House of Commons
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 029 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Thursday, March 1, 2007

Chair

Mr. Rob Anders

Standing Committee on Veterans Affairs

Thursday, March 1, 2007

● (0905)

[*English*]

The Vice-Chair (Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.)): *Bonjour, tout le monde*. Good morning, everyone.

Our chair is away. Rob had asked Peter Stoffer to step in, but Peter can't make it. If he shows up, he can gladly take my place.

Good morning, Dr. Belzile. Thank you very much for your presence today as we continue our study of the veterans independence program and the health care review.

If there's time at the end, colleagues, we'll just need that short time for a committee budget question.

With no further ado, we'll invite Dr. Belzile to make a presentation. I'm sure the clerk has talked to you about the time of your presentations.

Dr. Robert Belzile (As an Individual): Yes, 10 minutes.

The Vice-Chair (Mr. Brent St. Denis): Yes, it's 10 minutes, give or take. Thank you.

Please proceed.

[*Translation*]

Dr. Robert Belzile: I will be making my presentation in French, but I am prepared to answer your questions in English.

I would first like to thank the Committee for inviting me. I am here as an occupational physician. I would like to describe what such a physician does as part of a medical surveillance program for members of the Canadian Forces.

I have 30 years experience in occupational medicine. As regards post-traumatic stress disorder, the issue being discussed today, I have five years of experience with the RCMP dealing with policy as Chief Medical Officer for the Central Region or Headquarters.

One of my responsibilities relates to international peacekeeping police deployment. Thus far, the RCMP has deployed approximately 2,000 of its members to those countries where the Canadian Forces have deployed their own members. As Regional Physician with the Outaouais Branch of the CSST, or Commission de la santé et de la sécurité du travail, I am responsible for determining the eligibility of people with psychological injuries. Two percent of all work-related injuries in Quebec involve psychological injuries, including post-traumatic stress disorder.

This morning, I would like to begin by explaining what a medical or health surveillance program is, what it means, and what it can offer in terms of managing or getting a better understanding of post-traumatic stress.

Before setting up a program, it's important to know what you're doing. What you want to do is assess risks. Is it possible to assess the risks a soldier will be exposed to, because you can never know what exactly will happen to him specifically, since he is working in an operational setting? I will come back to this point later.

Then there is the question of eligibility. How does one go about recognizing and assessing someone who is coping with psychological problems? Who does that? Is it the military physician or the civilian physician? Where does the member in distress go to have his program assessed? Once it has been determined that he has post-traumatic stress disorder, what should be done? Should he be considered a dysfunctional member and therefore eligible for a lifetime pension? Should he be rehabilitated? What can he do within society? We don't have answers to all those questions, but through a specific program, we are able to find out where we're going.

Training in occupational health provides a way of assessing the risks. With any job, risks are manageable. For example, in terms of chemical-related risks, we know that members of the Canadian Forces are exposed to lead and thus we can do a blood test to ascertain whether the lead level is high.

In terms of physical risks, because members are exposed to noise, we can also do audiograms to determine whether they have hearing loss. That allows us to manage their health problem, if they have one, and to determine whether they should be compensated or not.

There are also ergonomic-related risks. It always brings a smile to my face when I hear on television that the Forces have bought this or that piece of equipment. But, is that equipment ergonomic? Can a soldier sit comfortably for six to twelve hours? I have travelled a few times in a tank, and I can assure you that they were not the best trips I've ever had to make. So, it is important to assess the ergonomic component as well.

There are also biological risks. I am referring here to wars in which viruses, anthrax, and so on are used. There are ways of managing that.

Finally, this morning's discussion deals with psychosocial risks, the famous post-traumatic stress disorder, depression and anxiety.

How does one go about assessing the risks? Well, you need to visit the missions. You have to develop a scenario with respect to how the soldier will be deployed, whether it's to Afghanistan, Kosovo, or somewhere else.

You also have to look at the job description. A colonel who is responsible for communications does not play the same role as a major or a corporal who is in the battlefield. The risks he is exposed to are therefore different. The risk assessment depends on what the soldier is expected to do and the equipment he is given. If he is going to be given a small, uncovered jeep, is not going to be armed and will be asked to go into a troubled area, that is more stressful and unpleasant. That is what we call a risk.

In occupational medicine, there is a theory that may be idealistic, but it involves trying to reduce the risk to zero. Unfortunately, in police and military operations, it is impossible to reduce the risks to zero. There is not a zero risk when someone is on the battlefield or in the process of arresting someone.

However, there are ways of trying to bring that risk as close to zero as possible. There is the matter of the equipment that is provided. For example, for police officers, there is the bullet-proof vest or the type of gun. And the same applies to members of the military. The equipment, the vehicles, and those sorts of things are important. If I know that I am travelling in a safe vehicle, that can deflect bullets when they're fired, I will be more at ease. It will be less stressful.

Second, there needs to be appropriate training. This is often discussed. If I had never driven a tank but will have to do so in Afghanistan, it clearly is not like driving a vehicle here on Highway 148. There are differences. There are excellent training programs in place. Training is important.

Third, there is the matter of personal protection. All the types of equipment that may be provided—for example, walkie-talkies for communication purposes—become very important in this context. Finally, once you have given soldiers good equipment, have ensured they have receiving the proper training and that they have every possible type of equipment they need in terms of protection and communication, there is the medical surveillance program. Who should be entrusted with this responsibility? We all agree that in order to drive a tank, you have to have good eyesight. If you can't see anything, even though you may be a very good driver and have the best possible equipment, you won't get far. So, we agree that eyesight is something that has to be checked.

Now, in terms of psychological issues, it is not quite so clear. In other words, when you have to determine who is going to be asked to drive a tank and who is going to be sent to Afghanistan, you can determine a soldier's skill level or aptitude through physical exams. The military has quite a good program for assessing risks. Someone with high blood pressure and diabetes may become less vigilant and, if he can't eat lunch every day, his sugar level will drop and he could have serious problems. We all agree on that.

In terms of psychological assessment, personality-related tests have been validated to see how a person reacts to stress. In some organizations, that test has been used since 1998. So, we do have some experience with it. However, there is no test that provides infallible results that are accurate 100 per cent of the time. These tests were validated with a view to screening out people who can't work in a stressful environment or have a pre-existing condition that could get worse. If a person has already had psychological problems, he or she will not automatically be rejected, but it is necessary to determine how that person will react. Stress can either crush you or make you stronger. It's important to find out about someone's childhood experiences or exposure to abuse. We have to be careful here. I know my friends who work to defend human rights and I respect them. We are not trying to screen everybody out, but if there is a risk that the person's condition will deteriorate with catastrophic consequences, then I won't expose that person to that kind of outcome. Our medical knowledge in that area is increasingly extensive, and we know that if this kind of person has a problem, it won't work.

In terms of the eligibility of occupational injuries, people always thought that soldiers were guys in uniforms who carried weapons but didn't suffer from post-traumatic stress. However, scientific research increasingly shows that microtrauma, exposure to minor risks, the fear of death, catastrophic situations, a dead child, human remains, and so on can and do affect people. So, we have to deal with that. Often, where post-traumatic stress is concerned, if no screening has been done, the person will end up turning to alcohol, drugs and will ultimately have problems with the law. We try to identify that, because it is absolutely clear, as your witness told you on Tuesday, that when people become dysfunctional, they no longer know what is important and what isn't and they are completely at a loss. Often, certain signs will indicate to us that a person may be suffering from post-traumatic stress disorder. How many times in my career have I seen people being fired from their jobs who were sick. If they are sick, they need to receive medical care and afterwards, we'll see what needs to be done. That still happens quite often. We also know that soldiers, like police officers, are not in the habit of consulting a psychologist when things are not going well. The clinical signs of post-traumatic stress are not obvious.

There are experts out there who can diagnose post-traumatic stress disorder, like Ms. Brillon who was here on Tuesday, but they can't be found on every street corner. There are only a handful of them out there. And it's not easy to diagnose PTSD. Before making that diagnosis, there is a great deal of work to be done. All the different linkages have to be made. It's very difficult to do.

Furthermore, the less a person believes it the more difficult it becomes to diagnose it, and the symptoms get worse. Then they come along and ask us whether the individual is exaggerating his symptoms. When a guy goes to see a psychologist, he is starting to realize why he is dysfunctional. He is starting to understand that on a specific day, when he didn't have time to fire his gun, he was afraid to die in those five minutes, and after that he became dysfunctional. But the diagnosis is difficult to make. Yes, there are some physicians and some psychologists who can. Also, the greater the chances of confrontation, the more serious the symptoms will become, with all the complications that go along with that.

● (0910)

For a person to be deemed eligible, he or she must have suffered trauma. In the past, it was believed that simply seeing this kind of thing on television could cause trauma. Now it's the perception that matters. Legal changes have been made along those lines. In other words, based on medically defensible principles, the fact that someone experienced a fear of death and that there was decompensation when the event occurred could be enough. That's what counts.

In terms of soldiers seeing friends die on television, we have attempted to establish a principle. The soldiers must actually have witnessed the event. For example, it could involve someone who is part of a detachment and whose tank blew up on a mission. We have specific guidelines to follow in such cases. And the case law clearly allows us to set parameters.

It's rather strange to see what determines eligibility in cases involving post-traumatic stress disorder, for both police officers and soldiers. The rumour is that the first application is always rejected. And yet, if a soldier fractured his arm falling out of a tank, that isn't questioned. But that is not the case with post-traumatic stress, and that makes me somewhat uncomfortable. Indeed, if we determine, relying on our diagnosis, that there was trauma, it's easy enough to add it all up. But who actually does that?

The problem is that it is people internally who see the soldiers. That also applies to the RCMP. One may wonder whether their primary responsibility is to ensure that there are people to go on these missions or to ensure that dysfunctional people do not go on them. Three types of specialists are involved in the process. First, medical specialists are tasked with determining whether or not the person is eligible. Then, occupational medicine specialists develop a diagnosis. For example, we might say to an individual that his audiogram is not normal and that the results justify both his receiving a pension and a hearing aid. So, he will then be sent to see a specialist. It is our duty to do that, ethically speaking, as occupational physicians.

Once we have determined the nature of the illness and the compensation that is to be provided, that person needs to receive medical care. Civilians can be called on to provide that care. But the treatment has to be provided in an objective manner. If it's the same psychologist or psychiatrist providing the treatment, one may wonder how things will turn out. The there is the whole rehabilitation process. That means supporting not only the individual, but his family as well. In terms of disability, we don't have any direct statistics. On average, a post-traumatic stress disorder case lasts from two to seven years. In cases involving real trauma, the chances of an individual going back to work are said to be about 30 per cent. However, he can do something else. I will close on that.

Thank you.

● (0915)

[*English*]

The Vice-Chair (Mr. Brent St. Denis): Thank you, Dr. Belzile. You didn't miss anything. I'm sure you'll have a good opportunity in responding to questions to bring anything else in that you'd like.

Colleagues, I'm going to start with either Rodger or....

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): I don't think so.

As a matter of fact, I thought this was going to be about shedding more light on where we are with the health care review. So I'm caught a little short with your presentation today. I appreciate your presentation, but if my colleague has some information—

An hon. member: I have to leave.

Mr. Rodger Cuzner: Oh, you have to take off. Okay.

The Vice-Chair (Mr. Brent St. Denis): Okay, we'll go with Gilles.

Go ahead, please.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Thank you, ladies and gentlemen.

Mr. Chairman, does that mean I have 14 minutes?

The Vice-Chair (Mr. Brent St. Denis): No, we will begin with a seven-minute round.

Mr. Gilles-A. Perron: Fine. Thank you.

Thank you for accepting our invitation. It's possible that, quite by accident, I will address you as “tu” or “Robert” in the course of our conversation. Everybody sitting at this table knows that you're my physician and that you have treated me. However, what they don't know is that every time I go to see you, we spent five minutes talking about Gilles Perron and about half an hour talking about post-traumatic stress, something that I very much appreciate.

I want to adjust the table so that we can understand each other. Like most of the people here, I believe that PTSD is a reality. I am one of those who believes we need to save people who are suffering. We have to make them functional again. I am even more interested in what we can do to reduce cases of post-traumatic stress disorder to a minimum in future operations.

Dr. Robert Belzile: That's a good question. Soldiers have a medical profile. We try to determine, for example, whether they have good eyesight—

● (0920)

Mr. Gilles-A. Perron: Is it a medical and psychological profile?

Dr. Robert Belzile: From what I can see, they don't do a psychological profile. However, when the RCMP deployed its 2,000 members, it did do a psychological profile of them. We did a psychological assessment and post-trauma debriefing to get a clear understanding of how these people experience stress. That was useful because our numbers were ultimately equivalent to those for the regular police population. We made a presentation to this Committee with the Department of National Defence.

They would need to do a psychological assessment using personality and stress-reaction tests. Those tests are valid in 80 per cent of cases. The danger, however, is that they might not want to screen people out. As soon as a test reveals something abnormal, a psychological interview is arranged to confirm the validity of the information.

Unfortunately, in some cases, we have to refuse to deploy some soldiers on missions involving too high a stress level, such as in Afghanistan, for example. People that participate in those missions have to be able to react positively to stress. Also, we are looking for resilient personalities. This is not something hypothetical. Increasingly, we can glean information from psychological tests or through a post-trauma debriefing. In other words, everybody has experienced stress in the course of his or her life. The question is how people reacted to it. Did they react positively and become stronger, or did it crush them? These personalities do exist, and that is what is needed for these kinds of missions.

Mr. Gilles-A. Perron: You are in a position to make a comparison between the RCMP and the Canadian Forces. To summarize, is it fair to say that we need psychologists with expertise in post-traumatic stress disorder to be part of the Canadian Forces' or RCMP's medical team and that they should be able to be deployed to the battlefield or the front?

Dr. Robert Belzile: That would be a good idea.

In terms of our deployments, the medical team, which included a chief psychologist, a physician, and a security supervisor, would make annual visits to see all the soldiers. We also know that when these visits occur, soldiers have a tendency not to ask for a consultation. That is why we would ask a lot of questions about what had been done. This is what is called earlier intervention. It is not a debriefing, because there isn't any post-traumatic stress. We simply want to know what they're doing.

When a soldier tells us that when he was in Haiti, he was retained at a roadblock for two days, I believe him, because I saw that. It's important for the team to be on the ground. That gives it greater credibility at the debriefing stage, because there is greater understanding.

Before going to Africa, I was told that I wouldn't believe what the guys told me, but when I got there, I did believe them. I know that our soldiers do have access to a medical service, but it is basically for first aid. We call that risk recognition and auditing the activity.

So, when I go to Haiti to see my 100 members, they are given first aid kits and I check to see whether they were able to see a psychologist, whether they used their medication for diarrhea, whether they had the flu, because there is pollution, and so on. We attempt to accurately identify all potential risks. We also verify whether incidents occurred that could shed light on stress-related issues they were unable to perceive.

Let's take a specific example. A Canadian police officer could be told to go up a mountain to arrest someone. When you arrest someone, they're not happy about it. If you don't arrest that person, you're going to have problems, but if you do arrest him, you're going to have even more problems. And then you have to make the two-hour trip back down the mountain without knowing what is going to happen.

So, that police officer experiences stress. Will he crack or won't he? I don't know. As far as military personnel is concerned, there is what we see on television, but it can be somewhat cosmetic. Sometimes we were supposed to leave at 7 in the morning, but we actually left at noon.

I think it is always important for a neutral, professional team to visit people in the field to assess the risks and get a better understanding of what people are likely to experience when they get back home.

● (0925)

Mr. Gilles-A. Perron: Dr. Belzile, I understood you to say in your presentation that you are uncomfortable with the fact that some veterans or RCMP members have trouble securing recognition of their post-traumatic stress, particularly by medical staff assigned to veterans.

Do you believe that this is due to the inability of those assigned to handle these files, whether they're public servants or somebody else, to recognize certain health problems, including post-traumatic stress disorder? If that is the case, do you believe it would be a good idea for qualified staff, such as yourself or Ms. Brillon, who came to meet with us, to brief public servants who are responsible for assessing veterans' applications?

The Vice-Chair (Mr. Brent St. Denis): Thank you, Gilles.

[*English*]

We can come back to you later.

Dr. Belzile, you can respond.

[*Translation*]

Dr. Robert Belzile: Yes, absolutely. We don't want these cases to end up in confrontation. There are established facts. Certain things make me feel uneasy. I can talk about the RCMP. In stress-related cases, they tell us we shouldn't talk about it. But that is not the way we do things. As occupational physicians, when it is determined that an individual is suffering from post-traumatic stress disorder and that means he is eligible for compensation, we consider him to be eligible and we pass on the file. From that point on, I am unaware of what the process is.

Of course, the actual officers are responsible for evaluating the cases. I believe you were given a good historical overview of PTSD last Tuesday. The case law as well as medical knowledge in that area are advancing every day. It is essential that officers base themselves on significant criteria. There are medical advisors. With us, cases are decided by our experts. It's not easy to question workers. Sometimes people are troubled by the questions because they're of a very personal nature. But we need to have the answers and all of it has to be validated by a physician.

Providing training to officers would indeed help them gain a better understanding of the phenomenon and facilitate the process. However, even if we provide better training to people, there will still be PTSD cases, because we cannot predict each and every situation. At the same time, if we are able to identify these cases and do some early intervention, people will not become totally incapacitated.

The problems associated with eligibility and case management mean that people are constantly fighting for their rights. We don't know what to do with them anymore. I, personally, prefer to ask an individual suffering from post-traumatic stress disorder what he intends to do. Yes, we will give him a pension, but I ask him if he can work. That individual has to declare himself to be disabled because no one believes him. His wife doesn't believe him because PTSD means he doesn't like anyone anymore and doesn't react to anything. His children probably think he is crazy and that he is a lost cause. We have to look at those issues.

Le vice-président (M. Brent St. Denis): Thank you, Dr. Belzile.

[*English*]

Ms. Hinton, please.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Welcome, Dr. Belzile.

I'll start with a couple of observations. I listened very carefully to what you had to say, and I found it very interesting. I'm certain you would agree with me that those people who decide to go into the police force or the fire department or the military understand that there's going to be a lot of trauma involved in their jobs. Our job here is to actually try to support them after they have done their duty.

One of the other difficult things for Veterans Affairs personnel, I would imagine, is that we don't get the case from the very beginning, because it's cross-jurisdictional. The defence department would be in a position to see this person coming out of service at the early stage, and it wouldn't come to Veterans Affairs for a time afterwards.

Having said that, what I'd like to know from you is the same question I asked the last witness. How do you think Veterans Affairs Canada can contribute to changing the negative stereotype for veterans who suffer in silence from PTSD? How do we break that barrier, so that the men and women who are serving are more comfortable admitting they have a problem and seeking help, without feeling that they're weak or that there's something wrong with them or that they are inferior in some way, because they have witnessed something that has been too difficult for them to handle and they need that support? How do you think Veterans Affairs Canada can help in this regard?

● (0930)

Dr. Robert Belzile: That's a good question.

Once you're back from a mission, you have a repatriation medical assessment. In the force I was in, the RCMP, we did psychological screening. The tests were done early, before deployment. If upon return there were some changes the member did not notice, we had an early intervention.

The second thing, as you know—and I don't know if it's the same thing for the military—is that all these extra psychological tests take a special psychologist, and unfortunately they charge a little extra. There are a lot of neuropsych tests, which are expensive. Of course, the bottom line is that they say they won't pay because you have to have your claim approved. I don't understand that. If I went to Afghanistan where I was exposed to a trauma, and the force doctor said I had stress, and then they said they wouldn't pay for psychological services until I had my claim approved, I have a problem with that.

That's what the RCMP do. They say they don't pay until you get your claim approved. So already it's confrontational in the sense that the guy has to fight, and that's where you get these horror stories: "They don't believe me. My case is delayed because I have to procrastinate, to elaborate on it." That's where the barrier is. That was my experience in the five years I was around that.

With the WSIB in Ontario and the CSST in Quebec, if you have stress, they say, well, we may pay the psychological fees, because the more we know about you, the more we can rehabilitate you.

We've learned. We did the same thing 10 years ago: "No way. You're a police officer and you chose to be a police officer. We sent you to Regina for six months. You know what the hell...it's impossible." Well, this doesn't work anymore. Early intervention and accepting the diagnosis breaks these barriers.

Those are the problems.

Mrs. Betty Hinton: We're in agreement on that. I think early diagnosis is extremely important.

I also believe, though, that there has been a fairly significant shift in giving the benefit of the doubt to a claimant. I'd like to see that expanded even further, so you don't have to go through this confrontation that you referred to and so there's recognition that there's something wrong with you.

We had a witness who was asked about people faking it. I'm sure there are always going to be people who try to do that. For the most part, I think people who are coming in for help are coming in because they have witnessed or participated in something that is psychologically very difficult for them.

In terms of the kinds of people we send to war zones or the kinds of people we have in the police force or the fire department, I hope I misunderstood a little of what you said. I wouldn't want to see everyone with sensitivities to human tragedy eliminated from serving in any of those capacities because they may be in danger of suffering from PTSD. I think those three services I just named require a lot of humanity to be able to execute the job properly. I wouldn't want people eliminated. I thought I heard you say something about screening them in advance and, if they have a soft heart, not putting them in there. I want to see people with soft hearts there.

What I want to do is to find a solution to support the person coming back from a mission, or the RCMP officer or the fireman. I want to see a support system to get them through this really rough part. I do not want to desensitize people who go into the service. I want them to be completely human. I want them to have a heart. I want them to care. But I want to support them when they come back.

Is there a balance we could come up with, or is there something that Veterans Affairs Canada could do to intervene and protect these people when they do suffer these kinds of traumas?

Dr. Robert Belzile: Yes, and in fact it's up to the employer, the force and the RCMP, to select the right person. You wouldn't argue that to drive an emergency vehicle with a red light on top identifying you as a police officer, you can't see. So we don't argue about that.

Psychologically, in regard to pre-trauma, that's where we have to screen out people. Unfortunately, if I was abused physically and mentally and sexually as a young kid, obviously I am now dysfunctional; I will not react positively to stress. That is one pre-traumatic psychological profile. Unfortunately, if I put that person under any stress, they're going to crack.

As you know, we have a duty under the code of health and safety to put the right person in the right place, because if we, as the employer—the Canadian Forces or RCMP—put in a man who cannot tolerate stress and he gets sick, that's where we will get sued. Before there were all these Veterans Affairs pensions, the members used to sue us, and some are still doing that. We see some of them on TV who say, hey, you sent me there and you knew I couldn't go there.

So you have a responsibility in regards to health and safety to choose the right candidate with the appropriate psychological profile. Unfortunately, we have to screen out people, but that's the minimum. As I said, it's not because you're divorced or you're having problems with the custody of your kids that I won't send you. Sometimes they want to go there, as they think it will be a break and they'll make a lot of money, etc. No, no, I have to choose. I have a team of specialists or psychologists, and we take a decision. We even meet the wife to see how she's going to react. We're preparing for the return.

So this is not black and white; there's a grey zone. But it's feasible, if you have an agenda and a vision, to do it.

● (0935)

Mrs. Betty Hinton: Okay, he's going to cut me off quickly—

The Vice-Chair (Mr. Brent St. Denis): Yes, be very brief.

Mrs. Betty Hinton: —so I'm going to get this in as quickly as I can.

When a witness of your calibre comes in front of us with a four-page CV, it's staggering. I mean, you've done enormous things here, and I would not want to argue with you on any psychological points, because you're the expert. But I would want to make one point. I have met many people who had horrible childhoods, with sexual abuse and beatings, and who come from alcoholic families and all of those sorts of things. I can tell you that with many of them, if I found myself in a really bad situation, I'd want them at my back. They are probably some of the psychologically strongest people you could possibly come up with.

Dr. Robert Belzile: And I fully agree, because they got stronger with that stress, and we put them in front of the action. I agree with you.

The Vice-Chair (Mr. Brent St. Denis): Thank you.

Excellent, Betty.

Rodger Cuzner, please.

Mr. Rodger Cuzner: Thanks very much.

I do appreciate the points made in this last round. I understand fully the importance of trying to profile these people before we expose them to combat or to the theatre, as well as trying to harden them prior to deployment, or at least allow them to get some appreciation for what they're going to face. I think that's imperative. But sometimes the horrors are so great that there's nothing that can prepare them for those, which was certainly brought out in Tuesday's testimony as well.

I want to get a sense of what you said, that the earlier the intervention on a psychological problem.... Most often in our committee, we focus on the care of the veteran farther down the road, after he's been released and what have you, but what you're saying is that the earlier it's detected the better. So are you comfortable that our medical people on the front lines in the theatre, our senior officers or military personnel, are receiving sufficient training in identifying some of the cues and picking up on some of the triggers, so they can say, listen, we're going to have a problem with this guy and we need an intervention immediately? I would think you wouldn't have enough trained personnel, or psychologists in the field, who would be able to do that.

So just give me your sense of front-line triage on—

Dr. Robert Belzile: That's a good point, and it's always difficult to assess.

Each military detachment has its own medical, but how much psychological support is there? That's why we have the employee assistance program, where I see George if he's ill. So there is a way, and we enable that.

In our mission, we have a police force detachment, and we have an employee assistance program that detects the guy who thinks he's too good, etc., and like Mother Theresa, he wants to say too much and he's doing too much. So yes, we can profile that.

The thing is that I don't know how much the guy can talk in Afghanistan. Of course, I would say you can talk to George, but George is at the same level as you are, and he can help you because he has the same type of gun and the same type of uniform. But you need to talk to Sergeant Professional, because the danger is that if you give that to anybody, it's going to feed the stress instead of managing it. The objective is to manage the stress through the whole situation and not take the risk. Yes, I agree with you that you cannot predict all risks, but if you know the worst scenario, you can react to it.

So is there an employee assistance program? Is there a co-worker to detect that and then go to a psychologist to get a debriefing? I went into a detachment and I had to repatriate a certain person who was talking about being too good. I just had to ride in his car with the UN, and that was enough.

Sometimes, unfortunately—and that's where you see these horror stories on TV—the guy doesn't know he is stressed; he doesn't know he's overreacting. Of course, as a friend, sometimes you're stuck. Is this normal? Is this George today? That's why a professional needs to make an assessment. That's why we tell George he has to go to see the psychologist, who'll tell him he's done enough.

Frequently we have this problem, because we have a lot of detachments in the north where they're deployed for three years. They want to stay for six years, but we say no after three years. They don't understand that they have to come home to real life. They don't know how they're reacting. They're sleeping with their guns in their beds, etc., and that affects their morale, but they don't know. If we check them pre-deployment, and while the mission is going on we audit the mission and review how stressful the situation is—we know how many physical injuries we have and how many psychological injuries—that's where we will save a lot of members from being sick and completely off upon their return.

● (0940)

Mr. Rodger Cuzner: My own police force, the Cape Breton Regional Police Service, has been sending a lot of personnel and have been involved internationally and what have you. Do they have access to the RCMP services when they come back?

Dr. Robert Belzile: Until recently, all the police forces were under the responsibility of the RCMP. We still take police from all municipal police forces. This is paid for by CIDA. And yes, they have the same program. When they return, if the psychological assessment of the force is *oui*, we send them. We have people deployed in Halifax and everywhere in Canada.

As you know, when you're under a UN mission, if you have PTSD, you can have a pension from the UN. We even build up the file. Boy, if you think it's hard with VAC, it's a mess with the UN. We say this guy is one of our members and is obviously sick, in the rational opinion of an occupational physician. If he's sick, he's entitled to certain benefits, and we will open the door. We don't decide for them, and we don't want to decide for Veterans Affairs Canada. We want to furnish all the appropriate information so that the decision process is made early and efficiently and is good for both parties.

This is the type of case where we need to number these people. In our deployment of the military in stressful situations, I don't know how many casualties we have today that involve psychotherapy, medication, ODS, or off-duty sickness, etc.

The Vice-Chair (Mr. Brent St. Denis): Thank you, Roger.

Thank you, Dr. Belzile.

[*Translation*]

You have the floor, Mr. Roy.

After that, it will be Mr. Shipley's turn.

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

Dr. Belzile, Ms. Hinton asked you a question, but I'm not sure I really understood your answer. If I heard you correctly, you said that every individual wanting to serve in the Canadian Forces should be given psychological tests so that we can assess their ability to handle the stress they will be exposed to. Furthermore, you said that the goal is not to reject people and that everyone is hired anyway. That is pretty much what I understood you to say.

I have a problem with that. I certainly wouldn't give a scalpel to someone who is afraid of blood.

Dr. Robert Belzile: No, I was trying to…

Mr. Jean-Yves Roy: … go quickly.

● (0945)

Dr. Robert Belzile: Let me explain.

Suppose we are carrying out a mission in Jordan, where we are training police officers. The profile required for the mission in Jordan is the following: we need Canadian Forces members or police officers with extensive experience. They don't have guns and they do not interact with the people. It is possible that some men will have hearing aids and that others will be taking pills for high blood pressure or diabetes. Hospitals in Jordan are like our own. So, those men can go to the pharmacy with their prescriptions.

Others are in Darfur. They sleep in tents and their base is about 200 kilometres away from Khartoum. So, we obviously can't send someone there whose hearing aid might malfunction and break. I'm talking about physical things. If somebody's glasses break, we can't send him to get a new pair of glasses. There is no doctor. What are we going to do if he needs to have his blood pressure pills adjusted or if he runs out?

It's the same thing for a psychological profile. In Darfur, the required psychological profile is that the soldiers not have mental health issues that could require therapy, medication, and so on.

I respect what the member said. Just because someone had problems when he was a child doesn't mean he will automatically be refused, but we do want to see how he is going to react. Some people react positively and gain strength. Others are crushed and remain wounded for the rest of their lives.

Yes, we do reject some. Taking part in a mission pays off. A lot of people line up for the job and I have to reject more than I accept. I have to be certain that a police officer who is 45 years old and wants to go to Darfur for a month—in the RCMP, it's nine months—will be able to get through it. Unfortunately, I have to reject him, not because he is sick, but because he doesn't have the required medical profile and I don't have the medical means of supporting him there. The RCMP has determined that the same medical support has to be provided to members whether they are here or in other parts of the world. That is plausible. In other words, I am not going to tell them they may die of a heart attack. They will be transferred to a high-level hospital where they can receive coronary care. When I used to visit the missions, I would lay out a method of evacuation.

In terms of the Armed Forces, when it is large enough, they have their own base. They have all of that and they do it very well with Germany. Those are the standards that we set.

Mr. Jean-Yves Roy: My question goes further than that. When a soldier signs a contract at the time of his enrollment in the Canadian Forces, is he subject to an initial psychological assessment?

Dr. Robert Belzile: Well, I looked on the National Defence website and I don't believe they do psychological assessments. They may establish a profile, but I don't know. So I can't answer that.

Mr. Jean-Yves Roy: So, they do a physical exam, but they don't do a psychological assessment.

Dr. Robert Belzile: I really can't say. To do the training, you need discipline—the weak ones break down under the strain—but there is no psychological assessment. We recommend that both the member and his or her family be subject to psychological testing. Who is going to support the guy when he comes back? It's the family.

Mr. Jean-Yves Roy: That should be done before they enroll.

Dr. Robert Belzile: Yes, exactly. We have had some problems because of human rights. However, most people agree voluntarily. If we're going to send someone to Africa for nine months, we want to meet the guy's wife, because she will have to help him. Most people agree to that, and we want to see how they react to stress.

Mr. Jean-Yves Roy: Why do you think they don't do it? You're a doctor, you have been assessed, and you have been tested. They didn't let you in just like that. Why don't they do it?

Dr. Robert Belzile: The problem is that there are two schools of thought. My area of specialization is medical surveillance. When you work at the Royal Canadian Mint, you have to work with gold, arsenic, lead and mercury. When I do urine tests for screening purposes, I find traces of those metals: that's a fact.

As for psychological tests, they are somewhat more intrusive. Psychologists are a little more reserved when it comes to making a determination. It's delicate. We don't have absolute power. However, increasingly, we do have tools.

The people responsible for protecting human rights, with whom I have often worked and whom I respect, used to tell me that if I ask Mr. Roy to take a test, I will have to test everybody. In addition, they would ask me to prove to them that it would or would not make a difference. I can defend the cases I've handled in the five years I've been implementing the program inside the RCMP. However, I have to justify every single rejection, because the human rights people get on my case and I am exposing myself to a grievance. I have no problem with that, because that's part of my job, but it's not easy. You have to be vigilant: a urine test won't tell me whether the soldier I've tested is a better soldier or not, but we test everybody.

In principle, we should be looking at the quality of our intervention, because that is the basis for our decision to deploy him. That's why there needs to be good equipment. This is what they used to do in the army: they had the best guy, but in terms of equipment, they gave him the responsibility of handling it—pulling the choke to get the vehicle going.

All of that is part of training. If I am given new equipment but haven't been trained… I may have the best radio in the world, but if I don't know how to use it, it's useless. The same thing applies to personal protective gear. Those are often stresses for people.

If I have a bad tank and I don't have the right uniform, because everyone can see me three kilometres away, then I will be stressed out, and when I experience stress, I am likely to fall apart more quickly. What I'm trying to say is that we can always do psychological testing, but there are four criteria: good equipment, good training, good personal protection, and the right medical exam. They are all part of a whole. We have often focussed only on the medical aspect or the equipment aspect. But that's what a medical surveillance program is all about.

● (0950)

[*English*]

The Vice-Chair (Mr. Brent St. Denis): *Merci*, Jean-Yves. We can come back to you.

Bev Shipley, please.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Mr. Chairman.

Thank you so much, Mr. Belzile, for coming out today. This has been an interesting talk, just as it was the other day.

What coordination is there with the Department of National Defence in terms of research? One issue that's coming about is that we need to spend more money on a number of areas. I'm concerned that we duplicate—I don't think that's wise—but we do need to know what the research dollars are to learn more about PTSD. With that, what progress has been made over, say, the last ten years in terms of knowledge on it?

Dr. Robert Belzile: That's a good question.

I can speak in regard to the RCMP. Interestingly enough, I was at the policy centre, and I tried for some liaison with the military—they opened their clinic recently—but, boy, I couldn't. I mean, the RCMP in the book says we are allowed to go there, but it was so complicated.

Unfortunately, my big brother the military could not help the RCMP in regard to liaison. We had to go à la carte.

The other thing is that of course we professional doctors do liaise one by one. I have a few military colleagues with whom I've spoken, etc., but nothing officially. And yes, I agree with you that the military spends a lot of money on that, the RCMP, and we should sit down and.... There are also a lot of universities with whom we should liaise some coordination. I know that the U.S., etc., had some committees.

So there are a lot of people. How much of this is duplication? How much of this is working on the same vision? It's difficult to know. As the occupational physician in charge of the RCMP, I had problems not with the doctors but with, “Robert, get a PO, an invoice, so I can speak to you”, and so on.

Mr. Bev Shipley: Was the issue with National Defence or RCMP?

Dr. Robert Belzile: Both.

Mr. Bev Shipley: Do you see that being the same issue here? Because if that's an issue, then that's the first thing that needs to be dealt with.

Dr. Robert Belzile: We should have regular discussions with Veterans Affairs. I don't know about the military, but unfortunately at the RCMP we had difficulty. Of course, the RCMP was a small player, at 17,000 members; the military was at 60,000.

Sometimes we'd wonder, why did they refuse that? But funnily enough, they were doctors from Veterans Affairs. I think we should have been speaking together.

Elsewhere, if I'm talking about Quebec and Ontario, we have committees of people who work at different levels—at the pension level, at the treatment level. We have committees on post-traumatic stress disorder, looking at the best treatment and how we should do this.

I did leave the force on September 1, 2006, but I must agree with you that this was very difficult.

Mr. Bev Shipley: What sort of cooperation do you see? Maybe you can't answer this, but we are not the only country experiencing this. There is a lot of research and knowledge in other countries. The United States and some countries in Europe obviously are going through the same sort of thing. Does it make sense to you that we rely on some of their background and coordinate these?

● (0955)

Dr. Robert Belzile: Definitely. The last committee I attended was with the U.K., Australian, and U.S. military, and it was about medical issues from immunization. What we were looking at was management of the risk of a deployed member or an officer in all these countries: what kind of immunization did we offer him, what kind of medical support with regard to psychological, physical, etc.

As you know, there are all these UN clinics—it's an observation, not a criticism—and sometimes they don't have Canadian standards. For example, in Haiti, it's the Argentinian ARDA, and sometimes we have to liaison with them. There are committees to improve that, but I don't know how official that is. When you work for the UN, you take the position they give you, and you're trying to negotiate from there.

Mr. Bev Shipley: Yes. I wouldn't want to suggest that the UN's the answer to a lot of things. But when we're talking about post-traumatic stress, do you have any idea of the percentage of actual people—and you're mainly familiar with the RCMP, maybe some with the military—who will need to be treated?

Dr. Robert Belzile: In the force—and I'm talking about my numbers when I left the force—it was 2%. Funnily enough, at the CSST, the Quebec compensation board, which is the only provincial compensation board that has entitlement for psychological illness, it's 2% of our workload. We have 300,000 cases a year, but 2% are psychological.

The problem with psychological impairment or entitlement of a disease is that they lose double the time. If, on average, any injury is 250 days, it's 500 days. That is the problem.

The other problem with a psychological illness is not only that it is twice as much lost time, but there's a percentage who are totally disabled. They don't have any capacity to return to work at all. That's the concern.

The numbers are not that bad. I'm talking about the RCMP and CSST; that's where I have numbers. I don't have numbers for the military. But at the end of the day, double the lost time and up to 50% are completely disabled for any return to work, etc.

Unfortunately—I'm just going to finish with that—the statistics for 2006, that was the old school. As you know, with PTSD, the new school is early intervention, early entitlement, rigorous management by competent psychologists, with EMDR, etc. If you send them to any psychologist, they'll know about all the bad things in their life from zero to 10, but it won't work positively in their return to capacity. So we feel that once we take the entitlement, we should have some control of the treatment. If you see anybody, they say go to a naturopath, etc. They might feel better, but at the end of the day, they won't get better. That's why we have to have some control of the success.

I feel that in the next five years, with this rigorous position, the numbers won't get worse.

The Vice-Chair (Mr. Brent St. Denis): Thank you, Doctor.

I'm going to take a turn for the official opposition, and then it'll be Mr. Sweet, and then possibly Betty and Gilles. Okay?

Just to pick up on something that Mrs. Hinton raised, the notion of pre-screening, if it's done right, logically, yes, you can mitigate a future problem by preparing for it ahead of time. But I can see issues of forcing people to be screened against their will, and other issues. If you have $1 to spend, hypothetically, you can spend that dollar ahead of posting—RCMP posting, military posting, what have you—or that same dollar after. If you only had that $1, would you spend it before or after?

Dr. Robert Belzile: Definitely before. There's all this community health. You could have advertisements on TV every night to stop smoking, but it's when I get my patient in front of me and I give him the rules. So I think individual screening....

Of course, with military and police positions, we know the risk. It's known. We've assessed the hazard for a long time. There's training. So we have a good passing grade with regard to these pre-deployment medical assessments, physical and psychological, which are working in reducing the outcome of disease. I'm talking about from a heart attack to if the guy's not physically in shape, etc. For example, if a police officer has asthma and I give him *poivre de Cayenne*, he has an asthma attack and he's useless. So this is a *fait accompli*. So these three deployment tests are good.

Psychologically, as you know, the RCMP has been doing that since 1998, so we have close to 10 years of that. We feel that it's been maintained.

● (1000)

The Vice-Chair (Mr. Brent St. Denis): How do you deal with the question—again, I'm sensitive to some of the points that Mrs. Hinton has raised—that somebody could be assessed as being at risk for more likelihood of having a post-traumatic stress incident, but maybe not? It's very much an ethereal or subjective thing that you're measuring, unlike a physical heart condition or asthma, etc. How do you deal with somebody who is assessed ahead of time and told, no, you shouldn't go and do that, but in their own mind they say, I can do that, and they suffer anxiety or trauma because they were refused to do something? You could create a catch-22 because of the difficult nature of what you're assessing.

Dr. Robert Belzile: I'm not saying we're 100%, but we do have standards that tell us the risk assessment. That's why the tests are not enough. It's an assessment by a specialized psychologist. We assess and we make a decision, and sometimes we're wrong and sometimes we're right. As you know, decisions in Canada can always be appealed. I don't mind that. There are grievance levels, human rights, and I go and fight with them and I don't have a problem with that.

But mostly my experience with that is that people understand. We explain the decision. Although we're in the military or the RCMP, we don't say, George, you're not going. No, it's George, here's the problem, here's the situation. Most of the time, 95%, I can tell you that the member agrees that yes, it's a good idea.

We're not there to have a confrontation. It doesn't help. If all my decisions go to confrontation and appeal, my boss will say, Dr. Belzile, you're very good, but you're costing the force too much, or the RCMP. So we're trying to have a solution, not a problem. At my level, it's a solution, not a problem.

The Vice-Chair (Mr. Brent St. Denis): Thank you.

I'll wait until the end for another short one.

David Sweet.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you, Doctor. My smile is because I appreciate your level of knowledge and your frankness. It's very refreshing.

I have a couple of very specific questions. Is there no official network among Canadian health professionals for PTSD?

Dr. Robert Belzile: There's an association of psychologists, but if you're talking about an official association between force members, the RCMP, or the other police forces, I haven't seen any.

Mr. David Sweet: I was at a meeting a couple of weeks ago with AllerGen, which is a network of doctors across the country for allergies and diabetes. Are you familiar with that?

Dr. Robert Belzile: Yes.

Mr. David Sweet: I would think that for PTSD, particularly because it's a disorder that we're still learning much about, there'd be some energy around the country to—

Dr. Robert Belzile: There is energy. In my job on the Quebec compensation board we do have education. I'm like a judge there and I listen to what his doctor says and the force, the Sûreté du Québec.... We have an educational training of about two years. But this is unofficial. I haven't seen any special police or military post-traumatic stress disorder education program specifically. I know there are four clinics, but how much communication of data?

As you know, the weakness is, as Dr. Brillon said...and on this I've built up my own statistics. Unfortunately, you can read all the books you want, but there are facts. We've sent 2,000 members, and we know how many have developed PTSD at the end of the day. Is it good or not? Do I have enough or not? I don't know, but that's what I can say.

At the end of the day, I compare my numbers with the normal force working in Canada. The big challenge we had...and as you know, we don't have a union with the RCMP, but a member rep said the mission is costing a fortune. We said, no, they're not sicker than you, etc. At the end of the day, that was the rationale for building up these statistics. So at the end of the day, because of rigorous screening, these members were not sicker, etc.

To answer your question, I was a member of the Quebec Association of Occupational Physicians, and we didn't have a special forum for that. It's a subject of discussion continuously. But should there be one with the force? Yes, because there are a lot of professionals—psychiatrists, psychologists, occupational physicians.

Funnily enough, we had one for pain, for all the chronic pain. We had a meeting with the judges and all the doctors, because for pain they all use narcotics. We don't like narcotics because there's a lot of dependency. I saw a forum for that, but not for PTSD specifically.

● (1005)

Mr. David Sweet: When I look at your resumé, I see that your experience is mostly with the RCMP. How currently did you have exposure to the military?

I'll tell you why. Mr. Stoffer asked the last witness about psychologists in the field, and we have since had a response. We have three psychiatrists at the Kandahar airfield, and Colonel Randy Boddam also leads a team of mental health nurses and medical technicians. But I thought I'd heard you felt there was no psychological profiling done on enlistees. I can understand that maybe we haven't gotten as far as family.

Dr. Robert Belzile: From what I saw here in the pre-deployment and our medical support to the Canadian Forces operation, I didn't see any. Now, I'm not in there working, so I can't answer more specifically. In the RCMP the health team, on a regular basis, once yearly, visited our members everywhere. We didn't see them when they came back on a stretcher; we visited positively.

I know the force has inside medical support, but this is for the broken arms, etc. How much are they doing in preventing, assessing, and auditing the risk? It has been a valued situation in regard to our UN mission to go and see the members, not when they're sick, not when they're having problems, but positively to assess the seriousness of the risk and assess the medical profile. Did we make a good decision in sending George, who had some stressful situations, and he made it or not? This could be feasible.

Mr. David Sweet: That's the other question I wanted to ask. I found your testimony fascinating around the resilient personalities who seem to develop character when they're put under stress, and others can become weakened and of course then have a disorder.

I know you have to do an interview as well, but are there any peer-reviewed instruments right now that are out there where you can establish a person's predisposition to having a post-traumatic stress disorder?

Dr. Robert Belzile: Yes, and as you know, the psychologist has the responsibility of testing. I have no problem working with psychologists. They're part of my life and I work with them. They're the specialists, but we doctors do the interpretation. And yes, there are tests to screen out serious illness. How precise are they? They are 80%, and that's good. If I take your blood pressure, or cholesterol, it's the same thing. If you look at all the tests we do on your body every day, you'll find they're reliable and good.

From our ten years of experience, in fact, our position will be that we'll take them and give them a chance. This is the position of Canadian human rights, and I don't have a problem with giving them a chance, because we want a solution, not confrontation. But when we're sure that we have to maintain this level of profile, and then for George we say, we cannot send you because...well, then we argue.

Mr. David Sweet: Yes.

You feel the accuracy right now is about 80%.

Dr. Robert Belzile: Yes.

Mr. David Sweet: These are the early days of PTSD, so you're pretty confident that as we develop more data—

Dr. Robert Belzile: Yes. Definitely.

Mr. David Sweet: That's the one thing we're having problems with: benchmarking from other jurisdictions that are also dealing with the same—

● (1010)

Dr. Robert Belzile: That's the big problem. The military are very concerned about their data. The RCMP is very concerned about their data. That's it.

Somebody—and I don't know who, and I don't have the solution—should share. Usually occupational physicians share that information, because we don't have numbers; we're not there. This is a thing we can share, because we don't have names. We don't have to say that in Afghanistan we had more than in Kosovo—no. We just share.

The Vice-Chair (Mr. Brent St. Denis): Thanks, David.

Thank you.

We're going to Ms. Hinton, and then to Gilles Perron.

Mrs. Betty Hinton: This is fascinating. I have a few concerns, and David just raised a couple of them. I would be very surprised to learn that there isn't any psychological testing done on RCMP, firemen, or military personnel before they're deployed. Surely there's some sort of testing.

You're coming from the RCMP side of it, and I would like you to reassure me now that tests are done as you enter the police academy that tell you what you can handle psychologically and what you can't handle. Canadians would be very reassured to know that there is actually some testing done.

Dr. Robert Belzile: I don't want to make a statement that would.... I can tell you that the only force in Canada that has compulsory periodic health assessment is the RCMP. It's every second year. That's the only force officially, the only police force.

[*Translation*]

Mr. Gilles-A. Perron: Is that the case at the Sûreté du Québec?

[*English*]

Dr. Robert Belzile: No.

I'll tell you how we're getting that. This member from the OPP wants to go to Darfur, and he has never had a medical. He had a medical when he graduated from the Aylmer police force in Aylmer, Ontario, but nothing else. We find out he has blood pressure problems, he is diabetic, and he can't see, and then he's upset because I can't send him to Darfur. This is a hypothetical case—it's not the truth—but this is the situation.

No, the only police force that has this medical is the RCMP. I had to go to the Commission d'accès à l'information. What would be the...?

Mrs. Betty Hinton: Do you mean the Privacy Commissioner?

Dr. Robert Belzile: Yes, privacy. I had to document each question with the commissioner, and it was a very good thing. I substantiated each question of this three-page questionnaire with the access to information, because it was built up to assess the physical and mental capacity of the police officer to protect the public, to have a gun, and to arrest people. When you arrest people, you don't only shake their hand; sometimes you have to be a little more forceful. These questions were blessed by the commissioner.

Mrs. Betty Hinton: I have a great deal of respect for police officers. My uncle was one for many years. You just reassured me. I would like Canadians to be assured that before they give a gun and the authority of a badge to someone, they actually are testing, and I was pretty sure they were testing. If that's going on every two years, that's reassuring in itself.

Maybe you're not in a position to answer this question, but it's one of the standard ones I have. Do you think there's any difference in the needs for traditional and modern-day veterans in terms of PTSD?

Dr. Robert Belzile: Definitely. For the new veterans, we have to have early intervention and do it right away. We have to recognize it, etc. Unfortunately—and this is an observation, not a criticism—the old veterans suffered a lot. I had a few who suffered, and that was terrible, but I think we're doing better with that. These types of committees are recognizing that; the public communication is helping.

We still find these horror cases who have suffered alone. These people have worked for our country. The thing is, as people say, the person resists going to see a doctor. He is military. What do you want? It's the type of question. This guy probably knows more than I do. The military has training—legal training, communication training. We don't know if he is undercover or not, so is he going to tell us the truth? It's an assessment, and you need a specialized person.

Of course, dealing with Veterans Affairs as a family physician—and I'm speaking for myself—is a little difficult. It's paperwork, paperwork; sometimes it's in Gatineau, sometimes it's in Ottawa, sometimes it's in Charlottetown. The thing they say to the guy is that he's missing something. It's always us, the poor family physicians, who did not complete the right form at the right comma. With my experience as a family physician, I try to help these guys. I said I'm a specialist in forms, so I should understand that, and I'm trying to get the communication.

The process is very complicated, to say the least.

● (1015)

Mrs. Betty Hinton: Well, I think we're on the same page on a lot of issues, Doctor.

I'm glad you recognize the difference also between traditional and modern-day veterans. So I go back to the original question that I asked you.

We talk about the traditional veteran, and there was an enormous stigma attached to any kind of admission at all that you couldn't handle what you had gone through, that you had some psychological scarring from it. I've been dealing with traditional veterans for so many years, and I've found that just in the last couple of years many of them are now opening up and talking about their experiences. They're going to talk to children in schools to relay what happened in their lives.

So that healing process is long overdue, but at least that ability to get the message out about what you've suffered, what you went through, is now happening for our 80-plus-year-old veterans.

Going back to what I asked you before, what can Veterans Affairs Canada do to change the negative stereotype for veterans who suffer from PTSD? What can we do that makes it all right for them to say, here's how I feel, here's what I went through, I need help?

The Vice-Chair (Mr. Brent St. Denis): Thanks, Betty.

Dr. Robert Belzile: That's a good point.

Well, usually from my observations they get this message: "You have your pension for PTSD, George, and here's what you're entitled to, psychological support." Then he goes to the psychologist, and the psychologist says, "Oh, they don't want to pay me. They say you need only two visits."

I think there's confusion around helping the member. Once he's entitled, and he's had all this fight, the thing is that there should be a support person. I know

[*Translation*]

for veterans, there is the Royal Canadian Legion.

[*English*]

You could have the communication you were entitled to have. Many times as an RCMP doctor, I told them, "You're entitled to that." But then they'll say, "No, no, if I go more than five times to the psychologist, they'll say I have a problem."

So I think that it's not clear what they're entitled to, it's not clear who supports them. What we have is a liaison officer whom they can call. You know, it's an extension of an employee assistance program. If you call Veterans Affairs, you always have the wrong person at the wrong time. It's very complicated.

I'm a doctor and I have special privileges, even in the RCMP. I know what box to call. But if this box doesn't answer me, where do I go? For the poor little guy, you know.... I had one who called Gatineau; he was in Charlottetown, and it was for a simple thing.

So communication is poor. It needs to be improved. Usually where we have a process, we build it up: "Okay, George, your case manager is Ginette." Well, he calls Ginette, and there's no specific.... If he wants a pair of shoes, it's *x*; if he wants psychological treatment, it's so complicated. So that's what is making life difficult.

They say to me, "Okay, I have post-traumatic stress disorder, I can be treated, I can talk about it, but every time I want something, boy!" These people, unfortunately, get upset with that. They get upset, and then they close the line. They say, "George is upset, don't speak to him". You send him a registered letter; "George, don't call here anymore." You know, that's part of the disease. They get dysfunctional and they don't understand what should be understandable.

So you have to make the process easier, and it's working with that easier process.

The Vice-Chair (Mr. Brent St. Denis): Thank you, Doctor.

Gilles Perron, please.

[*Translation*]

Mr. Gilles-A. Perron: Robert, I guess I'm going to get into some gossip here. You can either confirm or contradict what I say. I think there are some serious problems. I have been interested in post-traumatic stress disorder since 1998.

I want to say something to Ms. Hinton. Yes, there are a lot of older veterans, the ones who fought in World War II and the Korean War, who have serious problems. Since 1998, every year, on November 11, I attend the ceremony marking the end of the First World War. When you see men 85 and 90 years of age crying, it's because they have problems—mental problems. This is not the kind of event that should move people to tears. If a veteran cries, if he trembles, it's because he has problems.

The other thing that happens with our older veterans—and Pierre, who is here today, can confirm this—is that they get together at the Canadian Legion. I have nothing against that organization, but the guys deal with their post-traumatic stress by knocking back the gin. That's what they've been doing ever since they came home from the war, because before the war, they didn't have a problem with alcohol.

The wife of the President of the Canadian Legion in Deux-Montagnes, Victor Smart, told him that he was a good guy, but that his way of dealing with his mental problems was to knock back the gin. The way to treat post-traumatic stress is to change the attitude that is prevalent in both new and older veterans, which is that a soldier or a guy who has been to war and has mental problems is weak, a nobody. At Valcartier, psychologists work on the second floor: soldiers call it the "stairs of shame". They climb the stairs to the second floor to meet with someone who is going to check to see whether they have problems—between the ears, that is. I have to apologize for using such a vulgar term, but the fact is they are considered to be fags. We must try to get rid of their fear of receiving treatment.

There's another problem I'd like to raise—I have no experience in this area—and you can tell me whether I'm right or not. Towards the mid- or late-1990s, people began to take an interest in post-traumatic stress. I'm wondering whether we currently have enough psychologists with training in that area, or in something similar, to identify people with the disorder and provide the appropriate care. Should we not be training more of them? I get the feeling that it may be a new science or a new disorder for them as well. Could we not do something to try and train more of them?

I also want to answer David. In the Canadian Armed Forces, as Ms. Brillon pointed out—and she does deal with Valcartier, Quebec—there are no psychologists.

● (1020)

Dr. Robert Belzile: Since they don't consult a psychologist voluntarily, we decided to go and visit them and to do our own assessment.

When I go to Port-au-Prince, the psychologist and myself each take half the members and arrange meetings with them. We have a short list of questions we ask them to determine whether they are experiencing stress and how they're functioning. We visit their facilities and then we do our evaluations.

We should be doing this for the solders currently in Afghanistan. The people on the ground there now who are giving them band-aids are not the ones that should be doing that. I don't like the word "audit", but it refers to the kind of assessment we carry out. In my case, when a soldier comes back, I tell him to come and see me. That's what we do. We identify the health issues, and that's what has to be done.

There is also a second aspect to this. There are a great many psychologists in Canada, but there are not enough of them with expertise in post-traumatic stress disorder, and it's important to ensure that they know something about this. In other organizations, people wanting to treat PTSD were told they would be given training as to what to expect and what our objectives are. That is a form of agreement that we reach with these people.

Whether they are inside the Canadian Forces or not, the problem is that their salary is paid by the same organization in both cases, and there can be an appearance of conflict of interest.

Supposing Dr. Perron is the Canadian Forces psychologist and a soldier wants to come and meet with him. That person has the ability to take away his right to function, and so on. So, there has to be a Canadian Forces psychologist to set the standards to determine what he will be paid by way of compensation, how that will be done, who is to be referred to independent resources, and so on, but initially, that person has to be seen by an independent psychologist, and then by the military psychologist who can validate the decision. We cannot—and that is the problem in the Canadian Forces—ask a psychologist to diagnose PTSD, to treat that person and then decide when he can resume his duties. Unfortunately, a single person cannot wear all three hats.

From a professional standpoint, the Canadian Forces need psychologists to assess what their requirements are, keep statistics and pass them on to the committee to determine what needs to be done, but there is also a need for specialized resources. Furthermore, you can't make a soldier travel from Halifax to Montreal, or from Montreal to Vancouver, and so on.

It is possible to build such a system. I have worked for national organizations. We had our psychiatrists and our psychologists in each region, and each province, whose work was validated by an administrative psychologist who would tell us that such and such a treatment would not necessarily work. So, there are proven treatments out there. But you need to be careful, because people suffering from PTSD are manipulated by all kinds of psychologists. As far as we're concerned, the treatment has to have been proven. Sometimes someone suffering from PTSD will be told to go and consult a naturopath and eat flaxseed, and so on, but that won't help him boost his moral. And that's the reason why we need people who know something about this. The Canadian Forces needs psychologists, managers, and external specialized resources that are authorized by the Canadian Forces and can work independently to provide a diagnosis. And we need to be visiting our military personnel on the ground to see what is happening in Afghanistan and what level of stress they are exposed to.

We had a questionnaire for assessing the stress level. We want to know whether all our people in Afghanistan are sleeping properly. We can find that out by visiting them. In occupational health and safety management, it works on the basis of a pyramid model. At the base, if you have a lot of people who are not sleeping, there will be other ones at the top of the pyramid who are depressed. That is absolutely clear. That is how you manage it. So, when you go to see these people, if you see that they have huge bags under their eyes and that they haven't slept for a week, and that when you go to bed there you can't sleep because there is too much noise, that gives you an idea of the stress level. And the next day, they have to operate a tank, and so on. It's when they're exposed to stress that they are likely to go to pieces. So, that environment has to be known to you, because when people suffer from PTSD, what is important is what is going on in their head before, during and after.

● (1025)

[*English*]

The Vice-Chair (Mr. Brent St. Denis): *Merci.*

We have Mr. Cuzner. Peter was delayed due to a flight, so we're going to put Peter in, if he'd like, after Rodger. Then we'll go from there.

Thank you.

Rodger, go ahead, please.

Mr. Rodger Cuzner: I've just one question.

With your CV, it's obvious that you have international experience. I'd like your comments on how we stack up against other nations. Are there areas in which we lag behind in dealing with PTSD? Are there areas where we're really at the forefront, things that we're doing really well? Maybe we could have your comments on that.

Dr. Robert Belzile: I can speak only about the police force. I think there we're very proactive. We're proud of the program. In fact, we're one—

Mr. Rodger Cuzner: But you exchange with other police forces in the States?

Dr. Robert Belzile: Yes, because when we go to Port-au-Prince, Haiti, we visit all the police forces there and we visit the members. As you know, our members are scattered with other members from around the world, so we know.

Our pre-deployment, medical and psychological assessment is unique. Maybe France or another country like that has something, but the Americans were not there where I went. In regard to the visits, they find that excellent.

We visit all the UN and all the people. It's not a secret that Canada has an excellent reputation in regard to international peacekeeping missions most of the time. I think the chief of police officers in Abidjan, Côte d'Ivoire, was an RCMP member. The one presently in Haiti was also an RCMP member. So our reputation is good.

But this liaison that we have through the deployment of police officers with the UN creates more credibility. We improve the UN process, and it's an observation, not a criticism, that sometimes it's long and complicated, etc.

So in terms of the police officers, I would say we're proactive and we're very well respected. We're doing an excellent job. You could go and ask our members who work under our responsibility, and they would say the same thing. I hope so, anyway.

The Vice-Chair (Mr. Brent St. Denis): Rodger, is that okay?

Mr. Rodger Cuzner: Yes.

The Vice-Chair (Mr. Brent St. Denis): We'll go to Peter, and then I have nobody else on the list. Is there anybody else who wants to go on after Peter? David?

Mr. David Sweet: I just have one quick point.

The Vice-Chair (Mr. Brent St. Denis): Okay, then it's to Peter, and then to David.

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

I apologize to the witness for being late this morning.

Sir, Pascale Brillon was here as a witness at our last meeting, and she indicated that there is evidence that PTSD can be transferred from the person who has it to a spouse or quite possibly their children. I assume it would be the same for the RCMP. Would that be correct?

● (1030)

Dr. Robert Belzile: Yes. Funnily enough, I haven't heard it stated like that, but as you know, the successful way to reduce the risk when you come home is through family support. But when you come back from a mission, either as a police officer or a member of the military, you don't speak to anybody; you stay in your room, and it gets harder. The poor people who don't have the background education make the situation worse, so that's why they need to be trained.

Can they be upset when you come back and you don't speak and you're crying all the time and you start drinking? Of course. It can be a major stress. As for it being PTSD for the family, the psychologist is better than I am in terms of coming to that conclusion.

Mr. Peter Stoffer: I'm not sure if you had a chance to read it, but in *The Globe and Mail* today, they had a front page story about some children of some military personnel in Petawawa who are going through some pretty serious concerns. I won't get into the argument of who should pay for that, but there is no question that the family support is critical to assist.

Obviously when anyone is coming back from a tour of duty, from what Madame Brillon talked about, they've seen some pretty serious things, and some things we couldn't even imagine. I know we're short of psychologists throughout the country for this type of analysis, but should not the federal government or the department, in your view, try to do more to assist not just the veteran but the family members themselves?

Dr. Robert Belzile: Definitely, and as you know, we do it. If you're working for External Affairs, they'll book your family. When I went to France thirty years ago with my father, I had a medical. They do that. When we send families to the north, we assess all the children, because they're going to Iqaluit for the next three years.

The support definitely has to be done beforehand. We start that with the RCMP before you arrive, as I said. Sometimes we have problems with human rights, though. For example, you don't want us to see your wife to see how the situation will be when Peter comes back. But most of the time it's done on a voluntary basis, and about 90% participate.

It would be very interesting to inform the kids. As an occupational physician, I believe you cannot have too much information, if it's well done. You have to be transparent and advise them of what the risk is: your father's going to Afghanistan, and yes, there are some terrible casualties, but there's also the other side. It's a risk assessment.

These poor families are alone. They probably get their cheque, and if they go to see a psychologist, they have to fight, etc. I'm concerned about that. We need to help the member's family, because that's part of their life—more so if there was a death, and more so if the guy is sick and is not feeling well.

That's why there's the transition. That's why we have an aggressive employee assistance program that contacts the members once they're back. In fact, we see them a month after and three months after they get back, and we all have data on how they are. He won't call us, but we call him and say he needs to do a debriefing. The debriefing is not official, and I know there's a lot of controversy about that. It just asks him how he's doing, and we even speak to the family, because sometimes he doesn't know he's all upset. It's not evident.

So that's why we do the family assessments both before deployment and after deployment. Particularly in critical missions like Afghanistan, they should be assessed.

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

Merci.

The Vice-Chair (Mr. Brent St. Denis): I will go to others on my list. I have short questions from David and Gilles. Then we have a little bit of business after that, colleagues, so please stick around for a few minutes.

David.

Mr. David Sweet: Doctor, after hearing the aggregate of your testimony—you were talking about surveillance as well as this pre-deployment assessment and then, of course, the repatriation interview, debriefing—I think much of this workload could be handled by general practitioners like you who have an occupational speciality.

Dr. Robert Belzile: Background, yes.

Mr. David Sweet: Just to use some numbers, 80% of that workload would be in those areas, and the real specialists—psychotherapists, psychologists on PTSD—would be there over-seeing, validating the instruments that you're using, those kinds of things.

● (1035)

Dr. Robert Belzile: Definitely. That's what we do here in Ottawa. We have our outside consultants, who are specialized and follow the rules of confidentiality, etc. It's not done in-house. There's greater credibility, more communication. If I talk to the guy who's in charge of giving my profile where I'm going to be working when I come back.... We don't want that to be a problem. It has to be a solution.

So yes, and this could be feasible all over Canada.

Mr. David Sweet: Now that you've answered in that fashion, that leads me to this. I asked a question of the last witness regarding training for medics and other personnel. Really, on the briefing and the training on this, as far as a lower-level camaraderie issue to help people.... From what I'm hearing, everybody has a reaction to stress; it's just how they recover from it.

Dr. Robert Belzile: That's it.

Mr. David Sweet: There could be a significant amount of training happen for the rank and file and for those in supervisory positions, to be able to not only recognize but also help after a fire fight in order for all the comrades to decompress, etc.

Dr. Robert Belzile: After a critical incident we do a post-mortem, and sometimes a doctor is there just to have a debriefing and discuss it. It's not individual.

Definitely the co-workers are the key, because they know you are reacting differently from usual. And we train people. You don't want them to say to Gilles, “Hey, you're a little crazy.” They have to be polite. So they say, “Gilles, you're reacting differently and I feel you should see someone.” That's the type of rapport we're trying to get with co-workers. They're helping, because if they put a gun in his hands and he doesn't feel well, there could be a critical incident.

Sometimes you're scared when people act differently. You need to train people. It's not a problem to say, “Gilles, you should take a few days off—I see you're nervous; you don't see it—but you should.” That's the type of rapport we need to build up. We do that with police officers where we have a detachment of two police officers. We have no choice, because the other guy is saving a life. So if he's sick, you have to do something.

The military is the same thing. You work as group. So if you know you're working with George and he's not 100% and you're in a tank with him, if you have a problem, you know you have a problem. This is the type of rapport.

How much is built up? I haven't seen it yesterday, but I know this is the type of build-up we're trying to create between colleagues.

Mr. David Sweet: Thank you.

The Vice-Chair (Mr. Brent St. Denis): Thank you, David.

Gilles, for the last question.

[*Translation*]

Mr. Gilles-A. Perron: Can I make another comment, Robert?

I don't want to sound defeatist, but it seems to me we have a long way to go before we can take better care of these people. Even for the older veterans, we need to do a lot of training: training among the commanders—along the same lines as what David Sweet was saying—training for senior military people who are working on the ground and who can try to see what's going on.

It's not that they're doing it wrong, but they don't have any training when it comes to human behaviour. They may wonder why someone is behaving a certain way. Maybe it's because that person slept on the wrong side of the pillow or had something to drink the night before. Even I would be unable to determine whether someone has symptoms and if we should be asking ourselves certain questions. People need to be trained and made aware of this problem.

At the present time, the military doesn't recognize the existence of PTSD. During training on military bases, when young people experience stress, they are told they are suffering from serious nervous depression, with all the symptoms of post-traumatic stress disorder.

Robert, I want to thank you for this, because I believe you've helped us to see the direction we need to take. It rounds off the discussion we had with Dr. Brillon on Tuesday. I am taking the liberty of thanking you, because I am the one who suggested you be invited.

Dr. Robert Belzile: I want to thank the Committee for inviting me.

[*English*]

The Vice-Chair (Mr. Brent St. Denis): *Merci beaucoup,* Dr. Belzile.

Thank you to Gilles too for his initiative, and the support of all colleagues, on the PTSD.

We thank our witness.

Colleagues, we have a bit of work to do. so we'll just take a two-minute break to allow our witness to go.

There's a request that we go in camera for this discussion.

[*Proceedings continue in camera*]

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

Also available on the Parliament of Canada Web Site at the following address:
Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante :
http://www.parl.gc.ca
