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Chair

Mr. Rob Anders

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● (0905)

[*English*]

The Vice-Chair (Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.)): *Bonjour, tout le monde*. Good morning, everyone. I'm pleased to call to order this Thursday, March 22, 2007, meeting of the Standing Committee on Veterans Affairs.

We're very pleased to have with us today Dr. Stéphane Guay, who will no doubt enlighten us considerably on a very important subject when it comes to the health of our returning soldiers and our veterans.

We'll get started, and then I'll hand it over to Rob.

Dr. Guay, I think the clerk or the chair has talked to you about spending 10 minutes, give or take, on your presentation, allowing members a good chance to ask questions afterwards. And you'll have a chance to bring up whatever issue you would like.

With that, we ask you to start. Thank you for being here.

[*Translation*]

Dr. Stéphane Guay (Psychologist and Director, Centre d'étude sur le trauma, As an Individual): My name is Stéphane Guay, and I am a researcher and Director of the Trauma Study Centre at Louis-H. Lafontaine Hospital in Montreal. I am also an associate researcher for Veterans Affairs Canada, at the Sainte-Anne Centre located at Sainte-Anne Hospital. I am affiliated with the Department of Psychiatry at the University of Montreal. I am a psychologist by training. I received my PhD in 2001 and subsequently did post-doctoral studies on treatment of post-traumatic stress in civilians. This was a study aimed at determining whether the involvement of a relative could increase the effectiveness of treatment. At the present time, my main activities involve assessment of various methods of psychological treatment of post-traumatic stress in different types of sufferers, mainly civilians, but also some military personnel.

Since 2003, I have been conducting research projects that are supported by a variety of Canadian funding organizations, such as the Canada and Quebec Health Research Institutes, and the Quebec Health Research Fund. In recent years, much of my writing on the subject has been published in both Canada and abroad, and I have also presented papers at a number of different conventions. Recently, a book I wrote on post-traumatic stress with my colleague, André Marchand, entitled *Les troubles liés aux événements traumatiques : Dépistage, évaluation et traitement* was published by the Presses de l'Université de Montréal.

As regards my appearance before the Committee this morning, I believe that the fact I worked on two major studies involving Canadian Forces members is of particular interest to you. One of them consisted of analyses based on the Canadian Community Health Survey and the Supplement involving members of the Canadian Forces. That survey was conducted using a representative sample of the military population. There was a sample of 8 441 participants. I also conducted a study with military personnel at the Valcartier Base in Quebec City which was intended to assess the quality of life and social support provided to soldiers suffering from post-traumatic stress. We completed that study some time ago.

I believe I will be in a position to provide information and clarification with respect to the results of those studies based on the questions you have for me this morning. I am here today in my capacity as a researcher. I am also a psychologist and clinician, but I believe I have been invited to speak to you primarily as a researcher, and I will attempt to clarify data found in literature on the subject, as it relates to veterans, to the best of my abilities.

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): All right. That was fast. Well, there will be room for more questions, I guess. Are you sure you don't have anything else? Are you done? Okay, fair enough.

Now we'll go on to Mr. Valley, for seven minutes.

Mr. Roger Valley (Kenora, Lib.): Thank you, Mr. Chairman. I don't even have my water poured yet.

Thank you for the presentation. It was very interesting.

I'm going to ask a couple of questions that I didn't get a chance to ask the other day. Maybe you can help me with them.

You mentioned families. We know that's important, but we need you to explain just how important. We know that's a bit of a change, but things change. That's about the only thing around this place that's constant. Everything is changing all the time.

We've seen dramatic change in the things our forces are having to deal with right now. We're dealing with issues in Afghanistan that we didn't deal with before: suicide bombers, child bombers, all those kinds of things.

What new tools do we need to deal with some of these issues? What aren't we doing that we could be doing?

● (0910)

[*Translation*]

Dr. Stéphane Guay: I am not sure I understood your question. You're talking about the events that soldiers are exposed to on a mission and the children who commit these acts. I guess you are asking whether these events can affect the quality of life of military personnel when they return. Is that correct?

[*English*]

Mr. Roger Valley: Yes. When they come home, they're going to have to deal with some of these things that we haven't seen in past wars or past operations, so how do they deal with that? How do you deal with it when somebody comes back suffering from PTSD? How do you deal with it when they're dealing with an issue that's fairly new to the armed forces?

[*Translation*]

Dr. Stéphane Guay: Well, it's difficult to prepare soldiers for these kinds of horrific situations. There is no doubt that if a soldier who has children witnesses events involving children, whether they are victims or whether they're carrying weapons, while on a mission, his conception of life could be turned upside down by what he has witnessed. How can this problem be managed when they come home? Well, it depends on how much trouble he has coping. Whether or not he is suffering from post-traumatic stress, he can receive psychological support that will help him come to terms with those events and find meaning in them. The important thing is to avoid that having a negative impact on the ability of the family to function normally.

In fact, I believe that illustrates why it is important not only to act on soldiers' individual symptoms, but also consider the broader impact—in others words, the systemic effect or effect on the family.

[*English*]

Mr. Roger Valley: Thank you.

We've heard, and I think you've alluded to the idea, that quick action or action at the very start is a very important part of your job. It's not your job personally, because you deal with the problems afterward, but we bring our soldiers out of the difficult situations they're in and we know now that they head off to Cyprus or some kind of decompression. From what you know of it, how important is it for that to be immediate? We understand it's immediate right now; it's the first thing they face. How important is that, and do you actually look to see if there's more we can do in the decompression part of this, or do you not really deal with the issues afterward?

[*Translation*]

Dr. Stéphane Guay: Yes, absolutely. With any type of event that could have a negative impact on the effectiveness of a soldier's role when on a mission, I think you need to try to address the problem in order to avoid things getting worse. In terms of research, there is very little data to suggest that such interventions or strategies are effective, even on site. I believe we have to go further than that and assess the impact of this type of intervention, even though that is relatively difficult to do. Perhaps some resources should be set aside to that end.

In terms of what is called early or preventive intervention, reference is often made to debriefing, which can occur after what is called diffusing. That is probably what you are referring to. Diffusing involves giving an account of the events that occurred. Debriefing is intended to prevent problems from developing subsequently.

Research dealing specifically with the impact of debriefing on the prevention of PTSD clearly shows that it is not effective. It is possible not enough research has been done yet on this particular subject. In fact, there has been little research dealing with military personnel. However, a dozen or so studies have been conducted based on the normal practice and according to scientific methods. There are a number of literature reviews that deal with that. There really is an international consensus to the effect that universal early intervention—in other words, treatment of all the victims of a traumatic event, although we do not yet know of any cases involving soldiers—does not prevent the development of post-traumatic stress.

● (0915)

[*English*]

Mr. Roger Valley: Thank you.

I'm a bit confused, because I believe you just said that most countries, or all countries, believe in the debriefing, the decompression, whatever you want to call it. But you're saying the studies we have now don't prove that that's going to avert PTSD. So what do we do at this point? If we're not sure it's working, yet everybody's doing it—help me here—where do we go from here? Do we need a more in-depth study? I would have thought if everybody in the world was doing it, there would be some value to it. Are you saying the studies that have happened up to this point don't bear that out, don't show that?

[*Translation*]

Dr. Stéphane Guay: Yes, it is paradoxical. This is a common type of intervention, particularly in the workplace. It can involve soldiers, but it can also involve civilians—police officers, for example. I think it really flows out of a need to do something to help people who have been involved in potentially traumatic events.

Just to summarize my answer with respect to what you were asking earlier, I would that say although many people use it, according to many studies that have been conducted, it is not effective. You asked me what exactly we should be doing. Well, obviously, there is no simple answer to that question. From an ethical standpoint, the question is whether we should just let things go without any kind of intervention, and simply wait for problems to develop in some people, at which time we provide treatment or do whatever we can to help them.

In England, clinicians from various parts of the world got together and drafted a paper that sets out guidelines to be followed for interventions with people who have been exposed to trauma or have developed post-traumatic stress. They suggest not conducting universal debriefing—meaning, in every single case—but rather, treating only those who demonstrate a risk for developing problems in the short term, or in the two weeks following the event.

Having said that, it isn't always easy to use such a process for military personnel on a mission who have been exposed to that kind of event. I understand that particular context is complex. I simply want to mention that watchful waiting is what is suggested. This is a non-intrusive screening procedure used to repeatedly and regularly assess people's state of mind and provide more forceful or intensive treatment through cognitive behaviour therapy. That approach is based on research conducted over the last five or ten years with victims of sexual assault or road accidents who subsequently developed what is called acute stress response.

Acute stress response is a temporary diagnosis that can be made during the first month following a traumatic event. This diagnosis is made when people have developed a series of symptoms that closely resemble those of post-traumatic stress, the difference being that it occurs in the four weeks following the event.

So, it would be a good idea to implement a process for screening and treating only those who have the potential to develop post-traumatic stress. Indeed, they are at greater risk of developing post-traumatic stress because they already have symptoms that are closely related to PTSD. However, acute stress response is not a perfect predictor. Indeed, only 60% of people who meet the criteria for acute stress response actually develop post-traumatic stress subsequently. It is also important to continue to screen people who are not experiencing post-traumatic stress.

● (0920)

[*English*]

The Chair: Thank you very much, Mr. Valley and Mr. Guay.

Now on to Monsieur Roy, for seven minutes.

[*Translation*]

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

You just talked about acute post-traumatic stress. You gave a percentage. How many people did you say actually develop PTSD?

Dr. Stéphane Guay: In people presenting with symptoms of acute stress response, between 50% and 60% subsequently show symptoms of post-traumatic stress. When we only consider people with post-traumatic stress, as opposed to the number who experienced acute stress response prior to that, we see that the percentages are quite similar: between 40% and 50%. So, they do not equate perfectly.

Mr. Jean-Yves Roy: That was the purpose of my question. I have been listening to you, and I am thinking that any normal human being who finds himself in a situation like that is automatically going to demonstrate obvious signs of stress. I cannot imagine that you could witness someone being blown apart before your very eyes without experiencing some kind of stress. It may not be acute stress response, but there is no doubt that any normal human being would feel stress in such a circumstance.

Dr. Stéphane Guay: I fully agree with you. There is no doubt that the vast majority of people who witness an event such as the one you describe—body parts strewn about that they have to pick up—will experience stress. However, acute stress response is not just stress. It includes symptoms such as flashbacks and nightmares. You also have to have experienced dissociation when the event occurred, have problems concentrating, have symptoms such as hypervigilance, and so on. Not everyone presents with these symptoms. It's more serious than the simple stress response that most people have. It's a little different.

Mr. Jean-Yves Roy: I'd like to talk about the study you conducted on the health status of Canadian Forces personnel in their community. One is left with the impression that very few soldiers who experience post-traumatic stress actually seek help. These individuals are sent back to their communities—that was basically the purpose of your study, from what I understand—when, in fact, they are having problems that have not necessarily been identified. I would like you to tell us more about the results of that study.

Dr. Stéphane Guay: That was a study that Statistics Canada was commissioned to do by National Defence. The Canadian Community Health Survey is a Canada-wide survey on mental health. National Defence asked Statistics Canada to survey a representative sample of Canadian Forces members.

As part of that study, the lifelong prevalence of post-traumatic stress was examined, and it was observed that 6.8% of military personnel have apparently experienced post-traumatic stress at some point in their life.

● (0925)

Mr. Jean-Yves Roy: But without necessarily seeking help.

Dr. Stéphane Guay: Over the last 12 months, the percentage was 2.3%. When we wanted to know how many Canadian Forces members had consulted someone, we did some research with a colleague by the name of Deniz Fikretoglu. Those studies were published.

Basically, the proportion of people who seek help for mental health problems is between 40% and 50%. That is not only for post-traumatic stress, but for all mental health issues. So, as a general rule, within the military community, between 40% and 50% of people will seek help if they have a mental health problem.

But what is even more important, in my view, is the amount of time they wait before seeing someone. According to our study, people who had experienced post-traumatic stress during their lifetime waited seven or eight years, on average, before receiving treatment. That doesn't mean the treatment was not available; it may mean that they simply did not seek treatment earlier. Seven or eight years is a long period of time and, unfortunately, post-traumatic stress disorder can become chronic during those years.

Among civilians, it also takes quite a long time. At the Trauma Study Centre, we have treated more than 150 people who have experienced traumatic events in recent years. On average, those individuals had been experiencing post-traumatic stress for four years. So, it's exactly the same situation in the civilian population. Screening doesn't occur quickly enough and doing it sooner would be beneficial. Of course, we would need to encourage people to seek treatment earlier or, at the very least, remove the barriers currently preventing people from availing themselves of the services that are available.

We know that at National Defence, for example, there have been clinics in place for almost ten years now, if I'm not mistaken. So, services are available, but there are also barriers. As part of another study she conducted, my colleague, Deniz Fikretoglu, looked at what the main barriers are and the predictors of recourse to existing services.

The two most significant findings of her study are, first of all, that it is the soldier's own perception of his state of mental health that will prompt him to seek help or not. The greater his sense that his mental health problem is having a detrimental effect on his ability to function, whether we're talking about functioning in a professional, family or other environment, the greater the tendency will be for him or her to seek help. In other words, people who have a tendency to minimize their symptoms or to avoid thinking about them will not be as likely to avail themselves of services, even if they are available.

The other most significant finding of this study has to do with barriers that prevent people from seeking help. Variables taken from the results of the Statistics Canada study show that a lack of confidence in the Canadian Forces was the main reason why people decided not to seek help.

● (0930)

Mr. Jean-Yves Roy: What do you mean by a lack of confidence in the Canadian Forces?

Dr. Stéphane Guay: I really can't give you any details in that regard, but I can certainly speculate. This is not very precise, but I assume that the fear of revealing the fact that one is experiencing post-traumatic stress, of being expelled from the Canadian Forces, of losing one's job or of being stigmatized by others, are some of the underlying elements.

Mr. Jean-Yves Roy: As you know, it was recently reported in the newspapers—I believe it was last week or the week before—that soldiers with mental health problems were being sent back to Afghanistan. That means that people with very serious problems are being returned to theatre. That could exacerbate the issues, not only for the individual concerned, but also for the Canadian Forces, could it not?

Dr. Stéphane Guay: Yes, you're right. It is inevitable that some will return, but not necessarily. It is possible to identify more of them. As you know, people will sometimes pretend to have PTSD in order to receive a pension. On the other hand, some will hide it in order not to lose their jobs, because they want to remain in the Armed Forces. This latter phenomenon is much more widespread. And the fact that it is happening is not necessarily the fault of the Canadian Forces. There is no doubt that some people with mental health issues are going back to theatre. Will that exacerbate their problems? Well, it probably will, of course.

[*English*]

The Chair: Mr. Stoffer is next, for the NDP.

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

Are the studies you have done reviewed by your peers either within Canada or internationally?

[*Translation*]

Dr. Stéphane Guay: Yes.

[*English*]

Mr. Peter Stoffer: Specifically who would do that?

[*Translation*]

Dr. Stéphane Guay: It is an extremely lengthy and comprehensive process. The studies I have referred to were all published in such journals as the *Canadian Journal of Psychiatry* and the *Journal of Traumatic Stress*. Others will be published in these journals and others as well. The material is usually reviewed by two or three peers, in addition to the editor of the journal. As a general rule, when you submit an article or a study, you receive comments from the reviewers and are asked to clarify or change certain things. It is a very lengthy process, but an extremely reliable one as well.

[*English*]

Mr. Peter Stoffer: Are the subjects you study mostly what we call modern-day veterans, or would they include, for example, World War II or Korean veterans?

[*Translation*]

Dr. Stéphane Guay: They are modern-day veterans or soldiers who could at least become veterans, because they often have problems.

[*English*]

Mr. Peter Stoffer: Some of my colleagues have probably seen the movie *Flags of our Fathers* by Clint Eastwood. In the opening segment of the movie they show an elderly gentleman and his wife in bed, and he's shaking because he's remembering an event that happened in battle at Iwo Jima 60 years ago.

When I talk to some folks, they say that post-traumatic stress doesn't necessarily happen right away. It can happen many years later. An event that happens now is somehow buried, and then years later it comes out and you suffer from that. Is this a common occurrence you've seen in your studies?

[*Translation*]

Dr. Stéphane Guay: No, it is more the exception than the rule. What is known as delayed PTSD is infrequent. In my opinion, it is more frequent to see people learn to live their lives in spite of their symptoms and in spite of their traumatic memories, in large part through avoidance. Here I'm referring not only to behavioural avoidance, but also cognitive avoidance—in other words, avoiding even thinking about the event, and so on. We also have cases such as this involving civilians. Recently, we treated a former bank director who had been through a hostage taking in 1980. He had been experiencing severe post-traumatic stress for 26 years. This was a hostage taking in which a number of people were killed and injured. He himself had confronted the robbers, and shots had been fired. It was a very serious event. And yet he had managed to live his life for 25 years, although his ability to function had been altered. But he did manage to continue living throughout that period.

● (0935)

[*English*]

Mr. Peter Stoffer: We had a group here at our last session who work with the veterans. They mentioned a concern about some professionals who were exercising some caution about what they were doing—that maybe the professionals had issues or concerns about what that support group was doing.

Are you aware of that support group? Do you have any concerns about what they're trying to do to assist veterans and their families?

[*Translation*]

Dr. Stéphane Guay: Are you referring to the OSISS?

[*English*]

Mr. Peter Stoffer: Yes.

[*Translation*]

Dr. Stéphane Guay: I know generally about the kind of work being done by this group, which is really to provide peer support to soldiers who have been back from a mission for some time, have left the Canadian Forces, and have become veterans. The work they perform is very well regarded and seems to have positive effects. I don't have any data or studies that would attest to that, but I do know that, generally speaking, the group is well regarded and appreciated.

In terms of Veterans Affairs Canada working with families, spouses and close relatives, I can tell you that the Sainte-Anne Centre has developed intervener groups and that they are refining their interventions. I have discussions with them in order to provide any assistance I can, since I do have some expertise in developing interventions involving close relatives that can help veterans and people coping with post-traumatic stress.

So, I do know a little about it. For example, I know that they have spouses groups. They meet the spouses and get them to talk about the problems they are experiencing as a result of PTSD affecting their veteran spouse. These interventions are certainly an appropriate part of the mix. Living for seven, eight, ten or twelve years with a spouse who has PTSD, who has trouble talking about his problems and feeling positive emotions, who is more irritable, who has trouble concentrating, who doesn't sleep well, and so on, leads to lower quality of life for the entire family. Therefore, getting the family and spouses involved is a must.

[*English*]

Mr. Peter Stoffer: *Merci.*

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

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you for coming, Dr. Guay. I appreciate your taking the time to be here this morning as part of our discussions.

I want to follow up on a question my colleague asked about OSISS. You do research, you're a psychologist, and you've talked about a number of studies. I'll come back to that.

I had a very good presentation about what they do in peer support in OSISS. Obviously they aren't all researchers, but have you worked with them? How have you engaged them in your studies about the full breadth of support for our people? It seems that they, or organizations like them, would be very important to the support of our vets or our Canadian Forces people.

I believe you said you knew a little bit about them but you had never really engaged them, and I'm wondering why—whether it's them or someone else.

● (0940)

[*Translation*]

Dr. Stéphane Guay: That is correct; I have never actively collaborated with them. But there is no particular reason for that. The opportunity simply did not arise. However, I have done so indirectly. Someone conducted a qualitative study with spouses and therefore worked very closely with them. That person was a student of my colleague, Alain Brunet, whom I work with at the Sainte-Anne Centre. There is no particular reason why I haven't collaborated with them. I would obviously be very pleased to do so.

[*English*]

Mr. Bev Shipley: I want to follow up on that a little. I'm a bit surprised, and I want you to understand that we believe research is important. I have to tell you, though, that you're the only one who has come in and basically said to us that decompression before return is not effective. This is about studies.

My frustration is that it seems we get studies done by researchers who run both sides of the till a lot. I'm wondering how we are to make that decision based on different studies that are done by researchers with PhDs, and whatever. Some are saying it works and some are saying it doesn't. We actually have people on the ground who sometimes say we need to engage our peers, or we need to engage people in it.

I'd like a response on that.

[*Translation*]

Dr. Stéphane Guay: Just to clarify, I referred to debriefing, and not to decompression. I also mentioned that there was a consensus—in other words, a significant number of researchers agree that debriefing is not effective.

The clear consensus that has emerged is that debriefing does not prevent post-traumatic stress disorder. Perhaps I could begin by explaining what is meant by debriefing, before talking about what is paradoxical about all of these studies.

Debriefing is a form of intervention that generally occurs between 24 and 48 hours after a traumatic event—for example, a bank robbery. Within 24 to 48 hours of the event occurring, a psychologist or other mental health worker comes to speak with victims and, for about an hour, he gives people an opportunity to ventilate about the event by helping them through a number of different steps. He or she begins by getting them to talk about the facts, their emotions, and so on. So, that is a debriefing, as designed and generally applied in the business setting, but also in relation to different types of victims.

That is what I was referring to when I said it is not effective. Is "decompression" a process whereby soldiers have an opportunity to decompress somewhere for a week or so before coming back to Canada?

[*English*]

Mr. Bev Shipley: Can I follow up then—

● (0945)

[*Translation*]

Dr. Stéphane Guay: I would just like to finish what I was saying. If you're talking about that type of decompression, I have absolutely no idea whether its effect is positive or negative. It is very likely something that is appreciated and beneficial, but that has yet to be confirmed.

I would just like to complete what I began to say with respect to the paradoxical nature of this. Even though a debriefing is not effective in preventing post-traumatic stress, people like it a lot. When they're asked whether they're satisfied with the intervention, whether they're happy and whether they found it helpful, their answer is yes. However, we cannot rely on that indicator alone to say that there should be debriefing. Basically, debriefing is intended mainly to prevent problems from developing. If we are no more successful at doing that by relying on debriefing, as opposed to a control group where there is no debriefing, then we know that it is a waste of time and money.

[*English*]

The Chair: You have thirty seconds.

Mr. Bev Shipley: All right. I have just one question, and I'll have a chance a little later. On the debriefing, I guess I misinterpreted the debriefing and the decompression issue. It's interesting, and I don't think it matters whether it's with the Canadian Forces or with our emergency service people. In my former life as mayor of our municipality, I saw firefighters, for example, who would often come across fairly tragic incidents, and because we were in a community, from time to time they would know the people who had been killed or seriously injured.

We got involved by bringing people in who would be able to debrief and talk to them. They had an opportunity, not just then, within 12 hours, but maybe within two weeks. Every indication we had was that it was very positive and very worthwhile in prevention. We didn't used to have that. We saw some very serious side effects of a very tragic incident in which a neighbour hit a bridge, and one guy said it was kind of hard to scrape his friend's brains off the road. That triggered to me and others that we needed to bring in some specialists. When we had a different but similar incident involving two young kids, having those specialists, with what they were trying to do, had a very positive effect upon those emergency people.

So I have mixed feelings about the value of that. If you're saying it doesn't help, I will argue with that, because in respect of those individuals and whatever that ends up being, it may keep them from post-traumatic stress. I don't know, but if it is an opportunity in some professional way for them to get their feelings out and have someone listen to them and be able to deal with them maybe two or three weeks down the road, maybe six months down the road, I think that has a lot of value.

Those are just my comments.

[*Translation*]

Dr. Stéphane Guay: With respect to your comments, I can tell you that, of the excellent studies conducted on debriefing, one or two also dealt with firefighters.

I am aware of the situation as regards firefighters because I have met some. In fact, I met with representatives of the Montreal Area Firefighters Association last summer. What came out of that meeting with fire chiefs was that it is generally greatly appreciated. On the other hand, the fire chiefs also told me about some of the negative aspects of debriefing, namely that when these sessions took place, there were sometimes fairly negative comments made by colleagues who blamed certain individuals for their actions. They talked about that specific problem.

Having said that, I don't want to go into too much detail about this. However, I do want to say that we have not yet properly measured all the potential effects of debriefing and that if we are able to measure such things as quality of life or happiness, for example, we may get some results. At the present time, however, we do know that it does not prevent the onset of PTSD.

At the same time, it is important not to overlook the fact that human beings have tremendous resilience. It's important to remember that even when faced with an event that evokes strong feelings of aversion and that is potentially extremely traumatic—such as seeing a colleague die—the vast majority of human beings come out of it unharmed. In fact, 90% of people come out of it without psychological or psychopathological aftereffects.

I just wanted to emphasize that human beings are extremely resilient.

● (0950)

[*English*]

The Chair: Okay, thank you very much. We will now go to round two.

Monsieur St. Denis, go ahead, please, for five minutes.

Mr. Brent St. Denis: Thank you, Mr. Chair, and thank you, Dr. Guay. That was very helpful.

I recall reading a news article a year a half ago that in the wake of September 11 in New York, if my memory serves me correctly, a swarm of helpful counsellors came in to try to help the many people who were struck by what happened—family and so on—and also in the wake of one of the school shootings; I'm not sure if it was Columbine or another one.

This report suggested very much along the lines of what you're saying. We're amateurs, at least speaking for myself in this area, and it said that sometimes that early intervention, that swarming of help, was more negative. I can't interpret the meaning of that, but you're dealing in a field that is not a cut, not a broken arm; it's a very nebulous, hard to pin down situation. It underscores the importance of our looking at this as a committee, so we appreciate what you're saying.

We had the OSISS people here. They made a good presentation, and it brings me to the question of the balance between the helpful but unprofessional peer counsellors, the families, the friends, those who have gone through a trauma before, who are recovered, versus the professional. It can be helpful or it can interfere, if you have the wrong person in the wrong place at the wrong time with somebody who's experienced something.

Are you able to speak to the balance between the peer or mentor counsellor? We want to be positive about that and use those resources, but at the same time we want to be careful. Can you speak to the balance between the professional and the non-professional?

[*Translation*]

Dr. Stéphane Guay: Yes, certainly.

In fact, in terms of social support in general, there are a number of different types of social support that one can receive from one's immediate circle or environment. There is emotional support, there is more tangible support, and there is what is known as informational support, and so on. Every one of us needs different types of support at specific times—particularly when we are experiencing a stressful event.

Peer helpers are able to provide a different type of support from what is available from a professional. In that sense, they can be highly complementary. However, one cannot replace the other.

This is how I see peer helpers playing a useful role. They are particularly good at providing emotional support. They can also provide companionship by taking part in pleasant activities. Support does not only mean talking about difficult things; it also means having good times together. Peers can help them to experience that, to spend time in a group, and to have fun together. In that sense, their support is extremely helpful.

Professional support, however, is a more formal, specialized type of support, which may be closer to informational support, but also includes emotional support, to a certain extent. Indeed, when a psychologist listens to a soldier talking about what he's been through and all the distress he has experienced, he definitely has to demonstrate empathy and be an active listener. So, he also provides emotional support. In my opinion, it's very complementary.

At the same time, one cannot expect a psychologist to provide companionship, for example, or to take part in fun activities with the soldier. That is not the psychologist's role. Similarly, neither peer helpers nor family members should be asked to provide more formal or professional support.

In my opinion, we really need to separate out every person's role. That is the ideal situation, because peer helpers do not feel they have the necessary skills to provide counselling. And, as far as I am concerned, that is not what they should be doing; instead, they should be providing other types of support.

● (0955)

[*English*]

Mr. Brent St. Denis: In the case of a professional such as you, who is trying to determine or quantify as best you can the degree of the PTSD, is there such a thing as gradations or levels where you can say this is minor and you can prescribe a certain routine, a regimen of treatment, or this is serious? Can you determine that one on one, or is it too difficult to do that?

And with that, can you determine the balance between the peer counsellor and the professional? Could you say he just needs some time socializing as one extreme, and the other needs to be put in a hospital, if those are the two extremes?

[*Translation*]

Dr. Stéphane Guay: I think that depends on the needs of the individual. It is up to him or her to determine the kind of support that is needed. Peers should not force a particular type of support on these individuals. It has to be voluntary. When you impose the involvement of a support group, the impact can ultimately be a negative one.

So, there has to be a certain synchrony between the need for social support and what is offered in terms of support. In that sense, I think the best barometer is the individual concerned.

Mr. Brent St. Denis: Thank you.

[*English*]

The Chair: Thank you very much.

Now we go on to Monsieur Perron for five minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good morning, Dr. Guay.

Forgive me, but I may address you as Stéphane in the course of our discussion; but I want you to know that it is not out of a lack of respect on my part. I generally call everybody by their first name.

I was elected for the first time on June 2, 1997. In mid-July, I met my first constituent with PTSD. He was a young fellow the same age as my son. Since then, post-traumatic stress disorder has practically become an obsession with me. I've read the books written by Pascale Brillon, whom you most certainly know of, and I have become deeply involved.

Along the way, I have come to believe that there must be a way of predicting, when a young soldier is being recruited, the kind of psychological problems he might experience in the wake of a peacekeeping or war-related mission. It's too bad that Betty isn't here. I always tease her because she doesn't understand Quebeckers' black humour or people that speak in parables. I often say that if we can afford to buy C-17s, we can afford to invest in development and aid. I was really shocked when a witness we heard from last Tuesday, Maj Le Beau, a very nice lady, told us that before young soldiers are deployed, they are given a half-day of training to explain PTSD.

The written works of people like Pascale Brillon describe many different symptoms that make it possible to do a self-assessment and determine whether one has post-traumatic stress disorder. For example, people with PTSD suffer from insomnia, nervousness, have nightmares, and lose weight. We know that young soldiers are machos—we shouldn't shy away from using such terms—who say that they're tough.

In this country, we spend money. I'm not saying it's money that's poorly spent, but we do spend money to provide them with modern equipment. We spend money to train them physically for combat or to be in the army. On the other hand, we only give them a half-day of training to prepare them mentally for warlike conditions.

Why can't a member of Parliament like Gilles Perron dare to tell the Canadian government, whatever his political stripes, that every time it spends a billion dollars to buy equipment, it should consider investing 1% of that amount in veterans, in order to educate our young people and provide them with the proper care later on?

What do you think of my investment plan? Stéphane, I am certain that, like everybody else, you say you haven't got enough money.

● (1000)

Dr. Stéphane Guay: Prevention is probably the best remedy. I think there is probably much to be explored in that regard, including trying to increase soldiers' resistance to the events they will be exposed to on their mission or deployment. I am very much in favour of that. I think we should be investing a lot of money in research in that area, to try and see what works and what can really help them.

My first impression is that a proper self-screening procedure such as the one you described is probably the best solution. However, soldiers being the way they are, they may be reluctant to acknowledge they have a mental health problem.

I would just like to make two or three additional comments. To my knowledge, we are not currently able to identify soldiers who could suffer post-traumatic stress if they were exposed to a potentially traumatic event during their deployment. I don't think we have yet reached that stage.

In terms of our study of risk and protection factors in relation to our soldiers, we are still finding our way. We have identified three types of protection or risk factors. First of all, there are what are known as pretrauma factors—age, gender, past psychiatric problems or a family history of such problems, a history of physical or sexual abuse in childhood, or first-hand experience with other types of trauma. Then, there are peritraumatic factors—in other words, all the factors related to the seriousness and duration of the event, dissociation during the event, and so on. Finally, there are post-traumatic factors, particularly social or organizational support received after the event, and the number of stressors experienced subsequently, which may not necessarily result in trauma. For example, an individual may have difficulty sleeping. There are certainly factors at other levels as well, but I am just summarizing here.

Based on the current state of knowledge as to the extent to which these three types of factors can be good predictors, it is clear that pretrauma factors are not the best predictors of who will suffer from post-traumatic stress. The best ones are really the peritraumatic factors—in other words, the intensity and duration of the event, and how horrifying it was.

Having said that, such things cannot be predicted in advance. Every event is unique. There are events that one cannot even conceive of and for which no one could ever be prepared. Any soldier who came before you to give testimony could give you examples of horrifying events that he or she had experienced and that we could never have imagined.

● (1005)

Mr. Gilles-A. Perron: I have heard a lot about such events, Stéphane. More than 500 soldiers who have since left the Canadian Forces told me stories about atrocities. Just listening to them practically stresses me to the same extent. I have also met with young soldiers at the Valcartier base. Because they were afraid of losing their jobs, there was a curtain between them and me when I met with them. They did not want to be recognized. I think we need to invest in that area.

In closing, I would ask you to comment briefly on this. When we met with the last witness, I compared the Operational Stress Injury Social Support Program, or OSISS, to Alcoholics Anonymous. I don't want to denigrate Alcoholics Anonymous, because they do good work, but based on what I've read, the debriefing has to occur within a month or several weeks of the event. You cannot wait. That means that psychologists have to be in the battlefield.

Dr. Stéphane Guay: The ability to identify mental health problems as early as possible would certainly be beneficial but, in my opinion, that would lead to organizational problems. It is not easy to do. As a psychologist, I might end up being traumatized by my experience in the battlefield. However, there may be other options, particularly in terms of the processes and destigmatization. In this morning's *National Post*, it talked about the fact that Senator Kirby has been given a budget to establish a National Health Commission. I think that budget will be spent simply destigmatizing mental health problems. Just imagine, he is doing that in the general population, but it is even more necessary to do that in the military population, particularly because of what you just mentioned. There is a great deal of work to be done at the level. I could say a lot more about what I think should be done with respect to armed forces personnel and PTSD, but I will stop there.

Mr. Gilles-A. Perron: But that is exactly why you're here, Dr. Guay.

[*English*]

The Chair: I'd like to ask a couple of questions, if I might.

● (1010)

Mr. Gilles-A. Perron: No way. I'm leaving, in that case.

The Chair: I thought so. I guess there's a smoke involved as well.

You mentioned behavioural cognitive therapy. I don't know exactly what that is, but I'm going to take a stab at it, and you tell me how right or wrong I am.

I'm guessing that is where somebody suffering post-traumatic stress disorder exhibits symptoms. Maybe they don't want to be around things that trigger a memory of the events, or they have difficulty sleeping, etc. What you do—this is my guess—with behavioural cognitive therapy is educate them to the fact that those symptoms are related to PTSD, making them aware of it. That's my guess. I would like to get your sense of what it is and get an explanation.

[*Translation*]

Dr. Stéphane Guay: In fact, that is part of the therapy. Generally speaking, we are talking about cognitive behaviour therapy that includes three or four components. The first is psychoeducation with the person, treating the symptoms and what he or she is experiencing. Very often, particularly among military personnel, people are not aware of the fact that others may have the same type of symptoms. Where soldiers are concerned, if the symptoms only appear in one of the ten people who were exposed to the same event, that individual will obviously not easily be able to recognize them. As a result, the psychoeducation phase is extremely important, simply as a way of beginning the therapeutic process.

Following that, they are taught ways of reducing the physiological manifestations of anxiety—muscular tension, quick breathing, and so on. We use a method of relaxation or teach them a new way of breathing from the diaphragm.

After that, we usually move on to the main ingredient, which is exposure, in their mind's eye, to the scenario of the event, and then exposure to situations which are to be avoided. The first part is the most important one, obviously, where soldiers are concerned. We help them to gradually relive the scene associated with the event, recount what occurred and, in so doing, recall images and their thoughts. However, all of this takes place in a therapeutic context which allows the individual to come to terms with the images and memories in such a way that they no longer evoke strong negative emotions or cause as much distress. The idea is to gradually bring the person to recount the event to us, find some meaning in that event, and see it as forming part of the past.

The main problem for people with PTSD is that they are haunted by their memories on a daily basis. We try to help them to no longer be haunted. Of course, you cannot wipe out someone's memory of the event, but if you can bring them to talk about it and think about it without feeling distress, that is a major step forward.

After that, we can move on to exposure to situations or stimuli associated with the event. When psychological trauma occurs, associations are made between certain things and the trauma. It can be images, smells, or sounds. The idea is to generalize the learning that occurred during exposure to the scenario of the event and other stimuli that prompt the individual to recall the event subsequently, or on a day-to-day basis.

As a general rule, the final step is to try to prevent relapses. The idea is to consider the risk factors, which situations involve risks, and also to teach strategies that will allow the individual to manage those problems, if they re-emerge.

So, we are essentially talking about multiple components. Of course, to that can be added all kinds of very relevant modules, especially for veterans. I know that at the Sainte-Anne Centre, for example, we do a lot of work with respect to nightmares. Often, nightmares are part of the symptoms. In fact, the dreams are what cause distress. And the dream may not necessarily be an exact representation of the event to which they were exposed. There are intervention methods and strategies that allow people to stop having these nightmares, and that can be very helpful. We can also help with anger management, and with respect to other emotions which are not necessarily fear-related and are therefore not a result of anxiety—for example, guilt or shame—feelings that are often very prevalent in veterans and which must be addressed as part of the therapy.

[*English*]

The Chair: You made a mention in one of the responses here to hyperarousal. I'm guessing, and once again I'm just clarifying, that this would be where they are extra-sensitive to their environment. In a military scenario, you hear about somebody who is very sensitive when they are sleeping, for example. My father talked about that with Vietnam veterans. They were particularly sensitive, as if they were in a field of operations or what not. I'm wondering if you can go into hyperarousal a bit and explain that a little further.

● (1015)

[*Translation*]

Dr. Stéphane Guay: I am not sure I understand. All sorts of things can be associated with sleeping—for example, being in the dark and going over the events in one's mind and the distress that they cause. As far as I know, the simple act of sleeping—other than the fact that an individual may think back to the painful events or have nightmares—is not associated with that.

[*English*]

The Chair: I was trying to give you an example, but could you just give a more thorough description of what hyperarousal is as a symptom of PTSD?

[*Translation*]

Dr. Stéphane Guay: Hyperarousal is what is known in French as “l'hyperactivité neurovegetative”. It is one of the groups of symptoms that are part of the diagnosis. These symptoms include sleep disorder, problems concentrating, hypervigilance, irritability, and so on. Obviously, this kind of hyperactivation can mean that the person is constantly on the lookout. The simple fact of finding oneself in complete silence at bedtime or when in bed—silence in itself—can recall certain aspects of the trauma. It may cause a person to relive the trauma he experienced, to feel anxiety and to have depressogenic thoughts.

If, on average, they waited seven or eight years before receiving services and the post-traumatic stress has become chronic, there is a good chance they will have developed comorbid major depression. According to the Statistics Canada survey, more than half of Canadian Forces personnel experience major depression, and it is the same thing in the civilian population. People present with secondary depression and, very often, they will take antidepressants. It is also important not to overlook the effects of depression on mental health or on soldiers' general quality of life.

[*English*]

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

Mr. Roger Valley: Thank you, Mr. Chair. I just have one quick question and then I'll hand it over to Mr. St. Denis.

When we were talking earlier, you were talking about different methods of—I don't know if I'd call it treatment, and I'm not sure if I got the translation right, but what I got from it is that you used a term called “watchful waiting”. I'm wondering if that's self-explanatory. Is it the professionals who do this when somebody has actually been identified as having PTSD? Is it the professionals, the family? Can you tell us what kind of treatment watchful waiting is? Does it mean we're just keeping an eye on these individuals?

[*Translation*]

Dr. Stéphane Guay: It doesn't only concern people suffering from PTSD, but the term basically applies to them.

Having said that, it is important to identify mental health problems in the family, in spouses and in children, because such problems can have repercussions for them and manifest themselves in different ways.

As far as I know, soldiers do not easily talk to their spouses about what they are experiencing, or the events they were exposed to, often out of fear of contaminating or traumatizing them. If they don't talk about these things, their spouse will not understand why they are in that state or the magnitude of the problems they seem to be experiencing. Often they suffer from the isolation and emotional detachment of their spouse, because they have trouble talking about their problems. As well, post-traumatic stress means they also have trouble feeling positive emotions. That means, for example, receiving and giving affection, having sexual relations, and so on. There are a number of components.

Soldiers or people coping with PTSD often report that they are more irritable with their children. They are less tolerant of bad behaviour, which has a fairly important impact on the family. We obviously have to look after them.

It can even go further than that. Studies conducted on Vietnam war veterans show that there is more domestic violence and domestic dissatisfaction among members of this group. Is this domestic violence the result of symptoms of post-traumatic stress disorder? It most probably is, at least in part, and perhaps completely.

So, we have to deal with this problem. Spousal separation is not always disastrous. Some of you are most certainly separated or divorced, given the general trend in today's society. When our spouse ends up leaving us or wanting to separate because of our mental health problems, that is even more difficult to accept. The impact of a possible separation on a veteran must also be taken into consideration.

It would also be a good idea to screen close family members for mental health problems, and to look at family or spousal health.

● (1020)

[*English*]

The Chair: Thank you.

Mr. Brent St. Denis: I'll just take the last few moments of my colleague's time, if I may.

In relation to predicting in a given person's case the potential for a bad reaction to a difficult situation in the military universe, how much do we know in the area of prediction? Presumably funding agencies, governments, and so on, if they have $100, want to spend some of that $100 on the upfront aspect, the prediction and the preparation, but clearly the bulk of the dollars is on the follow-up, because you can't predict very well. Let's say it's $10 before and $90 after, just to make it simple.

Could you talk about the prediction and predictors a little bit, please?

[*Translation*]

Dr. Stéphane Guay: I'm glad you asked that question. If I had $100 to invest, I would spend half of it on developing treatments that could be used following development of PTSD, and the other half on research aimed at identifying individuals at risk and developing effective prevention strategies. Unfortunately, we have very limited knowledge in those areas.

I believe soldiers are a group with whom we could really do some very good work. They are what we call in our research jargon “captive individuals”. In other words, we can assess all of them before they are exposed to traumatic events. It would be very difficult to do that in the general population. You would have to assess several hundred thousand people in order to obtain a sample of individuals who would be exposed in the following months to traumatic events. With soldiers, we are dealing with a cohort of people who we know will most certainly be exposed to such events.

Of course, the ability to conduct research, to assess risk and protection factors before they leave, and to ascertain which of these factors enable us to predict the individuals who will develop PTSD could open up some very interesting avenues in terms of applying preventive and therapeutic strategies when they return. I would also invest money in the care to be provided people returning home. In my opinion, the current state of our knowledge is not adequate and we therefore cannot afford not to invest in prevention.

● (1025)

Mr. Brent St. Denis: Thank you.

[*English*]

The Chair: Thank you, Mr. St. Denis.

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

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

Dr. Guay, thank you very much for your time here.

I wanted to ask you a question specifically on one of the earlier statements you made, that in the military population there is a prevalence—his is from a study—of 6.8% who would have experienced PTSD. What is it in the general population? Can you give us a number on that?

[*Translation*]

Dr. Stéphane Guay: Unfortunately, we have not conducted studies in the general population here in Canada. As a result, I cannot draw any comparisons with the Canadian population. These studies were conducted in specific areas, including Edmonton and Winnipeg. I can tell you that in those studies, the rates were relatively lower—around 3% or 4%.

That is an excellent question, and it's extremely complex. Let me try and give you some answers in that regard. In the United States, the prevalence of post-traumatic stress in the general population over the course of a lifetime is also 6.8%. One is tempted to conclude that it is equivalent. However, another study was conducted in 2005. It is an excellent epidemiological study carried out in accordance with accepted practices.

The same thing was done in Europe, but the prevalence over the course of a lifetime was about 2% or 3%. That is quite surprising. There is a great deal of variation from one European country to the next in terms of prevalence. As you can see, this is a complex matter. Epidemiologists who conduct these studies have trouble explaining why there is so much variation from one country to the other on the same continent. They also have trouble comparing these results to those obtained in the United States.

Furthermore, I should also point out that the prevalence of PTSD among military personnel is somewhat underestimated in this study, for methodological reasons.

[*English*]

Mr. David Sweet: You did mention that PTSD is very complex. In fact, PTSD is a very broad spectrum disorder. The disorder covers all kinds of consequential behaviour after someone's exposed to a trauma. Is that correct?

[*Translation*]

Dr. Stéphane Guay: Yes, exactly. Post-traumatic stress is obviously one of the main disorders caused by exposure to a traumatic event, but there are also other disorders that can develop. They include depression, other anxiety disorders, panic disorder with agoraphobia, for example, or simply panic attacks, and so on.

Mental health issues at National Defence or in the Canadian Forces do not only involve PTSD. In fact, there are others that are far more prevalent than post-traumatic stress.

[*English*]

Mr. David Sweet: I'm listening to all the evidence, and I would like to clarify something on an earlier question from Monsieur Perron.

There is no better training that could be deployed right now for individual soldiers, and what's required now is more research. In other words, you weren't saying earlier that there was better training and we were refusing to give it to soldiers for recognition of PTSD. There's more research required on the whole complex issue.

● (1030)

[*Translation*]

Dr. Stéphane Guay: Yes, absolutely.

[*English*]

Mr. David Sweet: I also want to clear up one other thing, because your testimony is actually contrary to that of a group of witnesses we had here. The four witnesses we had from OSISS were quite impressive, and they said one thing that's of concern to me.

I have three military bases in my riding: the Argyles, the Royal Hamilton Light Infantry, and the HMCS Star.

One of the big barriers to PTSD, at least for a soldier to recognize it quickly and, of course, come forward, is a concern about careers. OSISS has made it very clear to the soldier that their mandate is to get the soldier healthy in order for him or her to have the mental capability to again function well and to go back to his or her career, which is very honourable. As well, it combats one of the major barriers or one of the major stigmas of coming forward.

But you suggested earlier that soldiers who had significant mental issues were actually being sent back to theatre. I need to know this. Is it conjecture on your part, or as a clinician, have you actually had soldiers in your care who were mentally dysfunctional and were sent back into theatre?

[*Translation*]

Dr. Stéphane Guay: In fact, no. It is an inference on my part, because we have not treated people who were redeployed subsequently and had problems again. This is something that can be inferred from the studies—when you see, for example, that someone who had been suffering from post-traumatic stress disorder for six years was deployed in the last four years. So, one can obviously infer from that that this individual was deployed even though he or she had symptoms. We can see that from the data base we have, particularly the Statistics Canada one. We can see that if, on average, individuals that have been suffering from PTSD for eight years went on a mission twice in that eight-year period, there are most definitely some among them who were deployed in spite of their mental health problems. But that is an inference. I have not actually seen people that it happened to.

[*English*]

Mr. David Sweet: Yes, I think the fact that it's a hypothesis is necessary for clarity. Statistics are at what I would call a 30,000-foot level compared to actual experience and practicum on the ground.

You mentioned developing a process for de-stigmatization. In fact, there's one question that my colleague has asked every witness, and I get the joy of asking it now. From the research you've done, what measures do you think Veterans Affairs and the Department of National Defence could take right now in order to begin the process and enhance the process of the de-stigmatization of PTSD?

[*Translation*]

Dr. Stéphane Guay: Yes. I don't know exactly how to go about it, but I think it's something that requires a lot of resources, because the fear of losing one's job is not only very strong, it is also very realistic. If you are deemed to be dysfunctional and cannot be deployed after six months, I believe the risks of becoming a veteran increase; they are practically 100%. So that is a well-founded fear.

At one point, I heard Gen Dallaire saying, in an interview on television, that what is traumatizing for soldiers is not only being exposed to these events on deployments and coming back with these problems, but also to be thrown out of the Canadian Forces, even though they have given their lives and dedicated at least part of their life to that service; their families, as well. So, the simple fact of having to leave gives rise to a lot of distress.

When you ask me what we can do to destigmatize PTSD, I guess my answer would be that major organizational changes will probably be needed. Perhaps we will have to try and find duties other than military deployment if, for psychological reasons, some people cannot go on missions. That is one of the things that we may want to consider.

Another option would be to promote systematic screening. That way, we would not target only people who are at risk or could be perceived as being weaker by their peers. We would target everyone and, that way, everyone would go through a screening process that would allow us to achieve the desired result, without stigmatizing anyone.

Those are two examples. We could go even further than that, but I believe the most important thing that has been done thus far to destigmatize operational stress, as soldiers call it, is really what Gen Dallaire said in that regard. There is no doubt that when a senior commander suddenly talked about what some consider to be a weakness, that most certainly prompted a lot of people to go and get some help. At the same time, I believe there is still a great deal of work to be done in that area.

● (1035)

[*English*]

The Chair: I'd like to follow up on something, if I may.

Say, for example, you have somebody who is clearly demonstrating all sorts of symptoms, and they obviously need help, but they're still in the process of trying to avoid recognizing that they have something. They're trying to ignore it, they're trying to pretend they don't have something, but to others around them it's very obvious. What are your suggestions for some of the best ways to get somebody who is obviously suffering symptoms to go and do something?

[*Translation*]

Dr. Stéphane Guay: I'm sure there are a lot of different answers to that question. However, I will give you one. I think peers need to be involved.

For example, the Correctional Service of Canada has developed a peer helper program which is primarily aimed at enhancing screening of mental health problems associated with critical events that have occurred as part of prison guard work, for example. The Operational Stress Injury Social Support Program can probably provide some assistance in that regard, if the program is connected to the Department of National Defence. I'm not sure whether it is limited to Veterans Affairs Canada or not. That could contribute.

This is how the Correctional Service of Canada's program works: the organization selects a certain number of workers or individuals within that organization who it believes have a natural ability or natural skills in terms of active listening, but who can also interact appropriately with their colleagues who have witnessed critical events. Let's take the example of a fight between two inmates: they have to come between the two to separate them, there is bleeding during the fight and one of the two fighters who was bleeding was HIV positive. That's the kind of event that the organization deems to be critical.

The procedure followed at that point involves a peer helper, to whom a certain number of people are assigned, going to talk to the prison guard involved in the incident, although not to ask him to talk about what happened, as you would in a debriefing. That is one of the aspects of this program that I find absolutely brilliant, as a matter of fact. He simply goes to see the guard and talks about some of the possible signs of post-traumatic stress; he tells him that if he ever requires assistance because he doesn't feel well or is constantly thinking back on what happened, he shouldn't hesitate to go and see him to get help or receive information about the kind of help that is available.

I believe a simple procedure such as that, which is non-intrusive and allows the individual to see for himself that support is available, if need be, is one example of the kind of process that could be applied to military contingents. That is a first suggestion.

● (1040)

[*English*]

The Chair: All right.

Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: Stéphane, I'm not finished grilling you yet.

You just talked about the Operational Stress Injury Social Support Program. I was really surprised. That is not a criticism. I would like you to tell me what you think.

Last Tuesday, we were told that peer helpers receive three days of training at Sainte-Anne Hospital and go back into the field to organize meetings on a volunteer basis, a little like what Alcoholics Anonymous does. I think three days of training is an absolute minimum.

Is it possible to teach someone the basic tenets of psychology or psychiatry so that they are better able to manage these centres or organize these training sessions? I would be interested in hearing your opinion.

Dr. Stéphane Guay: Well, as I said earlier, I believe that peers and professionals have complementary roles. Are three days of training adequate for a peer helper to be able to provide the support he should be in a position to provide? In my opinion, we are talking mainly about support in the form of listening, but not necessarily extended listening. I think the idea is that this person becomes a kind of vector who may be able to encourage or bring the individual involved to seek the services that are available.

I think the role of a peer helper really should be to do the strict minimum and simply get the individual to avail himself of the professional services he or she needs. Otherwise, it continues to be a case of specific skills or aptitudes. If there is no serious problem, if the person is just sad or a little anxious, it is possible that active listening will be enough. On the other hand, if there are more serious and persistent problems, and notably PTSD, I believe the peer helper's role, which should be valued, is to get that person to actually make use of the appropriate resources.

Mr. Gilles-A. Perron: A door has been opened to provide assistance to veterans. I agree that it's a first step. However, I am a little uncomfortable with one aspect of this financial assistance.

There is talk of establishing five training centres all across Canada. There is already one in Sainte-Anne-de-Bellevue. However, we know that this particular centre only has five beds for veterans.

I have an idea and I would like to see whether it is achievable. I will be talking about Quebec, but I have no doubt the situation is the same in all the provinces.

I know a veteran from Matane, the region represented by my colleague. He believes he is suffering from post-traumatic stress. I told him to get in the car, to drive for eight hours to Sainte-Anne-de Bellevue, to spend a day or two there, and then go back home.

I'm wondering whether we could set up a group of psychologists in Quebec who would be trained and mandated by Veterans Affairs Canada to provide follow-up with veterans. There could be one psychologist in each of the different regions, such as in Rimouski, which is located right in the centre of the Lower St. Lawrence region, another one in Lac-Saint-Jean, and so on. There may be thousands of veterans in Quebec suffering from post-traumatic stress. We just don't know.

If it's a health problem—for example, if I cut my arm and I need to see a specialist in Montreal, I will have no hesitation about taking a plane from Rouyn-Noranda to go and see him. However, if I have a problem between the ears but I'm not totally convinced that is the case, I may postpone that consultation to the following week or a time when I have to go to Montreal for something else. I may not end up going at all.

A psychologist who practices general psychology in a regional clinic, however, could be given special training by people like you or Pascale Brillon so that they could also care for people with post-traumatic stress. If it costs $150 an hour, well, the bill would simply be sent to VAC. That would save the veteran money, who would otherwise have to pay to go to Montreal to consult a specialist.

What do you think of that plan?

● (1045)

Dr. Stéphane Guay: I fully agree with it. That is an excellent way of providing specialized and enhanced services to veterans. It would also help to develop a network of psychologists, which would mean they could work more effectively to treat this kind of problem.

That is one of my goals as Director of the Trauma Study Centre. Knowledge transfer is one of my objectives. We need as many competent people as possible to be available to provide treatment. Both in the general population and here, people have to wait several years before they are able to access the appropriate services. That is a long time. Their problems become chronic, and there is absolutely no doubt that there is a cost when people are unable to receive the right services at the right time.

Mr. Gilles-A. Perron: A man from Kirkland Lake, the city adjacent to my own hometown, had to go to Toronto or Ottawa to be treated. It would have been easier for him to go to North Bay, which is closer, or to Sudbury, had there been such a centre.

Dr. Stéphane Guay: These services could be provided to veterans, but also to the entire mental health network.

In England, because cognitive behaviour therapy is the preferred treatment for a great many types of mental health problems, the British government has decided to launch a training campaign. It will be training some 10,000 psychologists to use the cognitive behaviour approach, because it is the best treatment for depression and anxiety disorders. Those two categories of mental disorders are the most frequent in the general population. In my opinion, it is money well spent.

[*English*]

The Chair: Thank you, Monsieur Perron.

Now on to Mr. Shipley, for five minutes.

Mr. Bev Shipley: I have just one quick question.

You mentioned earlier that there are other disorders that may or may not be more prevalent than PTSD. What other operational stress injuries would be linked to this? If we were talking about other operational stress injuries—and correct me if I'm wrong—I believe PTSD is one of those.

[*Translation*]

Dr. Stéphane Guay: In fact, operational stress is the terminology used by the Canadian Forces and veterans. Rather than calling it post-traumatic stress disorder, they call it operational stress disorder. It's the same thing, but they describe it as being a disorder connected to work carried out as part of a military operation.

[*English*]

Mr. Bev Shipley: Are there other things encapsulated within operational stress injuries?

● (1050)

[*Translation*]

Dr. Stéphane Guay: Yes. I imagine there must also be physical injuries, but I believe they have just determined that what they call TSO is what is known in the military as post-traumatic stress. It is an operational stress disorder, but I imagine there must be physical injuries as well. As I was saying earlier, it's important to realize that post-traumatic stress disorder in soldiers is not only caused by events they are exposed to on deployments. They experience many other kinds of events: it could be during their training, or it could a sexual assault while they're at their base.

In fact, whether you consider lifelong prevalence, as opposed to prevalence in the last twelve months, it doesn't really matter, because between 50% and 75% of post-traumatic stress disorders are caused by an event experienced while on deployment. That means that between 25% and 50% of events which caused post-traumatic stress are experienced outside the context of a deployment. So, these things do not only occur while soldiers are carrying out their duties during a deployment; they also occur elsewhere.

[*English*]

Mr. Bev Shipley: Is it just terminology then, the definition of a term? Is that what you're saying?

[*Translation*]

Dr. Stéphane Guay: Yes, I think so.

[*English*]

Mr. Bev Shipley: Thank you.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): I've listened very carefully to what you've had to say today and I've also listened carefully to the questions that have been asked. This is always a wonderful opportunity to receive a bit of an education on something we may not be exposed to on a regular basis as members of the committee. So I do appreciate this. I also appreciate your taking the opportunity to lobby for funds for your specific clinic. I think if I were in your position, I would have done exactly the same thing today.

But one thing you said today that I have to disagree with—and I stand to be corrected—is that it's your understanding that a lot of veterans suffering from PTSD don't say anything because they're afraid of losing their jobs. You are, I'm sure, aware of the Veterans Charter that was passed earlier this year, which would take care of any veteran and retrain him if necessary. So I have to take exception to the comment that they don't come forward because they're afraid of losing their jobs. From my perspective, I would say that wouldn't be the reason they may be fearful of coming forward. I think it probably has more to do with the stigma that's attached; somehow that thought process is still out there in the military that if you've suffered from this, you're somehow less of a soldier—which I don't agree with. But the loss of jobs to me is really not a big issue, because the families will be taken care of, the soldier will be taken care of, and retraining is available, as well as a support system.

So I'd be interested in the rationale behind your thought that it's because they're afraid of losing their job.

The Chair: Was there a question in that, Betty?

Mrs. Betty Hinton: I asked him to give me the rationale behind it.

[*Translation*]

Dr. Stéphane Guay: I will answer as best I can. Actually, I would just like to clarify one thing.

Earlier, I was referring to soldiers who are still with National Defence, not veterans. As you say, once they're veterans, they can no longer lose their jobs or pensions if they say they have PTSD.

If changes have been made to National Defence policies in that regard, I am not aware of them. I do know, however, that these people want to keep their jobs as active soldiers, continue to be deployed on missions, and play a role that jibes with the training they have received. They want to avoid being assigned to other duties or simply acquire veteran status. That is a tremendous concern to them.

● (1055)

[*English*]

Mrs. Betty Hinton: Thank you.

Mr. Gilles-A. Perron: I had some comments.

The Chair: Bear with me, Monsieur Perron. I'm in the awkward spot whereby we have spots for the Liberals and for the NDP still available, but none for the Bloc. If either the Liberals or the NDP were willing to—

Okay, Mr. Stoffer is nodding.

Monsieur Perron, go ahead.

[*Translation*]

Mr. Gilles-A. Perron: I just want to add something to Stéphane's answer to Betty Hinton's question. I have seen a lot of soldiers and I can tell you exactly how it is. This is Grandpa Gilles Perron speaking now.

The young people say they like the army and their job, but they will lose all of that if they admit they have problems between the ears—if they have to climb the stairs of shame, as they call it in Valcartier, to see the mental health specialist on the second floor. They know, and you know, Ms. Hinton, and we also know that notwithstanding the Veterans Charter, they may wait months, or even years, before being treated for post-traumatic stress. Why?

In Quebec—and you can multiply the number by ten—there is only one place where people can get help, and that is Sainte-Anne-de-Bellevue Hospital. However, there are only five beds available for hundreds of thousands of young people. This is a long-term issue. That means people aren't receiving a salary for a year and their family has nothing to live on. That is one of the factors underlying this problem. Another factor that shouldn't be forgotten, but that Stéphane did not mention, is that they are machos and, as far as they're concerned, it is not normal for a soldier to be sick. When they leave, they have really good reasons for doing so.

[*English*]

Mrs. Betty Hinton: It goes back to the stigma.

The Chair: Now it's over to Mr. Sweet.

Mr. David Sweet: Do you have time for another one?

Dr. Stéphane Guay: Yes, sir.

Mr. David Sweet: Fantastic.

Doctor, you mentioned, about debriefing, that there was no conclusive evidence that debriefing helped, and you mentioned a study. What was the size of the control group in that study around debriefing?

[*Translation*]

Dr. Stéphane Guay: There was not only one study, but a dozen or more studies carried out by researchers in various countries on different populations—so, they involved several hundred people.

[*English*]

Mr. David Sweet: Okay, so there's a lot of confidence in it, then, because of the number.

I apologize if I missed it, but I got quite a detailed analysis of debriefing and not so much of decompression. Is that because decompression is contingent upon the disorder the individual has and the amount of time it would take? Or are there some stages that you can walk us through concerning what decompression looks like compared with debriefing?

[*Translation*]

Dr. Stéphane Guay: In terms of decompression, I am not sure exactly what your colleague to the left was referring to earlier. I believe that he was talking about the week during which, following a six-month mission, for example, soldiers are taken somewhere to decompress.

I am not sure exactly what they do during that week. A little earlier, I was talking about diffusing, as opposed to debriefing. Diffusing is more of an organizational intervention, as a matter of fact. It is intended to ascertain whether every person's role has been maintained. It is much more closely connected to the nature of the work than it is to problems or emotions. It's different.

● (1100)

[*English*]

Mr. David Sweet: Thank you.

The Chair: I want to thank our witness very much for his presentation today. We all learned a lot.

I'd like to just deal with one matter of business here, in the sense that Mr. Valley has brought forward a notice of motion so that at our next meeting we'll be dealing with this: “That we continue our investigation into PTSD and at its conclusion we report it to the House as the first part of our health study.”

I believe it's been translated *en français*.

Mr. Roger Valley: Mr. Chairman, with Mr. Perron's help, he corrected the last part. It says:“...report it to the House as the first part of our study on the VIP and health care review”. It's just adding the official title. That's what is said in the French version.

The Chair: Is there any comment?

[*Translation*]

Mr. Gilles-A. Perron: Just about the translation. I did the translation, and I had it reviewed by Jean-Yves, Amy Mills and Michel. It accurately reflects the English version. So, the motion is being tabled in both languages.

[*English*]

The Chair: Monsieur Perron, as long as you're happy with it, we're all happy with it.

Go ahead, Mrs. Hinton.

Mrs. Betty Hinton: Because it's a notice of motion, is it appropriate to speak to it at all now, or do I have to wait?

The Chair: We had best wait until the next meeting, really. I don't see any point—

Mr. Roger Valley: Is there another committee coming in?

The Chair: No, some of our members—Mr. Stoffer is already out the door. There's your answer right there.

All right, thanks so much.

The meeting is adjourned.

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