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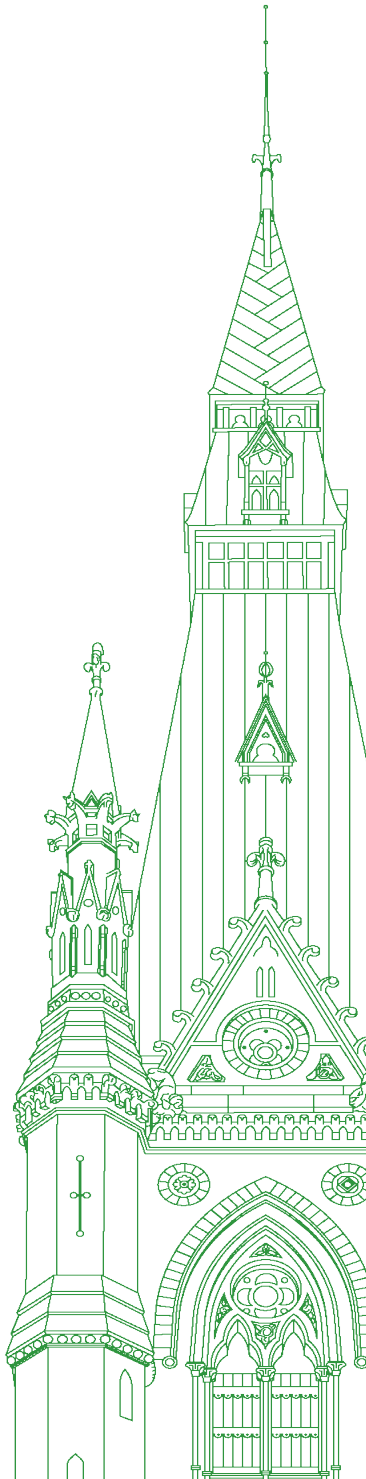

Chair: Mrs. Karen McCrimmon

# Standing Committee on National Defence

**Friday, December 11, 2020**

● (1300)

[*Translation*]

**The Chair (Mrs. Karen McCrimmon (Kanata—Carleton, Lib.)):** Good afternoon, everyone. Welcome.

[*English*]

I call this meeting to order.

Welcome to meeting 11 of the House of Commons Standing Committee on National Defence.

Today's meeting is taking place in a hybrid format, pursuant to the House Order of September 23. The proceedings will be made available via the House of Commons website.

Witnesses, if you will give us a couple minutes to begin, we have a couple of small issues of committee business to deal with. Hopefully we'll keep them to a minimum. Then we will start with you, our witnesses.

On committee business, a steering committee report was circulated. We need a motion to approve that report. There were suggestions for amendments, but it became clear that there were members who were reticent to accept amendments. I don't think there are any amendments now; it's just the steering committee report as it currently stands.

**Mr. James Bezan (Selkirk—Interlake—Eastman, CPC):** I move that the report be adopted as circulated.

**The Chair:** Than you, Mr. Bezan.

It is moved.

Mr. Baker, too, thank you.

There are two movers. That's perfect.

All those in favour?

(Motion agreed to)

**The Chair:** Thank you very much. That has been adopted.

That is the end of committee business.

Thank you, everyone. We will move on to our witnesses for today.

Our witnesses today are Rear-Admiral Geneviève Bernatchez, judge advocate general, and Colonel Jill Wry, deputy judge advocate general; followed by Colonel Rakesh Jetly, senior psychiatrist and director of mental health for the Canadian Forces Health Services Group; followed by Ms. Kyndra Rotunda, professor of military and international law at Chapman University.

I'll go to you first, Rear-Admiral Bernatchez, for your opening statement.

**Rear-Admiral Geneviève Bernatchez (Judge Advocate General, Canadian Armed Forces, Department of National Defence):** Thank you, Madam Chair. I will keep my opening remarks brief.

Please allow me to begin by introducing myself. I am Rear-Admiral Geneviève Bernatchez, the judge advocate general of the Canadian Armed Forces. I am the legal adviser to the Governor General, the Minister of National Defence, the Department of National Defence, and the Canadian Armed Forces in matters relating to military law. I am also legislatively entrusted with the superintendence of the administration of military justice in the Canadian Armed Forces.

[*Translation*]

I wish to thank the Committee for inviting my colleagues and I to appear before you today. I have the pleasure of being accompanied by Colonel Rakesh Jetly, senior psychiatrist and mental health advisor for the Canadian Armed Forces, and Colonel Jill Wry, Deputy Judge Advocate General for Military Justice.

[*English*]

People are at the core of everything the defence team does. The health and well-being of Canadian Armed Forces members, including their mental health, are therefore a high priority for Defence. The care and support of our members are of paramount importance to the operational success of the Canadian Armed Forces, and the military justice system's purpose is to support the operational effectiveness of the Canadian Armed Forces.

Indeed, as the Supreme Court of Canada reminded us last year in its landmark decision in R. v. Stillman, “The military justice system is...designed to meet the unique needs of the military”. It does so through its very purpose, which is to assure the maintenance of discipline, efficiency and morale of the Canadian Armed Forces.

The military justice system therefore recognizes the importance of mental health and includes necessary safeguards to help protect individuals who suffer from a mental disorder. For example, an accused person must be fit to stand trial. An accused person cannot be dealt with by way of summary trial if they were suffering from a mental disorder at the time of the alleged offence. The defence of mental disorder is available. Also, all accused members have access, free of charge, to a defence counsel, including full representation at court martial.

Last year, the Supreme Court of Canada also confirmed the constitutional legitimacy of the military justice system and affirmed that it is “a full partner in administering justice alongside the civilian justice system.” This validation of the military justice system's constitutional legitimacy comes as a result of the system's continued growth and evolution. The military justice system is enhanced through regular and periodic legislative developments; policy initiatives; external reviews; independent reviews mandated under the National Defence Act, such as the one appointed by the Minister of National Defence on November 16 of this year; judicial decisions; and, importantly, continued parliamentary interest in its development.

● (1305)

[*Translation*]

Together, these key processes contribute to the continued responsible evolution of Canada’s military justice system. This evolution is important, necessary, and positive.

My team and I take the evolution of the military justice system very seriously to ensure that it continues to meet Canada’s legal and societal norms and can ultimately serve its purpose of maintaining the discipline, efficiency and morale in the Canadian Armed Forces.

I understand that Colonel Jetly has some opening words for you as well. I thank the members of the committee for inviting us to appear before you today to assist in its important study.

[*English*]

**The Chair:** Thank you very much.

We'll go to Colonel Jetly now.

**Colonel Rakesh Jetly (Senior Psychiatrist, Directorate of Mental Health, Canadian Forces Health Services Group, Department of National Defence):** Thank you very much.

Madam Chair and members of the Steering Committee on National Defence, I am the Chief of Psychiatry in the CAF. I have several key roles, including advising the leadership on mental health issues. I'm the senior mental health clinician of the CAF. I conduct and facilitate a great deal of mental health research related to military members, and serve as the CAF representative on international committee meetings within NATO and beyond. I thank you for your interest in the well-being of the men and women of the Canadian Armed Forces, and in particular their mental health.

As we have learned through our high-quality research efforts, mental illness is common within the Canadian Armed Forces, just as it is in civilian society. Our studies, such as the 2002 and 2013 Canadian Community Health Survey—Mental Health CF version, allowed us to understand the burden of mental illness within our organization compared with the civilian population. Our depression rates in both studies were higher than those in the civilian population, and our PTSD rates increased substantially between 2002 and 2013—not surprisingly after the conflicts in Afghanistan. For example, the 2013 survey found a 15.7% lifetime prevalence of depression in members of the CAF. Lifetime PTSD was estimated at 11.1%.

Just a significant as these crude numbers, these studies also tell us a great deal about help seeking and perceived barriers to care, and help us to understand what we call “the need-care gap”. As we continue to evolve our programs, we are guided by these studies and science with an aim of providing CAF members with timely access to evidence-based care.

The well understood barriers to care include the fact that individuals are unaware that they have a mental illness that may be amenable to care. People also often prefer to handle things themselves. They fear for their careers, and of course, there is stigma: “People may think that I am weak if I go for mental health care.”

The programs that we have developed are specifically designed as countermeasures to these barriers to care. For example, the Road to Mental Readiness aims to educate, teach coping skills, reduce stigma and increase help seeking. The term OSI concretely legitimized psychological injury alongside physical injury.

I understand that this committee is also interested in discussing suicide prevention within the CAF. Sadly, suicides occur in our society, and the Canadian Armed Forces are not an exception. Depending on the source, but conservatively using Statistics Canada numbers, 11 Canadians die by suicide each day, which is approximately 4,000 per year. Within Canada, suicide is the second leading cause of death among the young and young adults aged 15 to 34 years, and it is three times more frequent among men than women. A third of deaths by suicide occur in those aged 45 to 59 years. A quick look at these numbers shows that the men and women of the Canadian Armed Forces are within these higher risk demographics.

We have, within the Canadian Forces health services, a commitment to better understanding suicide to better manage and mitigate risk. We are in regular communication with our allies and leverage collective wisdom to implement approaches that we feel would be helpful.

It is also important to remember that suicide is not a singularly health-related issue. It is a complex, multifactorial condition that usually involves a mental health condition, diagnosed or not; a stressor, which is usually an interpersonal stressor; certain personality factors or traits, such as impulsivity; and, of course, access to lethal means.

I can expand further as desired, but the model mentioned provides many opportunities for suicide intervention. As such, within the Canadian Armed Forces, we consider suicide prevention a collective responsibility that involves leadership, colleagues, peers, health care providers and the entire community.

In 2009 and 2016, we convened expert panels on suicide prevention. We invited academic and military experts from within Canada and from our allies to help assess and guide our efforts in this important area.

We have made recent changes that include working with the Canadian Psychiatric Association to create the *CAF Clinician Handbook on Suicide Prevention*. It is a comprehensive document that identifies risk assessment and management of suicidality. We adopted the Columbia suicide severity rating scale to standardize our capturing of elevated risk. We also introduced CBTS through our training program across the country. This is cognitive behavioural therapy specifically aimed to address suicidal behaviour, not just the underlying mental health condition.

● (1310)

In March this year, we in the Canadian Armed Forces, as did all Canadians, and indeed the world, faced an unprecedented stressor, the COVID-19 pandemic, which has impacted us all and has been discussed by this committee. From a mental health care perspective, mental health services were never closed. From the outset, our leadership considered the mental health care of members of the Canadian Armed Forces a priority. We faced challenges, as all health systems did. We had to comply with local, municipal and provincial policies, and had to manage risk to our patients and staff vis-à-vis the pandemic.

Services continued and continue to be provided. Mental health care has been provided across the country in our clinics, using a variety of means, ranging from in-person assessments with both patients and clinicians appropriately wearing PPE, by telephone, and virtually, using video platforms. There have been challenges along the way in this implementation, based on technology, such as limited Wi-Fi in some of our buildings, and the compatibility of commercial platforms. This is an area we will continue to refine.

We can discuss this further, as desired, but as someone who joined the Canadian Armed Forces at the end of the Cold War, I am one who remembers that health services exist not only to provide care to the ill and injured, but also to maintain the operational readiness for times when we are expected to respond and act on behalf of the people of Canada.

During this pandemic, the CAF did respond, both domestically and internationally, when called upon, and health services supported those on operations.

I'm happy to take any questions, along with my colleagues, that the committee may have, and to let you all know that this will be the last time you will be meeting me in uniform, as I am well into my transition back to civilian society at the beginning of 2021 after 31 years of service.

Thank you.

**The Chair:** Thank you very much, Colonel Jetly, and thank you very much for your service. You've done a lot of important work over the course of your career.

I'd now to call upon Ms. Kyndra Rotunda.

**Dr. Kyndra Rotunda (Professor, Military and International Law, Chapman University, As an Individual):** Good morning, and congratulations, Colonel Jetly, on you retirement. That's fantastic.

Thank you for inviting me to comment on Bill C-203, which would amend section 98 of Canada's National Defence Act by repealing the self-harm element of the malingering charge. This would preclude Canada's military from punishing service members who harm themselves to avoid military duty.

I'm a professor at Chapman University in Orange, California. I'm also a former army JAG officer. I currently direct Chapman's Military and Veterans Law Institute, where law students and recent law school graduates, working under my supervision, represent veterans and service members in all types of legal matters. I previously co-authored a short article with a colleague, Ari Freilich, entitled "Self-Inflicted Wounds: How Military Regulations Prejudice Service Members", which is what prompted an invitation to appear at this hearing. Unfortunately, Mr. Freilich was not able to appear—he had an immovable scheduling conflict—but I have incorporated his feedback into my remarks as well.

Turning to the issue, on one hand, we can certainly understand why a nation's military would be tempted to criminalize self-harm, especially on the eve of battle. Nobody, even the most disciplined and well-trained soldiers, will calmly run toward the jaws of death. We know that it takes incredible will and incredible bravery to resist that natural flight instinct. Some may conclude, in fact, that death or injury at their own hands, on their own terms, is better than death or injury by an enemy.

On the other hand, criminalizing self-harm hurts the most vulnerable among our troops. This is especially true as our understanding of post-traumatic stress disorder evolves and our military suicide rate steeply and continuously climbs.

I've learned through my 20 years of practising military and veterans law, which entailed six years on active duty, that convictions for the crime of malingering result in immeasurable permanent harm and suffering to our troops. It shames service members; it causes them to hide their distress; and it pushes them ever deeper into depression and closer towards suicide ironically. In shame, they avoid getting the help they need. It's no wonder that the United States faces a suicide epidemic among its troops. Last month, USA Today reported that the suicide rate among our troops was at a six-year high, at 25.9 per 100,000 troops. I've read that Canada has similar statistics, with more Canadian troops dying by suicide in a 10-year period than the number of troops killed in Afghanistan over a similar 13-year period.

I wanted to turn to just a few examples. Over the life of our clinic, we've encountered several cases of service members who had been severely punished for attempting suicide. Several years ago, we encountered a case of a decorated combat veteran who was tasked with defusing IEDs over multiple war tours. He was medicated and diagnosed with PTSD. While deployed and barely holding it together, he was “stop-lossed”, which meant that he was not able to return home on schedule. In distress, he shot himself in the chest. He readily conceded under hostile questioning from his command, while he was hospitalized in the psychiatric facility, that he had “wanted to die because he could not go back to combat.” His command never disputed that the suicide attempt was genuine, but they nonetheless saw his statement about not being able to go back to combat as admission of a crime. They saw no difference between his wanting to die because of his PTSD and a malingerer's fraudulent intent to preserve their own life at military expense.

As we argued in our Law Review article, other prohibitions on fraud or duty shirking are already sufficient to deter and penalize genuine malingering. Given the still-widespread misunderstanding and stigma around mental health injury and suicide, commands too often interpret any offence whose essential element is self-injury as a licence to punish and punitively discharge suicidal troops. This deters help-seeking, especially without clear due-process protections to prevent punitive treatment of people whose conduct is at least substantially motivated by mental injury or disease, whether diagnosed or not prior to the attempt.

● (1315)

Another one of our clients, a decorated 21-year-old combat veteran, was heavily medicated for diagnosed mental injuries, with a gashed wrist covered in scars and held together by four staples, when his team leader appeared in his psychiatric ward hospital room to threaten him with court martial for “attempting to injure or kill himself”. He was hospitalized in an army psychiatric hospital for five weeks before he received a stigmatizing misconduct discharge for cutting his wrist with a razor. He had no disciplinary record whatsoever. He was soon diagnosed with severe PTSD, and he nearly died of a second attempt, when his brother discovered him hanging from a rope.

Criminalizing suicide in the military is at odds with jurisprudence applied in the civilian sector. Most American civilian jurisdictions decriminalized attempted suicide by the end of the horse and buggy era. Over 50 years ago, drafters of the Model Penal Code wrote, “While attempted suicide is still viewed as [criminal] in a few states, we think it clear that this is not an area in which the penal law can be effective and that its intrusion on such tragedies is an abuse.”

The drafters also rejected the criminalization of non-suicidal self-injury. No American jurisdiction has criminally punished a suicide attempt since 1961. The California Supreme Court wrote 30 years ago that “all modern research points to one conclusion about the problem of suicide—the irrelevance of the criminal law to its solution”. The Federal Ninth Circuit court has agreed, saying that there is a “modern consensus” in this area of law.

Despite being out of step with modern law, the military nonetheless still punishes suicide attempts by its troops. Not surprisingly, the U.S. military's suicide and self-harm rate only continues to increase, despite these punitive responses to self-harm.

This also causes collateral damage under our system when there's a denial of VA benefits for those who need them the most. Most of the clients we represent in our institute are seeking an upgrade to their discharge level. This is because the Veterans Administration conditions most benefits on having an honourable or general level discharge.

The VA offers all kinds of robust benefits, including an educational benefit, which funds college tuition, books, fees and even a living stipend for veterans who are going to college full-time. However, in order to receive these benefits, service members must have been separated with a higher level discharge. Even a minor infraction can result in a general level and disqualify the service member from the educational benefit that's offered in the United States.

Service members who stand to benefit the most from that benefit are those with combat-related military occupational specialties: those who manned a weapon, those who served in the special forces, were ordinance experts and the like. These dangerous soldiering jobs have no civilian equivalent, so those needing educational benefits the most are those who saw the most combat, and those who are most likely suffering with PTSD and disciplinary infractions that seem to go hand-in-hand, frankly, with a PTSD diagnosis, often, unfortunately, including malingering.

For the above-stated reasons, I support Canada's proposal to repeal the self-harm provision from the definition of malingering, and I am happy to provide any additional information, as requested, or to answer any questions.

Thank you again for the opportunity to testify on this important matter.

● (1320)

**The Chair:** Thank you very much, Professor Rotunda. It is much appreciated.

We'll go to the rounds of questions now.

We'll start with Mr. Benzen, please.

**Mr. Bob Benzen (Calgary Heritage, CPC):** Thank you, Madam Chair, and to all of the witnesses for being here today.

Thank you to all our military personnel for your service to Canada.

Admiral Bernatchez, thinking about paragraph 98(c), it seems to me that we should maybe break it up into two parts. Part one would be pre-deployment and pre-battle, where someone who inflicts self-harm is charged with a criminal act because they're trying to avoid duty.

The second part would after deployment, after they have been in battle and seen the horror and the carnage of battle. They are now at a point where they are suffering a mental health issue. At that point, maybe they inflict self-harm. I don't think those two things are equivalent. One is trying to avoid duty and one now is a complication from being in battle.

Can you give your thoughts on how paragraph 98(c) maybe should be revised? How can we look at this differently?

**RAdm Geneviève Bernatchez:** The first thing that I want to do is acknowledge the interest and the concerns that are being expressed and that the committee has heard. Certainly the information that I want to provide to the committee is truly to inform the committee's understanding of the law and to be as fair as possible.

The first thing I would like to specify here is that paragraph 98(c) of the National Defence Act addresses a situation where a member deliberately causes injury to themself with the very specific intent of avoiding service. Classic examples that we can all be familiar with would be a soldier who shoots themself in the foot or cuts a finger specifically in order not to be sent to the front. That's how the Canadian military law jurisprudence has been dealing with this section of the National Defence Act.

To my understanding, at least, and I would certainly leave it to Professor Rotunda to comment, contrary to the uniform code of military justice, which does not require proof of an intention to avoid service, our code of service discipline specifically in paragraph 98(c) requires that element.

I would also like to say that there certainly has been a recognition by different allies of the requirement to address these circumstances in order to ensure that their force will be ready and available to fight or to come to the assistance of their population in times of need. The U.S., the U.K., Australia, New Zealand, Denmark, Spain, Italy, Germany and France, to name but a few, have very comparable provisions in their own codes of service discipline.

What I think could help here is not, perhaps, to get away entirely from paragraph 98(c) and what it seeks to address, but perhaps, as is done for other offences in the code of service discipline, to insert a note in the Queen's regulations and orders that would specifically indicate the intent. I'm thinking here of something that could read like, “attempts to die by suicide or when self-harm is committed for a purpose other than avoiding service is not covered by this offence”. That would clearly indicate the intent of the legislator and what the paragraph is not meant to address, and could appease some of the concerns, I think.

● (1325)

**Mr. Bob Benzen:** That's excellent. I think that would be very, very helpful, making it very clear so that the stigma of a suicide, especially after battle....

There's a worry that people won't come forward for mental health help, and I think that, if we remove part of that stigma, which is that they're going to be charged with a criminal offence with very high penalties, they may be more likely to come forward and do that. So thank you for that answer.

Professor Rotunda, in the States, you talk about the military's having a category of self-harm without the intent of avoiding service. Is that used a lot in the United States? Is it working, and is it allowing more people to come forward and get mental health help?

**Dr. Kyndra Rotunda:** First off, “malingering” is under article 83 of our UCMJ. It includes a provision that “Any person subject to this chapter who, with the intent to avoid work, duty or service—(1) feigns illness”...dismemberment, etc., or intentionally inflicts self-harm. So it does actually have intent. It's not as clearly spelled out as the Canadian law, but it does have that.

One thing that we have found is that when commanders are wanting to punish a service member, they quite easily satisfy themselves that the person was intending to avoid work. The example that we have of a service member who, through pain, after suffering a suicide attempt, admits that “I can't go back to battle”, is a very different thing from saying, “I'm afraid to go to this training”.

I do think the notion was expressed a moment ago of being able to parse out those instances where someone is healthy, able and well, but scared, like we all would be, and harms themself. It's being able to parse out those individuals who are suffering severely with mental disease. You had mentioned the notion of maybe having a pre-deployment versus post-deployment analysis. Distinguishing between someone who hurts themself pre-deployment, before they've been to war, versus someone who hurts themself post-deployment, I think is possibly a good way to get at the issue. The only thing is that you would want to be very careful about how you spell that out, because we have in our military, anyway, several people who come to military service, frankly, who have had violence in their past, who come with a lot.... They could be coming to military service with PTSD. While I think that's a step in the right direction.... I really applaud Canada, truly, for looking at this and really trying to get to how you might amend the statute in a way that could get to what we are trying to get at.

There are some instances, I think, where malingering does need to be punishable. We can't allow people to drop a brick on their foot intentionally the night before their ruck march because they don't want to go.

I don't know if I answered your question. I'm happy to go further.

● (1330)

**Mr. Bob Benzen:** No, I think you did. I think you enlightened us a little bit more and you're moving us in the right direction. Thank you.

**The Chair:** Thank you very much.

We go on to Mr. Baker, please.

[*Translation*]

**Mr. Yvan Baker (Etobicoke Centre, Lib.):** Thank you very much, Madam Chair.

My thanks to the witnesses for joining us today.

My question goes to the Judge Advocate General. What is Canada's record in terms of charges against members of the Canadian Armed Forces under section 98(c)?

**RAdm Geneviève Bernatchez:** Thank you for the question.

I will ask my colleague, Colonel Wry, to provide more information about the statistics.

From the statistics we have been able to gather in recent months, we saw that those charges were laid many times, more than 300 times, during the Second World War. So we established that the offence was a common one.

Since 2000, I believe that two charges were laid under section 98(c) specifically. In one of those cases, someone was found guilty and the other charge was withdrawn.

Perhaps my colleague, Colonel Wry, has other details for you.

[*English*]

**Colonel Jill Wry (Deputy Judge Advocate General, Military Justice, Canadian Armed Forces, Department of National Defence):** Yes, thank you, Ma'am, and to the committee for the question.

It is correct that since 2000 there have been two members who have been charged under paragraph 98(c). In the first charge, the matter was not proceeded with, and the second one proceeded to trial by summary trial and the individual was found guilty. I will say, from a bit of research into the details of that particular finding of guilty, the situation was not one where mental health was an issue. It was a situation where someone was on exercises and admitted at the time to taking particular action in order to be returned back to his home base and not to have to continue in those exercises.

That is our history since 2000, with only two members being charged under paragraph 98(c). Thank you.

[*Translation*]

**Mr. Yvan Baker:** Thank you very much.

Was the Canadian Armed Forces member who was found guilty punished? If so, how?

**RAdm Geneviève Bernatchez:** Thank you for the question.

I don't think we have that information. We will send it to the committee later.

**Mr. Yvan Baker:** Okay.

Do other countries, particularly those in Western Europe and the United States, have a similar provision to section 98(c)?

**RAdm Geneviève Bernatchez:** As I was saying earlier, according to the research we have done up to now, the United States, Great Britain, Australia, New Zealand, Denmark, Spain, Italy, Germany and France have similar provisions, all dealing with more or less the same thing. They are designed to prevent members called to serve in defence of their country or to support the people of their country, from avoiding that service by deliberately injuring themselves.

It would be a long task to list or describe each of the provisions of the codes of military discipline of those countries. It would take a lot of the committee's time. I therefore propose to send you the document that gathers the results of our research and the provisions in the codes of military discipline of those countries.

● (1335)

**Mr. Yvan Baker:** Okay, thank you very much.

I think I have less than two minutes left. Briefly, what effect does section 98(c) have on the motivation of Canadian Armed Forces members to seek help when they are considering suicide, for example?

**RAdm Geneviève Bernatchez:** Thank you for the question.

My colleague Colonel Jitney is probably in a better position to answer it, because he is the one responsible for the services provided to those who ask for them.

**Mr. Yvan Baker:** Okay.

[*English*]

**Col Rakesh Jetly:** That's an excellent question, because the answer is that in 30 years of working in mental health, specifically in the last 20 years, and sadly being involved with virtually every suicide investigation we've had in the CAF, certainly in the last 10 years, I've never truly seen this specifically stated by a patient or by their family as a reason for the person's not coming. But, again, you can never disprove a negative; that's a scientific impossibility.

I believe there are barriers to care. I think I mentioned them. Barriers to care include stigma; not being aware of having a mental illness, such as "I'm 40 years old and I'm dragging ass, and maybe it's depression, and maybe not", and that kind of idea; and certainly concerns about one's career are very valid and come across all our allies.

We never specifically ask them if they're afraid of being punished, but it's a case of, "If I come forward with a mental illness or any kind of health illness, will it impact my employability or universality of service?"

So, I do not have any knowledge at all about paragraph 98 (c) specifically in the Canadian Armed Forces that I have ever heard from a patient or a colleague. I'm the senior person. If it were coming up among our contractors and our uniformed members, I probably would have heard of it; but, again, that does not disprove a negative. Of course, people's concern for their career is a valid barrier to care.

**The Chair:** Thank you very much.

We'll move on to Monsieur Brunelle-Duceppe, *s'il vous plaît*.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe (Lac-Saint-Jean, BQ):** Thank you, Madam Chair.

I want to thank all the witnesses for being here today and for their service in the Canadian Armed Forces.

My first question goes to all the witnesses.

In the Canadian Armed Forces Suicide Prevention Action Plan, we read that "a history of attempted suicide is the number one predictor of future attempts". It also says that self-harm increases the risk factors for suicidal behaviours.

Do the Canadian Armed Forces keep data on attempted suicide or self-harm among the members? If so, do they use those data to establish their policies?

[*English*]

**Col Rakesh Jetly:** I'll start with that.

The whole science of going from intent, to ideation, to attempt—either serious attempt or "not serious attempt"—then to the actual suicide act is a bit.... There's some debate in academia as to how somebody transitions through it. Are there differences between serial attempters versus completers? I think that's the key.

You can never really get a good, reliable number of attempts, and I've attempted to speak about this with your predecessors. If somebody has an overdose on a Friday and wakes up on a Saturday and carries on with their day, we'll never know about it.

We have in place a reporting policy so that if somebody in the chain of command becomes aware of a suicide attempt, a form is filled out. We collect the information, and the communication between leadership and the senior medical authority on the ground is to ensure that the person is in care. The chain of command and the senior medical authority, whom we'll call a "base surgeon" given my army background, will communicate, because sometimes the boss knows or the military police might find somebody, and you have to make sure that the doctor knows. It's just to make sure they're on the same page.

That's sent up to our headquarters within our directorate, and we track it. We do have the numbers, and I believe in a separate filing we produced that document. I don't have it right now, but it's coming to you folks.

Our emphasis is ultimately on getting the person into care. The cognitive behavioural therapy suicide, or CBTS, treatment that we've implemented in the last few years, with training across the country, is in both official languages is in effect a pivot that follows academia. In most of my career, growing up, when somebody was depressed and suicidal, you treated the depression as hard as you could to try to make the depression better. Cognitive behavioural therapy for suicide helps you to target suicidal behaviour specifically, giving a person the safety, skills and safeguards to try to prevent it.

The suicide attempt approach really comes down, in our medical system, to ensuring that the chain of command knows what resources are available for their people, and our clinicians, on a one-to-one basis, help them get the skills to attempt alternative coping rather than self-harm.

● (1340)

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Wow, that was a very detailed answer. Thank you very much. Let me also take this opportunity to wish you an excellent and happy retirement, Colonel Jetly.

I have another question for you. Major Karoline Martin came to the committee on November 27. She works at the Canadian Forces Health Services Training Centre. In her testimony about Operation Laser, she told us that, when the clinicians began working at long-term care centres, they recognized very quickly that they had a high risk of mental health problems or long term repercussions.

Do you share that fear? Can you tell us a little about the actions that are needed immediately?

[*English*]

**Col Rakesh Jetly:** I absolutely share the concerns. We are asking our soldiers—and service members in general—to do some things. We're going to unfamiliar ground. As somebody who has been around long enough...I was in Rwanda a few years ago and saw a lot of death and a lot of suffering in places like that.

It's a two-pronged approach. The Road to Mental Readiness, education, training, self-care and coping was given to the people before and after the deployment, so they have the tools and know what resources are available. I think you heard about that from Lieutenant-Colonel Bailey, my colleague, who's been in the next office to me for about a decade. It's a great program that many of our allies are borrowing, as well.

On the other hand, in my curiosity hat, a few of us got together very opportunistically and thought that this would be a very important topic to study. We have started what we call a "mixed-methods longitudinal study" to study the impact of a deployment. We are doing surveys, questionnaires and interviews to see the impact.

To be honest with you, as a clinician scientist, I'm very curious. I could see some young soldiers perhaps wondering what the hell they are doing in this kind of deployment because it wasn't what they signed up for. On the other hand, somebody else might think that it's really nice to help people in their own country instead of 7,000 miles away.

We have this curiosity, which is surveying, questionnaires and interviewing to see the mental health impact and to see whether people felt well-prepared about the training, which will feed back to leadership.

We're also looking at the concept of moral injury, which is whether seeing the death, dying, suffering and helplessness leads to guilt, shame and other components.

It's two-pronged. We're absolutely looking after them in the best way we can from a practical point of view, but we're also curious and learning. I think many of us feel that domestic operations like this are going to carry on. We're doing research to continue, as a learning organization, to feed back our findings. This is the other thing we're doing.

● (1345)

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Thank you very much.

**Col Rakesh Jetly:** My pleasure.

[*English*]

**The Chair:** Thank you very much.

Mr. MacGregor, please.

**Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP):** Thank you so much, Madam Chair, and our witnesses.

I'm here on behalf of my colleague Mr. Randall Garrison today. On his behalf, I want to go along the line of why exactly we still have paragraph 98(c) in the act. Our witnesses clearly identified the fact that only two cases, I believe, were prosecuted in the last 20 years. Is it setting the wrong tone by treating self-harm as a disciplinary matter rather than a mental health concern? I realize mental health issues are very complex and there's a very wide spectrum.

Maybe our witnesses can inform the committee. Has there just been a general reluctance to engage with paragraph 98(c)? Is there anything you can provide that would illuminate us on that?

Thank you.

**RAdm Geneviève Bernatchez:** Thank you. Perhaps I can start answering the question, and then my colleague, Colonel Wry, could provide other information.

On the use of paragraph 98(c) twice since 2000, it's always very difficult in any justice system to explain why a particular section is used or not used. For example, in the military justice system we know that approximately 70% of the charges being laid all pertain to the same type of category. They are there to address circumstances that prevail at the time at which they are used. Perhaps—and this is only speculative—paragraph 98(c) has acted as a dissuasive to those who specifically intended to injure themselves to escape service, dissuading them from doing it because they knew that the offence was on the books. I don't know that; I'm just offering that as a possibility.

The other thing I can point to is that before paragraph 98(c) is used, like most offences, there will be a whole-of-command approach to advising those who would lay the charges and would dispose of the charges. The commanding officer would be consulting with his medical officer in such circumstances. Is the person identified as someone who is not apt to stand trial or is suffering from a mental injury?

They will also receive legal advice from their legal adviser. Is it appropriate or not to charge under this specific section of the National Defence Act? This is something that the charge layer would have to be advised of and there would be consultation. Advice would be provided to the charge layer to ensure that there's not inappropriate use of the charge.

Perhaps my colleague could provide further information.

**Col Jill Wry:** Thank you.

The only thing I would add is that it's important to remember that the purpose of the code of service discipline—and the military justice system, of course—is to advance and support discipline, morale and efficiency in the Canadian Forces. Part of the way it does that is through the processes that it brings forward, both to deter activities and conduct that will take away from the discipline, efficiency and morale, and also to provide a mechanism by which to enforce those offences and enable that conduct.

It's important to see that paragraph 98(c) is part of a larger mosaic of service offences that exist under the military justice system to serve to deter conduct and behaviour that would diminish the efficiency, discipline and morale of the Canadian Forces.

Thank you.

**Mr. Alistair MacGregor:** Thank you.

Talking about that "mosaic", Colonel Jetly, you talked a bit about this in your opening statement. What's the current state of mental health resources in the Canadian Armed Forces? What's the current state of waiting lists? Are there any vacant positions that are still a part of the problem? We do have some statistics about the extra demands that there are and the long wait times.

● (1350)

**Col Rakesh Jetly:** Yes, on the staffing, again, I will commit to providing the numbers on specific staffing. When I last checked, about 90% of all of our positions were filled. That has been a sort of a steady state for the last few years. A lot of it is due to normal attrition. Often we have challenges when a lot of the civilian clinicians who work are spouses of military members who get posted and moved around, which becomes part of the issue.

Mental health professionals are also in high demand. Our ratio of mental health providers to service members is one of the highest in NATO, so we are sort of lucky to be well resourced in those ways.

Wait-lists are something that we're always tracking. We're always looking for more efficiencies. The way we address it is that we have a regular receipt of wait-lists. We have our benchmarks. It's difficult, because there aren't really good civilian benchmarks for wait-lists for mental health, as opposed to knee and hip surgeries and things like that, but if people are outside of our guidelines, we work with the base to identify the reasons and the solutions that we do have, which I'm hoping.... I mean, a silver lining from COVID is the increased comfort with and use of telepsychiatry and telemedicine, because certainly a more distressed base can have access from other bases.

There's a good use of this in the triangle between Esquimalt, Vancouver and Comox, those three, a triangle in B.C. where having psychiatry or psychology reach out to the other bases and avoid travelling.... We're hoping for one like that to sort of even the playing field because, as you know, we have bases in very isolated places and we have bases like Halifax, which is within walking distance from a university centre.

It's an ongoing thing, with ongoing tracking and an ongoing challenge. We're far from crisis mode right now. We're in a steady state. We could always strive to be better, though. I'll give you the specific numbers in terms of HR.

**Mr. Alistair MacGregor:** Thank you.

Allow me to say thank you for your service and congratulations on your retirement.

**Col Rakesh Jetly:** I appreciate that. Thank you very much.

**Dr. Kyndra Rotunda:** Could I just talk quickly on that question?

**The Chair:** Yes. Go ahead, Professor.

**Dr. Kyndra Rotunda:** Thank you.

I just wanted to jump in one point, which is that [*Technical difficulty—Editor*] how many malingering cases there are. It's often not a perfect gauge to say how many reported cases there were. The reason I say this is that when I have Shepardized our section as well, I only get a handful of cases that actually went all the way through the military justice system.

What we see in our clinic is that quite a few of the cases we see—in fact, the majority of them—are people who did not go through a criminal process, but through an administrative process where they were separated with a lower-level discharge, the reasoning being just malingering—an attempted suicide charged as malingering.

Those never come up through the system, so on our side, if you were simply to look at the number of reported cases we have, that's not really representative of the problem we have, because so much of it is happening at a lower level. Our service members then cannot get some of the benefits that they need at the VA. I'm not sure how that works in Canada, so I just offer that for what it's worth as you evaluate the extent of the situation in Canada.

**The Chair:** Thank you very much, Professor.

We go now to Mr. Dowdall.

Go ahead, please.

**Mr. Terry Dowdall (Simcoe—Grey, CPC):** Thank you, Madam Chair.

I too want to thank you witnesses for coming back once again today. Thank you very much for that and for your years of service.

Colonel Jetly, I want to thank and congratulate you. I'm sure you're quite excited to move on to that next stage in life.

In 2016, we did a report of the Mental Health Expert Panel on Suicide Prevention, a joint suicide prevention strategy, which highlighted that for some of our members, the transition period between being released from the Canadian Armed Forces and becoming a veteran could be a particularly stressful and a vulnerable time.

My riding is Simcoe—Grey, which has one of the largest if not the largest base, CFB Borden. What we find here is that many of the individuals decide after their military career to stay in Wasaga Beach or Alliston or Angus, or some of the other local areas here, which is good. We certainly want to find a way for them to seamlessly integrate into our community here. I've heard many times throughout the years that they seem to lack that 24-7 in-person support close by. I know that if someone has stress or mental health issues, for instance, they have numbers and they have to go to Toronto, but driving in Toronto, if you weren't stressed before, you will definitely be stressed by the time you get there.

So my question for you is this. With what we've heard and talked about in this area, do you think it would be a good idea to reach out? I know we're doing a hospital expansion down here in Alliston, which it borders on. Would it be a good idea to work together to put some of those services close so that they're still here in the communities that they're in to hopefully help them through that stressful time? I know they're also stressed as well with the backlog in Veterans Affairs, so I think it's our duty to do anything we can to help them out.

● (1355)

**Col Rakesh Jetly:** It's a very multi-pronged question and it's interesting because I did spend my first four years in Borden, so I know Alliston, Angus, Barrie, the whole area, and I have a lot of pleasant memories of that area.

On transition, I think, we are learning more and more, as are our allies, about transition, and one thing that I've been speaking about a lot with my colleagues is the concept of transitions in the plural sense.

Borden is a training base, and many, many people come in from civilian society and there's that harsh transition into the military. They've just finished basic training. They're away from family and they're learning their skills, their trades. The first year, the first couple of years, we do have suicides, we have self-harm in our officer cadets, in our young soldiers who are starting off. There's the transition coming back from deployment. That first year after deployment is also a time of elevated risk of family difficulties, self-harm and mental illness. So that's why we have the screening, and the reintegration. We've changed the way people come home from deployment.

Then of course, yes, there's the transition out from the forces. It's a stressful time regardless. It's a difficult time regardless. You have to get provincial health cards again. You have to do all kinds of things that you haven't done before, such as find a family doctor, which is also stressful. Then if you add mental illness to that on medical release, you've sort of increased it even further.

In terms of the health care provided in local hospitals, I think it's Stevenson Memorial, if I remember correctly?

**Mr. Terry Dowdall:** Stevenson is the one that is actually going through a redevelopment. There have been discussions about perhaps working together. It would be good money well invested, and perhaps we could save some money and at the same time save some lives.

**Col Rakesh Jetly:** Yes, so the idea—and again, this is the difference between Canada and the U.S.—is that our health care, the provision of health care for our forces, by definition, is in partnership with the civilian health system. You know, we do cross that with federal funding, but we do not have hospitals anymore. We don't have 24-7, and when I started, we did. We don't do our own surgeries, so in a sense we are always in a partnership and really, it's the local senior medical authorities who develop those relationships. The base in Fredericton develops the relationship with the local hospital in Fredericton, and those types of things.

What I would encourage there is to have the discussion at literally the lowest level when defining needs, and I cannot speak for the surgeon general, for the CMP, or the CDS, but by definition, everywhere in the country we would not be able to look after our members without the civilian partnership.

So it certainly is, in principle, something worth exploring.

**Mr. Terry Dowdall:** Do you think there is a gap? There's a perception of a gap. Do you actually think there's a gap in access to services during those transition periods?

**Col Rakesh Jetly:** I think there's always a potential gap in the sense that people may have health needs 24-7 and our clinics are now sort of ambulatory care. We're sort of daytime. We're not open on weekends typically, and those types of things.

So after hours, we rely on the civilian system almost exclusively across the country in terms of emergency rooms and things like that.

So there's certainly a potential need.

**Mr. Terry Dowdall:** I have one last question.

Do you think it would be good to have a single, easy phone number, like 988, for people to phone when they are stressed? I know that everyone has their own little organization, but do you not think that, when people are totally stressed, that would make a lot of sense?

**Col Rakesh Jetly:** I'm a complete believer in leveraging technology, and I think the simpler we make things for people, the better, yes.

**The Chair:** Thank you very much.

**Mr. Terry Dowdall:** Thank you.

[*Translation*]

**The Chair:** Mr. Robillard, the floor is yours.

**Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.):** Good afternoon to the witnesses. Thank you for taking the time to come and appear before us. I have a number of questions for you. The first goes to Colonel Jetly.

Can you tell us about the Joint Suicide Prevention Strategy developed in 2017 by the Canadian Armed Forces and Veterans Affairs Canada?

● (1400)

[*English*]

**Col Rakesh Jetly:** In general, yes, I can speak about it.

If I can speak historically.... One of the reasons—your colleague who asked a previous question set this up nicely—why it is now a joint strategy is the absolute recognition that transition is a particularly high risk. There is a huge difference in the Canadian Armed Forces. We are in a very, very controlled, well-resourced environment. We have colleagues, a chain of command and a health system where everybody has primary care. That transition to the civilian world.... The idea is to have that seamless hand-off between the two government departments.

There are many, many items within that, and they deal with.... As I mentioned earlier, suicide is a complex factor, so it has to do with structure, vocation, health, moving and settlement, but the idea is that we recognize the fact that moving, itself, can be stressful, and stressors can increase suicidality, particularly if people are ill. A small but significant part of it is related to health services. What we have done is endeavoured to sort of improve the handover of people, particularly with identifying illnesses, to Veterans Affairs Canada, where early in my—

[*Translation*]

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

Colonel, how do the Canadian Armed Forces support their members who have tried to commit suicide or who have harmed themselves?

[*English*]

**Col Rakesh Jetly:** From an, I'll say, Canadian Armed Forces..., I can start with health services. Things in terms of health services—for a suicide attempt or a self-harm attempt—begin with a careful assessment to identify what illness is perhaps causing it. There are illnesses like major depressive disorder and post-traumatic stress disorder, which to lay people may be similar, but they're quite different. Then we apply the evidence-based treatment.

The entire focus there.... I think it's very interesting. In the military, we grow up with putting our our careers and the organization first. We put our families second, and we usually put ourselves third. What we demand of people at this time is to turn that completely upside down and to focus on themselves for self-care. The leadership has been, in my mind, almost always supportive. They put themselves in front, put their families second, put their careers and the missions behind, and focus on the care. We attempt to provide the evidence-based care—whether it's psychotherapy, medication, vocational rehab, retraining or whatever is needed—with the number one aim of getting people better. The number two aim is to help keep their careers and help keep them in the Canadian Armed Forces if that's what they desire. If not, we make sure that there's a smooth transition to Veterans Affairs, if they're eligible, but otherwise to the civilian system.

[*Translation*]

**Mr. Yves Robillard:** What is the current rate of posttraumatic stress syndrome among members of the Canadian Armed Forces?

[*English*]

**Col Rakesh Jetly:** It's a very tricky question because numbers are always tricky.

From the last population-based survey we did in 2013, the lifetime prevalence, I think I read, was 11.1%. That's a lifetime prevalence. It doesn't talk about cause. It doesn't say that it's because of Afghanistan. It could be from childhood, as one of our previous witnesses said. I believe—and I can be corrected later on—that the 12-month prevalence was just about 5%, which is about double what it was in the 2002 survey.

Remember that depression has been and always will be in the armed forces, even in times of war—just like in civilian society—the number one mental health condition, the most prevalent and the largest burden. PTSD varies from time to time, but trauma.... Our military members in most of our countries—Canada and the U.S.—have a higher propensity for adverse childhood events when they're growing up. It's the type of people we attract as well, so the PTSD lifetime doesn't necessarily relate to military operations, although military operations certainly are a big part of it.

● (1405)

[*Translation*]

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

[*English*]

**The Chair:** Thank you very much.

[*Translation*]

Mr. Brunelle-Duceppe, you have the floor.

**Mr. Alexis Brunelle-Duceppe:** Thank you, Madam Chair.

Colonel Jetly, BMC Psychiatry published a study on the Road to Mental Readiness program that was prepared for Canadian Armed Forces recruits. The study showed mixed results. Actually, no positive outcomes were seen on psychological functioning, resilience and military performance. In general, the conclusions of the study did the program no great favours.

Are you in a position to comment on the results of that study?

[*English*]

**Col Rakesh Jetly:** I missed the beginning because of the translation. What paper are you referring to?

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** The study was published by BMC Psychiatry; it looked at the Road to Mental Readiness program that was prepared for Canadian Armed Forces recruits. We are told that the program did not have the desired effects—

[*English*]

**Col Rakesh Jetly:** Who are the authors?

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** It's BMC Psychiatry.

[*English*]

**Col Rakesh Jetly:** I'm not familiar with—

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** I don't know the authors' names, but I can send them to you.

[*English*]

**Col Rakesh Jetly:** It's hard to comment on a specific report without knowing the authors' methodology. In general, what I can say about psychiatric care overall is that in the civilian world and military world, we have a long way to go. I think our evidence-based treatments, if we're lucky, whether it's civilian depression or PTSD, help 50% to 60% of people. A significant number of people don't benefit. I don't know if that's a specific military thing. We do have evidence that combat-related PTSD tends to respond less often, whether we're talking about Australia, Canada or the U.S., than civilian PTSD with the proper evidence-based treatment.

I absolutely 100% concede that more treatments and better treatments are needed, which is why continuing to do research and continuing to finding novel treatments is important. I just can't specifically comment on the report.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** I completely understand. Perhaps you might have been able to comment on the Road to Mental Readiness program, but if you have not read the study, there is no point. I don't know whether another witness has read it, but if not, it makes absolutely no sense to talk about it.

[*English*]

**Col Rakesh Jetly:** The Road to Mental Readiness is a training and education program, not a treatment program. Lieutenant-Colonel Suzanne Bailey runs R2MR. Like many countries and like our allies, we have education programs to help destigmatize, to teach skills and to teach mindfulness. We start that in basic training, when people first come in, to teach them mental health literacy, to teach them the language, to understand taking a knee if they're not feeling well, and to maybe even be kinder to each other.

That's part of the training and education program. The efficacy of a training program is different from the efficacy of a treatment program.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** I understand, but are you familiar with the program?

[*English*]

**The Chair:** Thank you.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** It is over. Thank you.

[*English*]

**The Chair:** Mr. MacGregor, please.

**Mr. Alistair MacGregor:** Thank you so much, Chair.

Untreated mental health issues understandably have a really big impact on military families. We heard testimony at a previous meeting about the increasing challenges that military family resource centres face, given the spillover of mental health issues on families. The testimony was about the problems at CFB Esquimalt, especially for after-hours care. If someone's in a crisis at that time, they have the chaplain team and the military police.

Have the military family resource centres received any extra help? Have they been consulted? They are independent non-profits, but they get almost all of their money from DND. Can you offer a comment on that, please?

**Col Rakesh Jetly:** I can't comment or give you an answer specifically to that, because it's not within health services that we look at that. I will tell you that we work very closely together with the family resource centres. I've had an incredible career in the sense that my colleagues from social work and other disciplines have taught me something that med school didn't teach me: Disease doesn't affect just an individual; it affects a whole family. We take a whole-of-family approach within health services. We do a lot of couple counselling. We do research on conjoint therapy for PTSD. We have an absolute interest in that.

In terms of the publishing, the journals and the academics, we do look at the family impact as well. However, I can't answer your specific question about resources for MFRCs.

● (1410)

**Mr. Alistair MacGregor:** Where could the committee follow up to get some of that specific information?

**Col Rakesh Jetly:** The MFRCs fall under morale and welfare. It's within the chief of military personnel, but I'll get back to you with the specific office. We're at meetings all the time, but they changed the name a little while ago. I think it's morale and welfare services.

**Mr. Alistair MacGregor:** Okay, thank you so much.

Chair, that's it for me.

**The Chair:** Thank you, Mr. MacGregor.

We'll go on to Madam Gallant, please.

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

Colonel Jetly, does a suicidal CAF member have to call the hotline in person, or will the hotline respond if the spouse of a CAF member calls on behalf of the member in a crisis situation?

**Col Rakesh Jetly:** Do you mean the CFMAP, the Canadian Forces member assistance program?

**Mrs. Cheryl Gallant:** I mean the hotline that if somebody is in extreme mental distress they are instructed to call.

**Col Rakesh Jetly:** I understand. We don't have a hotline in that sense. We have CFMAP, which is the Canadian Forces member assistance program, which isn't a suicide hotline. If a suicide hotline is called, the community suicide hotline, they'll follow their own procedures. There are some national ones, but there are different local ones.

**Mrs. Cheryl Gallant:** How do the CAF members under your direction facilitate the seamless transition of care when patients release from the military to civilian life?

**Col Rakesh Jetly:** There are many different procedures in place. One of the big divisions, of course, will be whether it's through Veterans Affairs. If people have an identified mental illness or mental injury that's attributable to military service, the really important thing we've changed over the years is making sure that they have their assured Veterans Affairs paperwork, their eligibility and veterans card, all of those things, in place prior to release. That's one of the most important things.

We also allow, and it's something we almost encourage, that if people know their intended place of release, we will make that handover to Veterans Affairs during the last six months. As one your colleagues earlier said in regard to how people tend to release, if you're in Borden, you might stay within the Barrie area.

In Ottawa, we have a Veterans Affairs OSI clinic and we have our own clinics. If we can find a clinician, we can help make that transition smoother, then, even while they're still in service seeing military family doctors and psychiatrists if they find a therapist within the Veterans Affairs system.

Closing the gap between that in the transition is certainly an important piece. The Canadian Armed Forces has just stood up a specific group, an organization responsible for transition. They would probably be able to answer the question better from a holistic or overall point of view.

From a health perspective, the transition group will essentially attempt to make sure that people have ongoing health care and are connected to family physicians. It often gets complicated, depending on where people elect to release from the military. They might move to a more remote community despite having health needs, so there are those challenges.

**Mrs. Cheryl Gallant:** The danger zone when people don't have that care is between their arriving home needing that service and the care not already being in place, and that's when the deaths come.

Going back to that phone line, it's not a hotline. It's a member assistance line. Are they able to communicate with the spouses or close family members, whether the member is in service or on the way out? Will they act when a family member calls because the member is in crisis?

● (1415)

**Col Rakesh Jetly:** I can't answer that.

We don't run CFMAP. I can certainly look into it and try to get you an answer.

**Mrs. Cheryl Gallant:** Would you, please?

I know there are a number of members on this committee who are interested in the answer to that specific question. Last week, we had Dr. Sareen as a witness, who was, I'm sure you're aware, a co-chair of the expert panel on mental health.

How many of the 11 recommendations have been fully implemented from that 2016 mental health report?

**Col Rakesh Jetly:** Of the 11, I can tell you the one that we didn't implement, the one that we looked at very carefully, was the Caring Contacts. We looked at it, and the science on it was sort of mixed, the additional setting of it.... So we didn't do that one.

In terms of the other one that's sort of in progress.... You could read them out to me, and I can speak to them, because you're asking me to remember 11.

The office, the individual person responsible for suicide, that hiring process is going on right now. We are, between us, sort of creating a function for tracking and implementation of new approaches and the research.

If you want to ask me about other specific ones, I can attempt to answer.

**Mrs. Cheryl Gallant:** No.

Have there been any noticeable changes or trends in the mental health status of CAF members during this pandemic?

**Col Rakesh Jetly:** We don't have the literature on that right now. We sort of co-chaired a NATO meeting on September 17. We sort of grabbed observations from all of our allies, NATO plus Australia and New Zealand. It seemed like most of our countries saw a drop in use within the first couple of months and then sort of an increase in use.

I don't think we're going to have the exact numbers until later on when we look at things. You have counter-balancing forces going on in the Canadian Armed Forces in the sense that our members are fully employed. A lot of the determinants of health are there, but they are sort of suffering from the same pandemic kinds of things.

There are some stressors that are the same in civilian life and some stressors that are different. We may have some protective factors and some risk factors. We haven't seen an alarming increase in substance use or in family violence, although those are the kinds of things that we're seeing in the civilian world that we're certainly tracking.

**The Chair:** Thank you very much.

[*Translation*]

Mr. Robillard, the floor is yours.

**Mr. Yves Robillard:** I have to ask my question right away just in case you leave.

A number of your colleagues, and you yourself, have spoken about the involvement of loved ones—fathers, mothers, extended family—in easy-going terms. I have met a number of people grappling with these problems, and they have told me that becoming involved in the process is very different from what you are telling us. I could provide you with a number of examples of that kind of testimony.

I'm simply bridging the gap between those people and yourselves. What do they have to do, if members of an extended family try to contact people in your group and are told that it's not the way things work?

● (1420)

[*English*]

**Col Rakesh Jetly:** I'm sorry, but I didn't really get the question because the translation was a little sketchy. Could somebody just summarize it for me? I'd appreciate that, if it was directed to me.

**Mr. Yves Robillard:** Will you give me the time to explain? I'll do it in English, if you want.

I was talking about the implications for relatives, people who are their fathers, mothers, sisters or brothers who try to get involved to help the process and are refused. That's not exactly what I heard from you and other colleagues of yours.

**Col Rakesh Jetly:** Again, I think that's a very important point. We do encourage members to include their families, but health conditions are private. If I have a health condition, and my spouse asks my doctor about it, the doctor is not going to speak to them without my permission.

We encourage members to bring in their families. We encourage them to bring in their spouses. I think spouses give incredible, what we call, “collateral information”. They can certainly help and can certainly be part of the treatment, if necessary, with couples counselling and family counselling. The permission to allow other people to come in relies on the member.

If we get a phone call from a concerned family member who gives us information, we certainly will be in a receive mode. We certainly will listen to the person respectfully and hear what they're saying, note it, document it and use it, but, without permission, we're not able to transmit and share the personal health information of an individual.

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

[*Translation*]

What are the reasons for the differences we see in the mental health problems of women and of men in the Canadian Armed Forces? Is the difference due to a different approach on the part of the Directorate of Force Health Protection?

[*English*]

**Col Rakesh Jetly:** No, I don't think so. The differences between male and female rates of mood, anxiety disorders, suicide attempts, addictions and those types of things are basically the same as they are in society. There's a biological difference between men and women, and that difference seems to carry itself into the armed forces.

**The Chair:** Thank you very much.

Go ahead, Mr. Bezan.

**Mr. James Bezan:** Thank you, Madam Chair.

I want to thank all of the witnesses for participating again in our committee meeting, and I apologize for the difficulties we experienced on Monday.

Colonel Jetly, again, congratulations. I've had the pleasure of working with you for almost a decade. I remember with fondness our travels across the country when I was parliamentary secretary. We were trying reach out to our troops to deal with their injuries and illnesses and the supports they were receiving in the Canadian Armed Forces. Some of those conversations were difficult, but I think we learned a lot from that.

Now that you're looking at parting ways with the armed forces and moving into the private sector, when you look back on your 30-plus years as one of the lead psychiatrists, and for at least the last decade the lead psychiatrist in the Canadian Armed Forces.... I know that in some of the early conversations we had, there wasn't even clinical terminology around PTSD for what it encompassed and how it manifested. Can you talk to how mental health has changed, from the standpoint of treatment and the science, in your time of service, up to where we are today?

I know we established the centre of excellence at the Royal to help our current serving members and our veterans deal with post-traumatic stress disorder and other operational stress injuries. I am wondering if you could talk about how things have changed in the last decade for sure, but also over the course of your career.

**Col Rakesh Jetly:** Well, I could give an hour-long lecture on that. I do remember our travels—

**Mr. James Bezan:** I'd probably come and see that.

**Col Rakesh Jetly:** I think in some ways I pinch myself. I think of deploying to Rwanda in the early 1990s, where mental health was an afterthought; we didn't think we needed it, but people who went suffered, and of course there's Roméo Dallaire and that whole story.

In one way mental health was the poor cousin of health care. Thankfully to the Canadian Armed Forces, the leadership and a few broken souls along the way, there was the realization that mental health is important and paramount, despite the thousands of years of history, knowing that psychological injuries have always outnumbered physical injuries in war and in deployments, whether World War I or World War II. I think that's the piece, a watershed moment for us in the Canadian Armed Forces, and our allies are extremely envious of the way we managed to create this whole operational stress injury paradigm.

What we've done is that we've basically given it footing and we have the Sacrifice Medal like the Purple Heart, the American one, albeit the latter doesn't recognize PTSD. With our medal, if three members are hit by an IED explosion, and one person dies and one person loses two legs, and the third person gets PTSD, all three receive the Sacrifice Medal. If you understand the military, that sort of recognition in pinning something on is important. I think for the whole oversight paradigm it's important.

More recently this interest in understanding guilt, shame, anger, the whole moral injury concept, which may explain some of the suicides, and also some of the resistance to conventional treatments, I think is really important.

The two main things that we're going to continue to work on in the future are understanding the biology, understanding what's happening in the brain, what's happening in the body, the inflammation, the heart disease, the diabetes, which seem to be higher in people with mental illness, and why soldiers with PTSD die earlier than others. I think Veterans Affairs, of course, cares about it.

I think that's important. I think leveraging technology, using your Fitbit, your wearables, getting to that point where we can create this 24-hour caring system using technology and things is important.

I still think the whole idea of personalized medicine is important. We're getting there, but the idea of the trial and error is frustrating for doctors and patients, so we need to understand a little bit more which treatments are going to work for whom, and start with the first one that we think is most likely going to work.

We've come an incredible way, and I pinch myself. I remember giving talks in Gagetown, where it was almost like I was being mocked for the touchy-feely talk, and I compare it to right now when nobody is laughing anymore at mental health.

I think we've come a long way, but it's a journey and there's a long way to go. I do believe that one of the other really important things is our engagement by looking up and out with the civilian community, and working with Bell and Bell's Let's Talk, and all of the different things that we're doing, because I truly believe that for soldiers, like athletes, if we're able to talk about our own mental illness and difficulties, I think that's important for the kids and for society. If the soldier can do it, the toughest guy who's out there can do it, why can't I if I'm an adolescent struggling? I think we've come a long way.

● (1425)

**Mr. James Bezan:** As we're coming that long way, are you seeing a major change in the culture, versus where we were before when if you were feeling bad, you're weak?

**Col Rakesh Jetly:** I think the change is so great, to be honest with you, I have to pinch myself. I've got leaders here on this panel with me and I've had the privilege of working with the rear admiral, and the way she looks after her people....

The calls that we get are about care for our people, and people are saying, “Hey, what are we going to do, what's available for our people?” I think that “people first” is almost like a cliché within military settings, but I believe it's genuine.

**Mr. James Bezan:** I know that the leadership—

**The Chair:** Thank you very much.

I'll have to go to Mr. Robillard.

[*Translation*]

**Mr. Yves Robillard:** Thank you, Madam Chair.

My question goes to Rear-Admiral Bernatchez and Colonel Jill Wry.

According to an answer given at the meeting of this committee on October 23, 2018, since 2000, only one member of the Canadian Armed Forces has been convicted under section 98(c). In your opinion, what explains that situation?

**RAdm Geneviève Bernatchez:** Thank you for your question. I will try to answer it. Then, my colleague can take over.

As I was telling the committee a little earlier, it is very difficult for us to explain why a legislative provision is used or not used.

I indicated that 70% of the offences are always the same, so it is very difficult to explain why this provision is used or not used. However, I can certainly say that section 98(c) has not been regularly used since 2000. Its very specific goal is to establish penalties for, or to deal with situations when, someone wilfully harms himself with intent to avoid his service responsibilities.

In my testimony earlier, I said that, between 1939 and 1945, during the Second World War, this section—or its equivalent at the time—was used more than 300 times. So we can see a correlation between periods of heightened operational activity and the need to use that section.

It has also been brought to my attention that there are many offences in the Code of Service Discipline for which charges are not regularly laid. Refusing an immunization is an example of one offence that will not normally incur a penalty. It does not mean that we do not need provisions for those situations. It simply means that, at a certain point, in a certain situation, the offence is not automatically punished.

● (1430)

**Mr. Yves Robillard:** What are the factors that explain a higher rate of suicide in the Army, compared to the other forces?

**RAdm Geneviève Bernatchez:** I think that Dr. Jetly is in a better position to answer that question.

[*English*]

**Col Rakesh Jetly:** There are many reasons. Traditionally, in most militaries and most of our allies, it's the junior members of the army, specifically the combat arms. We did see an uptick in that group, which has sort of settled down in the last few months. You can't absolutely say, but it also does reflect the people who are exposed most likely to the war, and they're in the trenches more often.

When we have 2,700 people or so deployed to Afghanistan, the few hundred people who are part of the battle group that spend most of the time outside the wire are certainly impacted.

There are also other theories. Junior members of the air force tend to be more technical, and tend to have different types of duties, and maybe different personalities are attracted. Certainly, if we're going to look at the near past for most of our military and our allied militaries, the conflicts in Afghanistan, Iraq and such can probably explain some of the differences. However, association and causality are, of course, two different things.

[*Translation*]

**Mr. Yves Robillard:** Attempts by parliamentarians to rescind section 98(c) of the National Defence Act have been met with failure.

In your opinion, why has it not been possible to rescind section 98(c) of the National Defence Act?

**RAdm Geneviève Bernatchez:** That question is for me, I assume.

**Mr. Yves Robillard:** Correct.

**RAdm Geneviève Bernatchez:** It is very difficult for me to answer that question because I am not on these committees and I am not a member of Parliament. I think that question should go your colleagues.

However, I will certainly be pleased to continue to support you in your deliberations and to help you make informed decisions.

[*English*]

**The Chair:** We move on to Mr. Brunelle-Duceppe.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Thank you, Madam Chair.

We are having a really fantastic discussion today. I just want to say that we are getting excellent answers to our questions.

The principle of universality of service in the Canadian Forces requires that members be ready for service. But exceptions can be made for mental health reasons.

My question goes to Professor Rotunda.

First, I am delighted to meet you. I am not sure if you mentioned this earlier, but does the principle exist anywhere else in the world?

[*English*]

**Dr. Kyndra Rotunda:** We have a disability process that our service members go through. Sometimes, depending on the level of disability, a service member might be separated with severance pay: a one-time payment. If they're significantly disabled—we consider the threshold to be more than 30% disabled—they can be separated with a disability retirement.

There are mechanisms to try to help service members get out of the services—

● (1435)

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Does the same thing exist elsewhere in the world?

That was the gist of my question.

[*English*]

**Dr. Kyndra Rotunda:** I can't speak to that. I'm sorry. I don't know.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Okay.

Can another witness tell us whether other countries have it?

[*English*]

**Col Rakesh Jetly:** Something to that effect exists within most NATO countries. It applies to different degrees depending on the countries that have obligatory service versus voluntary militaries. Ultimately, most defence forces.... And it's not for mental illness, it's for physical illness. It is for other things. The concept is always in review. It's always under scrutiny, within Canada, in the sense of is it the same to be deploying to a large base like Kandahar, where you have a hospital, as to a small village in Sierra Leone? We talk about this.

I will take advantage of saying to you that we have been taking a very progressive view as we've gone further with mental illness. We're really emphasizing more and more. I sit quarterly with my colleagues who are helping to make the decisions of actually looking at people's functioning more than their diagnoses. We look to see... if somebody has had three depressions, but they've only missed three or four days of work here and there, and they've been able to sail and they've been able function, we're not saying, “You can't serve in the military because you have this illness.” If they are functioning, and able to continue to do their jobs safely, we are encouraging, and the military is responsive to, accepting a little bit more risk when it comes to illness if somebody is able to function with treatment.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Are you able to—

**The Chair:** Your time is up.

Thank you very much.

**Mr. Alexis Brunelle-Duceppe:** But it was a good question.

[*English*]

**The Chair:** Mr. MacGregor, please.

**Mr. Alistair MacGregor:** Was that for me, Chair?

**The Chair:** Yes, Mr. MacGregor.

**Mr. Alistair MacGregor:** I actually have no further questions for our witnesses. I think I'll just end by thanking them all for their testimony and for being patient with us. I very much appreciate it.

Thank you.

**The Chair:** Thank you.

Would you like to give up your time?

Mr. Brunelle-Duceppe, carry on with your question.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** I could ask my question.

[*English*]

**The Chair:** If that's all right with Mr. MacGregor.

**Mr. Alistair MacGregor:** He can take my time.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** That's very kind.

It's actually a follow-up question.

Mr. Jetly, you answered my last question. Perhaps the rear-admiral could answer this one.

On average, how many Forces members are released each year for mental health issues? Do you have those figures?

**RAdm Geneviève Bernatchez:** We do not monitor those data in the military justice system, but perhaps my colleague Dr. Jetly has the information.

**Mr. Alexis Brunelle-Duceppe:** Okay.

[*English*]

**Col Rakesh Jetly:** We'll get you the specific figures. From the last numbers I remember, about 5,000 people leave the military every year. I think a third of them are for medical reasons. I don't know if we have the breakdown for mental illness, but we'll take that on advisement. We have the numbers of people who are released. We have the numbers of people who are released for medical reasons, which are the so-called 3B releases. I don't know if we've gone through the exercise of separating them by diagnosis. It gets complicated, because many times people have more than one diagnosis. Somebody could have chronic pain and PTSD.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** However, if we had the exact data on people released for mental health reasons, it might possibly give us an idea of a way forward.

[*English*]

**Col Rakesh Jetly:** Absolutely.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Okay.

You can give the committee the information later.

[*English*]

**Col Rakesh Jetly:** We'll look at it for sure.

[*Translation*]

**Mr. Alexis Brunelle-Duceppe:** Thank you very much.

[*English*]

**Col Rakesh Jetly:** Absolutely. It was a good question.

**The Chair:** Thank you very much.

We'll go on to Mr. Bezan.

**Mr. James Bezan:** Thank you, Madam Chair.

Mr. Brunelle-Duceppe always asks good questions.

I want to get a clarification.

Admiral Bernatchez, in answering questions earlier you mentioned that if someone refuses treatment, they can actually be charged under the National Defence Act, or under the code of service discipline.

**RAdm Geneviève Bernatchez:** I'm sorry, I don't believe that is what I meant or said.

**Mr. James Bezan:** Okay, it could have been in the translation then.

If somebody refused to get treatment, whether for a physical injury, a mental health injury or refusing to take a vaccine, they wouldn't be charged or disciplined under the NDA, would they?

● (1440)

**RAdm Geneviève Bernatchez:** I'm going to pass it over to my specialist in these types of granular data. I'm going to ask my colleague Jill to answer.

**Col Jill Wry:** Thank you.

There is no specific obligation to undergo medical treatments. There is, I can say, an offence under the code of service discipline for refusing immunization or vaccination. I'd have to tell you the exact section—

**Mr. James Bezan:** Are you telling me, then, that if somebody doesn't want to take the COVID-19 vaccine that's coming out right now, they can actually be disciplined for it?

**Col Jill Wry:** That would only be a situation where they're actually ordered to and it's an obligatory requirement. It's only if you are ordered to undertake an immunization or a vaccine. I would have to find the exact wording to give you for that particular section, but—

**Mr. James Bezan:** Will you please provide that information?

**Col Jill Wry:** Yes.

**Mr. James Bezan:** That would be interesting for us, for sure, especially with some of the questions around efficacy and safety of the vaccines at this point in time. I know I will be taking the vaccine, but there might be others out there who don't want to, so I do appreciate that.

**Col Jill Wry:** Yes.

**Mr. James Bezan:** While I'm talking to both of you, as judge advocate generals in the JAG office, one of your former colleagues, Lieutenant Colonel Jean-Guy Perron, testified when we were studying Bill C-77 back in November 2018. We were looking at whether paragraph 98(c) was a necessary under the National Defence Act, or whether there were other ways to deal with those who malinger. We heard from Professor Rotunda that they have found other avenues by which to do that in the United States

Under what other sections of the National Defence Act would we be able to charge those who use self-harm to avoid service, without paragraph 98(c)?

**RAdm Geneviève Bernatchez:** We would have to do some analysis to see how to get there. However, I would like to say at the outset that tribunals generally prefer to have specific offences, because when you have more general offences to address a specific behaviour, tribunal courts in Canada have a tendency to say that the accused did not get the opportunity to know exactly what they were facing. I think that the capacity to charge under other offences would require further analysis by my office. We currently have a specific offence that is incorporated in the code of service discipline, and if it were to disappear, it could signal also to the courts the parliamentary intent in that regard.

**Mr. James Bezan:** Admiral, could I just stop you there? We had a hearing back in November 2018 where we were looking at this section under Bill C-77. Colonel Strickey said at that point that they were going to look at that issue of self-harm and other areas. That was two years ago. I would have hoped that you had time during the past 25 month to actually pull together that analysis.

**RAdm Geneviève Bernatchez:** We have conducted quite significant analysis since 2018, as we committed to the committee at the time and we have elected to do it. That's the answer that I'm providing to you. I'm saying that there could be second and third degrees of effect of repealing a specific offence within the code of service discipline. That could signal parliamentary intent, and trying then to charge a member under a more general offence—for example, conduct to the prejudice of good order and discipline—could be seen by either my military tribunals or civilian appeal courts as something that is no longer available to the military. This is something that I cannot positively declare at this point, because a court would have to opine on this. I'm just alerting the committee to the second- and third-order effects that could happen if this specific office were repealed from the code of service discipline in the National Defence Act.

**Mr. James Bezan:** My final question revolves around the boards of inquiry that take place, especially when it relates to suicide. We already had Sheila Fynes at committee, whose son, Corporal Stuart Langridge, committed suicide. We are all also very familiar with the story of Lieutenant Shawna Rogers and how her family actually took the CF to court in Alberta to get access to the BOI report.

This adds insult to injury for families dealing with the loss of a loved one due to suicide. Has there been any advancement on sharing those findings and making sure that family get of all their questions answered in the unfortunate event of a suicide?

● (1445)

**RAdm Geneviève Bernatchez:** I am aware that those concerns have been shared with the committee. Unfortunately, this does not fall under my area of responsibility. It would have to be addressed by the chain of command.

**The Chair:** All right, thank you very much.

We'll move on to Mr. Spengemann, please.

[*Translation*]

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

Rear-Admiral Bernatchez, Colonel Wry and Colonel Jetly, thank you very much for giving us your testimony this afternoon. I also thank you for your service to our country. Through you, I would also like to thank the women and men serving under your command.

[*English*]

Colonel Jetly, congratulations on your pending retirement.

I want to take you back to conversations in previous rounds on the implications of serving in a combat role, either actively on the front lines of a kinetic environment or passively in a combat setting. We're seeing qualitatively and quantitatively different data out of that subset of members of the Canadian Forces and many other forces around the world.

Can you zoom in a bit and give us a bit more descriptive content on what you're seeing and hearing and how these data are being analyzed and compared to those of other settings that the women and men serve in?

**Col Rakesh Jetly:** As to the evolution of mental illness, we know there has been mental illness throughout the ages. There is the old saying that you're perfectly ready for the last war. Right now we've been analyzing this insurgency/counter-insurgency battle, how it happens in small groups without the formed units, what impact that has psychologically.

There is also the undeniable impact of physical injuries, such as concussions and the interaction between concussions and these things, so each mission tends to be different in the sense that we've gone.... And I've been around long enough to go to the massive humanitarian crises and peacekeeping missions, which have unique stressors—the inability to act sometimes and to prevent things that are happening in front of your eyes—to out and out war.

Each has a different, distinct flavour. There was the "peacekeeper syndrome", the rage that people felt sometimes in the peacekeeping era. There was the hopelessness, the helplessness, that a Rwanda can bring out in people, and with Afghanistan we're seeing a mixture of both. We're seeing sometimes the classic PTSD with the anger, but we're also seeing the guilt, the shame and especially protracted grief because of the combat deaths that we have seen at a frequency that we, as Canadians, are not used to seeing.

I'm not sure if that answers your question.

I always talk about having these large studies that you are alluding to. My colleagues have done them and I love these studies, but at the end of the day, a person is sitting across from you who is suffering and you have to address their experience.

We try not to assume what somebody is going to experience, but we do understand the unique qualities of asymmetric warfare. The enemy, in the case of the Taliban, almost had a mystique to them in the sense that all of a sudden they were there.

The grief and loss of losing loved ones, colleagues, comrades is certainly part of it there.

**Mr. Sven Spengemann:** Colonel, thank you very much.

In our previous session that was truncated for technological reasons, you made brief reference to the concept of unawareness of unwellness. That is a very important point.

**Col Rakesh Jetly:** Yes.

**Mr. Sven Spengemann:** We know the resources available. In your assessment, is it still not based sufficiently on a demand-based model? Do we need to do more to push the services into the laps of serving members, if that's the right phraseology?

**Col Rakesh Jetly:** Yes, I think we do. Again, I'm going to talk about mental illness care writ large across the world, more than picking on the Canadian Armed Forces.

I think we have a traditional model of face-to-face care—"I'll see you every Tuesday at nine o'clock for an hour"—and a lot of that is an accident of how long it takes the earth to spin on its axis and how long it takes the world to go around. If we were on another planet, it would be 30-hour sessions every year.

I think we can leverage technology. I think we can put into people's hands information and self-help, because, number one, people have told us that they don't have an illness, but they also resoundingly say, both in civilian society and in the military, "I'd like to be able to handle things myself."

I think we need to really leverage technology and give people the tools. Also, they can come to us. They can say, "Hey, Doc, I tried all of that stuff, but it's not working." I think that would be the way of giving it that 24-7 kind of approach as well.

● (1450)

**Mr. Sven Spengemann:** Very briefly, if I have a few seconds, are there any considerations with respect to proof of injury that the committee should be aware of on the part of a serving Canadian Forces member who is suffering a mental injury?

**Col Rakesh Jetly:** We have not gone that route, and it's something that I have fought against. I know that our U.S. colleagues had that at some point. I was fortunate to treat a Vietnam vet years ago. I think the fog of war happens. In fact, in one of my slides that I use in my lectures, I show somebody seeing a child die in their arms, but then we see everybody else going on with their business. That would be the person for whom, five years later, somebody would say, "I was there and I didn't see that happen."

We haven't gone that route. I think we certainly could easily verify somebody being in a mission. We could verify somebody being there. There is a consistency in their presentation. Can we sit and always identify whether there was a jeep accident on that date during the war? We can't. As far as I know, we haven't done that, and Veterans Affairs is diagnosis-based, not incident-based.

For Sacrifice Medals and certain types of things, we do look for more facts regarding the event itself, as to whether it was hostile enemy action. That's more of a bureaucratic awarding of medals, but it's not a care issue.

**Mr. Sven Spengemann:** Thank you, sir. That was extremely helpful.

**The Chair:** Yes. It was very good. That brings our questions session to an end.

I would like to tell the witnesses how grateful we are for the time that you took. You stuck with us and persevered through our first meeting and joined us again today. Some of the information that you shared with us today is absolutely fundamental to our study. I learned a great deal, and I think the other members of the committee did too. We really appreciate it.

Thank you to the committee. I appreciate your interest in this topic and how important it is to our men and women in uniform, who serve us so well every day.

To both the members of the committee and our witnesses, I wish you all a very happy holiday season, whether you celebrate Christmas or Hanukkah. We are all going to need that this year. It's some light at the end of 2020, which has certainly been a challenge. I appreciate all of your work.

With that, we are adjourned.