		
Parkwood Operational Stress Injury Clinic		
Don Richardson, Psychiatrist Western University, Department of Psychiatry		
Mounted Police Professional Association of Canada	2017/01/30	39
Sebastien Anderson Employment, Human Rights and Labour Lawyer		
Rae Banwarie, President		
David Reichert, Officer Retired Members Alliance		
Veterans Emergency Transition Services		
Debbie Lowther, Co-founder		
As an Individual		
Hélène Le Scelleur		
It's Just 700	2017/02/06	40
Marie-Claude Gagnon, Founder		
As an Individual		
Brian Harding		

Organizations and Individuals	Date	Meeting
Department of National Defence	2017/02/08	41
Jason Feyko, Senior Manager Soldier On, Director Casualty Support Management		
Laurie Ogilvie, Director Family Services, Military Family Services		
As an Individual		
Stephanie Thomas		
Mental Health Commission of Canada	2017/02/13	42
Louise Bradley, President and Chief Executive Officer		
Ed Mantler, Vice President Programs and Priorities		
Mission Butterfly Inc.		
John Champion, Vice-Chair		
Celeste Thirlwell, Psychiatrist Executive Health Team		
Royal Ottawa Health Care Group		
Shelley Hale, Director Operational Stress Injury Clinic		
Zul Merali, President and Chief Executive Officer The Royal's Institute of Mental Health Research		
The LifeLine Canada Foundation		
Liane Weber, Chief Executive Officer Companion Paws Canada		
Distress Centre of Ottawa and Region	2017/02/15	43
Breanna Pizzuto, Acting Community Relations Coordinator		
Mood Disorders Society of Canada		
Dave Gallson, Associate National Executive Director		
Philip Upshall, National Executive Director		
Vanier Institute of the Family		
Russ Mann, Special Advisor		
Nora Spinks, Chief Executive Officer		
Department of National Defence	2017/02/22	44
Sean Cantelon, Director General Canadian Forces Morale and Welfare Services		
Marie-France Langlois, Director Casualty Support Management		
Association québécoise de prévention du suicide	2017/03/06	45
Kim Basque, Training Coordinator		
Catherine Rioux, Communications Coordinator		

Organizations and Individuals	Date	Meeting
Roméo Dallaire Child Soldiers Initiative	2017/03/06	45
Roméo A. Dallaire, Founder		
As Individuals		
Scott Maxwell		
Joe Sharpe		
Department of Health	2017/03/20	47
Chantale Malette, National Manager Business and Customer Relations, Employee Assistance Services		
Department of National Defence		
Elizabeth Rolland-Harris, Senior Epidemiologist Directorate of Force Health Protection, Canadian Forces Health Services Group		
Department of Veterans Affairs		
Cyd Courchesne, Director General Health Professionals Division, Chief Medical Officer		
Alexandra Heber, Chief of Psychiatry Health Professionals Division		
Johanne Isabel, National Manager Mental Health Services Unit, Directorate of Mental Health		
As Individuals	2017/04/03	48
Joseph Brindle		
Philip MacKinnon		
Michael McKean		
Jody Mitic, City Councillor City of Ottawa		
Project For Life	2017/04/05	49
François Joyet, President Québec Chapter, Canada Company		
Andrée G. Roberge, President The Neuro Group Inc.		
As Individuals		
Ken Lee, Medical Consultant Parkwood Institute's Operational Stress Injury Clinic, Canadian Mental Health Association, Middlesex-London Branch		
Céline Paris, Psychologist		
Department of National Defence	2017/04/10	50
Rakesh Jetly, Senior Psychiatrist Directorate of Mental Health, Canadian Forces Health Services Group		

Organizations and Individuals	Date	Meeting
As an Individual	2017/04/10	50
Marvin Westwood Professor Emeritus, Counselling Psychology, University of British Columbia		

APPENDIX B
LIST OF BRIEFS

Organizations and Individuals

Blois, **Hervey**

Buckle, **John**

Canadian Association of Naturopathic Doctors

Hoeg, **Jason**

Jones, **Dan**

Lalancette, **Claude**

MacKinnon, **Philip**

Matchee, **Marjorie**

Mission Butterfly Inc.

Mounted Police Professional Association of Canada

Nevin, **Remington**

Reyes-Santiesteban, **Val**

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 27, 28, 29, 30, 31, 34, 37, 38, 39, 40, 41, 42, 43, 44, 45, 47, 48, 49, 50, 53, 54, 55, 56, 57, 58) is tabled.

Respectfully submitted,

Neil R. Ellis
Chair

Supplementary Report on Mental Health of Canadian Veterans: A Family Purpose

Background

The basis of this supplementary report to the ACVA Report on Mental Health of Canadian Veterans begins on Parliament Hill and the action of a lone veteran, Claude Lalancette. Mr. Lalancette was protesting September 19th and 20th, 2016 on Parliament Hill about his lack of assistance from Veterans Affairs Canada (VAC) for the treatment of his illness due to the use of mefloquine while he served with the Airborne Division in Somalia. Mr. Lalancette was visited during his hunger strike by VAC Minister Kent Hehr, Defence Minister Sajjan and (then) Parliamentary Secretary to Veterans Affairs and Associate Minister for National Defense Karen MacCrimmon.

Mr. Lalancette was told he would be given the opportunity to speak at the Standing Committee for Veterans Affairs (ACVA), which had just started a study on the Mental Illness and Suicide Prevention of Canadian Veterans. Mr. Lalancette spoke on 25 October, 2016. He returned for a second opportunity to speak on 27 October 2016. It was during his evidence given at ACVA that the committee first heard about the effects he and others would suffer due to the forced use of mefloquine by the Canadian Armed Forces (CAF). The committee would also hear evidence of the day-to-day effects the use of the anti-malarial drug would have on CAF members in their duty not only in Somalia, but also in other theatres of action. Lt-Gen. (retd) the Hon. Roméo Dallaire would describe his experience with the ordered use of Mefloquine as he led forces in Rwanda.

The committee would also hear clinical evidence from experts, more compelling first hand evidence from Veterans and their spouses on the effects the use of mefloquine had on their families after active service. The committee also heard about treatment for mefloquine toxicity from one Veteran, Dave Bona.

Rationale for a Supplementary Report

It is the opinion of the Conservative members of the committee that the final version of the ACVA report failed to accurately portray the role that the use of mefloquine by the Canadian Armed Forces had on our veterans and their families when attempts of suicide were made or when a veteran who used mefloquine committed suicide. Weak recommendations and the removal of the voices of Canadian Veterans were not acceptable to the Conservative members of the committee.

While the evidence presented may seem anecdotal, there was in fact clinical evidence that was key in revealing information that was not on the radar of the committee when the study on Mental Illness and Suicide Prevention was struck. In a medical sense, patients present anecdotal information on their health and from that information a doctor is to make a diagnosis and present a treatment plan – and so it must be for the use of mefloquine. The committee is bound to hear the evidence and follow it and present a reasonable outcome and plan of action.

Recommendations presented in the tabled report by the committee do not, in the opinion of the Conservative committee members, meet the parameters of the report and the recommendations in this document better represents the action the government should take.

Somalia

Much of the witness testimony that was not included in the final version of this report relates to the Somalia Affair of 1993 and the role that mefloquine and its side effects may have played in the matter. The committee heard from Corporal John Dowe, a veteran who was present at the base in Somalia during the incident which caused the death of Somali teenager, Shidane Arone. In his testimony, Mr. Dowe gives his eyewitness account of the actions of Master Corporal Clayton Matchee and Private Kyle Brown, excerpts of which are below[1]:

"… he (Matchee) started swearing and saying 'F***ing spiders'… and he started beating the baton on the legs and moving backward and then turned around to the rear of the bunker, continually smacking that baton against the sides of the wall of the bunker. There were no camel spiders there."

"I knew Clayton Matchee prior to the tour, so I have the ability to understand exactly what state Clayton Matchee was in at the moment, and what was going on. His beating camel spiders that weren't there is absolutely hallucinogenic and so was the psychosis of the rage he was in."

Master Corporal Matchee attempted suicide two days after the death of Shidane Arone and now has severe brain damage as a result. In his testimony, Mr. Dowe stated the following with respect to the effects this has had on the Matchee family:

"Clayton Matchee's family have … suffered the most because he's not entirely lucid to understand what's going on with him anymore. It's Marj, his wife, and it's the Matchee family, the mum and the dad, and the community, all of them, who have had to wear this."

Regarding Private Kyle Brown, Mr. Dowe stated the following:

"Kyle Brown faced the opprobrium of an entire nation. He was the scapegoat for the entire tour. … Kyle is having difficulty trying to come to grips with all of this. … He understands that there's a lot out there today that will speak a lot greater to what he had to suffer that night and what he continues to suffer to this day."

[1] ACVA October 27, 2016

Claude Lalancette echoed this sentiment when speaking about the disbanding of the Airborne Regiment following the Somalia mission[2]:

"… To this day, I feel the shame of the closure, all the blame and shame landed on Canada's elite. Most of all, I feel shame because I put the blame for the closure of the regiment on two individuals who were innocent: Clayton Matchee and Kyle Brown are victims."

The Conservative members of the committee believe that a more thorough study should have been conducted to better identify the true impact of mefloquine on this tragic episode in Canada's military history and on the veterans who, 25 years later, still feel its effects every day. In her testimony Dr. Ritchie said research on mefloquine was "not very deep" and needs to ramp up quickly.[3] In the same meeting, Dr. Ritchie and Dr. Nevin both agreed that the Somalia Commission should be reopened.[4] It is possible that mefloquine was not a determining factor in the tragic events in Somalia, but there is too much room for doubt. This doubt is even greater considering the repercussions it may have had on the lives of Master Corporal Clayton Matchee and Private Kyle Brown. Therefore, the committee recommends:

Report Recommendation 1:

That the Government of Canada mandate an independent body to establish or rule out any connection between mefloquine and the actions of Master Corporal Clayton Matchee and Private Kyle Brown during the event that led to the death of Shidane Arone.

The committee proposes that the final recommendation should indicate that the timeline for the independent body to begin should be no later 12 months from the day the report is tabled in the House of Commons.

Continued Use of Mefloquine

The committee heard of the irresponsible manner in which the CAF undertook a "clinical" trial of mefloquine without any proper record keeping. There was no follow up on the effects of the use of mefloquine faced by CAF members. To this day it is not entirely known who in the CAF was given mefloquine, or where they are today after leaving the CAF. The ability to follow up with these veterans is inadequate to provide either proper medical care or to indicate any level of accuracy in determining the effects of its use. Some Allied partners, notably Australia, have been extremely effective in locating its mefloquine users in the Australian Defence Force (ADF) and being able to ensure proper treatment for these ADF members.

[2] ACVA October 27, 2016
[3] ACVA October 25, 2016
[4] ACVA October 25, 2016

Many of Canada's Allied partners have either discontinued or drastically reduced the use of mefloquine. In a June 2017 report the CAF Surgeon General's Report on mefloquine, the use of the drug has been relegated to 'third line' use.[5]

In 2013, the United States military declares mefloquine a "drug of last resort", to be used only when an individual has contraindications or intolerance to preferred daily antimalarial, doxycycline and atovaquone-proguanil. The drug is "Black boxed" by the USFDA. The warning label states that neurological side effects may persist or become permanent in some people.

In 2002, the French military forces discontinue the widespread use of mefloquine in Djibouti, in favor of preferred use of the antimalarial doxycycline.[6]

In 2013, Germany designated mefloquine as a drug of last resort after both the USFDA and the European Medicines Agency confirmed in separate studies the side effects could be permanent, both issuing tougher warnings**.**

In September 2016, the Minister of Defense (MOD) in the United Kingdom (UK) introduced a new policy on prescribing antimalarial drugs, declaring mefloquine a third-line drug, again as with the U.S. military, to be used only when there are documented contraindications or intolerance to both.

The UK House of Commons Defense Committee further stated that they will monitor the MOD's policy in relation to malaria protection by requesting six monthly updates on the MOD's use of mefloquine. In order to assess the impact of the revised anti-malarial policy, a new method of data capture through electronic templates was introduced. This allowed better recording of the processes undertaken when prescribing antimalarial drugs at MOD medical facilities.

Similarly, the Australian military for many years has declared mefloquine a third-line drug, essentially also a drug of last resort. In Australia, mefloquine similarly comprises less than 1% of antimalarial prescriptions. This has been policy for well over a decade.[7]

Mefloquine was not used routinely by the New Zealand Defense Force at any point and only "intermittently for personnel intolerant to other meds.

Given the actions of our Allies, the Conservative members of the committee, feel the recent Surgeon-General's report was not strong enough in its rebuke of the use of mefloquine. Lt-Gen. (retd) the Hon. Roméo Dallaire stated in his testimony regarding the drug's effects on him personally:

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[5] S-G Report on Mefloquine June 2017 Recommendation 4, pg. 40

[6] L. Ollivier, R. L. Nevin, H. Y. Darar et al., "Malaria in the republic of Djibouti, 1998–2009," *The American Journal of Tropical Medicine and Hygiene*, vol. 85, no. 3, pp. 554–559, 2011).

[7] http://www.defence.gov.au/health/healthportal/Malaria/Anti-malarial_medications/Mefloquine/FAQs.asp.

"I was on mefloquine for a year. About five months into it, I wrote the National Defence Headquarters, and I said this thing is affecting my ability to think. This thing is blowing my stomach apart. This thing is affecting my memory, and I want to get rid of it. … I then got a message back, which was one of the fastest ones I have ever got back, which essentially ordered me to continue, and if not, I would then be court-martialled for a self-inflicted wound because that was the only tool they had. Mefloquine is old-think, and it does affect our ability to operate."[8]

The Hon. Roméo Dallaire's evidence is not different from others the committee heard, including Mr. Dave Bona who also served in Rwanda.

"The first day I took mefloquine for Somalia, in 1992, I almost immediately felt sick. […]My vision would go black and I would see stars, I would feel disoriented and dizzy after. This would happen initially only on mefloquine days, eventually they would occur randomly the rest of the time – lying down, standing in line at super market, sitting at the supper table. … The dreams I suffered from were quite horrific. They involved the violent death by my hand of my loved ones and my section members. They were just like they were happening. I would wake up. I stopped sleeping. The day I took the pill, from then on, early in the tour, I didn't sleep, and that continued all the way through to Rwanda… The only thing that I could control that with, while I was deployed, was alcohol. … The depression started to take over – I would bounce between anger and being so depressed that I would sometimes catch myself holding my rifle in my hands, just thinking how easy it would be."[9]

Following his unsuccessful treat for PTSD, Mr. Bona's psychologist altered his treatment to that for brain stem injury:

"Three years ago, Dave's psychologist changed his treatment plan to include the protocol of someone with a traumatic brain injury, a new therapy, one that retrains the brain around injured areas utilizing a type of electronically monitored neurofeedback. Results didn't happen overnight, and there were times that things seemed to get worse, but it finally settled in. The time span between rages lengthened his ability to settle down eventually quickened from a week, to a few days, and eventually a few hours."[10]

The Conservative members of the committee feel that the evidence provided strongly suggests that a great deal of work is required to further understand the effects and potential treatment for mefloquine neurotoxicity. The committee approved a letter to be sent to the Minister of Health to examine the effects of the anti-malarial drug mefloquine in detail.

[8] ACVA March 6, 2017
[9] ACVA October 27, 2016
[10] ACVA October 27, 2016 Letter from Terese Untereiner, wife of Dave Bona, read by Mr. Bona as an individual.

In her response dated February 22, 2017 the Minister stated "the benefits of mefloquine outweigh its potential risks under the conditions of use."[11]

However the Conservative members of the committee feel that given that the Surgeon General report affirming the testimony of the veterans exposed to Mefloquine at committee, the government should take immediate steps to contact all veterans treated with the drug to advise them on the reclassification of the drug from first line to last resort and advise them on where they can get more information and what they can do if they need medical help as a result of their on duty exposure to drug.

The Conservative members of the committee feel that the government should make a concerted effort to study mefloquine and its effects in order to provide the best possible treatment to veterans. In addition the recommendation should be enhanced for the government to be given a timeline to take action on the study. The recommendation is as follows:

Report Recommendation 2:

That the Government of Canada, in cooperation with all federal, provincial and international institutions concerned, initiate an independent research program to study the long term neurotoxicity of mefloquine**.** The research program should be in place no later than 12 months from the day the report is tabled in the House of Commons.

Report Recommendation 3:

Based on the Surgeon General report and the reclassification of the Mefloquine drug from a drug of first choice to one of last resort, that the government take immediate actions to contact by all possible means veterans previously exposed to the drug to advise them of their prior exposure to the drug; reclassification of the drug by Health Canada; where to get more information; assistance options and treatment procedures available to them.

Conclusion

The Conservative members of the Standing Committee on Veterans Affairs wish to thank all witnesses that appeared in personal and presented written briefs in the course of the committee's study on mental health and suicide prevention among veterans.

As we have mentioned several times, the Conservative members of the committee do not take lightly the impact that mefloquine has had on Veterans and their family. It is clear that these members of our veteran's community need assistance and support of the government to get the correct treatment for their neurotoxicity because of the forced use and botched trial for mefloquine.

[11] Letter to ACVA from Minster of Health, date stamped February 22, 2017.

On October 27, 2016 the committee heard evidence from four veterans; Claude Lalancette, Dave Bona, Brandon Kett and John Dowe – all who experienced the horrible side effects of the drug. During the evidence the Conservative members were visibly moved by their evidence. Cathay Wagantall (MP Yorkton-Melville) noted "What I'm learning as a Member of Parliament, more than anything, is that it seems to be the victims who have to go beyond what they've already experienced to get change.[12] Mr. Brassard (Barrie-Innisfil) was so visibly moved he had Robert Kitchen (Souris-Moose Mountain) question the witnesses as he could not; "The first thing I would like to say, gentlemen, is thank you for your service to our country. Your testimony today has had a profound impact on me. Robert, please."[13]

These comments of the Conservative members of the committee were echoed by members from the Government side. Colin Fraser (West Nova) commented, "I thank you guys for being here today and for sharing your story. I can assure you that all of us listened very carefully to the powerful testimony that you gave. Certainly, we want to take all of this and make recommendations to make this better."[14]
Former committee member from the government Jean Rioux (Saint-Jean) welcomed the witnesses of the day by stating; "I've been in politics for a long time, and I have to admit that your testimony today really moved me."[15]

He went further by stating; "I especially want to tell you that you are put together. You have presented your case, and I think you have chosen the right place to do it. We are here to represent you. I feel challenged as an MP today. This is perhaps one of the most important roles I will have to play. Thank you very much for making us aware of this problem. Everything has a beginning, and I think you will be seen as someone who initiated a new and important process."[16] Finally, Doug Eyolfson (Charleswood-St. James-Assiniboia-Headingley) used few words to express his views of their appearance in committee saying directly to Mr. Lalancette "I can't even begin to imagine what any of you must be feeling with all the things you're describing. Claude, again, I'm so sorry for the experience you've had. We know you do need help." [17]

The committee heard of many unique and regional treatments for PTSD and other mental health issues. These programs, most often run by volunteer groups many of which were CAF veterans themselves involved canine therapy, equine therapy, musical therapy, yoga and intense retreat programs. The Conservative members of the committee feel that information on these and other programs must be made available to veterans either

[12] ACVA October 27, 2016
[13] ACVA October 27, 2016
[14] ACVA October 27, 2016
[15] ACVA October 27, 2016
[16] ACVA October 27, 2016
[17] ACVA October 27, 2016

through their case manager or independently via the websites listed in the recommendation.

In closing, the Conservative members of the committee felt it necessary that the words of the veterans were not suppressed and that their stories were accurately presented and made public.

Supplementary report of the NDP on Mental Health of Canadian Veterans: a Family Purpose

Mental Health and Suicide Prevention – Strengthening Recommendations:

The genesis of this report came out of the committee's previous study on service delivery. The testimony heard during the previous study highlighted the urgency and critical nature of the impact of mental health on the veteran community. Testimony heard during the study on mental health and suicide prevention underscores the need for improved access to mental health care for veterans.

New Democrats believe that the testimony heard and outlined in the report Mental Health of Canadian Veterans: a Family Purpose warrants the following recommendations:

The NDP recommends that **Veterans Affairs Canada fast-track its study of dog therapy by taking into account international research, and implement a dog therapy program with national standards.**

The NDP recommends that **Veterans Affairs Canada make available training in military sexual trauma to all OSI clinics personnel, and ensure that each OSI clinic has at least one staff member with training and experience in treating military sexual trauma.**

Mefloquine and its Impacts on Mental Health:

The Minister's office requested that the committee also look at Mefloquine as part of this study. This supplementary report highlights some of the testimony heard on mefloquine and strengthens the recommendations made by the committee.

During the committee hearings New Democrat members heard many witnesses describe their experience with mefloquine and its impact on serving CF members, veterans and their families. The testimony also highlighted significant flaws in the mefloquine clinical trial in which Canadian military personnel participated. Witnesses testified that they were not provided with a choice about which anti-malarial drug they could take, and that the adverse effects impacted their sleep and behaviour. Testimony outlined a picture of the significant long term impacts of mefloquine as seen by their health care providers and the veterans themselves.

Dr. Remington Nevin highlighted the shortfalls of the supposed Canadian drug trial for the anti-malarial drug, mefloquine:

> One important point I think we should emphasize is that Canada's first experience with this drug was part of a safety study that was conducted in the early 1990s and through which the Department of National Defence gained

> access to large quantities of mefloquine for use during the early months of the Somalia mission. It was not a licensed drug in 1992 and into the first weeks of 1993 when many service members started taking the drug and deployed to Somalia.
>
> The Department of National Defence's access to that drug was contingent on participating in a safety study that should have informed the licensing of the drug, should have informed the content of the product label, should have informed physicians of the side effects that would be experienced with regular use of that drug.
>
> You ask what studies were done. The study that should have been done on military personnel was not done, and the drug was licensed without the benefit of what, in retrospect, probably was very important information.[1]

The Auditor General, in 1999, issued a report that underscores the testimony of Dr. Nevin and highlights the failures of the drug trial[2].

Veterans who took the drug described their experience regarding informed consent, veteran Jason Roy Hoeg who was deployed to Uganda in 1996, out lined his experience: “When we were given this drug, we were told it was to be the only antimalarial that we would have on our deployment. We were told to read the instructions that accompanied each box of pills, but no one mentioned the adverse side effects that this drug might cause.”[3]

Another veteran, Hervey Blois, who served in Somalia, stated: “I was never told what these known adverse effects were, nor was I ever told to discontinue the drug if any of these adverse effects developed.”[4]

The committee heard further testimony that on the day a battalion took their dose of mefloquine the collective impact of the side effects and nightmares that followed were referred to as “mefloquine Mondays”.[5]

Marjorie Matchee, the wife of veteran Clayton Matchee, shared her experience of how the drug affected her husband before he left for the mission in Somalia. Days before his departure he told her “We have to take this drug for malaria. … I tried to get used to it,

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[1] ACVA, *Evidence*, 25 October 2016, 1720 (Dr. Remington Nevin, As an Individual).
[2] Auditor General of Canada, April 1999, “National Defence and Health Canada: Non-compliance with conditions and inadequate monitoring with respect to the pre-licensing use of an anti-malarial drug.”
[3] Mr. Jason Roy Hoeg, *Brief*, published 20 February 2017.
[4] Mr. Hervey Blois, *Brief*, published 27 October 2016.
[5] ACVA, *Evidence*, 25 October 2016, 1110 (Dr. Elspeth Ritchie (As an Individual).

but I don't think I am ever going get used to this shit. You see things when you sleep. You see it in the daytime too. You can't shut your eyes to it."[6]

Several witnesses expressed that they felt dishonour regarding the disbanding of the Airborne Regiment in the Somalia mission. Claude Lalancette, a veteran of that mission, stated:

> Mefloquine was issued as an anti-malarial drug. This is where I can retrace the root of my mental health issues. … To this day, I feel the shame of the closure, ... Most of all, I feel shame because I put blame for the closure of the regiment on two individuals who are innocent: Clayton Matchee and Kyle Brown are victims.[7]

Another veteran, Corporal John Dowe, shared with the committee what he saw the night the Somali youth Shidane Arone died. His disturbing eyewitness account is critical as it highlights important details and the potential impact mefloquine might have had:

> In the case of Shidane Arone, he had been caught about 15 times before. He was a repeat offender. Things were much more tense at that time . . .[W]e were told in our orders groupto rough up the prisoners and send a message, to throw them back over the wire and make them understand we meant business. Does that give licence to Master Corporal Matchee? Of course not.[8]
>
> Shidane Arone was the prisoner in the bunker. … When I went inside the bunker, he was there with Kyle Brown, who was off to the side. Master Corporal Matchee was holding a wooden baton in his hand. … I was the lowest rank, … but he called me over. . . [W]ith the wooden baton he lifted up Shidane Arone's head and I saw a bruised and bloody face. The lips were swollen; the nose looked somewhat busted.
>
> … I didn't expect that the prisoner was in any sort of dire condition. … [M]y mind was thinking he just wanted to show me or tell me that we had a prisoner. I guessed. I didn't really know why I was there. Then he looked down, Master Corporal Clayton Matchee, who had just finished showing me the prisoner, and all of a sudden he [Master Corporal Clayton Matchee] started whacking Shidane Arone across the thigh with the baton, and he started swearing and saying "Fucking spiders" – I apologize for my language – and he started beating the baton on the legs and moving backward and then turned around to the rear of the bunker, continually smacking that baton against the sides of the wall of the bunker. There were no camel spiders there.

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[6] Marjorie Matchee, *Brief*, published January 16, 2017.
[7] ACVA, *Evidence*, 27 October 2016, 1540 (Mr. Claude Lalancette, Veteran, As an Individual).
[8] ACVA, *Evidence*, 27 October 2016, 1650–55 (Mr. John Dowe, Advocate, International Mefloquine Veterans' Alliance).

> What I experienced was Clayton Matchee in a state of hallucination, in a state of psychosis, in a state of severe aggression. Because he had turned around and was preoccupied with these camel spiders – and this all happened in a matter of seconds – I saw my opportunity to leave. … [I] started walking the hell away. … I just wanted to go back to bed. […]
>
> After 58 minutes . . in my cot in my bed space away from the bunker . . . I couldn't sleep. I was still somewhat in shock over what had happened…
>
> I saw a group of guys coming out and standing around that bunker that I'd been to an hour or so before. They were trying to revive Shidane Arone, who was now completely prone on the ground, unresponsive. They threw water on top of him, trying to revive him. They could not. . . .
>
> I knew Clayton Matchee prior to the tour, so I have the ability to understand exactly what state Clayton Matchee was in at that moment, and what was going on. His beating camel spiders that weren't there is absolutely hallucinogenic and so was the psychosis of the rage he was in.[9]

Later in his testimony, Mr. Dowe expressed his impressions further:

> Master Corporal Matchee experienced psychosis, hallucinations, and uncontrollable rage, which, being impaired by a drug and enabled by an unlawful order, put him over the edge. When he came to and realized what he was facing, what was happening with him, it was too much, and he tried to commit to suicide.
>
> Kyle Brown faced the opprobrium of an entire nation. He was the scapegoat for the entire tour. … Kyle is having difficulty trying to come to grips with all of this. He wants to be happy. He understands that there's a lot out there today that will speak a lot greater to what he had to suffer that night and what he continues to suffer to this day.
>
> Absolutely, Clayton Matchee's family have indeed, I believe, suffered the most because he's not entirely lucid to understand what's going on with him anymore. It's Marj, his wife, and it's the Matchee family, the mum and the dad, and the community, all of them, who have had to wear this.[10]

The NDP is surprised that research was not conducted to determine any possible link between mefloquine and the actions of our military personnel in Somalia overall, and also more specifically the possible impact on the actions of Master Corporal Matchee and Private Brown. As Dr. Remington Nevin explained to the committee:

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[9] ACVA, *Evidence*, 27 October 2016, 1650–55 (Mr. John Dowe, Advocate, International Mefloquine Veterans' Alliance).

[10] ACVA, *Evidence*, 27 October 2016, 1725 (Mr. John Dowe, Advocate, International Mefloquine Veterans' Alliance).

> The Somalia commission of inquiry really revolved around the central issue of the effects of unusual behaviour. The commission was terminated before the plausible effects of mefloquine in contributing to that unusual behaviour were fully investigated. I think we know now much more about those effects than we did even at the time. So there could be some utility to reopening the investigation, in light of our new understanding of the dangers of the drug and also what has subsequently been learned about the inappropriate use of mefloquine as an experimental drug during the early months of that mission. [11]

The NDP believe that a more thorough study should have been conducted to better identify the true impact mefloquine could have played in on this tragic episode in Canada's military history and on the veterans who, feel the effects of this drug to this day.

In her brief to the committee, Val Reyes-Santiesteban, blames mefloquine for the suicide of her son, Corporal Scott Smith, in Rwanda on Christmas Day in 1994.[12]

The NDP recommends that **the Government of Canada mandate an independent body to establish or rule out any connection between the mefloquine taken by Canadian CF Members and the tragic events that lead to the death of Shidane Arone in Somalia.**

The NDP further recommends that **the Government of Canada, initiate a study to determine the long-term neurotoxicity of mefloquine and report its findings back to parliament by December 1, 2018.**

[11] ACVA, *Evidence*, 25 October 2016, 1720 (Dr. Remington Nevin, As an Individual).
[12] Ms. Val Reyes-Santiesteban, *Brief*, published 16 January 2017.