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● (0910)

[*English*]

The Vice-Chair (Mr. Peter Stoffer (Sackville—Eastern Shore, NDP)): Good morning, everyone. *Bonjour, tout le monde.*

Our chairperson, I'm sure, will be here momentarily. In the meantime, I'll sit in for him.

We have a reduced quorum, so we'll proceed with our witnesses. We're very grateful that our witnesses are here today to discuss the subject at hand. We'd like to welcome Colonel Donald S. Ethell—

Now that the chair is here, I shall go back to my normal spot. When the chair sits down, please feel free to introduce your colleagues, and then carry on in your normal way.

Thank you.

The Chair (Mr. Rob Anders (Calgary West, CPC)): I take it you've been introduced? I heard somebody say they want to introduce themselves, so I'll let them do that.

Colonel (Retired) Donald S. Ethell (Chair, Joint Department of National Defence and Department of Veterans Affairs Operational Stress Injury Social Support Advisory Committee): Mr. Chairman, ladies and gentlemen, first of all, thank you very much for inviting us to appear before you today.

As Mr. Stoffer indicated, my name is Don Ethell. I'm the chair of the Operational Stress Injury Social Support Advisory Committee. With me are the two co-managers, one from DND and one from VAC. Major Mariane Le Beau is the program manager of the program in the Department of National Defence, and Ms. Kathy Darte is the co-manager from Veterans Affairs Canada. They are two of the hardest-working people on behalf of veterans and serving members.

Some hon. members: Hear, hear!

Col Donald S. Ethell: They paid me to say that!

Also with me is Lieutenant-Colonel (Retired) Jim Jamieson, master social worker, and he is the DND medical adviser to the OSISS program.

Can I carry on, sir?

The Chair: Yes, please.

Col Donald S. Ethell: You have been given a printed version of our brief. It's multi-coloured and it's in PowerPoint format, but it's very easy to read through. We will be referring to that as we go through our brief presentation at the beginning and then of course during the Q and A.

I'll not be reading all of the slides, obviously, but rather we'll just touch on a few of the high points and focus on what's new in the operational stress injuries social support program, the key determinants of its success, and the major challenges that face the organization.

I am sure most of you are familiar with the term “operational stress injury”. At the risk of digressing for a moment, that term in fact is a Canadian invention by the OSISS team, and it's been inherited internationally, which we'll get into when we talk about international activities.

As you know, OSI is not a diagnostic term, but rather a term developed by the OSI social support organization to put focus on the injury and to work towards destigmatizing the condition. The term is now in wide use by clinicians and non-clinicians as a way to encompass all operational-related mental health injuries—and, as I mentioned, nationally and internationally. I'm sure if the question comes up during the question period, these two officers with me here can attest to their participation on international forums in NATO, in Europe, and of course a lot of time in the United States, working with their colleagues who have served in the Iraq war.

The presentation package includes a background of the OSI advisory committee. This group was formed in 2002 and brings together a group of interested people from Veterans Affairs, Defence, veterans organizations, the RCMP, the ombudsman's office at DND, and various mental health professionals three times a year to provide advice to OSISS and feedback to senior management in both sponsoring departments.

The terms of reference are included in your package, but very briefly, it's to provide advice and guidance to the OSISS management team to improve delivery; to help identify systemic gaps or shortcomings in the peer support program; to assist the OSISS management team in coordinating the program; to deliver aspects of the peer support network with respect to agencies and departments; and to actively take part, where and when possible, in raising awareness of the OSISS program. As chair, I emphasize this to all of the committee members, recognizing that we don't have any executive authority, but they're encouraged, as they put it, to spread the gospel in regard to the outstanding success of the peer support program. The composition is 24 members, and they're listed in one of your handouts.

OSISS itself—you'll notice I switch from “committee” to “OSISS”—came into being within DND in the spring of 2001 in response to input from SCONDVA, the Croatia board of inquiry, and the DND ombudsman's office. Shortly thereafter, recognizing the shared responsibility for the welfare of Canadian Forces members and veterans, a partnership was formed with Veterans Affairs Canada.

OSISS was clearly the result of the vision and drive of one officer, Lieutenant-Colonel Stéphane Grenier. He is not here today because he has finished his tenure. He's a PTSD sufferer.

● (0915)

He served in Rwanda with General Dallaire for 10 months. He returned home, recognized he had a problem, but he lived with it. In fact, he was deployed to Cambodia, to Haiti, to Lebanon, and so forth, fighting that problem. Needless to say, at a certain point he did talk to sympathetic superiors, not the least of whom was the then General Dallaire, who was followed by General Couture—may he rest in peace—who became a champion of the OSISS program. By the way, although he's still a PTSD sufferer undergoing treatment, Colonel Stéphane Grenier is serving in Afghanistan as a public affairs officer. He says it's time to get back on the horse, and to his credit that's exactly what he's done. He has been decorated by the Governor General with the Meritorious Service Cross for his drive and initiative in establishing this program.

He's moved on, but he's been ably replaced by Major Mariane Le Beau, who, as I indicated, is an extremely hard-working officer and very dedicated, having spent many years—and has served in Afghanistan. The co-manager, of course, supported Stéphane Grenier from the start. Kathy Darte is one of the originals, as we call her, and works very closely with her colleague in DND.

The mission of OSISS is twofold: to develop social support programs for members, veterans, and their families who have been affected by operational stress, and to provide the education and training that will eventually change the culture toward psychological injuries in the CF. I emphasize “families” because families always have been important to those who have worn a uniform. Having served on 14 separate missions and having had to leave my family behind, for the most part, I can be very sympathetic with the emphasis on family as brought out with the recent passage of the new veterans charter.

The key to effective peer support, which is the heart of the OSISS program, is the initial selection of the right kind of people, the peer support coordinators and, recently, but gathering momentum, and rightfully so, as their peers, the family peer support coordinators. The numbers I will leave to the questions and answers, and they will be answered by my colleagues.

Aside from the basic two-week training course the peer support coordinators and family peer support coordinators always see, the OSISS program runs a far-reaching continuous education phase as well for both those groups, recognizing that they also have a need for self-care, which I'll leave to my colleagues in the Q and A.

In the end, it all comes down to developing trust with the members, veterans, and families who come forward to talk to a peer support coordinator, wherever they may be and wherever they are referred from, technically through DND and VAC. They may meet in an office, or, if they don't like that, maybe they'll meet in Tim Hortons, so they can talk the issues through and make the informal assessment and refer them accordingly, developing trust with members and veterans who come forward, allowing them to proceed at their own pace, and providing a supportive shoulder to lean on. If you wish, we can get into some personal experiences in the Q and A.

It's essential that the peer support workers understand the role they play, understand when to pull back, and be willing to refer the peer to a professional resource, a clinical resource. The danger of the peer support coordinator is burnout, compassion stress, trauma, depression, and physical illness. What is absolutely amazing and a testament to both the quality of the people involved and the level of care provided by both departments in this program is that there have been very few such problems in the five years this program has been running.

There are several new initiatives to talk about in OSISS, which you are welcome to pursue in the question period. The new bereavement peer support initiative delivers support to the immediate families of those who have lost a loved one in military service, again to be delivered by those who have been through a similar event. Notice the emphasis on the word “peer”.

There is considerable international interest in the success of this program, and, as I mentioned, both of the co-managers can talk on these approaches at some length.

● (0920)

The third location “decompression” operation in Cypress provides members rotating out of Afghanistan with an opportunity to spend a few days transiting from a theatre of war to their living rooms, all as part of a significantly enhanced redeployment program. Having personal experience with it, I can assure you that the program is successful. We have dragged in several people who were under my command who had been involved at the massacre sites and so forth. We were not going to send Captain X back to his wife 24 hours later. He had to be decompressed, which meant going away for three or four days and possibly being able to talk the issue through while receiving some peer support and a shoulder to lean on, as I indicated.

We have learned that there are several key determinants to success in a program like this. First, and perhaps most importantly, is the need to involve peers right from the beginning of the program development and policy. An excellent interdepartmental partnership is essential to success, as is the use of a multidisciplinary management team. The emphasis on self-care and realistic boundaries has been another key area.

As I mentioned in the beginning, the recruiting and screening of the right people is essential, and perhaps the area where this program has excelled, in my opinion. To help provide relief for that key group of peer support personnel, recruiting, training, and retaining a network of volunteers is vital.

This is all a fallout of this interdepartmental cooperation from ten years ago, when they were at both ends of the table. I guess they would talk, but since the new veterans charter, or starting with the Canadian Forces Advisory Council and the workups—and I'm getting off the subject here—a number of us in this room have been intimately involved in this process. It's very heartwarming to see that the two departments have come together. In other words, as recommended by the council, it's a seamless approach. That's where we are now, and these two officers here are examples.

In terms of challenges, there are certainly many out there. For example, there are still a number of systemic barriers in place. Some clinicians are still suspicious of non mental health professionals meddling in their business. I don't know if I'm allowed to say this, but having read some of the transcripts from previous witnesses here, I think you can understand that there is some hesitation by the professionals in regard to the peer support business. On the other hand, others who have experienced the value of working with a peer support coordinator literally sing their praises in both departments.

Just the physical size of the territory covered by this very small group of peer and family support coordinators is amazing when you recognize that there are currently only five OSI clinics from Veterans Affairs in place and a number of OTSSCs from DND. Especially for reservists who may live far from a major base, getting to where we have a peer support coordinator can be a real challenge.

Growing the volunteer network that I referred to is another challenge that our PSCs face each day—and I might add that it is their responsibility, in part. Once the investment has been made to find and train these folks, retaining them becomes another challenge. The peer support groups that are such an important part of this program also take a lot of effort and significant resources because many peers are reluctant to meet at on-base facilities. As I indicated earlier, even finding a place to meet can be a problem. That's why I indicated that sometimes they meet at McDonald's or Tim Hortons.

I'll just back up to that point because there are a lot of soldiers who will not admit they have a problem. They do not want to be seen going into a “mental health facility” or some facility like that on the base. They'll be identified, and in their mind, that's not good or it's not macho—if you want to use that term—since they have to stand up and brush it off. So there are avenues for them to approach.

● (0925)

The last challenge on the list is certainly not the least. Let there be no doubt that the culture of the Canadian Forces, in dealing with mental health issues, has changed significantly in the last six years or so. However, there's still a long haul ahead, and to my mind it will never completely go away. We have to continually fight the fact that there shouldn't be a stigma associated with an operational stress injury, including PTSD and the other subtitles.

Education and training are the key to cultural change, and as is often the case, the long-term investments are frequently overtaken by the shorter-term demands. To even sustain the gains made in the last few years, great effort is required, and this is, and will remain, a constant challenge.

Ladies and gentlemen, just before I finish, this very successful program is funded by both departments, of course, and 75% of those who are serviced are in fact veterans, and 25% are serving members, plus or minus a few percentage points, and I'll be corrected by these officers if I'm wrong on those figures. But it doesn't make much difference, because, Mr. Chairman, it's understandable that those percentages would be there because the uniqueness of this program is that a lot of the veterans, be they Korean War vets, be they Beirut war vets, be they vets of Yugoslavia or the former Yugoslavia and so forth, are coming forward: “I've got a problem”; “I was bombing out of Aviona and I've got a problem”; “I was part of the Swiss Air cleanup and I've got a problem”; “I was on that aircraft that crashed short of Alert and I've got a problem”; “I'm a SAR tech and I've got a problem”. These people are coming out of the woodwork, and they may be retired. So this program, in my mind, is literally an outstanding success.

Thank you for your attention. With that, I'd like to invite your questions. If you would address to them to myself, as required, I'll direct them to the appropriate officers, sir.

The Chair: Thank you very much, Colonel Ethell.

I take it you're the prime presenter and the other people will not be adding anything at this particular moment but will come later as questions arise?

Col Donald S. Ethell: Yes, sir.

The Chair: Okay. Thank you very much, Colonel.

All right. Well, over to our Liberal friends.

Mr. Valley, for seven minutes, to begin.

Mr. Roger Valley (Kenora, Lib.): Thank you very much. It was a very precise presentation.

I have quite a few questions; I'm sure the chairman will cut me off. But just quickly, on your map of the family support network, southern Manitoba, Shilo, is that the base?

Major Mariane Le Beau (Project Manager, Operational Stress Injury Social Support Advisory Committee, Department of National Defence): It's in Winnipeg.

Mr. Roger Valley: My daughter is at the university in Brandon, and she was part of the volunteer family support that dealt with some of the issues when we lost people out of the base. I hadn't connected that until I actually looked at the map and remembered some of the calls she made back home.

You mentioned the systemic gaps and shortcomings. Can you give us something quickly on what that would be and how we've addressed the systemic gap?

Col Donald S. Ethell: I'll hand it over to the two co-managers, if you don't mind.

Maj Mariane Le Beau: Yes, I'm sure each of us has something to say about that.

I guess for me, one of the most important systemic gaps is the culture issue, which has been identified as one of the very last items. On mental health issues in Canadian society at large, I don't think I need to explain to you here how much stigma is associated with those in our day-to-day world. You find yourself in a military environment, where it is compounded, where it is more complex, where the stigma is even stronger. So that's definitely one of the big challenges and systemic barriers we have to face. We're working really hard to deal with that.

One of the things we're working on is called the speakers bureau. This is specifically hiring volunteers, peers, who have suffered from an operational stress injury, who have recovered, who are screened and trained and are delivering operational stress injury briefings within the CF at leadership courses, at professional development courses, to help destigmatize and tackle the issue of the culture.

● (0930)

Mr. Roger Valley: That's just about education, about talking, about bringing it into the open, in plain language.

Maj Mariane Le Beau: Indeed, sir.

Kathy.

Ms. Kathy Darte (Program Co-Manager, Operational Stress Injury Social Support Advisory Committee, Veterans Affairs Canada): I would add to that and just stress that we continuously, through this program, are heightening the awareness and educating people on what it's like to live with an operational stress injury, what it's like to the individuals themselves, and also the impact it has on their families.

We're not struggling with it. Being with the program from the very beginning, I have seen these gaps narrow considerably. There were many gaps when Lieutenant-Colonel Grenier and I started in 2001-02, but there have been significant changes for the better.

All of the workers in this program who provide the support have an injury themselves, all of the peer support workers; we call them coordinators. All have a diagnosis of post-traumatic stress disorder, anxiety disorder, or depression. They've all been through treatment. They've all recovered to the point where they can continue to work on a daily basis. That's a very challenging thing to do, to work with others who you see in the same place that you were in many years ago. What they do is act as beacons of hope, because they become a prime example of early intervention, getting into treatment, sticking with treatment, that you can recover and get back to where you were prior to receiving your injury.

So we are very cognizant of that, and we work very hard to ensure the health and well-being of the folks who work in this program, that they remain healthy to do the work, because it's very, very challenging.

Mr. Roger Valley: Thank you.

Colonel, you mentioned the emphasis on family, the social support for families, which we've talked about a lot here. You're very clear on your passion for the families. Can you tell us, when did it start? You gave us quite a history. When did we realize that families were the biggest part of the support network that needs to be there for this stress? Has it always been there? Was it there 30 or 40 years ago? Was it there 10 or 15 years ago?

Col Donald S. Ethell: That's a good point. You can go back 40 years. I think back to when we were stationed in Germany—a young family—from 1960 to 1963 with a battalion. That was when the Berlin Wall was going up and the Cuban crisis was going on and so forth. When you were deployed, there was always a concern about what was going to happen to your family. Well, they had to find their way to the base and they would eventually get backloaded to Canada. That was the extent of the family support. Thank God for the regimental system, because it would kick in.

But since then, leaping ahead, as I keep bringing up, the Veterans Affairs and Canadian Forces advisory council was asked to come up with recommendations regarding a charter: either amend the old one or have a new one. During those deliberations, Mr. Pierre Allard, who is here today, from the Royal Canadian Legion, was a member of that council, as I was, and a number of us were tasked to go to various bases to talk to the troops informally, 30 to 40 people, privates to captains, a couple of ex-warrant officers, without any names taken, to have a round table discussion, with the consent of the base commander, with the consent of NDHQ, and so forth. We were supposed to do three—the army, navy, and air force—and we ended up doing eighteen of those.

Concurrent with our movements were two female members of our council who were there to talk to the families, sometimes at the military family resource centre, and sometimes they didn't want to meet there and would meet someplace else, at reduced numbers. It came out loud and clear, not only from the troops we talked to, that first of all they were grossly overtasked and stressed right out. They were stressed out, and the people who were left back were stressed out. When you have a section of four and three of them are gone, and one person has to do everything, what effect did that have on the family? Our family team brought it out loud and clear when we made the presentation to the deputy minister and others, and eventually to the minister, and it was accepted, that of all the things we were considering at that time, family would be at the top of the list. Believe it or not, ahead of the veteran, family would be first.

That report was passed and accepted by the minister and his department with the drafting of the new veterans charter, and so forth. So that's where it started. Since then, of course, as you've heard, this program has evolved in the last five years. It was written initially by Stéphane Grenier at his kitchen table: How am I going to influence the system to help my peers? And by the way, my wife has a problem too, because I have become a recluse. I've become a recluse, she's become a recluse, and there's an effect on the family.

That's not just unique to Grenier; it's unique to a number of us who have gone through that process: Where can we get some help? So the family has to come into it, but you have to walk before you run. The idea was, with the two champions of the OSISS program at the time, General Couture and ADM Brian Ferguson from the Department of Veterans Affairs, let's move forward, get the peers running, and we will address the family.

It may sound like, well, okay, bring the family along. They were brought along, and they're both together now and they're both being addressed. I'm getting into the business of the two co-managers here, but from my understanding, they're both being addressed. Sure, there's lots of work to be done.

Kathy or Mariane, do you want to add to that?

● (0935)

Ms. Kathy Darte: Colonel Ethell is correct, yes, families have always been part of the OSISS program. Our mission statement says it's for CF members, veterans, and their families. They've never been excluded from our program. They've been there from the very beginning in terms of design.

This program started off as a project. In the pilot phase we started with only four people, who happened to be veterans themselves. Then we implemented the family part. The family component of the program was fully implemented in 2005.

So yes, families are very much part of the OSISS program.

Mr. Roger Valley: Thank you.

Maj Mariane Le Beau: I would like to add something here.

Considering that I joined the program just last summer, I feel I have a wonderfully objective view of it, and I really want to make it clear that there was no blueprint. The OSISS program is a unique program. It does not exist anywhere else. The training and the way it functions is unique. It started slowly, with four peer support coordinators, and soon we'll be at thirty.

That's all I wanted to add.

Mr. Roger Valley: Thank you. Your passion for it is obvious.

The Chair: Thank you, Mr. Valley.

Monsieur Perron for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good morning and welcome, ladies and gentlemen.

I'm going to try to direct your attention to a similar matter, which is part of the situation, but which is not discussed enough. Yes, it is good that we recognize the people who suffer from PTSS, but what efforts are we making to prevent it? I'm speaking mainly to Ms. LeBeau, because I'm curious. When they are deployed on a battlefield or in a theatre of war, do recruits really receive training that enables them to assess themselves, detect any stress problems and decide to consult someone immediately? Are they trained for that?

Second, is there any qualified personnel, psychologists, and so on? I've been told that, in Afghanistan, for example, if it is discovered that someone has symptoms of post-traumatic stress, he or she is sent to an American or someone else or to the chaplain. Do we have qualified personnel?

My last question is really typical. There's no answer to it, but I ask it nevertheless. If we could have a good system, get organized and contribute to the superhuman effort you make when they come back from over there, how much money would we need? We're constantly short of money. Would it be better to invest in qualified personnel to treat people than to buy a C-130 or C-17 aircraft? What are our investment priorities?

● (0940)

[*English*]

Col Donald S. Ethell: I'll ask Major Le Beau to answer the first one and then I'll answer the second one.

Maj Mariane Le Beau: Actually, since Mr. Jim Jamieson is the medical advisor to OSISS from the Canadian Forces—

Col Donald S. Ethell: Good point.

Maj Mariane Le Beau: —I'll ask him to pitch in here as well.

[*Translation*]

I'd like to answer in French.

As regards recruits, you ask what training they receive. In the past two years, the Operational Stress Injury Social Support Program, our program, has systematically offered all recruits entering the Canadian Armed Forces an approximately three-and-a-half-hour session on operational stress injuries. That's a considerable effort; that's a lot of training hours.

Mr. Gilles-A. Perron: Three and a half hours per recruit is a lot of hours?

Maj Mariane Le Beau: A half day during the recruits course is the first stage. The second stage occurs during the master corporal courses. Starting in August, there will be the training at the Canadian Defence Academy. We're only talking about operational stress injuries in this case, Mr. Perron. We're not necessarily talking about stress management or other leadership techniques, but that's nevertheless part of the big picture. That will increasingly be integrated into all Canadian Armed Forces leadership courses. There's also professional development, that is to say a unit or base that organizes training days, and our peers, our coordinators go on site and give operational stress injury training.

In the five years that the program has been in existence, we've seen an increase in requests, in the way in which it is requested and offered. We see that people are increasingly familiar with it. Is it perfect, Mr. Perron? No, definitely not. There are still some people in the Canadian Armed Forces who know very little about operational stress injuries, but we've made a lot of progress.

[*English*]

Jim, in terms of competence—

[*Translation*]

Mr. Gilles-A. Perron: Madam, before moving on to another question, we've just learned that the Royal 22nd Regiment was sent to the United States to train in waging war in Afghanistan. While they were there, were the soldiers told about post-traumatic stress and how to recognize its symptoms? I don't believe so.

Maj Mariane LeBeau: I can't tell you whether that was done as part of that training in particular, but I know that there has been training at Valcartier. They organized peer helper training. They have a resilience program, developed by Ms. Routhier, who I believe was appointed here to prepare the soldiers who will be deployed to Afghanistan. So things are in fact happening.

In terms of the personnel in Afghanistan—

[*English*]

I would like to have Mr. Jamieson answer that question, because that's right down his alley.

LCol Jim Jamieson (Medical Advisor, Operational Stress Injury Social Support Advisory Committee, Department of National Defence): In general terms, there's extensive pre-deployment screening and education. It takes several weeks now, and included in that is a large portion on mental health concerns and mental health first aid. In addition, sir, as you may know, we currently deploy a mental health team with each rotation. There are always social workers, mental health nurses, and usually a psychiatrist in theatre, and now we're adding mental health clinical psychologists.

Post-deployment, the screening is very extensive, with follow-up after six months. We do everything possible to encourage the family to participate, but we cannot compel that. Through the military family resource centres, which Mr. Valley was referring to, there is considerable effort made to assist families pre-, during, and post-deployment. We can get into the details, but I don't think there's a resource problem with that part of it. I think we need to do more for families. I was hoping somebody would ask me to comment on that when Mr. Valley asked the question. There are systemic gaps for families.

Our major operational bases, such as Valcartier and certainly Petawawa and Gagetown are not located near major centres. In the United States, the family gets its medical care, while the member is in service, from the military. We don't do that here, and in a place like Petawawa, there are serious systemic gaps, even in getting a family doctor, much less any specialized care for the family or children when there are mental health concerns. Education and screening are fine, but if you haven't got the resources to plug people into to get the help they need, that's where we have a systemic gap, in my opinion.

● (0945)

Mr. Gilles-A. Perron: And on the last part of my question, Donald?

Col Donald S. Ethell: Sorry, I was listening to Colonel Jamieson there. It's sometimes difficult to understand the problems of the families that are dislocated from a major centre. It's just a fact of life. There's a great shortage of doctors, GPs, throughout the country, let alone psychiatrists and psychologists.

The second question you had was about investing more in qualified personnel versus purchasing aircraft. You said you didn't need an answer, but I'm going to give you the answer. The answer is, I can't answer the question because it's a departmental question. Allocation of resources in regard to military equipment is DND responsibility.

[*Translation*]

Mr. Gilles-A. Perron: Are you lacking funding?

[*English*]

Col Donald S. Ethell: Mr. Chairman, the funding can be described later on, if you wish, by Major Le Beau and Ms. Darte. They can describe what they have now and possibly what they've asked for in terms of the future.

LCol Jim Jamieson: Perhaps I can make a very quick comment.

Within DND for mental health services, the budget is doubling between 2005 and 2010. The number of resource people has gone up from 212 to 400-and-something. I think there's been a lot of realization that we've needed more resources, and certainly there's been a major push in that area.

The Chair: Thank you.

Over to Mr. Stoffer of the NDP for five minutes.

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

Thanks very much to all of you for your presentation.

As you probably are aware, a while ago there was a story in the newspaper about the children in Petawawa. Some of them are going through some fairly serious mental anguish. In the paper it mentioned that there was disagreement on who should provide the mental health care for those children on the base, the province or the federal government.

My own personal view is that because they're on a military base, it should be the military, the federal government, looking after their concerns. However, there is some debate that it should be a provincially run jurisdiction.

Who, in your view, using OSISS, should be looking after the concerns of the children in this particular instance, in Petawawa?

Col Donald S. Ethell: You could go back to when we had many troops in Europe, and the families and so forth, when it was, from my understanding, a DND responsibility. Those days are gone.

I'd like Jim Jamieson to answer this. It's a very important point. We've talked about it, but he's taken it on personally.

LCol Jim Jamieson: Some of us within the department are pushing very hard to do more for families along exactly the line you're saying. As I mentioned before, it is a critical problem.

Let me use Gagetown as an example, because I know it better. We've had money for child psychiatry, child psychology, as well as for just general psychology and psychiatry. We can't find people to go to these locations. So it's partly a resource problem, partly a locale problem.

As Colonel Ethell indicated, we have in the past provided direct medical care to our families. It is a provincial responsibility, and this is the dilemma we're stuck with. I must say, though, that even in the best world, having enough clinical psychologists for children in the Pembroke-Petawawa area would be difficult.

Who should do it? Officially, the province should do it. That's the way the legislation reads.

I guess we're not allowed to express personal opinions, but I think my opinion is pretty obvious when it comes to what I think we should do—namely, a lot more.

● (0950)

Col Donald S. Ethell: If I may, Mr. Stoffer, I'd like to go back to some testimony made in front of the Senate subcommittee, on November 22, by General Yaeger, the Surgeon General. When asked, “Is the challenge money?”, General Yaeger gave the following answer:

> No, senator, the challenge is not money. It is simply availability of appropriately trained people who are willing to come to work for us either in uniform or as public servants or civilians under contract.
>
> If I had a magic wand, I would wave it on mental health providers at the moment. As of today, that is our biggest challenge in hiring.

And that's what Jim Jamieson was articulating.

Mr. Peter Stoffer: Okay.

In your brief, I notice you have circles that show DND and VAC together. They're combined. But Health Canada would play a role in all of this. What role does Health Canada play in assisting OSISS and the people in that organization? Or do they play a role?

Col Donald S. Ethell: I'm going to ask Kathy Darte to talk about Ste. Anne's and so forth.

Ms. Kathy Darte: We have not been directly involved with Health Canada. The circles there show the partnership for this particular program. In this particular program, there is no eligibility requirement to come forward and access the services of OSISS. When families and children come forward to access service from our program—and we do get children coming forward on an individual basis—we try to plug them into whatever is available in their respective areas. So with families, yes, it is a challenge. We have to look, from the OSISS program, at what's available in the community, but also at what's available from DND and what is available from Veterans Affairs, because there certainly are programs there that are available.

For example, in Veterans Affairs, and also in DND, there is a 1-800 line, a counselling line. It's available 24/7. In the military it's called the Canadian Forces Member Assistance Program. In Veterans Affairs, it's called the Veterans Affairs Canada Assistance Service. Individuals can call that line at any time with any kind of problem, including psychological. There are other kinds of problems that come forward as well, but we'll focus on the psychological ones. Their costs will be covered by one department or the other, because the only question that's asked of the person who calls is, “Are you still in the military or are you out of the military?” That just directs the bill to the right department, whether it be DND or Veterans Affairs. They can receive up to eight sessions of counselling—family counselling, individual counselling, or child counselling. Hopefully through that program, the individuals will get counsellors in their locale. That is a starting point to getting them connected with individuals who are experts in their fields within their respective locales. So that's one thing that's offered.

And we do, through OSISS, make a number of referrals, or make people aware that the service is available.

Mr. Peter Stoffer: I have two quick questions for you.

A lot of reservists, of course, aren't part of military bases. They work for Canada Post, and they come home and go right back into their normal workplace. They don't have the camaraderie of a base or other military people to share their experiences with. There's an explanation in here that says if you understand it, it's easy to explain; and if you don't understand it, there is no explanation.

I thought that was pretty good. But for reservists and their families, how does this program assist them?

Also, Major Le Beau, you said there is no program anywhere else. Are you saying there's no program like this in any of our NATO countries? Do some of our NATO allies have a program similar to this? And if they do, do we coordinate or share information to look at best practices of how Holland or Australia or the States address their particular concerns as well?

Col Donald S. Ethell: That quote, by the way, is from Stéphane Grenier. It's a very famous quote, as a matter of fact.

● (0955)

Mr. Peter Stoffer: Yes, it's quite good actually. I'm going to use it.

Col Donald S. Ethell: This is an ongoing problem in regard to reservists. They disappear. Sometimes they don't want to have anything to do with the military. For that matter, in some cases, some guys in the regular force want to just switch off and go away. It's difficult. I know I'm getting into Major Le Beau's business here, but it's been a fact of life for years, and they just disappear.

Having said that, if they come forward to any of the PSCs or the FPMCs, they're there. In fact, they'll talk to anybody if they've got a problem in regard to the military.

The Chair: Mariane.

Maj Mariane Le Beau: Yes indeed, there is no difference for us, whether you're regular reservists or class A, class B, class C. That doesn't make any difference in respect to our services at OSISS.

I would say that the issue of reservists is something that the reserve units themselves are more and more aware of. And we have been asked—more so in the past year, actually, than we had been previously—to provide outreach briefings and information sessions to reserve units. So, again, it's a process, and it's getting there. That's the first one.

Regarding the type of program that OSISS is, there are variations. But I could sit down and really explain to you the details of how peers function, how we consider that they are not counsellors. There have been peer programs in the U.S. in the past. We would provide them with counsellor training and they would be counsellors. We have stayed away from that. Our peers are not counsellors; they are peers, and they don't do counselling. They're buddies in some ways, if you want to put it in that kind of context.

So in that respect, for NATO, as far as I know, it's like saying there are no two snowflakes exactly alike. You have to see all of the snowflakes. As far as I know, there is no program, and in the literature there is no program that is exactly like OSISS, and we do share with our colleagues.

Kathy, do you want to pick up on that one?

Ms. Kathy Darte: In response to your question on reservists, I just want to point out that, as I said earlier, everybody is welcomed into the OSISS program. We serve those in uniform and those out of uniform.

We have a number of reservists who have come forward and accessed services under the OSISS program. One of our trained peer support workers in the program is himself a reservist. His name is Vince Tytler, and he's working from Vancouver.

A large part of the coordinators' role is to make themselves known in their respective geographic areas, and part of that is networking. Part of that is going out and speaking to reserve units, telling them about the OSISS program and the services that are available, and just spreading the word in general.

Part of our program is not only providing one-on-one assistance to individuals, but also bringing veterans and members together in a group setting. Part of these group meetings involves reservists. They come and they meet with other peers, other buddies, other reserve members, other regular force members, and other veterans. So it's by word of mouth.

It is a challenge, because you're quite right, they do go back to their home locales. So we just have to continuously work on raising the awareness and education and on making the program known.

Regarding the international and best practices, that's a really good question. We—the managers, Lieutenant-Colonel Grenier, Major Le Beau, and I—have presented on our program internationally on a number of occasions. We know we have a really unique program.

There isn't a program anywhere in the world that's similar to this program in terms of how we've set it up. Other countries are looking to us. They want to hear about the program, so we've presented in Australia, in the U.S., in Europe. We are invited again to go back to Europe this year. We have presented to NATO.

There are a number of programs around the world that the militaries and veterans affairs have set up, but they're slightly different from ours. I think part of our success—and these other countries are identifying that—comes from both Veterans Affairs and National Defence's working together on this program. There's not a separate veterans program from the VA department and a separate Defence program. There's a program for all, in uniform or out of uniform, and families.

The other things we hear about from our international colleagues are the parameters and the emphasis that we put on this program. These individuals are very well trained. We do not just hire them and put them out to work. They all come with the same criteria for selection, namely that they must be a veteran—they must have been in the forces—and they must have an injury.

Then we train them. We provide extensive training, which is done by Ste. Anne's Hospital. Our Veterans Affairs mental health staff at Ste. Anne's Hospital, along with other individuals from Defence and from Veterans Affairs, provides training. It's almost continuous training. It's ongoing. We continuously reinforce.

The other things we emphasize in our program are boundaries—you have to stick within your role—and self-care, because in order to work with others you have to take care of yourself.

So I think the other countries are noticing that this is a very formalized program. It's formalized in how we've set it up and in how we continue to monitor these people. We continually need to watch them. Dr. Richardson—who's the medical advisor for Veterans Affairs to the program and who unfortunately couldn't be with us today because he's on holidays—and I are following these people through long-term research, looking at their health and well-being. We measure their health when they start to conduct this work for us, and then we continuously measure their health over the course of their employment with us.

Basically, what we're finding is that there is no decrease in the level of health of these individuals. In fact, they are getting better, and it's because they are now able to get back into the workforce, contribute to society, and help others who are in the same situation they were in.

● (1000)

Col Donald S. Ethell: Mr. Chairman, I'd just like to go back to a point that Mr. Stoffer made, and it's very important, in regard to people in the reserves falling away. Correct me if I'm wrong, Mariane, but all of the peer support counsellors are ex-NCMs, not officers. There's a good reason for that, recognizing that officers command and NCOs control men and they're on the ground. Secondly, Sergeant Bloggins is going to find it easier to talk to Sergeant Major or Corporal Smith rather than Colonel Whoever, regardless of how good they are, regardless of whether they've got the uniform on or not.

The other point was about people falling through the cracks, be it reservists or others. I'm not a psychiatrist, but I do know, and others in our area know full well, that stressful situations can be cumulative —the Sabra and Shatila massacres, Bosnia, going into Afghanistan, and so forth. The lads, or the troops who are serving over there now, may not know it right now, but two or three years downstream, as happened with Grenier to a certain extent, it will accelerate and intensify. His problem intensified. Having said that, those people now know that if there's a problem that does come up, they can come back; they don't have to go and hide in a hole or go out in the woods and so forth. They can come back and go down to the district office of VAC or they can track down a peer, a PSC, and ask: What can I do? Can you help me? Where can I go? Where can you refer me to? That's one of the strengths of that.

The Chair: Mr. Stoffer, we're in an incredible situation. Due to the length of the witnesses' responses, you've had three times your normal amount of time. Wow.

Now on to Mrs. Hinton for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Good morning.

I've had the opportunity on several occasions to be in the company of Colonel Ethell. There are a couple of comments I'd like to make, and I have one question that I'd like all four of you to answer afterward.

The comment I'd like to make is how much I enjoy your candour; you usually say exactly what's on your mind, which is exactly what we want to have happen in this room. You did make a comment earlier today, though, regarding the peer program, and you spoke about psychologists and psychiatrists, which I recognize you have a great deal of respect for, but I think the comment you made hit home with me. I think what I heard you say is that there's no substitute for experience, which is why you value the peer program as much as you do. I happen to agree with you. I think if you've been in the situation, you're in a far better position to support somebody who's going through these kinds of traumas, and I'm very pleased to hear more detail about the peer program. It's very interesting for me.

Another comment I wanted to make is I have a great deal of respect for everyone on this committee, but Mr. Perron and I may disagree on one point he made. I think there would be more stress if the plane, the truck, the tank, or the tools that are necessary to do the job weren't there. I think that would add to the stress that our men and women in uniform face on a daily basis.

In terms of reservists, I have one of the finest reserve groups in the country in my riding; they're called the Rocky Mountain Rangers. I know they do have a group of people who can talk to one another and they do have a spot where they can get together. So I'm hoping there's that kind of support group. Major Le Beau reinforced that today, that these kinds of programs are accessible and they can get help. So that's a positive thing.

I'm going to ask all four of you to answer a question that I have asked of every witness that has appeared in front of this committee on this issue. To date, no one has been able to answer it. How do you think Veterans Affairs Canada can contribute to changing the negative stereotype for veterans who suffer in silence from PTSD?

● (1005)

Col Donald S. Ethell: Thank you. That's an excellent question.

First of all, thank you for your kind remarks. I appreciate them.

I'll get around to your question in a minute, but just to go back to your point on experience in regard to clinical staff, psychologists and so forth, as you may be aware, the first ones went out to the field for two to three weeks initially in Bosnia, which wasn't long enough. Having been there, the troops viewed them with a bit of a jaundiced eye—that “I'm from NDHQ and I'm here to help you” kind of thing. The troops would much rather talk to their peers.

Having said that, it's my understanding—and this is a personal opinion—that the Canadian Forces health system is intentionally pushing clinical staff out into the field in Afghanistan, as you've heard. There's one there. The chief psychiatrist just came back from a four-month tour, and there are two psychiatrists who have replaced him. There is an individual in Halifax who was at one time a unit medical officer in Rwanda and a unit medical officer on the Golan Heights, who has specialist training and has spent one, if not two, tours in Afghanistan as the psychiatrist. He is the kind of guy who will take off his rank and talk to the soldiers; he is very, very good at it. So experience is building among the clinical staff, in addition to the experienced field soldiers who are talking to each other. But thank you for making that a point.

The change for the VAC or Veterans Affairs—and I'm saying this more as an individual rather than as a departmental employee of either department, which I'm not—has been dramatic, you could almost say, from ten years ago in regard to a caring attitude. Ten years ago there was almost an adversarial approach when somebody came forward to VAC for some type of annuity, treatment, and so forth. It's changed dramatically because the benefit of the doubt now goes to the individual—and obviously there's a certain bureaucracy individuals have to go through.

The culture is different, in my opinion, and that started with some significant changes within VAC six to eight years ago, when the emphasis was put on the individual rather than the system, with the benefit of the doubt now going to the individual. So I'm very positive that this type of activity will continue. With the example of the two circles overlapping, as Mr. Stoffer has indicated, or the seamless approach I mentioned, people are less likely to drop through the cracks than they were a number of years ago. Are there going to be people who will drop through the cracks? Of course. No system is perfect. But at least we've made significant inroads.

I don't know if that answers the question or not, Ms. Hinton, but thank you for asking it.

● (1010)

Mrs. Betty Hinton: It's close. I'll just repeat the question so there's no misunderstanding at all.

What can Veterans Affairs Canada do to change the negative stereotype—because it's out there—for people who suffer from this silent disease? What can we do?

Col Donald S. Ethell: What can they do?

You have a folder with a whole bunch of handouts. These are all over the place, at all the bases and all the offices. There are TV ads, and so forth. It's a monumental communications problem. The district directors have all of the veterans associations in once a quarter—and if not, the regional directors will have them in once every five months—to spread the gospel. They go out to service clubs and to regimental associations, and so forth, to talk about Veterans Affairs. I'm saying this as someone from western Canada who has participated in all of them. I've gone to listen and have heard the same thing a couple of times. We talk about this and we're quite frank. For example, on Friday in Calgary there will be a presentation by one of the peer support coordinators, along with those from Veterans Affairs Canada.

The district director is really saying to the representatives of all the veterans associations: this is where we're coming from, and please get out there and tell the people how we can help. That didn't happen many years ago.

So the emphasis is coming from Charlottetown through the regional directors, down to the district directors, if not directly, to get out there and spread the gospel.

Mariane.

Maj Mariane Le Beau: I'm sure you could see me smile.

Kathy and I actually read an article last night that was sent to me electronically from the U.S. I imagine it was published recently. It talks about stigma, a model of stigma that talks about self-stigma, how we perceive the stigma that's out there, and what seems to be the best way to work against stigma.

In many ways, this is what Don said. OSISS is probably the best program to help work against the stigma, because people who have gone through the experience have become better and are out there. There can be interaction, information, and education. It will probably be the best way to fight stigma.

If you want, ma'am, I can provide you with a copy of the article, if you're interested.

Mrs. Betty Hinton: Thank you.

The Chair: It's a good point.

Kathy.

Ms. Kathy Darte: I would like to follow up on that. I can actually say the support of Veterans Affairs for the OSISS program is really helping to change the stigma that's out there, both in society as a whole and within individuals.

There are 17 peer support coordinators working in the program, and 15 of those individuals are working from back offices. Within the back offices now there are individuals who are veterans and are actually clients of our department. They have gone through treatment, have recovered, and are out there helping other veterans. They are greatly assisting in our offices to help with the understanding and awareness of what it's like for individuals to live with these kinds of injuries. There is a lot of consultation between the Veterans Affairs staff and the peer support coordinators when they discuss what it's like to live with the impacts on the individuals and on their families. I think it's a big advantage.

At our OSI clinics, our operational stress injury clinics, we also have two family members, two family peer support coordinators who work from the clinics. It's another way of bringing in those who have lived the experience and who are prime examples showing that if they get into treatment early, they can recover and get back into society to fully contribute, to work, and to have fully functional families again. I think it's a big step in helping to raise awareness.

I think the article Mariane has referred to is an excellent article. It talks about stigma, the two kinds of stigma. It talks about societal stigma, which we all know is out there, as it relates to operational stress injuries. It also talks about self-stigma, the self-stigma within the individuals themselves.

In OSISS we're promoting early treatment, identification of the problem, and treatment. The self-stigma is part of what prevents people from getting into treatment, because they feel if they self-identify, it's going to have an impact on them in one way or another. We can encourage folks to come forward early, because if they get into treatment early, the recovery time is much shorter, with fewer impacts on them as individuals and on their families.

● (1015)

The Chair: Thank you.

Jim.

LCol Jim Jamieson: I'll be brief. I'd like to suggest three things.

Number one, I think VAC has to go out of its way to recognize veterans with mental health concerns related to operations, to service, to recognize them as heroes.

Secondly, and somewhat related to this I think—and I can say this because I'm not a VAC employee—in regard to staff training, this is the new veteran we're dealing with. It's no longer the Korean and World War II veterans, by and large, who tend to be pleasant in the office. People with mental health concerns are not always pleasant, but they are our customers. They are the people we serve. We need, right from the receptionist, who's incredibly important, to give recognition to these people, not to treat them as security threats who we talk to from behind laminated glass plates. I realize there's a balance between security and recognition, and I've been to many VAC offices and the staff by and large are great, but often you walk in and you feel like you're a threat to them, because there's this glass thing and no eye contact. “What do you want?” is the message you get. When you're already prickly, I think that recognition, that the reason I'm here is that you are the person I serve, has to be the first message, not that you could be a threat to us. I realize this is a very delicate issue.

I think the third thing, which my colleagues have been saying, is to continue to support OSISS. I'm not a direct employee of OSISS. I have a job whether OSISS exists or not. But it is a great thing, and I hope VAC will continue to support it.

Those are my suggestions. I think it's a multi-faceted problem. There's no simple solution to the stigma problem.

Mrs. Betty Hinton: Thank you so much.

Col Donald S. Ethell: With all due respect to Jim Jamieson's slight criticism of VAC—and I don't work for VAC either—that can be countered in part by the strengths of the OSISS program, because there are people who won't go near a VAC office, they won't go into the clinic on the base, but they will track down a peer because of word of mouth. If they need to go and talk to someone, it's the PSC.

Ms. Darte has indicated that the PSCs have their office within the district director's office. They don't necessarily meet their clients there, or peers. Some of them will, but others ask, “Do you want to meet here? If not, we'll go somewhere else. Do you want me to come to your home, or do you want to meet wherever?” And they'll get together outside the home. In other words, there's that conscious effort to make sure that people don't run into that wall, as Jim has rightfully said, coming through the door and there's a hesitation.

If you have an injury to your arm, it's going to get fixed. If you're going to walk into the doctor's office, first of all you have to admit that you have a problem. If you have a problem, then are you going to admit it to somebody else? That's the problem that Jim is indicating, because when you go into that office, you are defensive. “Am I going to talk to the doctor, or do I have to go and see a psychiatrist? I'm going to maybe talk to the padre or the minister, and so forth. Who am I going to talk to? My wife won't talk to me because I know she knows I've changed.” So there's that barrier to get around, going into the Veterans Affairs office.

Thank you very much. Did we answer the question, Ms. Hinton?

Mrs. Betty Hinton: Yes. That's the best answer I've gotten in all the witnesses we've been listening to. We listened to a group of witnesses before, relating to this issue.

I especially appreciate what Major Le Beau said, which will be very helpful, and also what Lieutenant-Colonel Jamieson said. That's constructive criticism, as far as I'm concerned, and I will be happy to pass that information on.

● (1020)

LCol Jim Jamieson: It's meant to be constructive.

Mrs. Betty Hinton: Yes. It's very constructive.

Col Donald S. Ethell: They were excellent questions, and I thank you for that.

As Ms. Darte has indicated, there are many countries looking at these people and asking, “How are you doing it?” At the end of this session, I have copies of a book to present to you and your committee, and one for the library here, Mr. Chairman, on combat stress injuries, written by a former U.S. marine and by a U.S. Navy captain, a psychologist and an Iraqi veteran. And there's a chapter in here written by four of our colleagues: Kathy Darte, Stéphane Grenier, Major Heber, and Dr. Richardson. That's all here. In fact, Naval Captain Nash, from Quantico, Virginia, has attended our meetings and has presented.

So they are looking at these people and saying, “Okay, how can we make this program work?” They have to have something good on the mark to be invited, as is indicated, to go to the Hague and to various other countries, and they're off and running early next month, back in the United States, to brief on the OSISS program—the very successful OSISS program.

Thank you for the question.

The Chair: Thank you very much.

Now over to Mr. Cuzner of the Liberals for five minutes.

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

This has been a great presentation.

I assure you that Mrs. Hinton asks that same question to each witness, and I did enjoy the reply from the witnesses today.

We've established that one of the challenges we face is that the individual has to recognize he has a problem. I certainly agree with that. The people around him have to be able to recognize there's a problem as well and to know there are programs that he or she can access. Then, third, is actually accessing those programs.

I represent a rural community outside of the Halifax area. Sometimes, actually knowing those programs exist in the regions becomes a challenge. And then there is accessing them.

I want to coattail on a question posed by Mr. Stoffer. This is a real situation. We had a great tragedy in Nova Scotia two weeks ago when we lost a young soldier, Corporal Kevin Megeney. But there's a dual tragedy. There's somebody on the other end of that tragedy, and that's the young fellow who was involved. It was an accidental shooting. There's another life in jeopardy here, and if the supports aren't there for that young soldier, I think he's at risk.

Could you walk me through the protocol? He's a reservist. What will take place now? How will he and his family garner the support to face what's ahead of them? There will be an inquiry and what have you, but I think there's some fear on the parts of some that....

Everybody around this table has probably had a life experience where they had a friend or acquaintance and maybe there was a tragic ending. When somebody takes his own life, everybody around says, “You know, we should have picked up on that. All the indicators were there, but we missed them.”

Could you walk me through how we can make sure this young soldier gets the support he needs?

Col Donald S. Ethell: I'll let the professionals answer, but I would like to add a comment, as I usually do.

I have been a soldier for many years, and this is not a unique situation, where a soldier gets killed as a result of an action of another soldier.

The shooter in this case has a.... Let's back up a bit. The family of the dead soldier will hopefully be involved in a bereavement program, or some of the people from the OSISS will be talking with them. That's their call; it can't be imposed on them. It comes through the assisting officer and so forth. So that is available from the OSISS program.

The shooter has a couple of problems. You may recall the incident a year or two ago where the shooter has now been charged. You can imagine that young soldier—and I don't know the circumstances of the event—has in the back of his mind, “This was an accident, but am I going to be charged because the other chap was charged?” He has to face that. I'll let the professionals talk about it, but I'm talking about it from the soldier's point of view.

I am sure the soldiers would close ranks, remembering that most of the units, subunits, and so forth have been involved with peer support training. And that's formal and informal. It goes back to the three and a half hours of training at a recruit school. That's the formal. There's informal, when you're having a coffee break: “How am I going to overcome this problem? Have I got a problem? Who do I talk to?” In other words, your bed mate, your tent mate, is going to be there. I would like to think that this is where it starts. I know there are mechanisms where, if necessary, the command can direct the individuals to seek help.

I'm way out of my depth here, so I'll hand it over to Major Le Beau.

● (1025)

Maj Mariane Le Beau: I guess in a way I cannot really comment on that particular case per se because I am not involved as the OSISS program manager. OSISS is not directly involved in that one, except for the bereavement part. We have not discussed bereavement yet, although it is in the presentation. It is for widows and parents who lose someone in operations. There's a direct, proactive referral through the military assisting officer who contacts the family. We have volunteers who have gone through a similar experience to provide peer support to the spouse, the widow, or the family members.

As for the individual, Jim, I believe you know the process.

LCol Jim Jamieson: Certainly this person will receive active outreach assistance with respect to mental health issues from the mental health team. I'd also like to suggest, though, sir, that OSISS does not go out, but we will talk to and treat anyone who comes to us. For many of our peers, that is their central problem. They have actually killed someone, whether it be an enemy or in this case, accidentally, a friend. The problem of living with that is very common, and if this soldier from your office wants help from us, we have an excellent person in Halifax, a retired chief warrant officer, infantry, who is tough as nails but a big teddy bear. We will be happy to support this person, but through OSISS he has to come to us.

Perhaps your office could even be instrumental in making sure he knows about us.

Mr. Rodger Cuzner: I appreciate that.

Col Donald S. Ethell: Does that answer your question, sir?

The Chair: Thank you.

Now we'll move on to Monsieur Roy for five minutes, please.

[*Translation*]

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

First, I'd like to speak to Ms. Darte.

Earlier you said that people calling on your services were entitled to eight counselling sessions. Did I understand you correctly? Why eight sessions? Who determined that? We're talking about post-traumatic stress here, and it seems to me that problem lasts years. So why are there only eight counselling sessions? Is it because you don't have the resources to offer more? There must be a theory behind that.

[*English*]

Ms. Kathy Darte: It's up to eight sessions. Maybe it's a stop-gap kind of program. It started off as being a crisis line service for individuals who are just at a loss, who don't know what to do. There's a 1-800 number they can call. They go into a main centre. The issue they're calling about is discussed. Then they connect them up with resources in the community for up to eight sessions, but within that timeframe of eight sessions they should be getting connected with DND or getting connected with Veterans Affairs. This is just sort of something we can do right away, and then we get you into the other systems that are out there to support you.

● (1030)

[*Translation*]

Mr. Jean-Yves Roy: I find it hard to understand how you provide support to operational stress victims. I've heard a lot of theories, and I've heard about some very practical things. I haven't read all the documents, but I viewed the matter more as a sponsorship program involving one or two members of the Canadian Forces or former members.

A sponsorship program isn't usually established for the short term, but rather the long term. If you offer someone a sponsor, but take the sponsor away after eight sessions, that person will drop out. You're pushing that person into the arms of someone else and you're asking them to start telling their story all over again. So everything has to be started over from scratch. I have reservations about this way of operating.

[*English*]

Col Donald S. Ethell: I will ask Major Le Beau to comment on that, and then I have a couple of comments.

[*Translation*]

Maj Mariane Le Beau: If the matter is perceived that way, I'm very pleased that you've asked the question. I don't think the distinction has been clearly drawn between the services provided by Operational Stress Injury Social Support and those offered by the program Ms. Darte referred to, a very specific short-term emergency assistance program. That program is under the authority of the Department of Veterans Affairs, but the Department of National Defence shares costs with it. It is nevertheless not our program.

You're right in saying that sponsoring can be a very long-term proposition. We can't determine the required number of sessions in advance. I like the image that you used. We talk more about peer support than sponsors. Some take part in the group and continue with individual interviews over the years. We hope they will eventually be able to become volunteers with us to help other people. That's how things are developing.

Mr. Jean-Yves Roy: Another matter that concerns me is the way you reach people. You talked a lot about it. In the figures you provided us, it's stated that approximately 2.8% of regular forces members and 1.2% of reservists have reported corresponding symptoms.

Of all the people affected by post-traumatic stress and identified as such by the Canadian Forces, how many do you reach? Even if their problem is identified by a Canadian Forces psychologist or psychiatrist, those people won't necessarily see you, will they?

Maj Mariane LeBeau: No, it's done on a voluntary basis.

Mr. Jean-Yves Roy: Among other things, you talked about a telephone system, but how do you manage to find sponsors in the remote regions?

I have a very specific example back home of a man who regularly comes to see me. He's currently in the public service, but let me tell you he's not easy to deal with. He doesn't have a sponsor for the moment, and I don't think he's calling on you. I'm not sure he's aware of the problems he causes around him. It's not always easy when he comes to see me.

Maj Mariane LeBeau: As Mr. Jamieson said, these are people who—

Mr. Jean-Yves Roy: It also causes him physical problems; you have to understand that.

How do you go about finding sponsors for people who live in regions like mine? It's not easy.

Maj Mariane Le Beau: I should probably point out first that we don't find sponsors for people in the regions: we hire coordinators who cover given regions. In the case of Matane, the nearest coordinator would be in Valcartier or Quebec City.

Mr. Jean-Yves Roy: That's about 400 kilometers away.

Maj Mariane Le Beau: That's correct. You're entirely right. That's a considerable distance.

There are currently 17 coordinators in Canada. There will soon be 19 for military personnel and veterans. There are six for families, but that figure will soon be increased to 12. So we're going to double the number of our coordinators for families in Canada.

Then there's the matter of volunteers. We're all entirely aware that it is impossible for us to have employees who cover all regular and reserve units across Canada on a full-time basis. By relying on volunteers, we want to extend the tentacles and provide support at various locations. Of course, it's easier when populations are concentrated.

Whatever the case may be, I'd like you to give us that individual's contact information.

● (1035)

Mr. Jean-Yves Roy: I asked the question, but I didn't get an answer.

How many people are you ultimately reaching?

Maj Mariane Le Beau: We currently reach about 2,400.

[*English*]

The Chair: Mr. Jamieson.

[*Translation*]

LCol Jim Jamieson: May I add something?

I suppose you know that the situation

[*English*]

that Kathy Darte talked about

[*Translation*]

only concerns people who don't want to go to the OSISS clinic. All Canadian Forces members and all veterans, as well as the spouses of members of those two groups, are entitled to use OSISS services.

[*English*]

But some people don't want to go there. They want to keep it private. That's just a gateway to help them get into services.

As Major Le Beau said, we do everything we can to find a trained volunteer in the community who will provide one-on-one support to the individual who's in a relatively isolated place. This has been difficult, but we have dozens of trained volunteers, many of whom are in relatively remote communities, who can be of service to people.

I hope that at least partly answers the question.

Col Donald S. Ethell: If I may, Mr. Chairman, I'm infringing on your time, sir, but—

The Chair: It's not my time; it's the time of that member there.

Col Donald S. Ethell: Sorry, but just to carry on, there's a step missing here that you're not aware of.

The OSISS committee, peer support coordinators, and so forth refer people to the OSI clinic. I'm not going to read it all through, but it has: "What is an OSI clinic?", "What services are available?", "What can I expect when I attend the clinic?", "How do I access the clinic?"

I'll leave this with you if you wish to make copies.

Very briefly, before you get to the aid appointment stage, an individual will go through a clinical nurse for various testings and so forth. Having personally experienced this process, I can tell you it's intensive. And there's some other testing by another staff member. Then the file is reviewed by the director, psychiatrist, and two psychologists as to who is going to see this individual on the initial assessment. A decision is made. The initial assessment is made. There is a follow-up session, another follow-up session, and then that report, whatever it may say, will go back through Veterans Affairs Canada for a decision in Charlottetown as to whether this individual is going to move forward and whether treatment—the eight sessions—is authorized.

Even though there are eight, I have enough faith in the system that if there is an ongoing problem with somebody, Veterans Affairs is not going to drop him. They will find a way.

Sorry, I didn't mean to infringe on your time.

The Chair: That's just fine. It's Mr. Shipley's time.

Mr. Shipley is up to five minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you very much. I appreciate all of you coming out today to be part of this process.

Can you just help me in terms of the operational stress injury, which is part of the post-traumatic stress disorder—I think one is part of the other. I am interested in who goes to you. Is there a gender difference in who will likely want to access the OSI service? Male or female, is one ahead of the other?

Second, is there a gender difference of who they would actually want to be treated by, or as a coordinator and the volunteer, who they would want to share their concerns with?

● (1040)

Ms. Kathy Darte: When we initially started the program, we thought that would be an issue, that there would be a gender difference. All of our coordinators in the beginning were of male gender. We knew there were many females out there who were also struggling with OSIs. We wondered if they would come forward.

It hasn't really been an issue in our program. We do have two female coordinators in the program and they see many males, and vice versa, the male coordinators see many females. The gender issue is really not an issue with the program, and if it is, that is discussed with the coordinator. It's made clear up front, and then the coordinator would assist that individual in getting them to speak to someone who is of the gender that they would like to speak with. So, no, it has not been an issue.

Mr. Bev Shipley: I found it interesting in the handout here that in terms of the operational stress disorder, it says, "When corrected statistically for age and sex differences, a study done through McMaster University found the lifetime prevalence of PTSD"—and this is strictly for PTSD—"in CF members matches that of the Canadian public at large". I would suspect most of us would have said those issues around operational stress injury would be higher with our people in the Canadian Forces just because of the nature of their livelihood.

If this statement is true—and this is a study, so we take those depending on who is doing them—is it partly because of the great training and the preparation, the knowledge they have of having clinics like OSI that they can go to? Does that show the value of what you're doing here and what we're doing for our military to keep those at that rate, or am I just reading something into that?

Col Donald S. Ethell: I will go first.

In fact, without pre-empting what they are going to say, the OSISS program has prevented that, and I'll leave the experts here to say that, remembering that there isn't a person in this room who at one time or another hasn't suffered from a PTSD for whatever reason—a stressful traffic accident, am I going to get re-elected, that sort of thing.

Some hon. members: Oh, oh!

Col. Donald S. Ethell: I don't think I should have said that, but I'm just using that as an example.

In all seriousness, in the general public, policemen, firemen, search and rescue, RCMP, and so forth are exposed to a lot of trauma, so you want to equate all of that compared to the Canadian Forces.

At least the Canadian Forces and Veterans Affairs have a system in place now. It's called the OSISS program.

Jim.

LCol Jim Jamieson: We could talk about this for a long time, and I'd be happy to if you want, but I'll try to keep this very brief.

First of all, by way of direct comment, the McMaster study did not use the same criteria as the CF-Statistics Canada study of 2002, which was much more rigorous. The Statistics Canada study did not screen in what we might call pre-threshold, post-traumatic stress symptoms. I wouldn't make too much of that article.

Secondly, OSI does not just refer to post-traumatic stress disorder; it includes other major concerns, like clinical depression. Our rates of clinical depression in the Canadian Forces, according to the 2002 study, are twice as high, age corrected, as in the general population. We also have higher levels of substance abuse, which is considered to be an OSI. We have higher levels of social phobia. People often think of that as speaking in public, but what we're talking about here are soldiers who withdraw from social interactions, who withdraw from family, who start to live in their basements. This is the acronym.

So yes, I think we do screen people, we do train people, and we do help them to cope with traumatic stress, but we certainly have our share.

The other thing, sir, is that the resources required to help someone with post-traumatic stress are considerable in many cases. I think it would be false to read that we don't have a number of mental health concerns. Well, it's more than my opinion; we do.

● (1045)

Mr. Bev Shipley: I have some interest in having not the whole thing, but the summary of what you talked about on that study. This was handed to us, so we didn't go searching for it. I think we want the true story about actually what is affecting some of the operational stress injuries, which go beyond the post-traumatic—

LCol Jim Jamieson: The Statistics Canada study of 2002 is the best study we've ever had, and we can certainly make it available, sir, to you and the rest of the committee.

Mr. Bev Shipley: I guess I'm looking for the executive summary of it, if that's possible.

I have one other quick one. In terms of the peers, the coordinators, and the volunteers in the training of those, is the emphasis on some of the professional training that you would help with these peers? When you have peers talking to each other, I would think those who have come through it will obviously have that personal experience that they bring forward. Sometimes not knowing...I think it mentions every circumstance is different. Having some professional training for that volunteer likely goes beyond the important part of compassion and understanding. I may have missed it, and I apologize, but is there some professional training for the peers before they actually get involved?

Ms. Kathy Darte: Yes, there is. For the peers who are actually hired, paid staff, there is intensive training in the very beginning, before they even go out and start to work.

Mr. Bev Shipley: What about the volunteers?

Ms. Kathy Darte: In order to be an official volunteer in the OSISS program, there are two important things that have to happen. You must be what we call medically screened. If you're in treatment, your therapist must say it's okay for you to even volunteer to do this kind of work. If we get that screening and we get all of the other checks and balances, then we bring volunteers into our program. And there have to be police checks and so on. Once we get all of that done, then we provide them with training by the mental health staff at Ste. Anne's centre. They receive three days of training, and it is official training, yes, before they start to work.

The Chair: Thanks, Mr. Shipley.

Now we'll go on to Mr. St. Denis, and Mr. Sweet if we have time. Just to let everybody know before this wraps up, we will want to briefly discuss who we will have on Thursday, what we would like to do for Tuesday of next week—some other witnesses.

Monsieur St-Denis.

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Thank you, Mr. Chair. I'll make sure that Mr. Sweet gets on. I'll keep my remarks brief.

Thank you very much for being here. A wide territory has been covered today, and I much appreciate that. I will go to the specific point about the availability, or lack thereof, of professionals, whether they're the doctors, the nurses, and the others in the field. If you had as much money as you ever needed, are there still the people out there to hire? What is the ceiling on this? Is it the dollars or the people? Please just give a quick answer to that.

Col Donald S. Ethell: Other than to say I have heard the figure that the Canadian Forces medical system has only 40% of the people it needs because of a lack of resources in the area, I'll let Jim answer the question.

You can throw all sorts of money at them, but if the people aren't there—There is a great shortage of doctors at least in western Canada, and maybe across the country.

Jim.

LCol Jim Jamieson: It is primarily a resource especially related to the specialized area of trauma management. We have difficulty getting psychiatrists, for example. Even if we can get them, many of them do not have the background we would like them to have to best work with our clients.

It's primarily a trained resource capability, but that has many ramifications. You might have the person who is willing to work in Ottawa, but they're not willing to go to Pembroke.

I would say the other issue is availability in the sense of serving the families. As we mentioned earlier, that's a very complicated, difficult problem.

Mr. Brent St. Denis: Does the military and/or Veterans Affairs have any plan that you're aware of to work with the colleges and universities or with Immigration Canada to somehow, over time, fill those gaps? Presumably the gap is not going to get smaller over time as our military engagements in the world become more complicated and less traditional, so I'm wondering if there is any plan that you're aware of to fill that gap going forward.

● (1050)

LCol Jim Jamieson: The short answer is, yes, it's difficult. We have difficulty even getting physicians to join the military, despite large incentives. There is a team of people who do nothing else but try to recruit physicians for the Canadian Forces. It's very difficult.

Mr. Brent St. Denis: In terms of career promotion, do young people think about psychiatry or psychology or psychiatric nursing in the military context while they're in high school?

LCol Jim Jamieson: I'm not aware of that, but I do know we will sponsor our own people to take specialties, and in only a few areas. Surgery, orthopedic surgery, and psychiatry are the only three I know of offhand. We will take our own people, and this is predictably where we have the highest success, of course. If you take military physicians and send them back to school to become psychiatrists, then if they understand the culture, they're inherently much more valuable.

Really, it's out of my area. I don't know who could answer that. Perhaps the surgeon general could answer your question better than I can, sir.

Mr. Brent St. Denis: Just as a short final comment—and please give just as short an answer—when you consider the pre-trauma situation, including the training of the troops going out, the preparation for families, the selection and preparation process, and the resources required to do that, whether they're human resources, dollars, or whatever, and the cost in terms of human cost, the financial cost of dealing with trauma issues and other service issues after the fact, do we have that balance right? Are we putting enough up front in the prevention versus the cure?

I know you never get it perfect. You can't totally screen people and there are reasonable limits on that. But do we have that balance right now, given our resources?

Col Donald S. Ethell: I'll let Major Le Beau answer that.

Maj Mariane Le Beau: I'll try to keep this short.

I don't think one is being disadvantaged over the other because of resources. There is a knowledge gap as well in terms of us knowing very little on how to predict the development of operational stress injuries. There are no foolproof tests in terms of screening, so there is a knowledge gap there as well.

Even afterwards, with some of the research that we've definitely used and based the program on, with some of the meta-analysis to look at the predictors of PTSD, some of the best predictors are not the things that occurred before but the things that occurred at trauma time and after that. The things that occur afterwards that are more predictable are peer supports and the level of stress in someone's life. Maybe these things then tell us that it's important to put the money into the events that take place afterwards, but that doesn't mean we need to totally disregard the prior events.

I hope that answers your question.

Mr. Brent St. Denis: Thank you.

The Chair: Thank you.

Mr. Sweet, you have whatever time we have left, and then I'd like to briefly interject.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you. I appreciate it.

Thank you very much for coming. Your contribution today has been substantial.

Lieutenant-Colonel Jamieson, in your answer to Mr. St. Denis—he went down the road I wanted to go down—you mentioned that a physician from the military who goes back and becomes a psychiatrist or psychologist knows the DNA of the force.

From your experience, would a soldier who has PTSD or any other related injury also be more apt to open up to someone who is military rather than a private contractor from a civilian background?

LCol Jim Jamieson: It depends on the individual. Some individuals want that familiarity. Some prefer to be treated outside. As much as possible, we give them the option.

In a city like Ottawa, that's not a problem. We have excellent trauma specialists—clinical psychologists, psychiatrists, social workers, and others—in the community, so we can make the offer. In places like Petawawa, we don't have that luxury.

Some people have become so traumatized, they can't even go on a base. They don't want anything to do with anybody in uniform, for whatever reason.

The short answer is that we try to give them the option, whatever seems to suit their case best.

● (1055)

Mr. David Sweet: I was encouraged, right at the beginning... because one of the big reasons soldiers won't come forward, at least for the many that I've spoken to, particularly the non-commissioned officers, is the esprit de corps, the band of brothers, the whole camaraderie aspect of the military. It's something they live and move in, and it's highly valuable. To come forward and threaten that by saying you've suffered a post-traumatic disorder experience would obviously be a big detriment.

Right at the beginning, Colonel, I think you were talking about a general who is now back in active duty even though he's a PTSD sufferer. Is that correct?

Col Donald S. Ethell: That's Lieutenant-Colonel Stéphane Grenier; as I say, he's back on the horse.

The CF representatives can articulate this a little better than I can, but the idea is to put people back in the field if possible, obviously under some guidelines. I don't know if you read the latest *Maclean's* magazine on physical injuries, but all of those lads want to go back and join their unit. They want to get back with their unit. They want to be with the unit. In fact one of them moved out of Ottawa back to Petawawa to be with his unit, just because of that comradeship, that regimental esprit de corps and so forth.

And that's where they feel they can get some peer advice, not only physical, but mental as well. If they have a problem, I'm sure they hear, just through word of mouth, why don't you go and talk to a peer support coordinator? They can provide some avenues for you to address.

It's only natural, having lived that world, that these lads would want to get back with the unit. They don't want to be thrown out of the military; they want to be made healthy.

It goes back to the statement we heard a number of times during our visits to the bases. When Veterans Affairs Canada started granting an annuity for PTSD for serving members—I don't know how many are currently receiving that, but it's in the hundreds—the word was, yes, the money is nice, but fix me. Fix me. Where can I go to be fixed? Now, that's not a nice term, but that's the term they use. They want to know, where is this peer support coordinator, and what can he tell me, where can he refer me?

Does that answer the question, sir?

Mr. David Sweet: Yes, but just specifically, if I suffer an operational stress injury, do I have good hope that if I'm capable, through the therapy, to come back 100%, I can be redeployed?

Col Donald S. Ethell: I'll let Major Le Beau or Colonel Jamieson take that, but in my opinion, if the circumstances are correct, and if the command's decision is made, then yes.

Jim.

LCol Jim Jamieson: Getting people back to work is always the number one objective.

Post-traumatic stress has a lot of focus on it, but let's start with something easier. For clinical depression, there are excellent outcomes. For post-traumatic stress, there are good outcomes over a longer period of time.

There's no written rule about this, but we tend to give people up to two years to get back or else they have to get into a different trade or perhaps leave the forces.

We've had many successes. If the right treatment and the right support are in place, the outcomes are excellent. As Mariane said a few minutes ago, what happens after the trauma is often a lot more important than what happened before. If we have all the things in place, the outcomes are excellent.

The terrible irony of this is that the longer you don't go for help, the harder it is to help you. We have a natural subculture of not being sissies and not going for help.

● (1100)

Mr. David Sweet: On the training the soldier gets, from everything I've heard here today, I'm under the impression that it's up to me to be alert to when I am suffering an operational stress injury so that I can come forward early.

We're now learning more and more about PTSD. Is there any training for me to be able to psychologically handle a severely traumatic situation so that I can avoid spiralling down to an emotional reaction that would cause an injury?

Maj Mariane Le Beau: On pre-deployment training, over the years, I would say there's again been a different “flavour of the month”.

I guess stress management training is what you would be referring to in terms of how to handle the stressors. It existed in the 1990s. There was then the critical incident stress model that the Canadian Forces used, implemented, and taught, and it also waned in terms of the approach. I guess it didn't seem to be as effective as some people had hoped.

There's battle-mind training, which is something new that the mental health people are using in third location decompression. It is stress management, helping people to switch in terms of their attitudes versus the front line and back home. But it's also an entire program of preparation for day-to-day living, and it's not only decompression focused. This might be a direction in which the CF will go.

But I again want to highlight that there's always been something. It may not be as efficient as we would look to it to be in terms of pre-deployment training, but we continue to try to find the best way of doing it.

The Chair: I only want to interject to say several things.

On Thursday we'll have Stéphane Guay. On Tuesday next week, I'm hoping we can bring back the bill of rights so that we can flesh it out and get it moved off the agenda. We'll then go back to the list of witnesses, and we'll have the clerk do the best he can in regard to those.

I know Colonel Ethell has some books he'd like to present.

If you could bear with me one second, sir, Monsieur Perron says he'll be 30 seconds.

[*Translation*]

Mr. Gilles-A. Perron: This concerns the question that Rodger asked you earlier about the young man who accidentally killed his companion. If I correctly understood your explanation, he is still in Afghanistan, and no one is taking care of him. He was told that he could consult someone on his return to Halifax.

LCol Jim Jamieson: No, sir. There is a team that deals with mental health in Afghanistan: a psychiatrist, two social workers and a mental health nurse. There's a team there.

[*English*]

But he's going to require help later too, and that's what we need to plug him into.

[*Translation*]

Mr. Gilles-A. Perron: You talked about—

[*English*]

The Chair: Colonel Ethell.

Col Donald S. Ethell: Mr. Chairman, thanks very much to you and your committee for having us here.

I have two copies of *Combat Stress Injury: Theory, Research, and Management*. It's part of a psychosocial stress series, as I mentioned, and was written by two renowned doctors, one of whom is ex-military.

In chapter 13 of this book, there's a chapter on the operational stress injury social support program, OSISS, a peer support program in collaboration between the Canadian Forces and Veterans Affairs Canada, written by Colonel Stéphane Grenier, Kathy Darte, Dr. Alexandra Heber, who is now a major and has joined the forces, and Dr. Don Richardson, who's the Veterans Affairs advisor.

I'll pass one copy to you, Mr. Chairman, for you and your committee, and one copy for your library.

Thank you very much for your time, sir.

The Chair: Thank you very much, Colonel Ethell. I greatly appreciate that.

I can tell by the way the committee has been participating with questions on this PTSD issue at the beginning of our study into health that there's a great deal of interest, so we appreciate your presentation. Thank you.

The meeting is adjourned.

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