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Chair

Mr. Rob Anders

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● (0915)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good morning, ladies and gentlemen.

We are, I think for the first time since I've been chair of this committee, in the room that SCONDVA, a joint national defence and veterans affairs committee, used to be in with all the war art and everything else. It's nice to be here.

I would like to thank our witness, Madame Pascale Brillon.

We would like to give you a chance to start off our discussions with regard to the health examination of veterans, particularly post-traumatic stress disorder. Usually the way this works is that we give either 10 or 20 minutes. You're certainly entitled to take 20 minutes if you wish, for your presentation. After that, we open it up to questions from the committee members.

We are now in your hands with regard to the presentation.

[*Translation*]

Dr. Pascale Brillon (Psychologist and Professor, University of Montreal, As an Individual): Thank you.

I want to start by introducing myself. I have a Ph.D. in psychology with a specialty in post-traumatic stress from the University of Montreal. This was the first study on post-traumatic stress experienced by women who had been raped. I was then hired by the Hôpital du Sacré-Coeur de Montréal to train psychologists and psychiatrists in post-traumatic stress. I specialize in the study of post-traumatic stress in terms of both research and intervention. Accordingly, I provide a great deal of training in post-traumatic intervention.

It is important to understand that, in Canada, we are just beginning research on post-traumatic stress, whereas the United States had to deal with the Vietnam war, which led to the return of thousands of very traumatized veterans. Consequently, Americans are very aware of this scourge, this syndrome. It has taken Canada longer to recognize post-traumatic stress disorder and for people to specialize in this field.

I work at the Hôpital du Sacré-Coeur de Montréal, where I see only victims. I provide training at the Valcartier military base to psychologists and psychiatrists treating soldiers and veterans returning from missions. I also continue to provide supervision at the Valcartier base.

Consequently, Mr. Perron invited me here today so that we can talk together about post-traumatic stress disorder. I will start by giving you a general overview of PTSD, because people are talking about it more and more, but we don't really know much about it.

First, we need to understand that victims of a traumatic event experience a series of symptoms. Atraumatic event is a life-threatening event or one that causes feelings of fear, helplessness or horror. The event causes not only fear but also feelings of horror and helplessness.

Our soldiers often experience such emotions. They will tell me, for example, that they did not fear for their lives, but that they were unable to bear the sight of dead bodies or of a 14-year-old child killing a pregnant woman. So, our soldiers often experience feelings of helplessness or horror.

Individuals experience a traumatic event, and then they will experience various symptoms if they are suffering from post-traumatic stress disorder. There are three kinds of symptoms. The first kind is avoidance. For most people, this is the worst experience of their lives. They will then seek to avoid everything related to that event. For our military personnel, this often means that they no longer want to bear arms, or wear their uniform, that they are no longer able to stand the sight of a military base, and that they have trouble looking at the flag because it is closely associated with this horrible experience. Thus, they are prone to avoiding situations associated with the traumatic event.

To a large extent, it's also about avoiding various thoughts. They no longer want to think about it, don't want to remember it ever again or talk about it. The biggest hurdle for psychotherapy is that most people don't want to talk about what they've experienced. So avoidance is the first kind of symptom.

The second kind of symptom is flashbacks, meaning people re-experience the event, when they don't necessarily want to, and in fact are trying not to. People may have flashbacks, nightmares or intrusive thoughts. Even if they don't want to, they are overwhelmed on a daily basis by these intrusive thoughts. The memories of the traumatic event come back.

In relation to everyday life, this symptom can take the following form: people tell me that, when they are talking, all of a sudden they recall a woman's crushed face; while they are watching TV, they hear the word “rape” and they recall their experience in Rwanda; they are walking down the street and they see a child, and they remember a child crucified on a barn door in Bosnia. So they are immersed in these images, which reoccur over several months when they are associated with post-traumatic stress disorder. So this is the second kind of symptom, what is called flashbacks.

The third kind of symptom is hypervigilance, meaning that the body is always on guard. The individual almost died, he was in an extraordinary situation, and then the veteran or victim remains in a state of over-stimulation.

In this room, for example, it would be very difficult for a victim not to be in a constant state of arousal, because there are windows, people everywhere, around us, behind us.

Someone who experienced bombings in Bosnia, the events of the World Trade Center, the horrors of Rwanda, will be extremely vigilant as to who is behind them, who can come in through this door, what is happening with regard to the windows. These individuals are constantly alert. This means, then, that they may be unable to concentrate because their mind is focusing mainly on what is happening around them. This means that they will find it very difficult to sleep because sleeping means letting go, giving up control, and that means they are vulnerable. Such people can also be extremely irritable because if they are constantly in this state of arousal, their stress level is at 9 on a scale of 1 to 10, and the slightest thing can set them off.

So, their spouses find it extremely difficult to live with these people on a daily basis, because they are in a constant state of arousal and irritability.

This syndrome manifests itself in the weeks and months following a traumatic event. Typically, it can be diagnosed when symptoms have lasted at least a month.

Clearly, some symptoms resulting from a traumatic event are not as long-term. For example, people experience symptoms such as shock during an emergency. They tell themselves that they can't believe what is happening. People may experience disassociation. Victims tell me that while the event was occurring, they heard their commander tell them to do this, do that, and they obeyed like a robot but that they were disconnected. They managed to do their job but without feeling anything. They were truly disconnected.

In the days following the event people often feel very alone. Victims feel as if they are the only ones to feel that way. They believe this is unacceptable, particularly for soldiers; they say that it is shameful to experience such symptoms. This is still the case today. If someone is afraid, if they have nightmares, flashbacks, they absolutely cannot talk about it, because this would be a sign of weakness, this is not worthy of someone in the Canadian armed forces. These are emotions that appear in the days following the event, and if they continue, we see the appearance of post-traumatic stress disorder.

When we talk about PTSD, we're talking about a disorder that occurs but that we previously believed to be rare. Currently, it is estimated... We are starting to accumulate data that indicate that it is not so rare and that horrible events can cause PTSD.

Different studies have been done. What can lead to PTSD? What factors may make this disorder worse? We note that this is the case when particularly horrible events, intrusive events, occur, therefore events that affect the victim. Not only did the individual see his colleague get shot, just beside him, but the victim's blood splattered on him. They saw grey matter on the ground. These are intrusive, unpredictable and violent events.

People will often talk about events involving children; such events increase one's chances of experiencing post-traumatic stress disorder. People will tell me, for example, about being sent to Rwanda and not being able to bear the fact that children were carrying weapons. They think that war is civilized only when it takes place between two trained male adults. They tell me that after they got there and saw children killing others, this seemed barbaric. And so, many people find this absurdity to be unbearable, even in the context of war. This can also be a risk factor for post-traumatic stress disorder.

Sexual events are also a significant risk factor in post-traumatic stress disorder. They are often associated with more symptoms because they are very intrusive and traumatic.

Obviously, there are also events that cause physical injury. If an individual witnesses or is injured during a traumatic event, he or she may be more likely to develop PTSD than if they had not been injured.

We also note—and I will conclude on this point—some differences based on the victim's gender. For example, we know that men and women do not experience the same kind of traumatic event. Women are nine times more likely to experience a sexual trauma than men. We also know that men and women react very differently to a traumatic event. We know that women are more likely to consult a professional following a traumatic event. They are more likely to seek help, which may improve their prognosis, whereas, particularly within the Canadian Forces, men are much more likely to feel ashamed and stigmatized.

● (0920)

Men are more likely to try to hide it, and to drink. Some studies indicate a very telling comorbidity between PTSD and alcohol abuse. Fifty per cent of traumatized men will be diagnosed as having a drinking problem. This doesn't mean just drinking a beer now and again, it's truly a diagnosis of alcohol abuse and dependency. This is cause for concern because, if you drink four bottles of gin at night, obviously you will no longer feel anxious. In the short term, this strategy works. The problem is that, in the long term, alcohol abuse will reinforce PTSD and really make the symptoms chronic. This is one thing we need to be very aware of. Untreated PTSD can really get worse with time. It remains chronic, and often, a diagnosis of comorbidity will follow, particularly for men, as a result of their alcohol abuse.

Another comorbid factor that may be cause for concern is realizing that untreated PTSD if often associated with a major depression. The following are symptoms of depression: sadness, difficulty sleeping, constant crying, loss of interest and suicidal thoughts. This is not insignificant, it's truly quite important and is very strongly associated with PTSD. According to the studies, 52% of women and 52% of men with PTSD will also be diagnosed with major depression if the PTSD remains untreated. Society tends to think that, generally, time will heal all wounds and that gradually the symptoms will diminish. This is not what the scientific studies are telling us. What we are seeing is that if nothing is done, several diagnoses may be made, as the victims will try to treat this anxiety the only way they know how, by, for example, drinking alcohol, or else they will develop symptoms of a major depression.

I want to take a few minutes to conclude my presentation, and then we can talk about it together.

Obviously, over the years we have developed a better understanding of PTSD, and of its aggravating factors, but also of what can be done to mitigate its effects. More specifically, there are therapeutic strategies and psychological strategies. There are three levels of intervention. The first level of intervention is the least well-known and that is prior to the trauma.

What can we do to help people who are known to be at risk—military personnel, but also police officers, EMTs, international cooperants—knowing that they may experience trauma, to help them increase their resiliency, their capacity to understand themselves, in order to decrease the prevalence of PTSD? This is the first level of intervention. We can talk more about it later. This is the least well-known and the least well developed.

The second level of intervention is immediately following the trauma, in the hours and days that follow. We know that someone has been traumatized; what can we do right away? You have already heard about post-traumatic debriefings; this is the second level of intervention. How can we help them in the short term? The purpose of this immediate intervention is to try to prevent the appearance of PTSD, to take steps to ensure that the PTSD is not as severe.

The third level of intervention occurs in the longer term, meaning after one month, once a diagnosis of PTSD has been made, and the symptoms, that is, avoidance, hypervigilance, flashbacks, have continued for one month, two months or three months. What can we do to help these victims?

● (0925)

To help these people recover, we need to ensure a level of intervention with longer-term therapeutic strategies.

There you have it.

● (0930)

[*English*]

The Chair: It's a very interesting presentation, and I appreciate that. I have questions off the top of my head, but I will defer to my committee colleagues.

Mr. Valley, for seven minutes.

Mr. Roger Valley (Kenora, Lib.): Thank you very much for the presentation and thank you for enlightening us on many of these issues.

You mentioned at the start that the Americans are much better at some of this, probably because they've had a lot more experience. How long is their experience? Have they been doing this—recognizing PTSD—since the Second World War?

[*Translation*]

Dr. Pascale Brillon: People have likely been suffering from PTSD since the dawn of time. Unfortunately, traumas are nothing new. However, the first scientific studies date back to the end of the 1800s, when the railroad came into existence. There were accidents, and strange symptoms were noted in the victims, such as their refusal to get back on the train, or having flashbacks of the accident.

The first hypothesis was that bits of metal had penetrated the brain and caused these symptoms. Nothing changed until the first two world wars. For the first time, new disorders appeared: shell shock, concentration camp syndrome and combat fatigue.

During that period, it was noted that military personnel experienced the same symptoms as those found in train accident victims: they refused to return to combat, they had flashbacks and nightmares about the experience. At that time, there was a very effective treatment for soldiers suffering from PTSD. They were considered cowards and deserters, and they were shot. Obviously you will agree with me in saying that this got rid of the PTSD once and for all. But it also got rid of the soldiers.

I say that with a smile on my face, but it's to show you just how far we've come with regard to this syndrome. It has long been seen as a sign of weakness among military personnel. They were thought not to be doing their duty towards their homeland, and to be deserters. They were punished for committing war crimes. In North America, it took the Vietnam war to bring about a change in attitude with regard to PTSD.

The Americans, who saw traumatized veterans returning home by the thousands, were unable to consider these individuals as cowards and deserters. In fact, many of them had been decorated, some of them had acted heroically in combat and others had graduated from the best known elite military schools. West Point is one such example. It was a shock for Americans. They wondered how such soldiers, who had graduated from the best schools and acted so heroically, could be suffering from such incapacitating symptoms.

It was also during the 1970s that scientific articles on rape trauma syndrome, as it's known, were published for the first time. Burgess and Holmstrom dealt with this in 1979. At that time, the very powerful American women's movement noticed surprisingly similar symptoms among completely different types of victims. Women who had been raped were afraid of sexual relationships, of men, had nightmares about the sexual attack and were in a constant state of alert. The American peace and women's movements were first and foremost in the fight to have the Senate recognize PTSD in 1980.

Since then, universities and some American veterans' hospitals have focused on what they call post-traumatic stress disorder. They are far ahead of us. When I did my Ph.D.—and it wasn't in 1920 but in 1993—it was the second Ph.D. in Quebec on PTSD. In 1997, when I began to provide training at the Sainte-Anne Hospital, a veterans' hospital in Montreal, it was the first time that the participants had received specific training on this subject. There was pressure in Quebec to make more psychologists available.

Currently, the troops are still not accompanied by Quebec or Canadian psychologists. For many years, our soldiers had to consult American psychologists. We consider this a start. We were lucky not to have experienced the Vietnam war. General Dallaire played an important role with regard to PTSD in the Canadian armed forces. He was one of the first to name this disorder. He dared to say that he had it. Yet, he was a general. His confession destroyed many taboos and helped to get this disorder recognized.

● (0935)

[*English*]

Mr. Roger Valley: Thank you. I'm glad we, as Canadians, no longer subscribe to that treatment of shooting them. That wouldn't be very appropriate.

First of all, I have two questions. One, how do we adjust, and how do we add, when the dimensions of war change? Suicide bombers are fairly new, especially riding on bicycles and everything else. Now we have to fear bicycles. How do you, as a professional, adjust for that?

Secondly, you mentioned the different timelines for interventions—at risk, immediately after, and long-term.

[*Translation*]

Dr. Pascale Brillon: Before the traumatic event, therefore, before they even leave for war, immediately afterwards, and then in the longer term.

[*English*]

Mr. Roger Valley: I'm interested in the one, "immediately after". What does the first 24 hours look like—the first 24 hours, the first week, and a month, in a snapshot?

So those are my two questions: how do we change with the dynamics of war; and how do we deal with the 24 hours, to the one week, to the month?

[*Translation*]

Dr. Pascale Brillon: Your first question is an excellent one. We have noted that our soldiers, like our police officers, are people who often want to help, and who have a particular vision of war. When they arrive in theatre and they see that their vision of war is nothing at all like what is really happening, that is a significant factor. Some soldiers tell us that they cannot understand how human beings can do that to others, that they have difficulty seeing children being killed and killing others. This should be part of the first intervention, meaning preparing soldiers prior to their departure.

Many soldiers have also told us that if they had known, before they left, what a dead body smelled like and known the barbaric acts being committed in theatre, things might have been easier for them. Our challenge will be to determine how to properly prepare them before they leave, and then, to test our therapeutic interventions. It's all well and good to put interventions in place, but we also have to ensure that they are effective.

Our problem is that many soldiers want to defend their homeland. This is their ideal. We have to remember that they have very strong personality traits. However, it is considered a sign of weakness to talk about managing stress prior to a trauma, and to talk about PTSD.

During the training I gave at Valcartier, clinicians told me they wanted more in-depth training, but they also pointed out that, when soldiers consulted them, they had to climb the stairway of shame. The entire base uses this expression to talk about having to go to the mental health centre.

I would invite your committee to ask Dr. Christiane Routhier, a specialist at Valcartier in the pre-departure program, to appear. This is all she does. She prepares military personnel before their departure, from a mental health standpoint. If you want more information on her preparatory work and its effectiveness, I would encourage you to invite her here.

Would you be kind enough to repeat your second question, please?

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): His time is up, Madam. Each MP has seven minutes to talk with you, Dr. Brillon, so we have to be quick.

Would you be able to tell, using tests, whether my colleague Jean-Yves or I are more at risk for suffering from PTSD today?

Dr. Pascale Brillon: That is extremely difficult to determine. Research is just beginning. We are trying to identify the risk factors for PTSD. We have several leads, but it is difficult because such research requires a huge population pool, not all members of whom will necessarily experience trauma. We have to assess the impact of the trauma immediately and then later. Logistically, this is extremely difficult. With the Canadian Forces, we have a good pool allowing us to conduct excellent research, but such research is very expensive. Currently we are lacking funding.

We know little about what may predispose someone to PTSD. We know that the more violent, serious, intrusive, unpredictable, and opposed to the values of the victim the event is, the greater the risk that he or she will have PTSD. We know that if the victim already suffers from stress or depression, the fewer adaptive resources they will have at the time of the traumatic event, but that is difficult to test.

● (0940)

Mr. Gilles-A. Perron: Dr. Brillon, do you know whether the army subjects future soldiers to psychological testing when they enlist?

Dr. Pascale Brillon: I don't know enough about the process to know what tests soldiers are given at present.

Mr. Gilles-A. Perron: Now I come to my second question. Let's put our cards on the table. I know there are soldiers suffering from PTSD or post-traumatic stress disorder, but I am especially interested in future soldiers. Can we protect them, even if we send them into crisis situations, so that they will not come back with PTSD? This would save the government a significant amount of money, because treating someone with PTSD costs hundreds of thousands of dollars.

Other related questions keep occurring to me. Should we have more psychologists on the battle fields? Should we follow military personnel more during training? In addition to physical training, can we give them mental training? Can we tell the Canadian armed forces to do something to save my children, my sons?

Dr. Pascale Brillon: I totally agree with you. Ideally, there are a number of things that will be done. The key is to work out how we can better prepare them for what is in store, better prepare them to manage stress and to recognize the symptoms of post-traumatic stress disorder. You have to make sure they know that if they come home and are tempted by alcohol, it could be dangerous. They need to be aware of what the symptoms of depression are, and how to do a better job of recognizing them, in order to prevent the onset of depression. That's a challenge. How do you develop a program which will be as effective as possible in protecting these men who go abroad?

You have to bear in mind they will see horrific things. Some things would be traumatizing to anybody. When you discover a child crucified on a barn door, even if you've been trained, you will be affected. Given what awaits them over there, it is important to put into perspective what can be achieved from a preventative standpoint.

Mr. Gilles-A. Perron: Ms. Brillon, I have been so close to my young veterans—that I affectionately call my "mixed-up kids"—and I could tell you stories about them that would make you cry for days. They make me cry at my age and I'm 66. I know what goes on.

In closing, I think it's important to get a little bit political about this; something I do rarely at this committee. You said something that really gets my goat: that there's not enough money. Could we buy one less aircraft from a big company and invest more in mental health services, just a little more on a pro rata basis on services which focus on the grey matter? This isn't mean-spirited politics, it's politics based on reality.

Dr. Pascale Brillon: If you're asking me if more should be invested in mental health for our military personnel, well, as a psychologist, I agree entirely with you. But it's up to our leaders, it's up to you to make this financial decision. Do they need this from a psychological standpoint? Obviously they do.

Mr. Gilles-A. Perron: If you had to put a dollar figure on that, what would it be, roughly? You don't want to say. Do you have an idea?

● (0945)

Dr. Pascale Brillon: All I know is that a lot more could be done.

Mr. Gilles-A. Perron: Could you give me an order of magnitude? What should the ratio be between veterans and psychologists?

Dr. Pascale Brillon: I can't even answer that question. All I can say is that we are trying to work out how we can do a better job of training them. They're going to have to be better trained, there will need to be more of them, and they need to be made available more quickly. It's very interesting to see what's going on currently with the psychologists in Cyprus. For example, after their service in Afghanistan, military personnel spend a week in Cyprus where psychologists are made available. As I said earlier about the second level, many services we're able to provide currently are provided after the fact. We still aren't able to be out in the field but, at least, we're in Cyprus after their military service before they come back to Canada. We could do a lot more. We also don't have enough money to assess the effectiveness of our therapeutic approach. If you invite Dr. Routhier, she'll be able to tell you about the effectiveness of services and what she is currently developing. That would be really interesting. But clearly we should be making an attempt to do a better job at doing more for our soldiers from a psychological standpoint.

Mr. Gilles-A. Perron: Mr. Chairman, after the meeting, perhaps it would be a good idea to go around the table and see if everybody's interested in inviting Dr. Christiane Routhier to testify before the committee.

Dr. Pascale Brillon: There's also Dr. Stéphane Guay who has been a researcher with the Canadian Armed Forces for a number of years. Testing and conducting research on our veterans is his full-time job. It would be fascinating to hear what he has to say about the research he has conducted internally.

Mr. Gilles-A. Perron: Mr. Chairman, should I understand from your answer that you think it's a good idea to have psychologists in the field?

Dr. Pascale Brillon: I think that the earlier our men and women in uniform get psychological help, the better off they will be. That won't mean that they will be able to go immediately and that they won't have to face certain taboos since consulting psychologists out in the field could be poorly looked upon, but soldiers would at least have the opportunity to see someone should they need to. Right now they have a lot of chaplains out in the field because they are servicemen and women themselves, but there still are no military psychologists accompanying them.

[*English*]

The Chair: Mr. Stoffer, for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman, and *merci, madame*.

A few years ago, Mr. St. Denis and I had an opportunity to go to Bosnia. We met one of the interpreters for the Canadian Forces, and she was a very attractive 24-year-old woman. I could just imagine what went through her mind when she was 14 and a nurse's assistant, and what she went through. I asked her how it was back then. She said, it's not something we talk about; it's something we have to live with. There was no help for her or the thousands of young people in Bosnia. They didn't have psychologists or anyone to help them. I can just imagine what our troops experienced back then and the concerns they have.

Are you aware of any program of the previous or current government to assist those people in countries we go to? I know we're short in helping our own people, but if we don't offer some sort of psychological counselling to young people in Afghanistan or Bosnia, then they could end up becoming the terrorists of tomorrow. Are there any programs that you're aware of where we can assist in helping those young people get through? If a soldier is there for six months and comes back with post-traumatic stress disorder, can you imagine what it's like for the people who go through this every day, almost? It must be very tragic.

I have two other quick questions. How do you separate real PTSD from someone who might be faking it? I had one person call me up a while ago who served a tour over in Cyprus. I checked, and he had seen no combat. He even admitted it. He heard so many stories from other people that he lived it himself, almost. He wanted to get that disability for the PTSD, if you see what I mean. How do you separate the real PTSD from that of someone who may be trying to fake it a bit?

Also, one person in Halifax told me that it is possible to transfer your PTSD on to a family member. Is it possible to do that? A soldier comes home after he or she has witnessed such terrible things; they've related these things to their spouse in a way that maybe wasn't appropriate, and then the spouse now develops some form of strain because of that.

● (0950)

[*Translation*]

Dr. Pascale Brillon: Let me start by answering your first question about civilians and what happens to them as a result of living through horrific events on a daily basis. If our soldiers are experiencing post-traumatic stress syndrome, one can imagine that civilians are also experiencing it. You're completely right: we have a lot of scientific data indicating civilians do indeed suffer from post-traumatic stress syndrome for years and years.

You can imagine all the women who have been raped. Rape is used as a weapon in times of war in many countries and the victims suffer for many years from post-traumatic stress disorder. As far as treatment is concerned—and that, after all, was your question— for several years there was an organization called Psychologists Without Borders which set about training people locally to provide services to the population. You can understand how tough it was for this organization to survive. Nowadays, the psychologists are part of well-entrenched organizations such as Doctors Without Borders. These psychologists don't attempt to treat locals through an interpreter, rather they spend more time training local psychologists, social workers and doctors who are familiar with the local culture and values and who will be able to help locals for many years in the future, even if our organizations have left.

So the answer is yes, from an international standpoint there is an increasing amount of interest around post-traumatic stress syndrome even within organizations such as Doctors Without Borders.

Let me now turn to your final question—I'll come back to your second question in a moment—which was whether post-traumatic stress disorder can transfer from one individual to another.

Well, indeed it can. In fact, we were aware of this in the 1950s, 1960s and 1970s when studies were carried out on the cross-generation transmission of post-traumatic stress syndrome afflicting concentration camp victims. Among Jews, who lived in concentration camps for years, the presence of post-traumatic stress syndrome was even observed among second and third generations. There was a lot of fear and terror associated with the Germans and weapons, and the incidence of symptoms of depression was far more pronounced among Jewish people than among other populations, even though they weren't themselves subjected to the trauma. They had heard about it or, since many victims didn't talk about it, suspected it.

There has been a lot of talk, particularly in the United States, about compassion fatigue which is a syndrome many health care professionals suffer from. Such people are in constant contact with victims, so much so that they are no longer able to listen to stories of horror and they develop flashbacks about things that did not even happen to them. For example, constant references were made to the situation in Rwanda in my department, references for example to women who were shredded, and I myself started seeing them when I watched the news because I had heard these stories told over and over.

You can imagine that some spouses might also develop some post-traumatic symptoms. So I'd urge you once again to invite Dr. Guay, who is a researcher with the Canadian army, and who will be able to give you statistics. From a clinical point of view, I can tell you that we have observed that the spouses of some servicemen and women have a fear of Arabs, that is of people of Arab origin, for example. Event though they have never gone to Afghanistan nor seen the horrors that go on, they can no longer stand Arabs. Unfortunately, such spouses blame the population in general because, in their eyes, these people are the reason why their husbands were sent to Afghanistan, why they almost died and why their children almost didn't see their fathers again.

We also observe avoidance of some stimuli. We've observed various fears and symptoms of depression among troops' family members.

Now let me come back to your second question, which is perhaps the toughest. How can you distinguish between someone who is genuinely suffering from post-traumatic stress syndrome and someone who is merely pretending? We do have data and experience to fall back on based on the fact that we regularly see people with post-traumatic stress disorder. You have to realize that only a very small number of people are going to imagine they have, or pretend to have, post-traumatic stress syndrome. The reason is that post-traumatic stress disorder is stigmatized. Even though there is financial compensation for life, it certainly is no gold mine, that's for sure. It's a disorder which is also very poorly looked upon by other troops in the forces.

● (0955)

Also, you'll understand that the diagnosing military psychiatrist has seen a lot of troops. So he's able to ask the right questions so as to distinguish between a genuine case of PTSD and one that's fake. The psychiatrist will consider what type of nightmares the individual is having, how chronic the post-traumatic stress disorder is and a comparison will be made between what the client is saying and what he said two, or five months earlier. You start to become quite an expert at making the distinction.

[*English*]

The Chair: Thank you.

We're now over to Mrs. Hinton for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you for this very interesting presentation. I was making notes throughout it. I was actually pleased to hear you mention Bosnia and Rwanda, because the same sorts of situations happened there as are happening today.

Also, you touched on it a bit, but the firemen in our country and the police face the same kinds of horrors that you're describing—burned children, and things that you don't think you're ever going to have to come face to face with. This is a very difficult situation for all concerned.

We have five operational stress institutions in Canada: Ste. Anne's Hospital in Montreal, la Maison Paul-Triquet in Quebec City, Parkwood in London, Deer Lodge in Winnipeg, and Carewest in Calgary. I'd like to ask you later on if you think that's enough or if you think there need to be more, but there are some other things I wanted to get into on this question.

I don't know how you would deal with someone who is used to looking at a child as a child and now suddenly they're in a situation where a child is actually strapped with explosives and prepared to blow themselves up, and the same with women. That's what's happening to many of our soldiers. Those are completely different scenarios from what they're ever used to. That must be very difficult.

One of the other things I wanted to mention is that aside from the psychological damage, if you find yourself in a situation all the time where the adrenalin is pumping through your body, you can deplete the adrenal glands, and that has a negative effect on the way you're dealing with things emotionally as well. When you've depleted that and you have nothing to rely on anymore, because you've used this “flight or fight” syndrome so often, it has to take its toll as well.

Those are just comments I wanted to make, and Doctors Without Borders sounds wonderful. I happen to have a sister-in-law who's part of a group, Nurses Without Borders. She's been in all the parts of the world that you've just talked about—a much braver woman than I am, I must tell you.

But how do you think Veterans Affairs Canada can contribute to changing the negative stereotype for veterans who suffer in silence from PTSD? We can't help them if they don't come forward. How do you think Veterans Affairs Canada could contribute to making that less of a stigma?

[*Translation*]

Dr. Pascale Brillon: If you don't mind, I'd like to come back to one of the comments you made which I found very interesting. And I'll take this opportunity to answer your question at the same time.

One very important thing that you mentioned is that there is a big difference between the two types of trauma—and I did not refer to this in my presentation—type 1 and type 2. Type 1 refers to a single incident: a woman is walking down the street and she's raped; a person goes to a bank and witnesses an armed robbery.

Our troops are often subject to this type of trauma, they're subject to type 2 trauma. Type 2 involves repetitive events: marital violence, incest. Physicians with Doctors without Borders are constantly in contact with horrors. This means something altogether different for our servicemen and women. It means that if they want to last for nine months—and that's roughly the duration of their rotation: from six to nine months—they also need to protect themselves emotionally. For many troops, this will mean dissociation. That means that they cut themselves off emotionally from what is going on around them and continue what they have to do. When they get back, many of them will have gaps in what they remember. It's also difficult from a therapy point of view because you have to ask them to re-experience certain emotions, to "reconnect", whereas when on active duty, the way they tolerated the horror was to "disconnects". So there's that type of trauma, and it means that if an individual "disconnect", he or she comes across as being strong.

That brings me to your final question: how can we as Canadians improve their condition and lessen the stigma? That will be difficult, because "disconnecting", going about your business without feeling emotions, and not being afraid, are examples of behaviour which are considered strong within the Canadian armed forces. In therapy, they're told that courage is not about *not* being afraid, it's about feeling the fear and doing it anyway. Feeling emotions may actually be an example of strength. So in order to promote healing, you have to get them to take the opposite approach to what they did to tolerate the horror and, sometimes, go against the grain of what is thought in military circles.

Our troops are extremely useful. They have to do horrible things, but policies are what they are and a decision is made to send them to fight because it's important for our country. They're very proud of that. Coming back traumatized is, for them, a sign of real weakness. They would have liked to have done what they had to do for their country without feeling any weakness. We have to show them that having post-traumatic symptoms is not necessarily a sign of weakness.

Gen. Dallaire has helped a lot with this. I think we need to be more aware that we're at war, and we need to decorate more soldiers and consider that they have done their duty to their homeland, even if they have post-traumatic symptoms, and not just decorate and recognize soldiers who didn't feel a thing. I don't know if I've expressed that well.

● (1000)

Mr. Gilles-A. Perron: You've expressed yourself very well, Ms. Brillon.

[*English*]

Mrs. Betty Hinton: That happens today. Post-traumatic stress sufferers are decorated on a regular basis, because they've been in very seriously war-torn countries, and so their recognition is there.

But let's go back a bit. We have World War II, we have Korea, we have Bosnia, we have Rwanda, and probably other places around the world that aren't coming to mind right now. We now have Afghanistan. So what can Veterans Affairs Canada do to change that negative stereotype? What do you think Veterans Affairs Canada could do to make it more palatable for soldiers who are suffering from these kinds of horrible stresses to be more comfortable about coming and saying, “I'm suffering from this; I need help”?

I recognize that it's not just soldiers. I sit at a committee that's full of men, so you're going to be my ally on this one. Women who have emotional problems—

[*Translation*]

Dr. Pascale Brillon: If I may, I'd like to talk about the difference between a soldier and a police officer or ambulance attendant. Ambulance attendants and firefighters who suffer post-traumatic stress disorder get the public's support. Police officers have a lot of trouble confiding in me that they were involved in a shooting and that despite this, they're still called meatheads or pigs out in the streets. In the same way, it's really hard for our servicemen and women to tell themselves that they went off to fight, that they risked their lives, but that they can't be sure they have the public's backing.

If they're going to fight and risk their lives, they need to feel that they are part of something. Perhaps they even need to come back as heroes. Many parents have asked us if they can at least be sure that if their son were to die at war, the entire population would see him come home under the flag, on television. They wanted to be sure that the country would support their son.

And that's your job, from a political point of view. If you're asking me whether, from the psychological point of view, it would be good if our troops felt more support from the public, then the answer is yes. If you're asking me from a psychological point of view if more can be done to ensure they're acknowledged and decorated whether they come back dead, alive or ill, the answer is still yes.

[*English*]

Mrs. Betty Hinton: I'd love to go on, but he just told me I'm cut off.

The Chair: Such is the way of the committee.

Mr. St. Denis, for five minutes.

● (1005)

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Thank you, Mr. Chair.

I commend my colleagues for their excellent questions, and Dr. Brillon, your responses have been very helpful.

In simplest terms for us, mostly novices at this issue, we see something that happens physically—a gunshot wound or something broken—and in a comparative way that's what's happening in the head. Something has been broken. From your experience, can you quantify and say that half of the time or three-quarters of the time we can, by interventions, make people better again? Is there enough commonality among the cases? Is every case unique, or is there enough commonality among the different PTSD cases that you could say, if we put the typical victim on this regime of repair, most of the time they're going to come out okay?

I'd like your thoughts on that.

[*Translation*]

Dr. Pascale Brillon: There have been a lot of scientific studies on the effectiveness of our work, but not from a military standpoint. In Canada, research has only just begun on the effectiveness of mental health services in the military, and these studies are often deemed confidential. So they aren't published in scientific journals. If we look at international science reviews, you'll see that mental health services provided one month after the initial traumatic event are effective for level three, that is the long-term level. There have been many studies carried out to determine the effectiveness of treatment where rape victims, armed robbery victims, police officers and ambulance attendants receive 14, 20 and 30-session treatments. We know that these strategies work. After 30 years of scientific research on the psychology of trauma, we're able to document this.

Nevertheless, we're faced with a challenge. The populations tested as part of this research are "pure". You're looking at one victim, one serviceman who experienced a single event, who is neither clinically depressed nor an alcoholic, who doesn't have any personality disorder or seem to be suffering from stress. This must be considered in a research environment. If you want to test the effectiveness of the treatment, you have to study the "purest" population out there. The problem is this population doesn't normally turn up at our clinics. Scientific studies on what we call at-risk populations, or populations suffering from complex post-traumatic stress, are just starting to be seen. But as far as "pure" populations are concerned, we know that therapy works.

When doesn't therapy work as well? Well, there are a lot of additional stress factors that need to be taken into consideration. The first factor is social support, spousal support, and support from society and the country as a whole. Dr. Guay is a specialist in this area and will be able to tell you about this, if you're interested. Do I feel that I am supported by my country? A lack of social support, comorbidity, depression and alcohol can all make the symptoms worse. We also know that the way a person thinks after a traumatic incident plays a key role. Being ashamed of what you did in combat is also a factor.

A very interesting study was conducted by highly specialized veterans' hospitals in the United States. Thirty years after the Vietnam war, what are the key characteristics displayed by veterans who live at home and are well-adjusted, and what are the predominant characteristics of veterans who are hospitalized and still suffering from post-traumatic stress syndrome? The primary factor is national support. The second is feelings of shame and guilt about acts that were carried out. This is fascinating and helps us a great deal in targeting the way we treat military personnel.

A soldier may come home and say that he is ashamed of what he did. That was especially the case in the Vietnam war. The country didn't support the troops. They came home and were considered murderers, killers of children and civilians. Huge demonstrations took place in New York, Washington and Boston. Not only did the troops think they'd get killed, but when they came home they weren't even heroes, they were murderers. That was an aggravating factor when it came to post-traumatic stress disorder. Now we have a better understanding of what these aggravating factors are and we are now able to integrate them into our therapies. Now, I told you about the factors which make it harder for therapy to work: shame, guilt, comorbidity, and a lack of support.

● (1010)

[*English*]

The Chair: I apologize, but again we're over time.

On to Monsieur Roy.

[*Translation*]

Mr. Jean-Yves Roy (Haute-Gaspésie—La Mitis—Matane—Matapédia, BQ): Thank you, Mr. Chairman.

Please excuse me, I've lost my voice.

Ms. Brillon, I've heard you talk about social support, societal support, and the support that a country needs to give its troops. Let me tell you about something I've often heard from Canadians and Quebeckers which might surprise you.

There is a huge difference between what is happening now and what occurred from 1914 to 1917 and from 1939 to 1945, when conscription was the norm. Many of the people who were involved in these two wars had no choice and didn't necessarily have any will or desire to go to war: they were forced to do so.

That's not true of our troops today. Today's troops are individuals who have made a rational decision to enlist in the army. They initially made the decision knowing full well that one day they might have to go to war or be part of a peace-keeping mission. I make a distinction between the people I referred to earlier and someone who makes an adult decision to go to war and then expects support from his or her society or country. Basically, when individuals make such a decision, they know full well that one day they may have to shoot at someone or that they may be shot at themselves. This wasn't the case from 1939 to 1945. Nor was it the case from 1914 to 1917 because these people were forced to go to war.

I'm not saying that we shouldn't support our troops, but I want to know whether people are sufficiently aware, when they decide to enlist in the army, of what may happen to them. If I decide to drive at 160 km/hr, I know that I may kill someone or get killed. Obviously, the same is true if I choose to enrol in the army.

My question is whether these individuals—and this comes back to Gilles' question—are sufficiently aware of what may end up happening to them when they actually sign a contract with the army, whether it be the Canadian, American, French or any other army in the world. That's my question. Are they made aware of these risks? Don't we romanticize things, in a way? I remember the old slogan: "Sign Up, You'll Travel". You will indeed travel, but you'll find the travelling very tough when you go to Bosnia or places like that. Are these people really made aware of what they'll be facing?

Dr. Pascale Brillon: You know, when an 18-year old enrols... Well, when you're 18, whether you're a soldier or not, you're invincible. Whether you're behind a steering wheel or a gun, you're invincible. So, you've got troops that sign up when they're 18, who have grand national values and who want to save the world. Police officers, for example, have similar personality traits: they want to save people. This is quite ingrained in them. Now, when you enlist at 18 and you feel invincible, that it's all a big adventure, that you're not going to die and that if you were to die you'd do so in dignity and glory, you stay in the army. But when you're 41 and you've got two children aged 3 and 5, that's no longer true. Obviously that changes the way troops perceive war.

As a psychologist, I'm against all war. Politically, that's different, but as a psychologist, I'm against all war. On the other hand, if my country decides to go to war, well, we need to support our troops 100%. Either you send them to war-torn countries and support them 100%, or you don't send them at all. What I can tell you as a psychologist is that if you send them based on a political decision, well then you need to support them psychologically 100%. Does that answer your question?

You talked about awareness.

I believe that they are aware of what they're doing, and that they accept the risks. And these aren't the type of people to make big demands about wanting support. We're not talking about those kinds of people. When they enrol, and they end up living for example in Rwanda one year, then in Haiti, or Bosnia the next, they're going to manage just fine. But when they get to Afghanistan, for example, then something happens. A soldier might see his or her fellow soldier step on a mine and get blown up. Troops like that come and see me and they tell me that it's just too much, and they can't take it anymore. They can just no longer bear the memory of having brain splattered all over their hands. They just can't process it. They can't deal with it. So there are the type of people who have already served, for whom things went well, but who snapped over some incident.

● (1015)

Mr. Jean-Yves Roy: I have a bit of time left.

[*English*]

The Chair: You're actually over your time.

[*Translation*]

Mr. Jean-Yves Roy: I'd like to put one last question.

I understand that you are not in the armed forces, but in your opinion, is the current training given to our soldiers, that is very much focused on physical fitness and strength, etc...

Excuse me?

Mr. Gilles-A. Perron: Nothing for the brain.

Mr. Jean-Yves Roy: Nothing for the brain, as he says.

I would not go so far as to say that, but is this training psychologically adequate for the work that they will have to do on the ground? Is there too much physical training and not enough mental training?

Dr. Pascale Brillon: Much more could be done in the way of mental training.

Soldiers say that they want to be fit. Fitness requires daily training. Some even speak of extreme fitness.

We have started telling them that they could also be mentally fit; and mentally fit does not mean fearlessness and insensitivity. This is something new. This means being connected and open, because we know that completely repressing one's emotions is far more hazardous.

At first thought, it seems as if repressing your emotions and charging ahead will protect you. Now we know that this is not the case. Therefore, much more work could be done in creating programs for developing mental fitness, certainly.

Mr. Jean-Yves Roy: All right. Thank you.

[*English*]

The Chair: Now we'll go to Mr. Shipley for five minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Doctor. It has been a very interesting morning.

You talked about the number of dollars that are required, the amount of money that it takes to do the research. Can you tell me how much cooperation and coordination there is between Canada, the United States, and other countries that are dealing with the same thing? How do you make that work so that we aren't lone rangers, funding research on top of research, on top of research?

Secondly, dollars for treatment is separate from dollars for research. I'm not sure I've yet understood that distinguishing part of your comments, so I'd like to have that.

I can't get over, actually, how much you are emphasizing the significance of support, what that means to an individual in our Canadian Forces. One of the comments was about a plane and taking the money away. I think they're two separate issues. I think we obviously have to equip them properly so that it takes away some of those issues of not being well equipped or not being well prepared, but I think it's a separate issue in terms of dollars for treatment, pre-, post-, and in the long term.

Those are just a couple of questions. Perhaps you'd deal with those first, please.

[*Translation*]

Dr. Pascale Brillon: This is really difficult for me because I really am not part of the army. I am really independent of the entire system. I provide training outside the system, and it would be very difficult for me to say how much money should be spent on psychological training or on research in that field.

Nevertheless, I know people who work there, I am aware of their qualities... I am thinking of Dr. Brunet or Dr. Guay, who are specialists in trauma in the Canadian Forces. These people are very highly qualified. I am sure that they could do much more research and much more work on the symptoms of our soldiers. They could try out strategies and evaluate their efficiency.

So, as you put it so well, what kind of money should be invested to have more psychologists immediately available at the time of incidents or afterward, etc.? In addition, what kind of effort should we make to provide the researchers with equipment? Providing psychological treatment is fine, but it is even better if we know that the treatment works. For years, we thought that debriefing was working, but just recently, after thorough testing, serious drawbacks were detected. Therefore, it will be very important to test the results of the psychological treatment.

That being said, military personnel is not an easy subject for research, because the results are not popular from the political perspective. A certain percentage of our soldiers have post-traumatic stress disorder, and a certain percentage of these still have it 2, 5 or 15 years later. Nevertheless, it would be very interesting to get the data so that they can get better service.

Your first question was about the collaboration between Canada and other countries on research. Am I right? Was it about research, or about treatment?

● (1020)

[*English*]

Mr. Bev Shipley: Yes.

[*Translation*]

Dr. Pascale Brillon: Was it about both?

[*English*]

Mr. Bev Shipley: No, research first.

[*Translation*]

Dr. Pascale Brillon: Scientific research is always considered at the international level. When I publish articles in English, they are distributed all over the world. When Dr. Guay or Dr. Brunet publish articles, the same applies. These people provide training abroad, they receive training and they attend conferences and scientific presentations all over the world.

One of the most important conferences that we attend is the International Society for Traumatic Stress Studies conference, held once a year in the United States. Here, scientific researchers from all over the world who are specialized in post-traumatic stress disorder gather to exchange their findings.

Yes, there is a great deal of communication going on in this scientific field. We are increasingly interested in what others are doing. I know that many military psychiatrists have been trained in veterans' hospitals in the United States to learn clinical practices from others. Research is already very much at an international level, but what can we do about clinical practices? How can we learn more about what others are doing? There is no need to reinvent the wheel each time. We can take advantage of the experience of others, as we are doing more and more.

However, it takes money to send psychologists or psychiatrists to the United States for training and to bring them back. It costs money. There are many who find it difficult to attend international conferences and receive training for post-traumatic stress in the armed forces. Funds must be provided so that our psychologists and psychiatrists can afford to get training abroad and to come back.

[*English*]

Mr. Bev Shipley: In identifying people with PTSD and the treatment of people with PTSD, are we making progress?

[*Translation*]

Dr. Pascale Brillon: Yes, absolutely. We are making great headway in Canada because we have gone far in a very short period of time. However, a tradition has already been established in the United States. Let me say that there has been a great deal of progress since I obtained my doctorate 10 years ago. We must continue.

[*English*]

Mr. Bev Shipley: Thank you. I understand.

The Chair: They'd all like to keep going, but of course they have time limits.

Now over to Mr. Cuzner for five minutes.

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): Thank you very much.

Doctor, it's been an excellent presentation here today, and some great questions right around the table.

I know for everybody around the table, when we went to school, there was what we know now as ADD or ADHD, but they used to just be the bad little buggers who couldn't sit still for most of the class. So as we learn more about PTSD and become better at recognizing the actual cases, since statistics have been taken, and over the various conflicts that not only our own soldiers but our allied soldiers as well have been in, are the numbers increasing as warfare changes?

There has been an obvious change from our Second World War veterans to what our soldiers deal with today. Are the numbers of instances increasing or decreasing? Can you make a comment on that and rationalize the numbers, why they are going that route?

● (1025)

[*Translation*]

Dr. Pascale Brillon: This is difficult to evaluate, because we had the means to evaluate post-traumatic stress disorder in the 1980s, between 1980 and 1985, but we have no data on the number of cases of post-traumatic stress disorder for the Second World War. There is little data on Vietnam veterans because the research was just beginning at that time. From now on, we will be able to document those cases. If our research can show the number of Canadian veterans who currently have post-traumatic stress disorder, in 10 years, we will be able to compare the figures with those of future wars. We will be able to determine whether the new kinds of warfare are more harmful and devastating and we will know what factors should be included in our practice, in our vision of the armed forces and in the training that we can provide the soldiers to bring the figures down. Therefore, it is very hard to tell if there is an increase in the number of post-traumatic stress disorder cases, because we had no way of detecting them in the past.

[*English*]

Mr. Rodger Cuzner: I guess it's trying to establish a base from which to measure that. I think you would want to measure just to see if in fact what you're doing—the preparation of the soldiers prior to entering combat or whatever—is successful.

The other thing I want to ask you about is the involvement of the families. I would imagine that this would be a case-by-case type of initiative, but how do you engage the family in the treatment of a veteran who may be dealing with the syndrome?

[*Translation*]

Dr. Pascale Brillon: We are trying to give an increasing role to family members. Once again, I would encourage you to invite Dr. Stéphane Guay, who is specialized in the role of the family and of the spouse with regard to post-traumatic stress disorder. He works at the Louis-H. Lafontaine Hospital in Montreal and at the Sainte-Anne Hospital for veterans. He could really be of great help to you.

I know that more and more attempts are being made to create groups that include spouses who meet with the soldiers and discuss things with them. In addition, groups are created solely for spouses. We are trying to increase the family's role because we know that a traumatic event has a ripple effect. The impact does not only occur at the point where the rock hits the water, but it makes waves in families and through the entire social fabric. We know for a fact that therapy improves when spouses participate. We know that spouses also need help and they often suffer from distress. Therefore, we create groups to help them.

Once again, let me encourage you to invite someone who is within the Canadian Forces and who could give you the latest updates.

[*English*]

Mr. Roger Valley: I'll take the 30 seconds.

The Chair: All right.

Mr. Roger Valley: Just very quickly, you didn't get a chance to answer my second question. I wanted to know, because the first 24 hours, the first week, or the first month when a solider drops a machine gun and is coming back here.... I know that in the forces what they do now is probably different from what somebody like you who actually has to treat the result does. Can you tell us what you think should be in the first decompression, debriefing, whatever you want to call it? Later on they may not take counselling, but at least at that time they're still in the forces. And are we doing the right thing now?

[*Translation*]

Dr. Pascale Brillon: This is interesting. In fact, the challenge is in finding out how we can help them while they are members of the Canadian Forces.

Currently, if someone can be hired as a soldier, he must be available for deployment, which means that if he is hired, he can be sent anywhere. This is what is currently required of the members of our forces. It is difficult to suspend a member of the forces from duty. In fact, as a member of the forces, he must be available for deployment at all times.

Perhaps we should look at ways of creating more links between veterans and the armed forces in this respect, so that a soldier's condition does not deteriorate while he is still in the forces. They only get psychological treatment when they become veterans, but then it is too late. They should be treated earlier.

People are becoming a little more aware of this, but in my opinion, more efforts must be made to treat them earlier, while they are still uniformed members of the armed forces. This would avoid a crystallization of the post-traumatic stress disorder by the time that they receive treatment as veterans.

● (1030)

[*English*]

Mr. Roger Valley: Thank you.

The Chair: Thank you.

Now we're over to Mr. Sweet for five minutes.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you very much, Mr. Chairman.

Thank you very much, Doctor, for your very enlightening presentation and for your answers to the questions you've had to field here so far.

Just to carry on with the same theme about sensitizing our forces, there was a book published some time ago called *Psychology: The Purchase of a Friend*. It wasn't meant to demean the profession of psychology; it was more to illustrate the importance of the debriefing nature of a friendship.

Are there some things that can be done? Has there been research in the area of taking it right down to the grassroots and actually educating those who are in the regular forces on recognizing PTSD and the importance of dialoguing with their colleagues, etc.?

[*Translation*]

Dr. Pascale Brillon: Yes, many things could be done about that. Once again, I suggest that you invite colleagues who are in the armed forces.

As someone from the outside, I can say that it would also be useful to invite soldiers who are suffering from post-traumatic stress disorder, or soldiers when they return from missions. Their testimony could effectively help other members of the forces, they could give feedback regarding their experience, and they could describe their current condition. These are the kinds of activities that could bring about greater awareness.

Post-traumatic stress disorder was only discovered recently. For that reason, I had to write two books. Post-traumatic stress needed to be recognized and more clearly identified. The École polytechnique de Montréal, Dawson College, our forces that are currently much less involved in peacekeeping than in offensive military action, have all contributed to recognizing the existence of post-traumatic stress disorder.

Nevertheless, we are dealing with a very tough culture, one that is very severe, a culture that stresses strength and endurance and that denigrates emotion. If we recognize the negative impact on the health of soldiers, if we view post-traumatic stress disorder as something that can be cured or treated and not as a sign of weakness, it will be very helpful.

[*English*]

Mr. David Sweet: You were talking about pre-emptive measures, but you focused on pre-emptive being after the trauma happened and before the symptoms became too severe. But there are things we can do pre-emptively prior to going into the theatre of conflict that would sensitize them or give them that psychological fitness that you're talking about.

Dr. Pascale Brillon: *Oui.*

Mr. David Sweet: Okay. Then to my last question, because I have that feeling from the chairman that this is going to be chopped.

You said that right at the moment you don't have the capability of knowing which personalities would be predisposed to post-traumatic stress disorder. But is there research going on right now to see, as we get these cases, which people are more likely to be affected and, of course, less likely? Of course, you can tell the outcome would be to stream them into the positions where they would best fit.

[*Translation*]

Dr. Pascale Brillon: Yes. More and more studies are being done internationally to identify the factors that cause a predisposition to post-traumatic stress. Some have been identified. We know that someone who has symptoms of depression and anxiety as well as a very rigid world view could be considered as being at risk.

Once again, the early diagnosis of such cases is difficult. Some people might have these symptoms without ever exibiting PTSD, because they have never come across a sufficiently traumatic event. However, there are people who do not seem to be predisposed, but who go through traumatic events serious enough to make them suffer from PTSD.

Let me give you an example. The University of Montreal did a study on post-traumatic stress disorder among women who have been raped. Eighty-five per cent of women in the study showed symptoms of post-traumatic stress disorder a month after being raped. This shows that the predisposing factors do not play much of a role.

We believe that long-term cases of PTSD can be predicted by considering three factors: the factors previous to the traumatic incident, the incident as such and the treatment after the event. PTSD is caused by all three types of factors. An intense trauma can affect everyone, whether they are predisposed or not, the seriousness of the trauma will cause PTSD. If a trauma is less serious, it can cause PTSD if I am strongly predisposed, and treatment plays an important role.

Do you understand? Do you see what I mean?

Consequently, PTSD can be predicted by the number of factors in each category. Do I have many predisposing factors? Was it a major traumatic incident? Do I have much support following the incident? These were mentioned earlier: social support, my way of living with the trauma, how others treat me, and comorbidity. Obviously, with more factors in each category, I am at greater risk.

● (1035)

[*English*]

Mr. David Sweet: You are actually saying there are horrors that are so great that no matter what personality you are, you are going to suffer some kind of PTSD. Then it's only determined by what your physical capability will be to heal afterwards whether it's going to be chronic, long-term, or short-term.

[*Translation*]

Dr. Pascale Brillon: Exactly. Some traumatic events are universally traumatic, in more than 85% of the cases. I'm referring to torture, gang rape, and certain combat experiences, especially barbaric ones. Even when a person displays very few pre-traumatic factors and maintenance factors, the level of trauma is significant, even crucial.

Obviously, the higher the number of factors in each category, the longer and more severe the convalescence is, and the more refractory a person will be to therapy, so on and so forth.

[*English*]

The Chair: Mr. Sweet, you were right. I am going to cut you off.

Mr. Stoffer, you may take five minutes, if you would.

Mr. Peter Stoffer: Thank you, Mr. Chairman.

Years ago there was a television show called *M*A*S*H*, and there was a psychologist who showed up as well. He was in uniform and he was on the front lines, so he could witness what the troops were witnessing. Do we have psychologists over in Afghanistan, so far as you're aware, on the front lines?

[*Translation*]

Dr. Pascale Brillon: To my knowledge, there aren't any. Once again, I would refer you to people in the army. I do not believe that there are any military psychologists. There are social workers, psychiatrists, doctors and military chaplains, but to my knowledge, there are no military psychologists working on the ground.

[*English*]

Mr. Peter Stoffer: It appears through your testimony today that we don't have enough people like you and with your training in this country to assist not just the veterans but their families as well. Obviously there must be tremendous stress levels on people such as you. It must be trying to hear these stories, day in and day out.

My question may be of a personal nature, and if it's not appropriate you could just say you don't want to answer. But how do you and people of your training and your education relieve the pressure valve, apart from turning to substance....? Hearing these stories day in and day out and trying to help other people must be very demanding for you personally. Who looks after you?

Mr. Gilles-A. Perron: Me.

Mr. Peter Stoffer: What do psychologists do to relieve the pressure so that they don't have that transfer themselves?

[*Translation*]

Dr. Pascale Brillon: That's a good question. Indeed, if we want to recruit more psychologists, we want to make sure that they are able to treat soldiers and victims without becoming affected themselves. Of course, when I go home at night, I don't rush to put on the movie *Full Metal Jacket*. I've been exposed to that kind of thing enough during the day. Obviously, we want to be careful with our human resources, I'm talking about people who work with soldiers and victims.

During training, psychologists and interveners learn how to remain vigilant to ward off professional fatigue, what is commonly known as compassion fatigue. I talked about this earlier. One has to ask oneself how one can decompress during the weekend, talk about other things, or in my case come to Parliament rather than listen to my clients' horror stories. By diversifying one's activities, one can remain in a profession for a long time.

What I say to the people I train is that this job is like a marathon and not a sprint. One has to pace oneself in order to remaining the profession for a long time. To remain empathetic towards victims and open to their distress, one must be available, and learn how to take care of oneself. Usually, this is rather effective.

● (1040)

[*English*]

Mr. Peter Stoffer: If you were in charge, how many additional people do you think our military would require right now just to meet the anticipated injuries that may be coming back? I mean the injuries between the ears. It's always interesting to note when you hear of an incident such as a car accident and they say that nobody was injured. That is physically, but they never talk about the mental injury.

It's anticipated that a lot more of these soldiers from Afghanistan will come back with mental injuries, or the injury between the ears. How many more people do we require in order to anticipate the additional workload that people like you will have to endure?

[*Translation*]

Dr. Pascale Brillon: That's very difficult to judge. In fact, that is why I spent a lot of time providing training at Valcartier and at Hôpital Sainte-Anne. We know that our soldiers are coming back soon, and we have to be highly effective in order to treat them quickly.

In fact, we already know that a problem is about to arise. We realize that once those serving in Afghanistan return home, we will have to set aside those who served in Bosnia and Rwanda. We cannot treat 25 patients per day: we can only see 6. Already, we already know that we will have to put aside the older cases to at least deal with the new ones as quickly as possible. In fact, the earlier we provide treatment, the better the prognosis. We absolutely have to be able to see them when they come back.

For now, I think we'll be able to see them. I, for one, supervise psychologists and psychiatrists working in the Canadian armed forces. Those are the people who will be able to tell you more. In any case, these people have asked to receive training as soon as possible, before the soldiers come home. Unfortunately, because of their workload, they are going to have to suspend the cases underway.

[*English*]

Mr. Peter Stoffer: I have a final question. Is it easier for a man to speak to a woman psychologist or a male psychologist?

[*Translation*]

Dr. Pascale Brillon: That depends on the people concerned. For many men, to meet with a male psychologist makes them competitive, especially if the psychologist is a military man. Some fear being perceived as weak, or in many cases, gay. They wonder if the psychologist views them as a deserter, or as they say in the army, a "dodger".

In fact, some soldiers say that their colleagues are simply seeking financial compensation. They view those who seek help as not following through on their military convictions, not "real" soldiers. Often, soldiers find it easier to meet with a woman.

[*English*]

Mr. Peter Stoffer: And for a woman soldier?

[*Translation*]

Dr. Pascale Brillon: I have the impression that it's easier for women to see a female doctor, whether military or civilian. What is important is that she be a trained psychologist or psychiatrist.

[*English*]

The Chair: Thank you.

The chair is going to exercise some prerogative here. It is Conservative time, so I'd like to ask a few questions.

I realize the value in what you've laid out for pre-emptive dealings and then things when people just come back from theatre. Of course, we have a lot of soldiers who haven't had the benefit of either of those, so there are people who are dealing with it much later.

I'll also say that the way I relate to this is in terms of rape scenarios and things like that, because constituents of mine have approached me about some of these things. I haven't served in combat, but I have dealt with or talked with them about some of their experiences.

How do you encourage a horse to drink from the trough? You can lead a horse to water, but you can't make it drink. How do you deal with that in terms of some people who may be reluctant to seek help, in the case of soldiers or rape victims, but nonetheless you can tell they're exhibiting all the characteristics—the alcoholism, the depression, the lack of sleep, and everything else? How do you get them there? How do you get them to accept it? How do they learn to overcome the triggers or minimize the traumas that affect them, and so on?

● (1045)

[*Translation*]

Dr. Pascale Brillon: I hope I've understood your question correctly. You will tell me whether I have, based on my answer.

When military personnel are suffering from PTSD, how can we ensure that they recognize the symptoms themselves and come for treatment?

In fact, we hope that the COs will recognize the signs in their men. The COs often are very fatherly towards their men. Good officers have a great deal of empathy and are very attentive to the health of their men. We hope that, when it comes time to tell personnel that they are suffering from a trauma, that they will take the first steps. We also hope that this disorder will be increasingly recognized within the armed forces, so that military personnel can themselves recognize their own symptoms. So to date we have been talking about two sources of referral: the CO and the soldier himself.

The third source of referral is the spouse. Sometimes the spouse will tell her husband that he is unbearable at home and that this has been true since he returned from Afghanistan. In some cases, she gives him the choice between getting help or getting a divorce. Many people come for that reason. They are very resistant, but they come nevertheless because if they do not their spouse will leave them.

In some cases, the spouse wakes up at night because her husband cries out in his sleep. Some military personnel believe for a few minutes that they're still in Afghanistan; they grab their spouse and run with her into the basement to protect her. It's as if they were still on mission and they know it. Furthermore, the spouse is often the one who is able to accurately assess how much their spouse is drinking. He thinks it's just a little beer and that it's not really serious.

In short, we typically have three sources of referral: the CO, the military personnel themselves or their families. When the family sends the individual for treatment, it's a necessity.

[*English*]

The Chair: Understood. I was intrigued by your comment as well with regard to the transferring between generations. I'm thinking of the situations in the armed forces where you have what are known as “army brats”. In a sense it's a family word—generation after generation serve in the armed forces. Maybe one of the best ways we can deal with that is to just have Stéphane Guay come and talk to us with regard to the spouses and stuff. I think that would be an interesting thing. It's one thing to deal with the soldiers, but then of course there are the spouses who have to be dealt with as well in terms of the after-effects. That could even affect the children of military personnel as well.

Do you have any thoughts or comments on that?

[*Translation*]

Dr. Pascale Brillon: I will go back to what I said earlier.

With regard to transgenerational transmission, we noted that the children and grandchildren of concentration camp victims also showed symptoms of distress. The second or third generation also show signs of post-traumatic stress. PTSD symptoms can contaminate not only the family but also the children and grandchildren. We have learned this from our observations in the only longitudinal study we have, meaning concentration camps.

I completely agree with you, we must watch for symptoms in the family, in order to provide it with support. We know that this helps military personnel to return to active duty. We also know that, if the spouse is involved, if she is doing well and receiving support, this will greatly assist the serviceman in sticking with his therapy.

[*English*]

The Chair: My time is up.

Mr. Perron.

[*Translation*]

Mr. Gilles-A. Perron: Mr. Chairman, I want to ask you for seven minutes, since I'm going to spend the first two providing information.

Dr. Brillon, I want to share some information regarding individuals suffering from PTSD in the armed forces. I have had the opportunity to question anglophone military commanders. We were told, at first, that the percentage of soldiers suffering from PTSD was between 4% and 6%. I was told that it was 10% for francophones. National Defence told me that it was 0%. These people do not recognize or do not want to recognize the existence of PTSD.

In a meeting with a commander at National Defence, I was told that military personnel suffered from severe depressions. When I asked him what the symptoms were, he told me that the service men were less attentive, that they tended to isolate themselves, to drink and take drugs and have family problems. He also told me that, in some cases, they kill themselves. I told him that these were PTSD symptoms.

I am not a psychologist, but, since 1998, I have taken an interest in young veterans suffering from PTSD, because they are like my kids: they are the same age as my son. I have met hundreds of them. Some were still in the armed forces at Valcartier. During these meetings, we were separated by a curtain so I could not identify them. They were afraid of losing their job. I don't know what the situation is like elsewhere in the country, but in Quebec, from what I gathered, many servicemen sign up at the age of 18 to earn money or make a career for themselves rather than drawing on employment insurance or on another such program. We need to acknowledge this.

Generally, these young veterans said that they did not get any support from the Department of Veterans Affairs. They said that they had served their country and risked their lives, but that they had not been able to get help, and the few that did waited a long time for it. I understand them.

For example, only five beds at the Sainte-Anne Hospital are reserved for individuals suffering from PTSD. If we treat them like second-class citizens, I wonder what we would need to do to treat them like first-class citizens.

I would like to hear your comments on this. I apologize for getting on my soapbox, but this is nothing new. Perhaps that is why I do not suffer from PTSD.

● (1050)

Dr. Pascale Brillon: No doubt it helps.

The percentages you mentioned apply to the general population. The prevalence of post-traumatic stress disorder among the general public is between 8% and 14%. Typically, the number of women suffering from PSTD is higher because they are more exposed to sexual traumas. We know that sexual traumas are generally associated with more severe symptoms.

If we were to conduct a study in Ottawa, we would see that approximately 10% of the population have been victims of armed robbery or a car accident. So I find it surprising that the percentage for such a high-risk population, the Canadian armed forces, is the same.

Mr. Gilles-A. Perron: Those are the figures that the CF gave me. I don't know whether they are correct.

Dr. Pascale Brillon: I think those percentages are low, in actual fact. However, I do not have any research data on the armed forces. Dr. Guay, however, may be able to provide you with more information.

I should also say that there is a great deal of shame and stigmatization in the Canadian armed forces. Research can only be done if people answer. Some female soldiers told me that they had experienced horrors, and had been raped. They told me, however, that they had no intention of talking about it, since they already had to work twice as hard to remain in the army and not be considered as second-class soldiers.

We need to understand that it is difficult for researchers to get an exact percentage because of the shame that soldiers feel, because it is not easy to assess them and because it is not necessarily a desirable percentage, politically speaking.

● (1055)

[*English*]

The Chair: Mr. St. Denis, for five.

I just want the committee to consider this as the last set of questions, because we have a small bit of business.

Mr. Brent St. Denis: Thank you.

Picking up on something that Mr. Sweet was getting at, I wonder to what extent the Legion movement partly came together because of the need of people to talk. I think that just having somebody to talk to, whether it's a professional, a friend, or a colleague, often can lead to at least some degree of amelioration of a post-traumatic stress disorder occurring.

Should there be some kind of mentoring system? When you leave the military, is there somebody assigned to you that you must talk to, at least for an extended period of time, just to be sure there aren't some hidden issues that, unlike a physical wound, are not evident? Should there be some sort of institutionalized mentoring to at least allow for some of these cases to be identified, as opposed to somebody volunteering?

[*Translation*]

Dr. Pascale Brillon: Your point is very interesting. Earlier we were talking with Mr. Stoffer about the possibility that people might fake PTSD, but we know that there are also people who hide their PTSD. Both extremes are possible, meaning that there are people who are exaggerating their symptoms in order to get compensation and there are people who refuse to admit that they have it. In general, we feel there are many more people hiding their PTSD, for an important reason.

First, we have said it over and again, it is a source of shame, it has a very bad reputation in the Canadian armed forces. But there is another reason: if someone suffers from PTSD and they are therefore a veteran, this means they are no longer in the army. For many, this means the end of their lives. For many soldiers no longer being able to wear the uniform, carry a gun, no longer belonging to that great big family... Many people sign up because it is a corps, there is team spirit: you can die beside someone else, and they can die for you. For many people, the CF fills graps they experienced during their childhood. They didn't have that family, that discipline, that confidence in others, that motivation that comes from the feeling that they are doing good.

What we see, when they come to therapy, when we tell them that they are suffering from post-traumatic stress disorder, is that they think this means they have to leave the CF. But the CF is their whole life. They don't want to think of themselves as civilians because civilians are "losers", they're dummies. Being in the military means being associated with pride in your country and pride in yourself.

What you said was extremely important: how can we ensure that they can remain in the forces, keep that identity, continue to serve their country and feel good about themselves?

As far as I know, there is no room in the forces at present for people who are sick. However, if we were talking about police officers, I would tell them that they are not currently fit to return to mobile patrols, but that they can find an administrative job or part-time work. This is not possible in the armed forces. We cannot tell soldiers that they will do administrative work on a part-time basis. Their regiment may be deployed. This means that they may be sent on a mission. Many of them believe that having PTSD means giving up everything that gave their lives meaning, it means forging a new identity for themselves. They were soldiers, with all the ranks, the hierarchy, the team spirit and the uniform, and now they are civilians. The army doesn't think much of civilians.

[*English*]

The Chair: I would like to thank you for your appearance, and I think Monsieur Perron would like to back that up.

[*Translation*]

Mr. Gilles-A. Perron: Dr. Brillon, you gave an excellent presentation. I think, looking around the table, that I've never seen this committee so attentive, and hanging on someone's every word like that. Thank you very much and continue your good work. My greatest wish would have been for the 308 MPs to have been here along with the members of the forces and veterans, because you have taught us a great deal.

● (1100)

Dr. Pascale Brillon: It was my pleasure.

[*English*]

The Chair: Just to let everybody know, I think we have a matter of business we'll want to touch on.

To the witness, I say thank you very much. I hope we'll follow up on some of your recommendations for other witnesses and guests we could hear on this issue.

Committee members will please stay.

Mr. Stoffer.

Mr. Peter Stoffer: Thank you, Mr. Chairman.

Ladies and gentlemen of the committee, I am speaking with regard to the Vimy trip commemorating the 90th anniversary. It starts, I believe, around April 5. It's come to my attention that there's just a slight bit of an issue with the perception of a minister taking members of Parliament instead of additional veterans and/or their representatives. A way to get around that is to allow the minister the opportunity to take additional veterans—or veterans, period—with him in the official delegation.

If we move a motion agreeable among all of us saying that the committee would like, as a committee, to travel to the Vimy Ridge memorial to represent all parties and to represent Canada as well in conjunction with the minister's trip, there's an opportunity for us. I would like to seek unanimous consent to move a motion and to waive the 48 hours. We could at least give our chairperson and our researcher the opportunity to ascertain the logistics of that, so that this committee itself would be able to travel, because we ourselves haven't travelled internationally yet. They would be able to ascertain the opportunity for this committee to go to Vimy for the 90th anniversary of that memorial.

It's April 5 to April 9.

The Chair: Thank you very much, Mr. Stoffer.

Mr. Valley is next, and then Mr. St. Denis.

Mr. Roger Valley: I support Mr. Stoffer. I think it's important that we be there. I have both this business and personal reasons. I think it's important, but I want somebody to tell me if we can charge it to this year's budget. Can we book the plane fare and the rooms right now, and get it done?

The Clerk of the Committee (Mr. Alexandre Roger): Yes.

Mr. Roger Valley: I think that's important. Part of our mandate is to make sure we're looking after veterans. We haven't spent any money this year, as you said. We have lots and lots of room in the budget; let's deal with it under the budget before the end of March. I think it's a good idea.

The Chair: The clerk tells me that of course it will have to go to the Liaison Committee, but he says yes, it is possible.

Go ahead, Mr. St. Denis.

Mr. Brent St. Denis: I think it's certainly a good idea and I'll personally be supporting the motion.

I will be checking, though, just to see what happened at the 80th. I think, as much as we want to respect our veterans, there is a role for parliamentarians in all of this too. I don't want to set a precedent that parliamentarians are going to be forever ignored in the future by the minister of the day, whether Conservative, Liberal, Bloc Québécois, or anything else. I just put it on the record that I'm concerned about a precedent.

I am going to check and see what happened for the 80th. If it's been standard practice forever that it was just the minister and a minimum of support staff who went to these things, fine. I don't think that's the case, however. If we're always going to be backstopping the minister through our committee all the time....

The veterans are absolutely important in all this, but so too is our role as parliamentarians. We don't always know that the budget committee of the House is going to approve these things. I think the minister should know that it isn't without some questioning that this position is being taken.

● (1105)

Mr. Roger Valley: Just to be slightly more blunt, we want to make sure the committee members are there. If we're there, to be totally blunt, we don't want the minister taking a whole bunch of other MPs because he didn't have room for us.

The Chair: No, no. I'll share with the committee my understanding of this. As it's been explained to me, it really has depended upon the circumstance and the Minister of Veterans Affairs and the occasion. There were times when they took members of Parliament; there were times when they took almost entirely veterans. It was dependent on the situation at the time. On some occasions when the minister brought members of Parliament, veterans groups actually openly protested and publicly created embarrassment for the government for doing so. I think to avoid the possibility of that, with regard to this particular instance, the minister has opted to take veterans with his contingent of 15 people. I don't know if that explains it in terms of 1980, but it gives you some context for the past.

Go ahead, Mr. Stoffer.

Mr. Peter Stoffer: I think Mr. Brent St. Denis makes a valid point, and it's something to look into. The point I'm trying to make is that in fairness to the government and to the minister, our veterans are in their mid-80s now. The last trip to Holland was the last hurrah for many of them. This will definitely be the last hurrah for some of them.

If it's possible to do it this way, I think I would be supportive, but I think Mr. St. Denis makes a good point: there is a role for all of us in this particular regard.

The Chair: Also, keep in mind that the government is paying for 5,000 students as well, so there will be lots of people taken.

Mr. Roger Valley: That's not what we were told.

The Chair: Oh, that was my understanding.

Mr. Roger Valley: We were told that the students raised their own money.

The Chair: Oh, I'm sorry. Forgive my ignorance. You're absolutely right. I'm sorry, 5,000 students will be going. You're exactly right.

Mr. Roger Valley: You scared me there, Mr. Chairman.

The Chair: That was a blurb on my part.

That's the motion we have before us.

Mr. Sweet.

Mr. David Sweet: Actually, my heart is in the motion, let me put it that way, but I am concerned about optics. And in fact, if 5,000 kids raised their own money, then that even heightens my concern a bit more.

But I do think there is something we could probably do. The key thing would be whether we are serving the veterans by being there.

And if that's the case, does anybody see any problem with our firing off a letter to the Royal Canadian Legion and maybe one or two other organizations, just saying that we would like to be there and we would like to serve? We would phrase it, obviously, with the appropriate language, that we'd like to know that we were being a service to veterans and would like their input on that.

The Chair: Okay, that's an interesting point.

Mr. Shipley, and then Mr. Stoffer.

Mr. Bev Shipley: David has relayed...not necessarily my concern, but certainly we all have visions of some of the comments and concerns that have come up before about it.

This is about veterans. If we're there to support and the minister sees that is to be, instead of just other members of Parliament, certainly this committee should be representing the veterans.

I think we just need to talk to our people. We need to obviously reflect through this. The veterans are obviously the people who need to go, each and every one. Those who desire to be there should have that opportunity. So that's the first go.

I think it's all about optics at this point in time, and within optics, it's about our serving the veterans in some way by being there. Then that's party to our discussion with the minister about this committee.

The Chair: Understood.

Mr. Stoffer.

Mr. Peter Stoffer: Concerning Mr. Sweet's case, this will be the fourth time I've done this, representing not just the government but also the committee. At the Boston Seafood Show, when there was an all-party committee there, the fishing producers and the fishermen loved it.

When we were over in Holland a year back, being an all-party committee, the veterans and the families absolutely loved the fact that all parties were represented.

When Brent St. Denis, Monte Solberg, and I were in Bosnia together, we weren't politicians. We were people representing the government and the country, and it worked out extremely well.

You're always going to get somebody who will say that you're on a jaunt and you're not really caring. We can't avoid those arguments. But I can assure you that the lasting impression of watching veterans and their families and these kids who will be there, seeing parliamentarians of all parties unanimous in their support of the event, goes a long, long way.

● (1110)

The Chair: All right.

Mr. Bev Shipley: Mr. Chair, I have another commitment at 11.

The Chair: I understand. We want you here for this. Unless there are any other comments—

Mr. St. Denis, very quickly.

Mr. Brent St. Denis: I like the way Peter put that.

David, with great respect, I don't think we should get permission. We either believe in what we're doing, as a committee, as parliamentarians, and we do it because it's in our hearts to do it.... I don't want to get into a position where we're asking permission, because they have their own politics. There will be people who might gripe about this or that. That's part of our job, sadly. But we want to either express support for them or not.

And whether some of us go with the minister's delegation or we go as a committee, it doesn't matter to me. That's more of a budget thing, and I don't even agree with the minister's worrying about the optics. I mean, we're not chopped liver. We're elected by the people, we're here to do the job, and we should go.

Mr. David Sweet: If I did use the term “optics”, my concern is the institution of Parliament and also reducing the value of the trip for the veterans. I mean, if we're going to vote for it unanimously between parties, I have no problem with answering to that fact. But to diminish the event for the veterans—that would be my concern.

The Chair: Out of sensitivity for Mr. Shipley, please, so he's included in this vote, the motion has been put by Mr. Stoffer.

(Motion agreed to) [See *Minutes of Proceedings*]

The Chair: Now, before we break—Mr. Shipley, you're free to go—we have Monsieur Perron on another matter.

[*Translation*]

Mr. Gilles-A. Perron: I have another motion to table which does not require 48 hours' notice. Following Dr. Brillon's appearance, perhaps we could ask Mr. Guay and Ms. Routhier to appear before the committee.

The Chair: We will do that, yes.

Mr. Gilles-A. Perron: And the speeches we heard... I will leave it to the clerk to draw up a list of future witnesses in keeping with what we have heard today from Dr. Pascale Brillon.

The Clerk: Yes.

[*English*]

The Chair: I feel this is agreed by the committee. I see nods around the table. Yes.

This meeting is adjourned.

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