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Chair

Mr. Rob Anders

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● (0905)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good morning, folks. We have another veterans affairs meeting.

I would like to welcome Monsieur Gaudet back. He's been away; I understand that the other committee he was with has finally put its report in to the House. We're very grateful to have his familiar and smiling face back at our committee table.

I would like to welcome our witnesses this morning from the Department of National Defence. We have Ms. Margaret Ramsay, Major Chantal Descôteaux, and Dr. Marc-André Dufour.

You can collectively have 20 minutes, or you can have snippets thereof, or you can slice it however you wish. Afterwards these folks on the standing committee get a chance to ask you questions and pick your brains. We also, at the end, have a motion from Mrs. Hinton to deal with today at our committee.

I give it over to our witnesses. Please go ahead with your presentation.

Mrs. Margaret Ramsay (Acting Senior Staff Officer, Canadian Forces Mental Health Initiative, Department of National Defence): Good morning, all.

Mr. Chairman and members of the Standing Committee on Veterans Affairs, my name is Margaret Ramsay. I'm the acting senior staff officer for mental health services within the directorate of general health services. As such, I'm responsible for the administrative issues related to mental health services across the Canadian Forces.

With me are Major Chantal Descôteaux and Dr. Marc-André Dufour. Chantal is the base surgeon at CFB Valcartier and has the overall responsibility for all medical services at the base, including mental health services. Dr. Dufour is a clinical psychologist and is the practice leader for psychology within mental health services at Valcartier.

We're pleased to have this opportunity to meet with you today. I would like to brief you on the CF mental health services. The purpose of this briefing is to provide you with an overview of how mental health services are delivered within the Canadian Forces. As you may know, we are currently in the middle of a five-year project, called Rx2000, to markedly improve these services. Among other things, the five years will see an increase from 229 to 447 in the number of mental health providers available to our CF members.

Mental health care is provided in an interdisciplinary fashion in the Canadian Forces. Disciplines involved in this care provision include family practitioners, psychiatrists, physician assistants, nurse practitioners, social workers, mental health nurses, psychologists, pastoral counsellors, and addiction specialists.

I just want to go over a bit of background with you. In 2001 the Canadian Forces coined a new term, “operational stress injuries”, OSI, that regrouped several mental health conditions that are often the result of stress and trauma. OSI is not a medical term. “Operational stress injury” is officially defined as any persistent psychological difficulty resulting from operational duties performed by a CF member. The term OSI is used to describe a broad range of problems, including PTSD, which usually result in impairment in functioning.

In 2002 the Canadian Forces medical services contracted Statistics Canada to conduct a mental health survey of CF members to determine the prevalence of PTSD and other mental health disorders. This study found that 2.8% of the regular force and 1.2% of the reserve force reported symptoms consistent with a diagnosis of PTSD at some time during the year preceding.

Over the course of their lives, 7.2% of the regular force and 4.7% of the reserve force would have met the diagnostic criteria. The survey determined that depression and panic disorder were significantly more prevalent in the Canadian Forces than in the civilian population. The survey also revealed that regular force lifetime prevalence of PTSD, post-traumatic stress syndrome, equates to that found in the Canadian general population.

Levels of service within the CF—Mental health care is organized into two levels of service provision. This organization is differentiated by the degree of specialization of the service and is defined as either being primary care or secondary care in its delivery. Primary-level mental health care is denoted as psychosocial care. The psychosocial service is the first level of mental health clinical services and functions with the patients care unit delivery, which is called a CDU. In addition to a crisis intervention service, it provides a number of social work administrative services.

Psychosocial services are considered to be brief interventions. Higher degrees of specialization—secondary care—are called mental health services and are accessed through referral from primary clinical services. These secondary services are organized as a series of programs of various degrees of specialization.

Some of these programs consist of the operational trauma and stress support program, the general mental health program, and the addictions treatment program. These are three of our most common programs that are utilized.

Another basic principle of mental health care delivery is its use of regular interdisciplinary case intake and review. Care provided both within the Canadian Forces health care clinic and by external service providers is regularly reviewed. In this way, CF members can be assured that their care is of the highest quality, consistent with evidence-based best practices.

As to service locations, to address the medical needs of Canadian Forces members, mental health clinical services are available in all medical clinics across Canada. As well, the Canadian Forces has five large clinics that offer a full range of mental health services and include operational trauma and stress support centres. These centres are located at Halifax, Ottawa, Valcartier, Edmonton, and Esquimalt. Geographically, they're placed across the country to provide service regionally.

Canadian Forces members and families can also contact the Canadian Forces member assistance program—CFMAP—a 24-hour, seven-day-a-week confidential referral system. This is a 1-800 number. This program provides external short-term counselling for members and their families initially more comfortable in seeking assistance outside the direct military health services.

That concludes my brief for this morning.

● (0910)

The Chair: All right. Do your colleagues have things they'd like to add to that presentation? No? All right, fair enough.

For the Liberals, for the first seven minutes, we have Mr. Valley.

Mr. Roger Valley (Kenora, Lib.): Thank you very much.

Thank you for your presentation this morning.

You mentioned a number of things. I'll go to your last comments first, if that's the way I could do it.

You talked about the service locations. Some of us here serve in northern Ontario, and we realize that there are no bases—or no base in my neck of the woods, in the Kenora riding. You talked about the clinics. You mentioned there are five across Canada. The two closest I see to us would be probably Ottawa and Edmonton.

What happens when there's a service member who needs service and he's sent back to one of the communities, like my own home community, Dryden? He's a thousand miles away from any type of help. There's not much support network in his peer group there. Because there are no great numbers of people living there, there aren't great numbers of people who serve.

So what happens? Are there services provided locally, where someone would come in? Could you run us through what happens if there's a member there who needs to be helped?

Mrs. Margaret Ramsay: If it were an operational stress injury, first we would probably like them to come in to one of our larger centres for a good assessment, to make sure that we have the proper, thorough diagnosis and the full protocol of assessment done on them. Then we would refer them back to their local area and try to set them up with community providers. We have a number of providers in communities right across the country. There are about 500 on the list who are listed with Blue Cross. So we would have them served there by local community providers.

Mr. Roger Valley: If there isn't a local community provider, which happens in many cases, I guess, they would have to stay in the larger centre?

Mrs. Margaret Ramsay: Especially if they're that far away from a large centre, we would try to get some type of resource closer to where they live. We certainly try to do that. Petawawa is a good example, where we don't want people on the highway driving from there down to Ottawa. We try to get local resources, and we're also increasing the resources in that area at the base.

Mr. Roger Valley: I'm basically talking about areas that don't have general practitioners, let alone the psychiatric type of service that you need.

Mrs. Margaret Ramsay: I know. These would probably be reserve members who have retired.

Mr. Roger Valley: No, we have people back in the community who just came from Afghanistan.

Major Chantal Descôteaux (Base Surgeon Canadian Forces Base Valcartier, Acting Brigade Surgeon, Department of National Defence): We provide care for the active members, not the retired ones.

Mr. Roger Valley: I'm talking about people who are actually coming back to the community. They're still in the service. They're back for whatever time they get off for a leave and stuff like that.

Mrs. Margaret Ramsay: We have resources in almost all the communities across Canada.

Maj Chantal Descôteaux: If he's still a serving member, he's supposed to be at his home base.

Mr. Roger Valley: As I understand it, they get a certain amount of time back in their community when they come back from Afghanistan.

Maj Chantal Descôteaux: They have a month of leave, but their home base is where they serve, and that's where the care is.

Mr. Roger Valley: Okay.

You mentioned I think it was over 7% in the regular forces who can suffer from an OSI. I might have missed it, but you mentioned that it's considerably higher than in the Canadian population. Did you have a figure for the Canadian population?

Mrs. Margaret Ramsay: No. For PTSD, it was the same as the Canadian population. For depression and panic disorder, we were higher than the Canadian population. For depression, it is about twice as high, at about 7.2%

Mr. Roger Valley: Thank you.

Lastly, one of the things we've talked about is what we can do when we identify things. It's been raised before at this committee. Is there anything we can do to identify it before they're deployed? What happens in that circumstance? Is there any kind of screening to know whether or not somebody is susceptible to this kind of issue?

● (0915)

Mrs. Margaret Ramsay: Do you want to start, Major Descôteaux?

Maj Chantal Descôteaux: We have a process whereby each member who is deployed has to be screened by mental health professionals. They have an interview.

We also see our military members regularly for annual medicals. This is where we would address things. In the period before deployments, for a member to be tagged "green to go", he has to go to a doctor and a social worker.

Mr. Roger Valley: Has the process been redefined as we understand more and more about the issue of operational stress injuries? Is it something that becomes more complex compared to what it would have been 60 years ago to 40 years ago to 10 years ago?

Maj Chantal Descôteaux: Yes, they go into great detail in looking at family life, financial problems, and mental health problems. We look at all of that.

[*Translation*]

Mr. Marc-André Dufour (Psychologist, Mental Health Services, Candian Forces Base Valcartier , Department of National Defence): We also call the spouse in order to obtain information, verify whether she is aware of what the CF member will be doing, to see whether she is prepared for the CF member's departure. Generally, the interview lasts between 20 and 30 minutes for CF members about to deploy. In situations where further attention is warranted, interviews can systematically last up to one hour, prior to the deployment.

Maj Chantal Descôteaux: We don't necessarily have any studies that could indicate, at the time of enrolment, who should or should not enlist in the Canadian Forces, who is more at risk. No such studies have been done. We know that recruiting centres do not test candidates for various factors, such as drug addictions. The same is true for alcohol abuse and various personality traits. Recruiting centres admit a broad range of people; however, some screening could be done there in order to retain the ideal candidates. Currently, we would need to conduct studies in this regard, in order not to discriminate against individuals who wish to enlist in the Canadian Forces.

[*English*]

Mr. Roger Valley: Thank you.

Can you tell me, when someone comes out of the theatre, how important is the immediate debriefing? Maybe all three of you could give opinions. How important are the first 24 hours, 36 hours, one week, or two weeks? Can you give us an assessment on how important that is?

[*Translation*]

Maj Chantal Descôteaux: We believe that the time they spend in Cyprus is extremely important. This decompression period takes place in an area outside the combat zone. Often, military personnel see this as something they would rather not go through so that they can immediately return home, however, ultimately, they are very happy for this period. This is the first decompression period, and I think it is essential.

Mr. Marc-André Dufour: Another interesting aspect of the decompression period is that they are still all together. They have experienced the same things and they are not being sent off home, alone. Yes, they will go back to their families, however, they have experienced something unique that is difficult to talk about and share with people within their circle. Being with the very individuals with whom they experienced those events is another element that can act as a protection factor.

Maj Chantal Descôteaux: Earlier, you talked about reservists returning from in-theatre, who have their decompression period, return to Canada and remain with the group with which they were deployed for a period of time before going back to their communities. Sometimes, symptoms don't appear until this last period. If we could ensure that these reservists had another class C contract—we're talking about money—at the same base for a one-year period, we could keep these people working near us, which would allow us to treat them and to screen for any problems. If they had another one-year contract upon their return from their mission, they would be near us, which would probably improve the care they would receive.

Mr. Marc-André Dufour: All CF members must also undergo a post-deployment interview, meaning after their deployment. Usually, this interview lasts about an hour and 15 minutes or an hour and 20 minutes, during which we go over the events that occurred during their mission. CF members must complete a very detailed questionnaire, including questions on post-traumatic stress and alcohol consumption. This is what we call improved screening, which allows us to identify to some extent CF members who may present various problems.

● (0920)

[*English*]

Mr. Roger Valley: Thank you.

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

Monsieur Perron with the Bloc is next, for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron: Good morning, ladies and gentlemen.

Chantal and Marc-André: I want to speak mostly to you. I apologize for calling you by your first names, but being 66 years of age, I feel that I may do so.

I was sickened, some weeks ago, when Ms. LeBeau, whom you no doubt know and who works for OSISS, the Canadian Forces Operational Stress Injury Social Support Program, came here to testify. She told me more than once that before CF members are deployed, they get approximately three and a half hours of training during which they are told a little bit about the problems that may occur in relation to PTSD. I cannot comprehend this.

Maj Chantal Descôteaux: Do you mean that it's not enough?

Mr. Gilles-A. Perron: It is absolutely not enough. We are spending millions of dollars sending them to the southern United States. I have no objection to them getting field training, but we are spending almost nothing on training them between their two ears. We are physically training them, but within the Canadian Forces, we are doing very little to train them mentally.

Mr. Marc-André Dufour: Field training includes mental training, which is very important. The realistic nature of the training—

Mr. Gilles-A. Perron: That is not what I'm talking about.

You know Pascale Brillon. She goes to your base, Valcartier, and I think we can recognize that she knows a great deal about this subject. She is recognized not only in Quebec, but also nationally and internationally. So, I take what Pascale says as gospel. I don't know whether your soldiers have red Pascale Brillon's guide for sufferers. Pascale told us that we need to treat PTSD as soon as possible.

How many psychologists are there in Afghanistan, for example? How many psychologists will follow the Royal 22nd on site? They must be treated within the 24 or 48 hours following or as soon as possible after experiencing a stressful event.

Maj Chantal Descôteaux: There are many parts to your question.

Mr. Gilles-A. Perron: This is a discussion; let's go over my suggestions.

Maj Chantal Descôteaux: First, within the eastern area, particularly at Valcartier, we are extremely innovative and we are trying to implement many things. Currently, we have a program called the Resiliency Training Program, which was used for the first time this year, prior to the summer deployment of our troops.

Resiliency training is the kind of psychological training you're talking about. It is a psychological frag vest.

I would ask Marc-André to explain a little bit more about this program.

Mr. Marc-André Dufour: In fact, Dr. Christiane Routhier, a psychologist, was freed from all her other duties in order to be able to work full-time on the Resiliency Training Program, or RTP. This program is much more extensive than a mere three hours on PTSD. Obviously, it deals with operational stress. It also addresses terrorist tactics. What's extremely interesting about this program is that in order to get the soldiers to take it more seriously, we present stress as a combat weapon. This is an extremely interesting concept that was developed by Dr. Routhier so that soldiers would see that this is a weapon used against them, that it can cause damage and that it is very subtle. Symptoms of their injury may occur several months after their return here. Nevertheless, it is a weapon and it is the cornerstone of terrorism. Furthermore, it is a war of fear. They will scare you and you will be afraid: this is basically what we tell them. We tell them what fear is, what psychological stress is but also what physiological stress is. We give them the tools to minimize their anxiety and to learn to breathe better and even techniques to slow down their heart rate.

We normalize stress, which is also extremely important. We do not tell them that they won't be afraid, that everything is going to be fine, that they're trained and that everything will be great. We could tell them that but we also tell them that it's normal to experience stress, that they will experience stress. After we name it, we tell them how to deal with this stress. That's what we teach them.

● (0925)

Mr. Gilles-A. Perron: Pardon me, I wish to say something.

Earlier, you said that this was the first time. Have there been any studies or statistics that show how many there are when they return, compared to those who returned from Bosnia, for example?

Mr. Marc-André Dufour: Indeed, the project is going to be validated. Soldiers who underwent the tests before being deployed are also going to take the tests upon returning from their mission. It is a matter of assessing the efficiency of the measures, which are meant to be preventive.

We are talking about stress, but as has been raised by chaplains, there's also a component regarding the combatant and death. We talk about death, and the link between armed combat and death, which is a possibility. We lead the soldier into thinking about the meaning attached to the mission. He will be making more money, of course, and that's nice, but given the context in which he is being deployed, he must be asking himself questions that go above and beyond that fact.

Mr. Gilles-A. Perron: Chantal, I want to come back on what you said about the psychological profiles drawn up before hiring a soldier. I am fully aware of what this is about, because since I was elected in 1997, post-traumatic stress disorder among young people has become an issue of particular concern to me.

I know that the RCMP has a program that allows for the psychological profiles of members to be drawn up. I also know that the value of these profiles has not led to a consensus among psychologists and researchers. I understand your situation. Another issue you confront, as does the RCMP, various police forces and firefighters, is access to information. If a soldier or a police officer wishes to forego a test, you cannot force him to undergo it: he is protected by the Canadian Constitution. Breaching this right may even lead to lawsuits.

When I think about all of these problems, an image pops up in my mind. I met a young soldier at the Valcartier base. He talked to me about the stairway of shame, referring to the stairway that leads to the second-floor offices of psychologists. One must not forget that these young people are macho—pardon the term—young men who see themselves as strong and for whom the concept of death is unfathomable. We were the same when we were their age.

I wish to congratulate you, because at least you are working in the right direction. However, you still have not told me how many psychologists are actually on site.

Maj Chantal Descôteaux: You asked several questions.

Mr. Marc-André Dufour: The issue is being clarified, but currently, there are no psychologists on the ground. That position does not exist within the armed forces.

Maj Chantal Descôteaux: Within the uniformed military, there are social workers and mental health nurses. The American forces have military psychologists. I believe that it would be very worthwhile to consider something similar. You must understand that we would never send a psychologist to the theatre of operations to carry out a long psychotherapy session to talk about childhood trauma and things that happened with his matter when the soldier was two years old. Concrete measures must be taken on the ground, encouraging measures.

Mr. Gilles-A. Perron: Or send them back home.

Maj Chantal Descôteaux: Absolutely. True psychotherapy happens at home, at the garrison. With respect to psychological assistance provided within the theatre of operations, we could certainly entertain the possibility of having uniformed psychologists. The concept does not exist within our armed forces.

Mr. Marc-André Dufour: I trust the social workers and chaplains who work within the theatre of operations. In Afghanistan, there is also a psychiatrist.

Maj Chantal Descôteaux: There are also mental health nurses.

[*English*]

Mrs. Margaret Ramsay: Since we started in Afghanistan we have had a psychiatrist, a social worker, and a mental health nurse in theatre at all times. We're also looking at trying to get psychologist reservists in the military as class B reservists. There's a project on right now with PSel to try to do that and deploy them in theatre.

[*Translation*]

Mr. Marc-André Dufour: Psychologists go to Cyprus during the decompression week. People from Valcartier have been coming back from Cyprus recently.

Maj Chantal Descôteaux: We've been hearing a lot about the stairway of shame from people from the outside, interestingly enough. I have been practising within the armed forces since 1993, and I can affirm that requests to receive assistance coming from soldiers is increasing. The stigma of asking for help is beginning to disappear. Ancient prejudices attached to old attitudes are on the way out with the departure of those retiring, and the upcoming generation is quite different.

The fact that we have mental health programs which allow us to talk to our troops with an eye to prevention, has created links which have slightly facilitated access to our services. On this issue, I wish to say that we want to put greater emphasis on prevention through programs like these, but that the Canadian Forces is lacking the resources and funds to do so. This does not only apply to mental health, but to other general areas. We do our best with the resources we have. This is what has facilitated ties to our troops, and I think we are going to hear less and less about the stairway of shame.

● (0930)

Mr. Marc-André Dufour: The week spent decompressing in Cyprus is also conducive to asking for assistance. In fact, during that week, soldiers meet with mental health professionals who insist upon the importance of seeking help. Perhaps you have read the document entitled *Battlemind Training*, written by Mr. Carl A. Castro. In very specific terms, he talks about elements of operational stress and describes the scenario of a soldier returning from a mission. Once again, it is a matter of importance of seeking assistance. This is what we tell our soldiers to do in Cyprus, and it's excellent. However, in order to be as consistent as possible, we need the necessary staff at the garrison if we are to meet the demand.

[*English*]

The Chair: All right. Thank you very much.

Monsieur Perron, just to let you know, they went four minutes and 32 seconds past your seven, so—

Poor Mr. Stoffer has been aching to ask a question, so he's next, for five minutes, please.

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

Folks, I'm not sure if you've had the chance to read the *Globe and Mail* this morning.

Mrs. Margaret Ramsay: No, I haven't, sir.

Mr. Peter Stoffer: I suggest all of us read it, because it really puts into light what we ask our Canadian soldiers to do. For those of us who are parents and those who know kids, I cannot imagine what it would be like to have your ten-year-old boy say, "If you die in Afghanistan, I'm going to be mad at you for the rest of your life." Talk about suffering PTSD before you even go. I read this article, and it's extremely moving.

You said that OSI actually results from operational duties performed by a CF member, but is it not possible that they could have these stress-related duties before they even go?

At the Phoenix Centre now there's assistance. Petawawa made a lot of news recently, and I know that the federal government has now made an arrangement with the province to do something, but it took an ombudsman report and media coverage to get both governments moving, which I find quite shameful.

But in a situation of this nature, which I'm sure is not an isolated incident, what specifically are the military and the various bases—public or private—doing to assist this family, more specifically?

Mrs. Margaret Ramsay: I think you've raised a really important question and a problem we have. The families do need a lot of support.

I don't know if you realize it or not, but the military is not mandated to treat the family. We can provide supportive care to the family, but it is still up to the provinces to provide care for the family. So we're caught in this kind of back-door support to the family.

Legislation is probably needed to change that, but we have no power over that. We try to support the family in every way, and it does have great repercussions. We have added 25% more resources in our project for mental health care providers and social workers to try to provide that support to families.

It's not just a Petawawa issue; it happens at all bases.

Mr. Peter Stoffer: I appreciate your response. It is a question that we need to ask the political and bureaucratic levels, and not necessarily you. I know that most of you would do it if you had the resources.

Mrs. Margaret Ramsay: Absolutely.

Mr. Peter Stoffer: Also, the other day I spoke to a lady at CFB Halifax. They've been advised that as of March 1, when an individual leaves DND and goes over to VAC, in order for them to get a medical assessment—They used to go to their CF doctors to get that assessment done, but that's no longer possible. The person now has to go to a private doctor to get their assessment in order to make benefit claims through VAC. I'm wondering if you were aware of that. Why would DND and VAC together ask that of an individual who has been treated by CF doctors for all this time and has all their medical information there about either physical or mental concerns?

We heard the other day about the baton, one DND and one VAC. When a person moves over to VAC, if he or she is applying for a benefit, VAC will tell them they have to have a medical assessment done. They go back to the CF doctor and they are now told that they can no longer do that and that they have to go to a private doctor. I wonder why that is.

● (0935)

Maj Chantal Descôteaux: I'd like to answer that. For physicians and mental health practitioners working in the CF, our life has been very difficult, since a military member can apply for a pension while still serving. This is very important for you people to understand. If you could take this point, I think we would be very pleased.

When I started to practise medicine, the patients I was seeing wanted to get better, to stay active, and to go back to their normal military life. Now that they can access a pension while serving, they are looking for a benefit, money, so they will come more often to see me about this ankle that is not so bad any more, or for that little cut, or for their hemorrhoids, because they want a pension. It's the same for mental health problems. If you know that at the end you could have that big amount of money if you were diagnosed with very severe PTSD, what is the advantage of your getting better?

This has been a big struggle for us, trying to cope with these two elements. I preferred the way we were doing it before. If you were still serving, you were getting your care, but if you were found not able to continue in the CF and had a permanent disability, then you could apply for a pension, and the process would start and move on to VAC, etc.

Now that they can do that while still serving, it is difficult for us to see who is playing the system and who is really sick. For those who are really sick, we're almost

[*Translation*]

rewarding them for being ill. Unfortunately, it is more advantageous to be ill because of the monetary benefits provided for such reasons.

[*English*]

It's a struggle for the mental health people and for the general practitioner, because we're not in the business of giving a diagnosis to someone that will make money for him. We're in the business of saying "you're back to being okay". There's a kind of expertise needed when someone wants a pension.

A psychiatrist, psychologist, or GP may get involved and say yes, he's got severe PTSD, but if I say no, he doesn't have severe PTSD, he has light PTSD, and he can get better, my relationship with my patient can change, and he can no longer want to be with me just because of that.

It's a bit like in the civilian sector. Expertise is given by experts, but if you are the treating physician, you are treating the patient to get better. This is a big struggle for all of us. We really wish that the system would change and go back to being that you ask for a pension when you're due to get out of the military. I think the Americans are not doing it the way we're doing it. They're still doing it the way we were before.

[*Translation*]

Mr. Marc-André Dufour: There truly has to be an independent process. Currently, they use our progress notes, psychological reports, in addition to the medical doctor and psychiatrist's report, as well as therapeutic material and clinical documents to determine the sum of money.

There are cases of soldiers who come back angry because they did not receive the compensation they thought they were entitled to, in light of the level of suffering they feel. They ask why we're not listening to them and what we have not understood. As providers of treatment, that puts us in a very uncomfortable situation.

We must truly separate the evaluation related to the treatment, that is the work that I carry out, in addition to that done by other Defence mental health professionals, from the assessment, the procedure used to establish the monetary amount of the pension. This must really be separate in order to avoid that type of situation.

I also want to point out that we are not saying that soldiers are manifesting symptoms in order to receive money. This is not the case. In fact, it's absolutely human. I believe that a soldier is financially penalized if his state of health improves. There is a financial penalty associated to improved health. It is the system which is detrimental to the treatment. There is no trace of bad intentions or manipulation, but if a soldier sees one of his colleagues receiving compensation, he will naturally ask why he hasn't received as much. Therefore, he challenges the treatment, the work of the professionals, whose job it not to establish the amount of money.

All of this confusion leads us to say that the two processes, that of the Department of Veterans Affairs, and ours, should be distinct.

● (0940)

Maj Chantal Descôteaux: That's even been the cause of acts of violence in our environment. When military personnel are suffering, their less appealing personality traits might come to the surface. If the psychiatrist hasn't said exactly what the member wanted to hear to become eligible for compensation, he or she can get very angry. In Marc-André's office, there is a hole in the wall. Sometimes, I have to call the military police to get everyone calmed down. That is often related to the issues we are talking about right now.

Mr. Marc-André Dufour: On the Internet, military personnel find the charts of veterans that state that a given clinical profile corresponds to a certain amount of compensation. Then they assess their situation and say that the health care providers who treated them did not assess them correctly. But we do not determine the amounts of pensions. But in their minds, since people who do determine those amounts use the notes in our files, the outcome is to some extent our fault. That is when we might see aggression. But it's understandable.

[*English*]

Maj Chantal Descôteaux: It's really not our role to determine.... We will cooperate with VAC, and we are. In Valcartier we have this great system. When someone is released, our case managers meet with VAC case managers, we transfer the care, and we talk to each other. Most of the time the psychologist involved in the treatment of the patient is already a civilian psychologist who will continue with the care of the patient. We have a nice way of communicating with each other. But it's that part about money—

You've noticed, probably, since Veterans Affairs changed its policy and has gone more towards rehabilitating people, which I think is perfect, that there's a decrease in the demand. There's not that much money involved, in the end. We're telling them that we will treat them, and there are fewer people asking for these services.

The Chair: Thank you, Mr. Stoffer. It reminds me of the old economic adage that a cent is matter.

We'll go to Mrs. Hinton for seven minutes, please.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you.

I pulled up the story that Mr. Stoffer's referring to, just so I could get a bit of background. Apparently, the family you're referring to, Mr. Stoffer, has been getting therapy for over a year now. I would like to point out that the federal government put $230,000 into the Phoenix Centre to help families such as these. So we are doing our part. I know that the panellists here are doing their part to serve our military. I appreciate that very much.

There are a few questions that come to mind. We've listened to a number of witnesses now who have been discussing PTSD. It's obviously a very difficult disease to deal with and to diagnose, as well. I'm getting the impression, from listening to the witnesses, that there is really no predictor for who might or might not come down with PTSD. It seems to be—

Maj Chantal Descôteaux: There are some predictors, ma'am.

Mrs. Betty Hinton: Are there?

Maj Chantal Descôteaux: Yes.

Mrs. Betty Hinton: Okay, could you explain some of those predictors when I finish the question? Then I'll give you my thoughts on it.

There are circumstances that happen, situations that people get put into, and it's a case of it building and building and building. It's usually, from what I've been hearing from witnesses, not a single incident. So I would be really happy to hear what you have to say on that.

Maj Chantal Descôteaux: For the predictors—and maybe Marc-André will be able to complete—we know a certain number of predictors: the type of personality you have, if you're all black and white, a very rigid personality, you don't bend a bit, you are more prone to that. If you already have a *toxicomanie* problem, you're more prone to that.

● (0945)

Mrs. Betty Hinton: Alcohol, drugs?

Maj Chantal Descôteaux: Yes.

If you suffered trauma when you were a child, you're more prone to PTSD. These are some of the major ones.

Do you want to hear more about repetitive trauma?

Mrs. Betty Hinton: I'm just going by what I've been listening to from witnesses. I've come to the conclusion in my own mind, and you may disagree with me, that aside from those indicators, there's really nothing you can use as a measure, if you will, about how one person is going to react to these kinds of circumstances.

Maj Chantal Descôteaux: There is no blood test for that, but I think there could be studies done to look at that aspect.

Mrs. Betty Hinton: Okay.

You also touched on what has always been my concern. I ask the same question of every group of witnesses: How do think Veterans Affairs Canada can contribute to changing the negative stereotype for veterans who suffer in silence from PTSD? You pretty much answered me. You told me that the dinosaurs are leaving, that this new generation of soldiers are a little bit more open to saying they have a problem and need help, rather than being stoic about it.

You're very anxious, Dr. Dufour. Go ahead.

[*Translation*]

Mr. Marc-André Dufour: When we talk about operational stress more than about post-traumatic stress, we are moving forward on the issue. There is no doubt post-traumatic stress exists—it is a clinical diagnosis. Operational stress is a very interesting concept. In my view, it would be difficult for any member of the force who experiences operations and situations in Afghanistan—I hear the stories they bring back—not to be traumatized. However, operational stress is normal. Stress is presented as a combat weapon. That means it's part of the game.

I have not practised with the Forces for very long, but on the basis of what I hear some long-serving members of the Forces and corporals say, they experienced extremely stressful situations but had no right to respond. They had no right to be stressed. If they exhibited stress, they were excluded and set aside. They did not even have the right to talk about it.

Now, they are told that they should not put their heads in the sand, that they will experience stress, that they will be afraid, that the enemy's goal is to make them feel afraid, and that they will experience stress. When we explain ways they can use to respond to stress, we give them the right to have a reaction to stress.

In the past, two things happened in the Canadian Forces. Members of the Forces experienced extremely stressful events, and—what I would call the second level of trauma—had no right to respond and were perceived as cowardly if they did speak out. Well, I can tell you that, with this kind of message, a soldier will not speak out and will become withdrawn. That's why today, we still see soldiers who served in the former Yugoslavia, and 10, 12 or 13 years after the facts, after losing two families, two houses and so on, come to see us for the very first time because they are completely destroyed. Those soldiers were told that if they talked about it they were weaklings. They were not supposed to talk about it. The whole thing festered inside them, became part of their personality. They became adapted to their trauma. In their heart of hearts, they end up believing that it is normal for veterans to live that way. It's dreadful.

Now, we tell them that those feelings are normal, that they are part of the mission, that they will feel stress. Even as we teach them to handle their C-7, we tell them that they also have to learn to handle and manage stress. We give them preventive tools and tell them that professional help is available if those tools don't work. That's when we move out of the pathology. We are trainers, who don't show them how to shoot—we show them how to breathe. It seems a bit strange when you first hear it, but that is what we talk about.

We say that operational stress is normal, that they will experience it, and that there are professionals there to help. As a result, military personnel come to us much more quickly, and we are seeing that. We are starting to see people who are coming back from Afghanistan. I can tell you that this is very different from what we saw with soldiers stationed in Yugoslavia. They have been living with their trauma for 10, 12 or 13 years, and it has become entrenched. Now we see much less avoidance, with anxiogenec situations well targeted. We can work much more easily with that. We can identify the trauma military personnel experienced in a certain vehicle, and establish a gradual scale of exposure—Pascale Brillon might have talked about this—so that we can gradually desensitize the member to the situation that first engendered the anxiety. With this approach, therapy takes much less time and has a much higher success rate. So we should encourage members to ask for help by normalizing stress reactions. That is the angle we need to take, and that is angle we do take.

● (0950)

Maj Chantal Descôteaux: It's a matter of education. Ms. Ramsay needs money to do this, and to have clinical personnel who focus exclusively on this. We have had to do without one of our clinical practitioners in order to establish this program. In a sense we are shooting ourselves in the foot, but we are helping ourselves for the future. We have to gear our efforts to prevention and think outside the box, think up new approaches.

At present, our resources—

Mr. Marc-André Dufour: In fact, we are using current resources for the prevention component. There is no particular function or position—there is no prevention officer as such. We are all clinical practitioners, and in addition to treating patients we take on the responsibility of conducting these very important prevention exercises. However, we cannot do everything, and mental health care providers are exhausted.

Maj Chantal Descôteaux: So are other care providers.

[*English*]

Mrs. Betty Hinton: He won't interrupt your answer, but he will definitely interrupt my question. I'm going to try to jump in with another one before you answer.

The Chair: I'm sorry, but you're already over your time.

Mrs. Betty Hinton: That's what I thought.

The Chair: We'll now go to Mr. St. Denis, for five minutes.

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

Thank you very much to our witnesses today.

Dr. Descôteaux, I'd like to pursue your very interesting and almost startling information about incentives.

This is no disrespect to military personnel who feel they are ill, but if our policies somewhat skew the system, we are in fact using resources that should go to those who need to pursue the benefits route, and we're using other resources for those who pursue getting better. We have to better differentiate that, because the goals are different.

If your resources and your team resources are mixed, and at the intersection of your service the two are colliding, we're not really serving either of the two streams of personnel in the best possible way. Sometimes the best-intentioned policies have an unintended consequence.

I'd like to underline for our researcher that this is an important area for our committee. Thank you for raising it.

In respect to those two streams, do you have any suggestions on how it can be better done? Is it a matter of reverting to the old way of doing it, distinguishing between those who can get better and those who say they give up getting better and want to go the benefits route? Are there some solutions you can offer?

Maj Chantal Descôteaux: In our military medical system, someone who comes for help and needs to be restricted in some areas gets a temporary medical category. For the first six months we will say okay, you're unfit for deployment, you have to see someone in the mental health department weekly, and are not able to lift 30 pounds, etc. We write down all the limitations. This is for the first six months. Then there is a second six months if we have not succeeded in curing him.

After a year, or a year and a half, depending on the problem, then we usually say whether the restrictions are permanent or not. If they are permanent, then the person has a permanent category, and there's a process in the medical system and the administration system by which he will know if he's going to be released or not from the CF—retained with his restrictions or released medically. When this message comes in, this is when it would be best for someone to have permission to ask for a pension, because up until that moment, efforts will be made to cure him, to help him get better.

Once it's determined the limitations are permanent, then with permanent limitations it's okay to ask for a pension. If you are allowed to ask for a pension for your knee while you're in your twelfth year of service, and yet you still serve until you reach your 25 years of service, what kind of a permanent injury is that if you're able to continue to run and do forced marches? That doesn't make sense to us. Yet we have these patients who are active duty members and who are getting their snow plowed in winter because they have a pension, which we know about, for their back, and yet they're still on fully fit duty, working as an infantry guy. This is ridiculous. We have examples of this. We're looking at that and asking, what is this? The individual is being paid for his back and we're paying to mow his lawn and whatever and he's an active duty person. It makes no sense. It should only be when we determine there are permanent limitations.

● (0955)

Mr. Brent St. Denis: It's no disrespect to those who need health services to ask this question, because if we're taking resources away from those who need them because the system has become skewed, then we have a duty to look at it.

Some of us are new to veterans affairs. There obviously was a policy rationale for that. Are any of you able to say, as dispassionately as you can, what the policy rationale was to allow for an active service person to apply for pension?

Maj Chantal Descôteaux: I'm not sure exactly why. Honestly, I don't know why.

Mrs. Margaret Ramsay: It's just that the pendulum has swung too far the other way now. We need to correct it.

Maj Chantal Descôteaux: Put it in the middle.

Mrs. Margaret Ramsay: Put it back in the middle, yes.

I think Veterans Affairs would have to answer that question as to when their policy changed.

Mr. Brent St. Denis: Okay, thank you, Mr. Chair.

The Chair: Now on to Monsieur Gaudet, for five minutes.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chairman. I'm very happy to have the opportunity to speak here today.

You do not often mention the spouses of personnel posted on missions. I often meet those spouses, and they're extremely anxious. In your remarks this morning, you said nothing about the families. It's like the pre-pro, if I might say—before they leave. Couldn't there be some kind of—?

Maj Chantal Descôteaux: As Ms. Ramsay said, we're not responsible for treating families. It is important to make that point. I would like to treat families, but then I would have to treat the children, the wife, the husband, and there are already clinics to do that. Treating someone is not just a matter of treating his or her mental health. We also have to take into account the biological, psychological and social aspects involved. We are not equipped to do that at present.

Some services are provided for families, however. Each base has a family support centre. Frequently, those centres provide the services you mentioned—in Valcartier, for example—and they work very closely with us.

Here is what we can do with regard to treating the family. If a military person experiences operational stress and might benefit from our seeing his spouse or children so that they can understand what he is going through, then we will do that to the extent that we can.

But you will understand that I have to tell my staff to give priority to forces personnel coming back to Canada. I do recognize, however, that treating a member of the forces also means treating his family and those around him. If we cannot treat them ourselves on site, we make sure that we route them to appropriate resources, such as the family centre where psychologists and social workers are available, or to some centres in town.

Briefing sessions are provided for all spouses before forces members leave, in cooperation with the family centre. Unfortunately, family members are not all military personnel and we cannot force them to attend. Frequently, they don't show up to the briefing sessions.

There are Internet sites available for them as well, with Web cams and all kinds of things. Between the time I was first deployed and today, there are much greater possibilities for armed forces members to talk to their families. There are a number of services, but the members and their families do have to use them.

Mr. Marc-André Dufour: If we are to help the soldier's spouse or family, the soldier has to be with the Canadian Forces. We must provide services to the military. We help the soldier's family indirectly in an effort to help the soldiers themselves. That is what we are asked to do. Is it the best thing to do? Could we expand the services? We'd have to see. For the moment, however, the purpose is to help the soldier.

If the soldier is on a mission and his spouse comes to seek our services, we cannot provide help. We would have to send her to the Family Centre in Valcartier, or to provincial resources, because the soldier is not one of ours.

● (1000)

Mr. Roger Gaudet: I understand your point of view, and I don't see a problem there. However, a wife's anxiety about her soldier husband might mean that she is afraid to approach him to understand what he is experiencing. But regardless of what it is, it is the husband and wife who live with each other, and there must certainly be anxiety between them.

Mr. Marc-André Dufour: I agree, Mr. Gaudet, but it's not up to me to say what's best. I'm telling you what we are asked to do. Could we do more? Yes, we probably could. However, what I have talked about here is what we are being asked to do in our directive.

Mr. Roger Gaudet: Why don't you invite families to Cyprus when the soldiers come back, so that they can decompress together?

Mr. Marc-André Dufour: That would be an interesting approach. We would have family tournaments, most likely.

Mr. Roger Gaudet: I'm just asking the question.

Mr. Marc-André Dufour: Yes, I will answer that question.

The purpose of Cyprus is just to give soldiers a chance to let their emotions out while sparing their families. It's very intense there. The stories told are very particular.

I don't know whether you've ever seen thousands of soldiers coming back from the wars, but I'm told it's a very good thing their families are not there. Soldiers experience what they have to experience amongst one another, and share what they have to share. When they get back to their families, they have decompressed more.

Maj Chantal Descôteaux: Otherwise, they keep their emotions inside to spare their spouses. They don't want to discuss the things they see, while we want them to discuss those things. We want them to let it out.

However, as we were just saying, when soldiers come back we would like to organize some sort of get-together to which families are invited.

Mr. Marc-André Dufour: Exactly.

Maj Chantal Descôteaux: We do that before they leave, and we do certain things after they come back. We could try to organize a meeting between the soldiers and their families. We will look at the possibilities.

Mr. Roger Gaudet: Please don't drop those ideas.

Mr. Marc-André Dufour: At present, we have been focusing on the pre-deployment aspect, as part of the Resiliency Training Program. We are now looking more at post-deployment, and Ms. Routhier is working on that aspect. We're exploring a number of avenues to see how we can extend the program in Cyprus, where soldiers decompress among themselves, to see what we could provide.

Once again, these tasks are added to our usual tasks as mental health care providers, without the addition of any personnel, and with a continuing influx of requests. That is the problem.

Mr. Roger Gaudet: I was just coming to my next question.

It is just a short question, Mr. Chairman.

[*English*]

The Chair: No, Mr. Gaudet, I'm sorry. If I let you, then Mr. Perron goes even further next time. Monsieur Perron makes up for everybody.

Mr. Shipley, for five minutes, please.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you very much for coming out. This is a great opportunity for us to find co-relation.

I found your comments in your presentation about the things that are changing interesting, Ms. Ramsay, in terms of, over the next five years, the increase in terms of health care services, also in terms of the connection that we need to continually make between Canadian Forces, Defence, and VAC. I think, quite honestly, we need to do that. I want to turn more toward the VAC and some of your thoughts about that, because that's actually what our mandate is.

Everyone talks about how we need to do more. I don't know that we ever will get to wherever the "more" is, but it does not take away from our desire to be fair and to provide our veterans with the services, the protection, and the health care they need.

I'm wondering if you can just talk a little bit about the relationship that has changed between National Defence and VAC in terms of being able to provide better services as that transition happens. We get caught in this in-between, transitional period; it was brought up by Mr. Stoffer and confirmed in some clarifications by Ms. Hinton. Would you comment quickly about that relationship change, if there has been any?

● (1005)

Mrs. Margaret Ramsay: There definitely has been a change, I would say, over the last four or five years. We've just signed a memorandum with VAC. It's called the operational stress injury network, and what we're trying to do is work closely on a network of clinics right across the country. VAC has opened up five more OSI clinics, and we have our five. We're trying to cover off the whole country and have equal access to each other's clinics.

This is a work in progress, and there are going to be all kinds of things we have to work on, like priority access and clinical procedures of assessment—whether we agree, and who should get assessed at which clinic. But it's definitely a work in progress. We meet regularly with VAC—I'm meeting with a group from Sainte-Anne-de-Bellevue this Friday—and we talk about these issues.

We're going to set up an advisory committee to meet every three months to advise the steering committee that meets in Charlottetown, and DND and VAC are represented there. But it's a close network.

We've also included the RCMP in that operational stress injury network. They're the other organization that uses the VAC services as well, and they're out there with similar injuries as our own soldiers'.

I'd say the relationship is good. It's a work in progress, and we meet regularly.

Maj Chantal Descôteaux: For the situation we have in Valcartier, which is the biggest army base in Canada—and I want to point that out—this is where the gap is. When I have a really sick patient who is going to be released because of operational stress, or whatever, I need a good set-up team that can take over the care of this patient.

As you know, in Quebec, anyway, it's very hard to access a psychiatrist and a GP. A psychologist is not too bad. But we need interdisciplinary care for very difficult patients and right now it's difficult to find that. So often you will hear from veterans that the difficulty they had is when they left the military because of that hole, that gap there.

The clinic we have in Ste-Anne-de-Bellevue is a good start, but it's in Montreal. It's not in Quebec. It's not in Edmonton. It's not in Petawawa. So close by our big army bases, at least, we need clinics like Paul-Triquet, which is one we have in Quebec, but it's partly provincial and it's not working out. They have three offices in there. I know they're moving towards having something better, a big building and facilities, but that's where the gap is.

When we determine that someone has a permanent category and is going to be released medically, I need, while he's still serving, to switch the care to these people downtown so my team and I can work on the active members and get them to stay in the military.

If we are very busy with very sick people who are just waiting to be released—and this is too long a process in our system—my staff is booked weekly with those chronic cases, and the waiting list to see the sick people quickly who are new to the program is too long. So I need the care of these very sick people to be taken over by a team that is ready to do this so I can better concentrate on those who need it. That way we can have better success in treating it, if we're not too late in intervening with that.

Mr. Bev Shipley: My follow-through is that we have medical care treatment shortages of individuals, of professionals. In Ontario it's a big issue, obviously in Quebec and other provinces—So that is a hurdle.

There was a question the other day about when we open these clinics, where do you get the staff? Where do you get the professional people? Of course they reach out to the private sector and they work in cooperation with the private sector. That is what we were told.

When you have a patient who comes in and you're transferring them to VAC, do those professionals need a different training from what they would if I were the patient?

● (1010)

Maj Chantal Descôteaux: Yes, definitely.

Mr. Bev Shipley: —being a parliamentarian who has PTSD?

Maj Chantal Descôteaux: Unfortunately, when that big bunch of patients from Bosnia in 1992 was released and went downtown for treatment, I think VAC had to quickly react and find psychologists downtown, but the quality of care of some of those psychologists was not at the level we would like. They did their best at that time, but now I think we really have to have a special team that is specialized in working with PTSD patients. It's the same with us.

[*Translation*]

We members of the Canadian Forces and people who treat veterans, need specific funds to help us update our knowledge of the relevant issues. It is an enormous task. We see what the United States and other countries are doing. We find ways among ourselves of sending one of us to the U.S., to the convention in Sainte-Anne, but we should be doing much more of that kind of thing. For the good of Veterans Affairs, we should ensure that people who treat our patients when they are released are more competent than they are at present. I'm not saying that they are all bad, but the quality is perhaps not ideal. This issue needs to be looked at more closely.

Mr. Marc-André Dufour: There is also a link with knowledge of the military environment. The military is a world unto itself. By working in it, we end up understanding how it operates, but I don't know how long a civilian psychologist—and I am one—with no knowledge of military reality, who suddenly starts working at Veterans Affairs, might need to understand the jargon. That, to my mind, is a problem. However, we in Valcartier and in other bases can provide support for those people, to ensure they gain a sufficient understanding of the military environment. We could organize on-the-job training periods, organize training through universities. However, we must remember that this burden would be added to the thousand and one other tasks already on our shoulders. There again, that is the real problem. Ideally, this is something we would be happy to do, but we will no longer have time to see patients. What choices would we make?

Thank you.

[*English*]

Mrs. Margaret Ramsay: We met with VAC and came up with a memorandum of understanding on who would be the providers for clients transitioning to VAC, and it's only psychiatrists, clinical psychologists, and masters-prepared clinical social workers. We came up with a common provider list in Blue Cross.

What we try to do in the military, when we know somebody's going to be released, is get them referred to one of those clinicians, so that the transition is smoother when they leave the CF and are then a VAC client.

That helped, but we still have a long way to go in making sure we identify those providers in the community who have the expertise to deal with PTSD.

Maj Chantal Descôteaux: PTSD is not something that is taught in school that much, PTSD; that's the reason. The two biggest challenges in psychiatry are treating PTSD and obsessive compulsive disorder.

The Chair: Now we go on to Mr. Cuzner for five minutes.

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): I have two quick questions. I appreciate the forthright gander we've received here today at some of the disincentives. We've been through it on employment insurance reform, where there were significant changes in the mid-nineties. I'm sure that when people made the changes, they did so with a certain purpose, but all of a sudden you have these unintended outcomes and consequences. There were actually disincentives in the program, but we were able to go back to address several of them to take those disincentives out.

Is there movement within the Canadian Forces now, an ongoing evaluation of how you deal with those pension issues that you're able to assess? Is there anything you're working on now that might be able to change how it's being administered now?

Maj Chantal Descôteaux: No.

Mr. Rodger Cuzner: No?

Mrs. Margaret Ramsay: It's not a Canadian Forces issue. We don't give them the pensions. It's Veterans Affairs who grant—

● (1015)

Mr. Rodger Cuzner: Oh, Veterans Affairs grants them first? Okay.

Mrs. Margaret Ramsay: —the pensions to the serving member.

Maj Chantal Descôteaux: We keep telling our chain of command that this is not a good thing, so I'm happy to tell it to you today, but the member applies to VAC.

Mr. Rodger Cuzner: To VAC first? Okay. Jesus—

[*Translation*]

Mr. Marc-André Dufour: But they use the clinical file we prepare at National Defence. Therefore, in determining pension amounts, they are using material prepared in relation to treatment contained in medical files. That movement is completely—

[*English*]

Maj Chantal Descôteaux: And before, they would use that material—

Mr. Rodger Cuzner: So there's no recommendation on your part?

Maj Chantal Descôteaux: Recommendation?

Mr. Rodger Cuzner: Is there a recommendation for this on your part, or not?

Maj Chantal Descôteaux: Yes, that's the one I gave you. We should not be allowed to apply for a pension until we're close to release. That's the recommendation.

Mr. Rodger Cuzner: I was very pleased to see that you're actively recruiting mental health professionals for the reserves as well. I think that's a very beneficial program.

With the increase in the number of reserves entering theatre in Afghanistan.... Your response to my colleague's question was that when the members are going back to their base, they have access to the professionals on the base. What about the reservists who go back to their own communities? What type of services do they have access to? Do you do contracting with professionals?

Maj Chantal Descôteaux: Reservists coming back will have a screening by us, the supporting base, but they go back to their downtown area very quickly. I recommend we don't let them go back downtown, that they stay with us and work for another year, so we can have them close by. They're getting paid and we're there, we can support them. We can screen them better. They stay in a group. They can vent with people, not be somewhere where nobody understands what's going on with them.

That's our first recommendation. The second one is that if they're sick, they should come back to let's say Valcartier, to be assessed. That's what they should be doing. We assess them. We give the diagnosis and then we set up care near their home. But unfortunately, the way it's working out with VAC—that's another thing—is that sometimes they will not come back to us. They're still reservists, but they will go downtown. They will get a phony diagnosis, an incorrect diagnosis made by someone downtown who is not used to this.

Let's say they get an incorrect diagnosis of PTSD and not the proper care for what they have, which is really an adjustment disorder with a personality disorder. Then we're stuck in a bit of a fight with the patient. Patients come back to us and say they should have a medical release because of the diagnosis they were given downtown, and here's what we should be doing. We get into a fight.

It's not well set up. They should come back to us. They should not be allowed to go on pension yet. We give the diagnosis. We treat them as best we can and then we set up their care downtown and VAC takes over. That's another point where we have problems with reservists.

The other thing with reservists is it's not clear, to me anyway—

Mr. Marc-André Dufour: For me too.

Maj Chantal Descôteaux: For many base surgeons, how do you deal with reservists? What level of care are they allowed, depending on their contracts? I guess the ombudsman is doing something, because they have come to our base. It's an issue. It's not clear in our laws, if you will, so I'm trying to give the best care I can to all those who come to us, but the most difficult patients are those who have personality disorders and are playing the system a little bit. These patients present a challenge.

Then you have those who are really sick and don't know they should come to us to get proper care. So we're doing our best. What's good is that we give them all the necessary information before they're deployed, so they know when they return, they should come to us. I'm not sure it's the same throughout Canada, but we're trying.

Mrs. Margaret Ramsay: We do a four-month post-deployment screening as well, and all the reservists are called in for that medical and mental health screening.

● (1020)

Maj Chantal Descôteaux: But if they are reservists, sometimes they don't come.

Mrs. Margaret Ramsay: It's not easy to contact them sometimes. We have them for the year. But we definitely have noticed that reservists are demanding a lot more service. In Newfoundland, we're putting in extra resources already. In St. John's, we've just added psychology. We have a full-time social worker in Gander, mainly because of reservists coming back. We realize there's more need on the base, and they are coming to the base for care.

Maj Chantal Descôteaux: And the quality of care given to these areas is even more important to look after and to supervise, as Marc-André was saying.

It's very difficult to treat PTSD patients. It's sometimes easier for a family physician to say if they want sick leave, here it is, take that pill, and for psychologists to say they feel sorry you. That's not how we are supposed to deal with that.

So we have created a bunch of people who think they are worthless, not able to work any more. They just want to say they have not been treated well, etc. This is not the way it's supposed to be. People can get better and can be active again in society. It's an issue. We need to look at how care is given everywhere and we need to be able to supervise that as much as we can, with people like Pascale Brillon and Stéphane Guay.

Mrs. Margaret Ramsay: We don't even talk about returning to work. We talk about "remaining at work" when you're sick and get treated, because we know when people are off work, the longer they're off, the less likelihood there is they're going to get better and return to work. So we're really trying to promote that.

Maj Chantal Descôteaux: And I think we're getting there. We have the return to work program in most of the clinics, but this mentality is not there in the civilian sector. A lot of doctors find it so easy to just say sick leave, sick leave, sick leave. It's very difficult to practise medicine the right way and to tell someone you think it's time they went back to work, because if they don't, they'll be in their basement drinking and taking pills and thinking they're worthless.

The Chair: Thank you very much.

Now we'll go over to Mr. Sweet for five minutes.

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

Ms. Ramsay, you had mentioned a 2002 study that was done. Do you know what the sampling size was for that from the military?

Mrs. Margaret Ramsay: It was 5,000 regular force and 3,000 reservists.

Mr. David Sweet: So that's a substantial example.

Mrs. Margaret Ramsay: Yes, it definitely was very substantive.

We had Statistics Canada do it because they were independent and it was all confidential. So there were no permanent records. They were all kept out at Statistics Canada.

Mr. David Sweet: Good. I just wanted to know the size of the sample—

Mrs. Margaret Ramsay: Yes, that was the size of the sample.

Mr. David Sweet: —to know how much we could rely on that number. But a 5,000 sampling is very good.

Major, you'd mentioned that it's very difficult to treat PTSD. Is obsessive-compulsive behaviour in that vein as well, and is that why there are so few psychiatrists and psychologists who are available for that?

Maj Chantal Descôteaux: What we know in psychiatry is that these two anxiety disorders are some of the most difficult to treat and treat the right way. We need to be *à la fine pointe* with these things, get the proper training, but also continue medical education on these things. If we're talking about VAC, ensuring that this psychologist downtown in little Saint-Meumeu-des-Creux is good to treat this is very tough. So if we could have these big clinics where we have experts and we are sure that when we're sending a patient there he's getting the best, that's what I would like.

Mr. David Sweet: But as a professional, you feel that there's probably some aversion to psychiatrists and psychologists specializing in this because of the complexity and the difficulty of the disorders. Is that what I'm hearing?

Maj Chantal Descôteaux: There's difficulty to access psychiatrists, for anything.

● (1025)

[*Translation*]

Mr. Marc-André Dufour: It's because of the volume of clients. In the Canadian Forces, there are a fairly high number of consultations for post-traumatic stress. In the civilian environment, we do see cases of post-traumatic stress, but they're not related to military operations. The context is different, and the types of trauma involved are different. Pascale Brillon explained that there could be a variety of traumas experienced over a long period. This means that we can certainly identify trauma among police officers or firefighters, but the trauma experienced by soldiers is quite specific.

With regard to the issue of keeping abreast of knowledge, we must point out that our client volume does make it possible to acquire the needed expertise. With regard to training, however—and training is something I consider important—we do need to keep abreast of things, given that our mandate is very specific. However, we are really scraping the bottom of the barrel to get training budgets, and that is disgraceful. We have a duty to keep abreast of current knowledge, and when international conferences or important events are held, we are almost down to drawing the short straw to see who gets the chance to go. It's a real problem.

[*English*]

Mr. David Sweet: Okay. And you're talking about a training budget for development for your own professionals there, right?

Mr. Marc-André Dufour: Yes.

Maj Chantal Descôteaux: And VAC.

Mr. David Sweet: Your information was a lot more encouraging regarding the deployment of soldiers and exactly the kind of training that you give them to be more resilient, as you had mentioned.

You had alluded to this, but I just want to be specific: Is there research going on right now on two things, the first one being to broaden the predictors? Most of the predictors are extraneous, they're external—right?—substance abuse, whether the person was abused earlier in life, that kind of thing. You only mentioned one, a rigid personality as far what's happening existentially in their mind. Is there research going on right now to broaden the base of predictors so that psychiatrists and psychologists can maybe train those social workers in order to dig deeper to determine whether someone is going to react? That's really the nature of it. It's a reaction to the trauma that is non-resilient and becomes, of course, a behavioural problem or a psychological problem. Are you aware of more research going on?

As to the second one, has there been some research to date about sensitizing, or whatever terminology you want to use, but exposing the soldier to the stress that they're going to experience, in order to give them the capability of being more resilient when that comes? I know they do training, war games so to speak, but that's with their own personnel. That's not, as one witnesses said before, seeing a young boy who is nine years old strapped with munitions and actually killing people. That's something that is absolutely obscene in our culture.

So I'll leave those two with you.

[*Translation*]

Mr. Marc-André Dufour: I am not a researcher. It would have been interesting to have put this question to Stéphane Guay, for instance, who does research that is really specific to this issue. He no doubt does research in this field, I am convinced, but I cannot tell you what type, nor can I tell you what is being done exactly.

[*English*]

Maj Chantal Descôteaux: In Valcartier there is a research centre next to us. They have a cyber room. Again, that's another initiative we have. We attended a cyber therapy meeting and the American army was there to train people. You go into a cyber chamber and you're 3D—on the ceiling and the floor. And you are in the theatre. This is where we would like to connect with the research centre, and we have started to do so. But again, it is on our own free time, which we don't have.

One of our psychologists is trying to see if we could do a training program that could help with people's resiliency, by maybe seeing dead people and reacting— We would also like to use the same centre to screen people before they go. If they don't react well to the cyber room, they are probably not fit to go.

There are avenues in which we could go, but right now we do not have enough people to do all that. We wish we could. There is research being done, but not on our part for now.

I think we are going to cooperate with that research centre for that cyber room. Research will come out of that.

● (1030)

Mr. David Sweet: What was very encouraging was that you're developing these teams of professionals. Have you actually gone to the major institutions in Canada and communicated with them about the shortage of psychologists and psychiatrists?

Mrs. Margaret Ramsay: Absolutely. We are doing that all the time at major conventions. In fact there is a symposium at Sainte-Anne-de-Bellevue in May. We will have a recruiting booth there for both public service HR and Canadian Forces HR.

Maj Chantal Descôteaux: We could have more people working with us, but we're not allowed. We don't have the organizational charter to hire. I know they are looking at that. It is a work in progress. We have to see how efficient we are before they allow us to have more people in that trade. We wish we could. I think we would get civilian psychiatrists and psychologists to join us, because it is a really interesting and dynamic team. Right now, and I can only talk for Valcartier, I realize that we should be allowed to have more people on our positions charter.

Mrs. Margaret Ramsay: We're validating that as we go base by base, to see what is the right mix and number of clinical providers at each base.

[*Translation*]

Mr. Marc-André Dufour: With respect to Valcartier, that also raises an infrastructure problem because, even if we did have the staff, we would have to put them in the parking lot or on the roof at present. We do not have the required facilities.

[*English*]

The Chair: Thank you.

Mr. Stoffer, for five minutes.

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

Madam, would it be possible for the committee to have a copy of the survey questions that were done?

Mrs. Margaret Ramsay: Absolutely.

Mr. Peter Stoffer: It would be great to have that. It would be interesting to see what kinds of questions were asked of the 5,000 and 3,000.

Also, what is the average age of the health care providers of the various groups you've identified within DND?

Mrs. Margaret Ramsay: It totally varies. I was just in Esquimalt last week. We have a couple of psychiatrists who are retiring—cutting back a bit and working part-time—to very young people who are coming in.

The only thing is that we usually look at experienced personnel. We are not taking brand-new graduates out of university right now. We still do not have a mentor program in place. We are usually looking for three to five years experience for clinical psychologists, and the same thing for social workers.

The military is different. We train our own personnel through training programs at university and then do our own mentorship.

Mr. Peter Stoffer: I know what most politicians do after a stressful day of talking to constituents and battling back and forth in the House of Commons, but who looks after you folks? I am sure if somebody punches a hole in your wall or threatens you or consistently harasses you, not just once, but repeatedly, that has to take a personal toll on you and your family. If it's a personal question, you don't have to answer.

Besides sports, and the camaraderie of each other in working through your concerns, when you go home at night, sometimes you're alone. You must think about your day, and it must be very stressful. Who looks after you?

Mrs. Margaret Ramsay: Do you want to take that?

Maj Chantal Descôteaux: What I have realized with respect to the uniformed doctors in the military is that we tend not to go to these people, because we refer our patients to them. So if we are sick, we will not seek help from them. We found a psychologist downtown who is older and very experienced who will take over the care of the uniformed doctors. Usually the other trades, like nurses, social workers, and other medical trades, are comfortable being treated by them. This is for the uniformed people.

We have seen instances when people like me—base surgeons, military psychiatrists—were sick, and it's a challenge. It's almost impossible to treat a colleague or the person who is supposed to be your boss. So we try to be ingenious. We will see a base surgeon from another base who comes to our region. We'll set up stuff like that or have people downtown especially for us.

As for the civilians, I will let Marc-André answer that.

[*Translation*]

Mr. Marc-André Dufour: As public service employees, we have access to employee assistance programs which enable us to consult health professionals. With such a heavy mandate, we need teamwork in the real sense of the word. We have significant interdisciplinarity in our work. For instance, if a patient's case is particularly difficult, we can discuss it with our colleague, who is in the next office, and who is a psychiatrist and is also seeing the same patient, or we can raise the matter with the social worker who knows the family, etc. Resources in the civilian sector do not have this capacity.

The psychologist in private practice sits in his office, isolated, and also sees many other patients. He may telephone his colleagues, but we know that the physical distance creates a barrier, so that he may not dare to place the call. As a team, we have the advantage of having regular meetings where we can share our ideas about difficult cases and we also give ourselves the right to "vent", as we say in our jargon. We have the freedom of saying that we find this hard and we may say things that we obviously would not say in front of the patient. The meetings also serve as a safety valve, which is very, very important.

With the increase in the workload, we now have the problem of no longer being able to talk to each other. At Valcartier, for instance, generally speaking anywhere from 25 to 35%, if not more, of the staff are unable to attend our meetings because they are busy training soldiers who are leaving on mission or conducting pre-deployment or post-deployment interviews. This is creating a situation where we are no longer able to catch our breath, and unfortunately, our work is now somewhat similar to that done in the civilian sector.

This situation must not occur. We must ensure that we have a working environment where we can say that people are dedicated to the clinic but that they have time to meet and that this time is sacred. We are not, however, able to do this because we are too busy.

Contrary to the situation in a hospital or in the civilian sector, as health professionals it is part of our job to meet with the soldiers and to prepare them for their mission. Prevention is very important. Part or our job is to meet with them before they leave on a mission and to talk to their spouses to make sure that everything is in order. Part of our job is also to meet with them when they get back. Right now, 2,400 soldiers are getting ready to leave, which is a great many people. If we are to do 75-minute pre-deployment interviews for 2,000 individuals, and on top of that deal with people who are undergoing therapy, it is going to get very difficult to juggle everything and we run the risk of burning out.

● (1035)

Maj Chantal Descôteaux: As regards your stakeholders

[*English*]

who are working with VAC, they don't get what we're trying to get. That's why we need to set up these clinics where they can talk to each other. We have to send some of our active duty members downtown, because we are not enough to care for them. But we liaise well with the psychologists, and we pay them to come to Valcartier to sit down with us when we have the interdisciplinary meetings. So they also get to vent with us.

The Chair: Thank you, Mr. Stoffer.

We'll go to Ms. Hinton for five minutes.

Mrs. Betty Hinton: Thank you.

This has been very interesting today. I have never had witnesses sit in here who I haven't found interesting, but this has been very educational as well.

These are just my thoughts. Sometimes self-examination, as well, helps you realize that you have stress or that you have a problem you need help with. I'm wondering whether that's encouraged. That would be a question I'd like to ask.

This is just a comment, and it may sound silly, but when the microwave goes off at home, it makes me anxious. I couldn't understand why until I did a little self-examination one time. If you're a member of Parliament, your life is ruled by bells. They ring, and the quicker they ring, the less time you have to get there. It causes some anxiety. You don't want to be late for this, that, or the other thing. One day when this microwave went off, my husband asked me why it bothered me so much, because it's such a minor thing. And I finally realized that this was exactly what it was; it's because of the bells that happen here. You know, it's that old Pavlov's dog-training kind of thing.

There have to be a number of instances with military personnel when something that is just a normal, everyday occurrence that happens all the time triggers some sort of reaction in the individual. I would be interested in hearing what the major or Mr. Dufour—

[*Translation*]

Mr. Marc-André Dufour: The Resiliency Training Program that I talked about earlier also includes a peer support component. Even if military personnel are not fully aware of what they are experiencing, we try to train people within the units, ideally people of the same rank, to alert one another. We call this the buddy system. In other words, people are assigned to pay attention to another person, his or her buddy, in order to be able to tell that person when something is not right, when the person is not behaving normally, and ask whether the person is aware.

At Valcartier, we also have suicide prevention committees and committees on violence in which military personnel in the units can participate. These act a bit like eyes and ears for us on the ground, if you like. They can recognize when someone is not doing well. We even make sure that the therapists' photos are posted somewhere. That way, military personnel can identify, for example, the addictions counsellor.

During the post-deployment interview, when military personnel return to Canada, they fill out a self-evaluation questionnaire that describes various symptoms. They have to indicate for example, if they react strongly to a given situation and if their reaction corresponds to one or another of the reactions described. So this is done when they return and it is important because they do not always have the time to stop and be aware of what they are experiencing. Our presentations focus on this to some extent. The military personnel recognize themselves. Mr. Castro's *Battlemind*, which I mentioned earlier, is an example. I have clients who have seen that presentation and really identify with this because, for example, they see a military member speaking to his son the way he would speak to a subordinate. He uses a harsh, directive tone which would be totally appropriate in an operational theatre, but when he is talking to his five-year-old son who wants to play with him, he needs to change his tone. He needs to adapt. These are scenes from people's lives, so it is easier for members to recognize themselves in these situations. It promotes self-examination and encourages people to ask for help, obviously, because the health services are being promoted at the same time. We need to be able to fulfil our mandate.

● (1040)

[*English*]

Mrs. Betty Hinton: You may not be in a position to answer this, and I'm not trying to put you on the spot, but 7.2% is a fairly high number, and that's for depression and panic disorder, is what I heard you saying. That's two times the normal Canadian average. I'm sure that if you were to look at firemen, for example, and that's a perfect example, they have to go into burning buildings, they know they're putting their lives on the line, oftentimes dragging out children who have succumbed to the smoke and have died, or seen people burned alive. It's got to be horrible. Do you have any comparison between firefighters and military personnel in terms of these numbers?

Maj Chantal Descôteaux: I think that if we look not in that book but the other book, of Pascale Brillon, she's reported a few studies. You could have percentages, but it varies in studies. After being exposed to a trauma, there is about a 15% chance of developing post-traumatic stress disorder, whether you're in the military or not. I think, if I remember correctly, she points out a few traits, so there must be something out there, but I'm not sure.

The StatsCanada study has not looked into that, but they took a very good sample, which is 5,000 people, but of the 5,000 people, how many were from the navy, the air force, and the army? This is another thing that I would just point out. If the 5,000 are from the army, maybe the numbers would be different now.

[*Translation*]

Mr. Marc-André Dufour: What I am going to say is not based on research, but I believe that the fact that people are far away from their usual social networks probably means that they have less protection from post-traumatic stress. It is not easy to go through difficult situations on the job, but if you can go home at night and be with your loved ones and call a friend, those things help protect you. The possibility, for example, that a firefighter might lose a colleague in a fire, another one the next day and yet another three days later is much lower than being in that kind of situation in Afghanistan, where people are killed on a regular basis. Military personnel suffer repeated traumas and are far from home. Military life requires a tremendous ability to adapt. That is the way it is; that is the way it has to be. But from a mental health perspective, it is still very difficult. That is my opinion.

[*English*]

The Chair: Monsieur Perron, for five minutes.

[*Translation*]

Mr. Gilles-A. Perron: I am going to be accused of speaking too much and too quickly.

Chantal, I really appreciated your great presentation. You complained, no doubt rightly, that funding was inadequate. I would not say that I am uncomfortable, but I wonder how it is that National Defence, which is prepared to invest billions of dollars for planes, tanks, shoes, boots and uniforms, cannot set aside 0.5% or 1% of its budget for mental health.

I would like you to look into that and send me a letter or a report indicating how many thousands, tens of thousands or millions of dollars should ideally be spent for mental health. I would like to have the numbers. I know it is not easy.

● (1045)

Maj Chantal Descôteaux: In my opinion, mental health does not only involve mental health services, which Ms. Ramsay is responsible for. It involves health in general.

Mr. Gilles-A. Perron: Health in general.

Maj Chantal Descôteaux: It involves our entire health group. It includes front line doctors, medics, nurses, infrastructure, buildings and vehicles. Our budget includes all these things and money is also spent training these people. Today, we are talking more specifically about health. I'm not the one who makes the regulations.

Mr. Gilles-A. Perron: Perhaps you can give us a ballpark figure.

Maj Chantal Descôteaux: I have the feeling that the chief medial officer of the armed forces, Ms. Kavanagh, our big boss, could tell you what proportion of the budget is spent on health care. I don't have that information, but perhaps Ms. Ramsay could provide it.

[*English*]

Mrs. Margaret Ramsay: We were given $98 million by the project management board to make the increases I gave you in the briefing notes—to add the 218 personnel and some infrastructure. We're certainly spending all that money. So compared to other parts of the health care system, we have been treated fairly well in amounts of dollars. But it's a growth industry, and we can always use more.

These clinicians are very expensive to hire. A psychiatrist's salary is $250,000 to $300,000. These are expensive resources to attain, but we have been treated fairly well by PMB, with the $98 million we were given in April 2004 to spend over five years.

[*Translation*]

Mr. Gilles-A. Perron: How many soldiers are there at Valcartier? Marc-André or Chantal, how many of your colleagues are involved in health care? Is it a ratio of 1 to 10, 1 to 100, 1 to 1,000 or 1 to 10,000? If you can't answer that now, you can send it to us later.

Maj Chantal Descôteaux: The numbers vary depending on the season. In the summer, the cadets and reservists come to Valcartier. We treat between 7,000 and 9,000 patients, including reservists.

Mr. Marc-André Dufour: There are about 30 mental health workers, including all the professions.

Mr. Gilles-A. Perron: For 7,000 patients?

Mr. Marc-André Dufour: Yes. These are not 7,000 people taken from the general population. We might have enough resources in times of peace, when things are normal. But we have to adjust our human resources because of the mission in Afghanistan. The mission in Afghanistan has changed the situation. Pre-deployment interviews are much longer and the level of danger is much higher, so our military personnel is more anxious. When they come back, chances are that more of them will ask for treatment. We therefore have to make adjustments to provide mental health services which are better adapted to the fact of the mission in Afghanistan.

Mr. Gilles-A. Perron: Thank you very much. This has been very interesting and I have learned a lot.

Here is another suggestion. Pascale told us that it was hard to recruit practising psychologists or psychiatrists, and that it was especially difficult to find competent psychologists who could be trained. We could speak to psychologists' associations in different provinces and ask them to train young professionals with a view to counselling military personnel. Most psychology graduates fresh out of university have a general background.

Mr. Marc-André Dufour: Indeed, there is no connection between the university and military worlds. Thank you.

[*English*]

The Chair: Thank you very much.

I'm intrigued. Did I actually hear you say that psychologists cost $250,000 to $300,000?

Maj Chantal Descôteaux: That's for psychiatrists, doctors.

The Chair: That's fascinating. Wow. Is that for the military base ones?

Mrs. Margaret Ramsay: Yes. These are civilian psychiatrists who we're hiring.

The Chair: Thank you very much.

Witnesses, we have one other person who will ask questions, potentially, but his motion is being dealt with. It's a committee business thing.

Mr. Brent St. Denis: If there's consensus, we can deal with my questions with other witnesses.

● (1050)

The Chair: That's fine.

We have some committee business to deal with. So thank you very much for your testimony here today. I know I always learn things from your presentations. What I take from today is that one of these days I'm going to visit Valcartier to see the base.

Thank you very much for appearing and giving us some sense of changes we can make to the programs and various things.

We'll take a five-minute break.

● _____ (Pause) _____ ●

The Chair: We're going to deal with Mrs. Hinton's motion.

Gilles has raised an issue about a report, concurrence, etc., but I'm going to ask that he have a written motion for that. We'll deal with it at a subsequent meeting.

● (1055)

[*Translation*]

Mr. Gilles-A. Perron: Mr. Chairman, I can give committee members my point of view. Rather than discussing it here, we can talk about it outside of the meeting. I will officially present a motion to that effect. This morning, I discussed with the chairman the fact that the report on an ombudsman should be adopted in the House. But we can talk about that another time.

[*English*]

The Chair: The clerk has pointed out that we have a teleconference at the next meeting at 9:30, so from 9 to 9:30 we have a half hour. If Mr. Perron likes he can put it forward. I hope it's done in a written format. I think it's an interesting concept, but today we're dealing with this motion.

Mrs. Hinton has notice of motion:

> That, pursuant to Standing Order 97.1 (1), the Committee present a report to the House requesting an extra 30 sitting day extension to complete its consideration of bill C-287 - An Act respecting a National Peacekeepers' Day.

Do you wish to speak to it?

Mrs. Betty Hinton: Do I wish to speak to it? Well, yes.

It's pretty straightforward. I think it's important for us as a committee, since it was referred to us as a committee, to discuss Mr. St. Denis' private member's bill. Because of our agenda we haven't gotten to it yet. In order to get to it, we require a 30-day extension.

I think any member who puts forward a private member's bill has the right to have that bill discussed in committee when it's sent to committee, and we've done a disservice to Mr. St. Denis if we don't do that, so I'm asking for a 30-day extension so that we can have it on the agenda and discuss it.

The Chair: Go ahead, Mr. St. Denis.

Mr. Brent St. Denis: First I have a procedural or technical question to the clerk. What is the date by which the committee needs to dispense with it, as we sit here now?

The Chair: I believe it's May 2.

Mr. Brent St. Denis: It's May 2; okay. How many meeting days do we have between now and May 2?

There are two—Thursday and Tuesday. Okay. Are there witnesses set up for Thursday and Tuesday?

The Clerk of the Committee (Mr. Alexandre Roger): There are only witnesses set up for next Thursday, which is the teleconference.

Mr. Brent St. Denis: Is Tuesday open, then?

The Clerk: Next Thursday is open as well.

Mr. Brent St. Denis: So the Tuesday coming is open. That's May 1.

The Clerk: That's right.

Mr. Brent St. Denis: Personally, I think all business is important. You could make a ranking if you felt like it, but in the case of private members' bills, it's not that the committee needs to judge the merit of a bill; it has a duty to deal with private members' legislation as it comes. I don't know if there's an opening Tuesday. I would actually say to Betty that I imagine it won't take more than one meeting to yea or nay this bill; we could deal with it Tuesday and we wouldn't need to suspend.

If we suspend it for another 30 days, we're into June, and then who knows how long that can go on? I would actually not agree with Betty on this point, personally.

Mrs. Betty Hinton: My understanding is that if I don't put forward this motion and ask for the 30-day extension, we're not going to be able to get an opportunity to discuss it. I haven't a problem with next Tuesday or next Thursday—it's fine with me—but if this motion doesn't pass, then you may not have that opportunity. I'm trying to give you insurance that we will discuss this.

Mr. Brent St. Denis: Absent a motion to this effect, the committee will be deemed to have reported it, so my bill is not lost, regardless.

● (1100)

Mrs. Betty Hinton: We need to discuss it as a committee.

Mr. Brent St. Denis: I don't disagree with that.

The Chair: We're going to go on to Mr. Stoffer.

Mr. Peter Stoffer: Is it possible to move a friendly amendment to the effect that this bill will be debated on Tuesday?

The Chair: Is that considered a friendly amendment?

Mrs. Betty Hinton: Well, I don't think you can amend this part. This is just a technicality. I'm putting it forward in this format because it's the normal format in which to put it forward. I have no problem, and I don't think anybody has a problem, with discussing it next week, but it can't be a friendly amendment because it's a specific—

The Chair: Go ahead, Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: I have a question for the clerk. You control the schedule of our meetings. Can we discuss this next Tuesday or Thursday? If not, when would the earliest opportunity be to discuss the bill?

The Clerk: It all depends on how much time the committee needs to discuss it.

Mr. Gilles-A. Perron: I suppose it could take a couple of hours, but probably no more than that, because this bill—

The Clerk: We could spend an entire meeting on the bill. We could also discuss it at the end of a meeting, for perhaps half an hour or so. However, if the motion is not adopted, it will be automatically reported to the House, without amendment or debate, which would imply that it has been debated. Do you understand what I mean?

Mr. Gilles-A. Perron: I understand. There are several technical details I am not familiar with. That's your area.

The Clerk: Fine. I hope I answered your question.

[*English*]

The Chair: Okay, now hold on. We're going to recognize Mr. St. Denis and then Mr. Stoffer.

Mr. Brent St. Denis: If I understand Betty's motion, it's just to protect the committee's right to have something to say about the bill. With the understanding that it's on the Tuesday schedule, we all agree to the extension, which we may not need. It's there as a backstop. It doesn't need to be in a friendly amendment, although I appreciate Peter's amendment. Then I'm okay.

Mrs. Betty Hinton: Right. There's no underhanded stuff here. It's straightforward.

The Chair: Mr. Sweet.

Mr. David Sweet: The conversation's pretty well if all of the members feel, as Mr. St. Denis does, that we can go ahead and approve this, put it on for Tuesday. I mean, that was my concern: if we put it on for Tuesday, we don't approve this, we don't have any latitude if we do get into a discussion—there's a couple of things I'd like to discuss about the bill—then we can't reschedule it. So if everybody feels that way, and if we're ready to move on that, I'm fine.

The Chair: Mr. Stoffer.

Mr. Peter Stoffer: I'm just wondering, why the 30 days? Is there a technical reason why it has to be 30 and not seven, for example? Is there a specific reason for that?

The Chair: I think it's just a standard form.

Mr. Peter Stoffer: Oh, it's standard.

A voice: It's in the Standing Orders.

The Chair: Okay. So I think we have an understanding about this, that we'll be dealing with this on Tuesday.

Mrs. Betty Hinton: Is there unanimous consent?

The Chair: I think so.

All right, meeting adjourned. See you all Thursday.

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