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Chair

Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): I call the meeting to order.

Today we continue our study of the health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

Today we have another expert panel. We'd like to welcome you, Colonel Gerry Blais, director of casualty support and administration, and Colonel David Weger, director of health services personnel.

Gentlemen, I understand that you both have presentations to make. We'll get you both to make them, and then we'll open it up to the usual round of questions. The floor is yours. Please proceed.

Colonel David Weger (Director, Health Services Personnel, Department of National Defence): Thank you, Mr. Chairman.

Mr. Chairman, members of the committee, I am Colonel David Weger, the director of health services personnel for the Canadian Forces. I thought it might be useful, by way of my opening remarks, to provide the committee with some idea as to what my general terms of reference are, and more specifically, what the responsibilities of my position are.

As director of health services personnel, I am responsible for two major areas of activity: health services, individual training and education, and health services, occupational management. I would also note at this point that I deal with these areas as they pertain almost exclusively to uniformed health services personnel, that is, those health services personnel who are in the military. I play no direct role in the mental health world, nor do I work with operational stress injury or post-traumatic stress disorder.

Within the realm of health services, individual training, and education, I am responsible for the development of training and education guidance, the establishment of occupational standards, the strategic oversight of training delivery, validation of training programs, and management of our maintenance of clinical skills program.

In all, there are in excess of 300 health services related individual training and education activities. These activities run the spectrum from primary care paramedic training at the Justice Institute of British Columbia to post-graduate medical specialty education at various Canadian universities, and from basic field medical services training at the Canadian Forces Medical Services School in Borden to the joint medical planner course at the NATO School in Germany. My directorate is also responsible for the administration of the Canadian Forces first aid program.

On the occupational management side of my portfolio, I am responsible for helping to manage the 19 health service occupations found in the Canadian Forces by ensuring that the Canadian Forces has sufficient uniformed health services providers to meet its operational needs. This includes the identification of recruiting targets, the establishment of periods of service, the creation of occupational structures that foster career progression, and the attraction and retention of health services human resources.

By virtue of my position, I am also the team leader for five human resources initiatives under our major health services reform project, Rx2000. Three of these initiatives deal with the enhancement and sustainment of clinical skill sets, one with the attraction and retention of health services personnel, and the last with both these areas as they pertain specifically to the nursing profession within the Canadian Forces.

I would be more than pleased to answer whatever questions you might have that pertain to my areas of responsibility.

Thank you.

The Chair: Thank you.

Go ahead, sir.

Lieutenant-Colonel Gerry Blais (Director, Casualty Support and Administration, Department of National Defence): Mr. Chairman, members of the committee, good afternoon.

I am the director of the Centre for the Support of Injured and Retired Members and their Families, commonly referred to as the Centre, which is a joint effort of the Department of National Defence and Veterans Affairs Canada. Part of this mandate includes acting as the director of casualty support and administration for the Canadian Forces. The centre provides information, advocacy, and referral services for ill and injured regular force and reserve force members and veterans, their families, and the chain of command. All services are available in both official languages.

[*Translation*]

The Centre provides a range of administrative support measures to injured Members, manages a variety of programs and offers many services, including:

[*English*]

provision of a 1-800 help line; searching for service records and other information; investigating files and documentation related to pension or disability award entitlement; guidance and approval of reserve disability compensation and the extension of class C service for reservists injured in a theatre of operation; providing information and assistance on Veterans Affairs services and benefits; coordinating requests for one-time financial assistance and support to provide for aids to daily living in urgent circumstances through the use of a contingency fund; providing emergency funding for travel from isolated areas to be with sick and injured family members; approval and payment of funeral benefits and family travel to funerals, memorials, and the bedside of ill and injured members; and counselling members on their entitlement to CF transition programs, including the vocational rehabilitation program for serving members;

[*Translation*]

authenticating the eligibility of medically released members for the Public Service Commission Hiring Priority Program; assisting medically released members in finding employment through the Transition Assistance Program; facilitating the interdepartmental transfer of security clearances; providing information and applications for the National Military Cemetery in Ottawa; providing pastoral assistance to veterans and their families through the Pastoral Outreach Program.

● (1540)

[*English*]

We develop and regularly update reference material and publications such as *The Death and Disability Handbook*, *The Commanding Officer Guide to Casualty Support and Administration* and *The Assisting Officer Guide*. We provide training and 24/7 assistance to assisting officers of injured members and the next of kin of members who are killed or who pass away while serving. Through the operational stress injury social support program, where military personnel are suffering from an operational stress injury, we offer information and support to them and their families. And through the speakers bureau, we provide awareness training pertaining to operational stress injuries.

Thank you. I would be pleased to answer any and all questions.

The Chair: Thank you. We'll start the questioning with Mr. Coderre.

[*Translation*]

Hon. Denis Coderre (Bourassa, Lib.): Thank you, sirs. It is a pleasure to have you here with us this morning.

As someone who is unfamiliar with this area, I have a question for you, Colonel Blais. In the event of a death, we must deal with the family and with loved ones. Of course, we open our hearts to these people and we help them. I am not just talking about entitlements, pensions and the like. I want to know if long-term psychological help is available to the family after the death and burial have taken place.

LCol Gerry Blais: Approximately six months ago, we brought in a measure that helps families a great deal. Thirty days or so after the burial has taken place, a designated officer meets with the family, along with the officer in charge of the detachment, a chaplain from the Pastoral Outreach Program and an official from Veterans Affairs Canada. Canadian Forces and Veterans Affairs Canada provide emotional support to the family. The Centre operates detachments in 11 locations across the country.

Hon. Denis Coderre: Therefore, psychological help is available, if necessary.

LCol Gerry Blais: Absolutely.

Hon. Denis Coderre: Fine then.

In addition to sustaining physical injuries, members may be scarred emotionally. As a Member of Parliament, I have met with several veterans and other individuals with complaints about compensation. When these persons come to see us, we get the impression that they have no one else to turn to.

Practically speaking, what recourse do these persons have when they encounter compensation problems or when they are dissatisfied with the treatment they have received, for example, when they have the impression that they have been more or less forgotten? Are the real problems on the administrative level? I am not asking you to get into specifics, but simply to explain to me how client services work.

LCol Gerry Blais: Veterans Affairs Canada is largely responsible for this area. I cannot get into issues that come under their jurisdiction. However, if a person has a problem, he can get in touch with us. The Centre is also staffed by people from Veterans Affairs Canada. Along with VAC personnel, we can help the member research his military records, among other things, to help him document his case and achieve a successful resolution to his problem.

Hon. Denis Coderre: I see.

[*English*]

Colonel Weger, when you're talking about taking care of all resources, does that include the military hospital? At Kandahar airfield, are you responsible for specific needs like bringing in more nurses? Are you in charge of that too?

Col David Weger: Indirectly, I am. In places like Kandahar, I generate the personnel employed by our directorate of health services operations. But the actual responsibility for staffing the facility lies with our directorate of health services operations.

Hon. Denis Coderre: That brings me to the question of retention. Of course there is the issue that we're missing some specialists and nurses. How do you proceed proactively to keep the people or to bring some and keep them inside the forces?

● (1545)

Col David Weger: There are a number of different programs we employ. The one with which we've had the greatest success thus far is actually an Rx2000 initiative dealing specifically with attraction and retention of medical officers and, to a lesser extent, pharmacists.

We have, over the last three years, brought ourselves from approximately a 45% deficit in the number of medical officers that we required to slightly less than a 10% deficit now. So we're well on the road to recovery with the general duty medical officers, the equivalent of your family physicians, and we anticipate hitting our preferred manning levels by the summer of 2009.

The medical specialists—that is to say, within the military context specifically, general surgeons, anesthetists, orthopedic surgeons, internal medicine specialists, psychiatrists—are very small groups to begin with. There are only 10 of each within the forces, with the exception of five psychiatrists. That is to say, that's our manning level. And we can be in as serious a deficit as 100%, as we are currently with radiologists, or at or over PML. In fact, we are currently over the preferred manning level for anesthetists. The ideal manning level is 10, and we currently have 12 in uniform.

They are the harder group to attract, and they have traditionally been the harder group to retain. Our retention, by way of comparison, for our general duty medical officers has gone from about 50-odd percent in 2000 and 2001 to—we're forecasting—about 65% by as early as this year.

Hon. Denis Coderre: What's your best argument to keep them?

Col David Weger: It's a combination of things.

Hon. Denis Coderre: You're making them an offer they can't refuse?

Col David Weger: It's pay. It's continuing professional education offers. To a certain extent, the operations we're engaged in—in Afghanistan currently—are an attraction factor. They certainly are for a number of the specialists, the direct entry specialists, that is, licensed and qualified specialists we've recruited over the last two or three years.

Hon. Denis Coderre: If you're staying in Canada, there's of course an issue of sensitivity, urban versus rural or regional. What's your strategy? Because, of course, if you're going to Valcartier it's going great. My colleague will probably talk about Petawawa and some other areas where there is an issue. You can have all the infrastructure you want, but if you don't have the people to work and give us the proper help and you aren't able to keep them, this is an issue.

How do you manage?

Col David Weger: Actually that, again, is not specifically my portfolio. The bulk of my responsibility with the military specialists is to ensure that they are working on a day-to-day basis in a way that will maintain the skill sets we need in operations. The trauma skill sets, by and large, they're not going to be able to maintain in places like Petawawa.

Most of our specialists, particularly the surgical specialists, are embedded in the trauma hospitals in places like Toronto, Vancouver, Calgary to a certain extent, and also Montreal. Basically taking care of the needs of our individual soldiers is largely done on the specialist side by either hiring or using a fee-for-service system through the civilian sector. The responsibility for recruiting and securing those services falls under the responsibility of our director of health services delivery.

The Chair: Thanks, Mr. Coderre.

Mr. Bachand, you have seven minutes.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you for being here.

One question has been bothering me since I visited Camp Mirage where a morgue is located. When I toured the camp, I was informed that steps would be taken to make this morgue more functional.

Are the soldiers killed in Kandahar sent to the morgue at Camp Mirage? If so, have facilities at the morgue been updated over the past year?

LCol Gerry Blais: The Commander of the Expeditionary Force is the person in charge of that area.

● (1550)

Mr. Claude Bachand: I understand. Thank you. That would be a good question to put to them when they testify before the committee.

I recall reading in several specialized journals that you were making an effort to reintegrate injured soldiers. That does not necessarily mean sending them back into combat zones. For instance, if a solider has had his legs amputated, he cannot return to active duty.

At one time, when CF members were unfit to perform the duties for which they had been hired, they were demobilized and told their services were no longer needed. Is it true that now you make a special effort to reintegrate them into the Canadian forces, by assigning them to duties better suited to their physical condition?

Col David Weger: That question has more to do with health services. The chain of command in the theatre of operations and clinicians who specifically treat the injured work together.

Mr. Claude Bachand: To whom should I be directing that question?

LCol Gerry Blais: Perhaps I could clarify the issue a little from an administrative standpoint. Currently there is a program in place to help injured members reintegrate into the workplace. We make every effort to reintegrate them into the workplace as quickly as possible, whether it be in their particular field or in some other area.

We first want to ensure that the work gives them a sense of purpose. That is very important because we do not want to relegate them to minor tasks. For example, a double amputee from Edmonton is current providing support services to injured members. These are the types of things that we do.

Universality is an enduring principle when it comes to Canadian forces services. Ultimately the issue is whether these members have a future in the forces and whether they can conform to the premise of service universality. Every possible effort is made to reintegrate them into the workplace. If that is not possible, then we do everything we can to help them find a good civilian job.

Mr. Claude Bachand: What about the options available to some soldiers, especially those who are suffering from post-traumatic stress disorder or who are seriously depressed. Do you consider medicating them and sending them back into combat zones?

Speaking of drugs, I would imagine drug costs are covered by the Canadian Forces. Could a soldier who is very depressed and who is sent back to Canada possibly rejoin his originating unit in a theatre of operations, while under medication, for the purpose of seeing whether if he is fit for duty?

Col David Weger: If the member is suffering from a permanent, or chronic problem, steps can always be taken to improve his condition. However, as the Brigadier General stated when he last appeared before the committee, it is not possible to heal every person suffering from post-traumatic stress disorder or from other mental health problems.

Our clinical section personnel may be in a better position to answer questions about cases of this nature.

Mr. Claude Bachand: Eventually, we will need to hear from the people working on the clinical side of things.

Public services come into play when dealing with members with special conditions or in need of medical care. I understood you to say that the public sector in each province was responsible for providing this care. How does this work? Does each province bill the government for the cost of the care provided to CF members? Is that how it works?

Col David Weger: We do a combination of things. Uniformed mental health services providers are stationed on most of our bases. I believe virtually all of the psychiatrists work out of the clinics on military bases. We provide a range of services to members. Perhaps the person responsible for health service delivery could better answer that question. He could explain the balance we try to strike.

● (1555)

Mr. Claude Bachand: I see. There is a balance between the two sectors.

Col David Weger: The public sector is not alone is providing services to members.

Mr. Claude Bachand: Some trauma centres are located on military bases. The Canadian Forces ombudsman has already talked about the possibility of opening trauma centres off base, since victims of post-traumatic stress disorder are stigmatized to some extent.

Would you be in favour of an initiative like this?

Col David Weger: I am not a clinician. I am an administrator. Therefore, I am not in a position to say how to best go about treating persons, regardless of their mental or physical condition. That question would be better put to the Director, Health Services Delivery, or to our health services officials.

Mr. Claude Bachand: I see. Thank you.

[*English*]

The Chair: Thank you, Mr. Bachand.

Ms. Black, you have seven minutes.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you, Mr. Chair.

Thank you to both of you for coming to the committee today.

I've been meeting with some families of military personnel who've served overseas and have come back with various traumas. A couple of the families I've met with have felt that there have been many obstacles in the way of getting a diagnosis, that it was a very lengthy process even though they were incredibly concerned about the person who'd come back from the mission. I'm sure that's something that all of the Canadian Forces is looking at and attempting to improve the services for.

But I want to ask particularly about the issue for reservists, because we know in the next rotation there's a large number of reservists going over—in fact, quite a few from my own community, New Westminster, the Royal Westminster Regiment.

One of the concerns I've had, and I know it was raised at the meeting last week—I wasn't here, but it wasn't addressed; there was no answer given in the testimony—is how will it work now for reservists? We know when the regular forces come back they'll be stationed at a base, they'll be part of the military community, for want of a better word, and yet reservists will go back perhaps to a community in the north or a community not near a base. How will the follow-up be done for post-traumatic stress disorder or acquired brain injuries, or any other kinds of injuries that reservists may find once they've gone back to their home communities?

LCol Gerry Blais: From an administrative point of view, there are now, in 11 areas of the country, detachments of my organization, the centre. They are there to look after regular forces and reservists. We are working right now at expanding the detachments to have more staff, and they are going to look after all the injured in any particular area.

So the first thing that's very positive is that any reservist who returns from theatre with an injury is serviced on class C reserve service, which means he or she has all the same benefits as a regular forces member. That will be extended until such time as the person has recovered and the commanding officer and the doctor certify that the person can go back to work.

Ms. Dawn Black: I guess my question is a little bit more specific. I know they've said that in six months they will have an examination of returning soldiers on the base. How will that follow-up take place if someone is in Pouce Coupe or northern Alberta and not near one of the 11 centres you talked about?

LCol Gerry Blais: The detachments are very mobile, and they have a region, not just a small area of responsibility. They will ensure that they maintain contact with these individuals. Through that contact, they will also be in contact with the member's case manager and ensure that the person has the information, whether the medical service is going to be provided in the person's own community or at the base. Either way, the persons travel—

● (1600)

Ms. Dawn Black: So they would do some travelling to seek these people out?

LCol Gerry Blais: Absolutely.

Ms. Dawn Black: I have another question, and it flows from the testimony last week but also from personal interest. I don't know if you're the appropriate person to ask, but I'll throw the question out, and you can let me know.

I'm interested in the screening that's done for recruits, the psychological screening. They said in the testimony last week that it's not done, basically. They don't do much in the way of psychological screening for recruits. I know they do it in police forces across Canada, so I wonder why the Canadian Forces doesn't do that.

Also, in talking to military families, I've been told by some that the first reaction in some cases, when they've raised the possibility of post-traumatic stress disorder or of some kind of occupational stress injury, is that they've been told sometimes that it's probably a pre-existing condition, which they've argued against. I'm just thinking that if you had an effective and proper screening process, you would know if there were pre-existing conditions that would result in this kind of behaviour or illness.

There was an article in, I think, one of the Vancouver papers, where I live, about a really horrible example of the lack of screening. A fellow who'd actually been an associate of the Hells Angels, who had been, I think, charged with murder in British Columbia, was able to get through whatever screening process there was. He was in training in Quebec, and it was his fellow service people who were alarmed by his behaviour and went to the authorities above, and he was eventually discharged. I can't help but think that if there were a proper and thorough screening process, this kind of situation wouldn't arise. You wouldn't have someone like that who gets through the process and becomes enlisted and then has to be discharged. Also, it would certainly lessen the number, perhaps, of people who show mental health problems later in service.

So I'm wondering about the whole issue of psychological screening.

Col David Weger: Certainly neither of us is the ideal one to ask the question to, but perhaps I can point you in the right direction.

With respect to the efficacy of psychological testing to pick up things of the nature you've identified, likely the best people to talk to are the directors of health policy. The medical recruiting office falls under their responsibility and could very likely provide you with some information, or could at least point you in the right direction with respect to that specific area.

In a wider sense, on the actual recruiting process and the screening associated with that, the director general of recruiting and military careers or the commander of the Canadian Forces recruiting group would be the most likely sources for answering those questions more effectively.

Ms. Dawn Black: What sort of educational training do soldiers get about post-traumatic stress disorder? Are sessions given so they can self-identify and understand what might be going on if they're starting to show signs or feel within themselves signs of a problem? What kind of education do you provide to help them self-identify—or their families, for that matter?

LCol Gerry Blais: As a component of the operational stress injury social support program there is a speakers bureau. These are folks who have lived through either post-traumatic stress or a form of operational stress injury, and they now speak at all leadership courses to ensure that people are aware. That starts at the lowest level, at the master corporal level, and they go all the way up. We're currently trying to widen that mandate so we get it into as many training modules as we can to ensure that people are aware of the signs and how this actually occurs, and to reduce the stigma.

Ms. Dawn Black: Oh, I have no time. Thanks.

The Chair: We'll go over to Mr. Blaney for seven minutes.

[*Translation*]

Mr. Steven Blaney (Lévis—Bellechasse, CPC): Thank you, Mr. Chairman.

Welcome to our CF members responsible for health services.

Lieutenant Colonel Blais, I want to thank you for being here. This is our second meeting on post-traumatic stress disorder. Basically, we want to ensure that returning soldiers who are experiencing mental health problems receive the treatment they need.

Last week, we were somewhat reassured by the testimony we heard. Witnesses explained and demystified this disorder. Nearly 25,000 soldiers have been rotated through Kandahar since the start of this mission. I learned that nearly 17% of the soldiers returned from this mission with mental health problem, addiction issues and so forth. That number is quite high, in my estimation. Could you confirm these figures for me?

Two things can happen to a soldier deployed to Kandahar: either he can sustain a physically injury or experience situations that leave psychological scars. Can you describe for us what happens between the time a solider is injured or suffers emotional trauma in a theatre of operations and the time he returns to his home base?

● (1605)

Col David Weger: Again, we may not be the best people to answer your question. You would be better off speaking to a member of our health services who could walk you through the process.

Mr. Steven Blaney: I understand.

Colonel Weger, you are the Director, Health Services Personnel. You explained to us how you are responsible for training and rehabilitation programs. Is that correct?

Col David Weger: Not exactly. Basically, I am responsible for ensuring that health service providers have the qualifications needed to serve our personnel deployed overseas. My responsibility extends to professional training courses for our medical technical personnel, that is to providing the skills required to operate in the field. However, I am not responsible for training non health services personnel, or for training personnel associated with rehabilitation. That is truly the domain of health services.

Mr. Steven Blaney: So then, you provide training to medical personnel, to technicians working in the field. Is that correct?

Col David Weger: Yes. I am responsible for ensuring that they have opportunities to develop their skills.

Mr. Steven Blaney: Do you work with military or civilian personnel?

Col David Weger: Almost exclusively with military personnel. One or two courses are available for civilian personnel working in clinics, but in 98% of cases, we work with military members.

Mr. Steven Blaney: I see. Thank you.

LCol Gerry Blais: I would be happy to answer any other questions you may have. From a non-clinical standpoint, I can be of some assistance. When the member returns to Canada, a designated officer is assigned to him.

Mr. Steven Blaney: Regardless of the nature of the injury, whether physical or otherwise?

LCol Gerry Blais: Regardless of the injury. The designated officer acts as a guide, so to speak, for the injured member. First of all, he helps the member find his way through the administrative system. He also helps the member get to his appointments. If the member has problems with his chain of command or some such thing, the designated officer is there to lend a hand. As I said, the centre will be assigning more staff to certain detachments to provide one-stop shopping for injured members. They will be able to avail themselves of the Return to Work Program. All services, with the exception of health care services, will be available in one location to make life easier for injured members.

Mr. Steven Blaney: When you say that you plan to assign more staff, are you implying that at this point in time, you are not necessarily able to handle all of the members who are either injured or experiencing some trauma?

LCol Gerry Blais: We have the capacity to deal with them but at this time, a great deal of support is provided by the member's unit. However, that may not necessarily be the best place to get the support needed. Therefore, if we develop a centre of expertise to deal solely with injured soldiers, we will be able to offer them an improved level of service.

● (1610)

Mr. Steven Blaney: So then, regardless of whether a soldier is physically injured...For example, a member may return to Canada and not yet realize that he has a problem. He may subsequently exhibit signs of the disorder. At what point do you intervene?

LCol Gerry Blais: As a rule, the member must be diagnosed first as having a problem.

Mr. Steven Blaney: Who makes that diagnosis? Is it Health Services?

LCol Gerry Blais: Health Services personnel are the only ones who can make that diagnosis.

Mr. Steven Blaney: That would be military health services. That is not your area of responsibility.

LCol Gerry Blais: No, it is not.

Mr. Steven Blaney: Your area of responsibility is...

LCol Gerry Blais: I am responsible for providing support through social programs, for providing administrative support to CF members.

Mr. Steven Blaney: I would like to come back for a moment to the case of a returning member who has been diagnosed with a drinking problem, for example. What kind of help would he get?

LCol Gerry Blais: Health clinics are staffed with counsellors to help members with problems of this nature.

Mr. Steven Blaney: Will an officer be assigned to this member?

LCol Gerry Blais: Certainly, if that member's drinking problem is tied to job-related stress.

Mr. Steven Blaney: The member may have developed a drinking problem as a result of his deployment to this area. I imagine health services personnel assess his condition.

LCol Gerry Blais: That is correct.

Mr. Steven Blaney: Thank you.

Lcol Gerry Blais: There are cases of comorbidity.

[*English*]

Col David Weger: Drugs.

[*Translation*]

Mr. Steven Blaney: Thank you, sirs.

[*English*]

The Chair: Thank you.

That ends the first round.

Just before we get started in the second round, I want to mention that the Auditor General, in her report last October, indicated that there needed to be more emphasis put on the qualifications of the people who are treating the military. This must fall into your bailiwick. There was a suggestion that the Canadian Forces Health Information System needed some continuing work. Do you have a comment on how that is progressing, and are we keeping better track of who we have doing the treatment and who we're treating?

Col David Weger: The Auditor General actually made three specific recommendations linked to what you've just mentioned. The first one is related to CFHIS and is again not my area of responsibility. I do know that the project is progressing, and specific details can be obtained through the chief of staff of the Canadian Forces health services group, under whom the project falls.

The two concerns that the Auditor General specifically touched on with respect to the credentials and competence of military health care providers had to do with compliance with our program for maintenance of clinical skills on the one hand, and on the other the fact that we lack the mechanism to ensure that all our care providers actually hold appropriate licences or credentials.

Since the report came out, the latter of these two has certainly been a particular area of focus, and the credentials cell within our directorate of health services delivery, to whom I would refer you for specific numbers, has been moving forward very aggressively to confirm that everybody does have the appropriate licensing. I can tell you that we have confirmed that 100% of our military physicians are licensed by a provincial body and that they have also focused very aggressively on verifying the numbers for pharmacists, dentists, and nurses this year, as a starting point.

The Chair: Thank you very much. And I thank the committee for allowing me that.

Go ahead, Mr. Cannis, for five minutes.

Mr. John Cannis (Scarborough Centre, Lib.): Thank you, Mr. Chairman.

Gentlemen, welcome.

Inasmuch as we are in a theatre, and an unusual one in which casualties are unusually high, questions so far have been focused on the current casualties and on how we address our men and women who return with ailments and so on. But in your presentation, Mr. Blais, you talked about your responsibility for veterans as well. In our view, veterans are those who come back and have served in the most recent and in previous conflicts as well. I believe they're just as important.

One of the questions I'd like to ask needs just a short response. Some time ago there was some question in terms of the funeral expenses or funeral compensation. At one time there seemed to be confusion over whether the former minister had indeed sent the letter to take care of it. It wasn't taken care of, then it was.... Nobody really knew until the Dinning family, I believe it was, came to Ottawa, and we got to the bottom of it.

Has that issue now been addressed? Is there a clear policy from your point of view, if you can tell us, that upon the loss of life of one of our soldiers, that compensation is there without a year's delay?

● (1615)

LCol Gerry Blais: That is very much so. It used to be that funeral expenses were paid by the bases throughout the country, and the understanding of the regulations was not necessarily the same in every area. As of April of last year, the authority for approval and payment of those benefits was centralized in my directorate, and as soon as we receive the bill from the assisting officer, it's paid on the spot.

Mr. John Cannis: So now it's standardized right across the country.

LCol Gerry Blais: Very much so.

Mr. John Cannis: Thank you very much for clarifying that.

There is another question I'd like to ask in terms of our veterans. We have veterans hospitals, such as Sunnybrook in Toronto, for example. We do get calls—maybe not that many, but we do get calls. In my view, and I'm sure in the view of everybody here, one call is one too many. They have difficulty; they can't get service.

We know how the system works in terms of money transferred federally to the provinces, and the provinces administer the health system, but are there funds that you know of that go directly to supporting veterans hospitals?

LCol Gerry Blais: That one is definitely a Veterans Affairs issue.

Mr. John Cannis: So when you mention veterans, that doesn't fall under your—

LCol Gerry Blais: We assist them with individual problems, if you will, but the overall mandate for health care for veterans is a Veterans Affairs issue.

Mr. John Cannis: That was it, Mr. Chairman. Thank you.

The Chair: Go ahead. There are a couple of minutes left.

Hon. Denis Coderre: You're in charge of administration, Colonel, meaning all the checks and balances and the flow of information, so if we need some answers, I assume you're in charge regarding the health services. Is that right?

LCol Gerry Blais: Not health services, no. It's the social support and all the administration surrounding the care, but not on the health side.

Hon. Denis Coderre: So if there are some needs.... I'm just trying to figure out the accountability. The buck stops here for everything regarding social services; that's under you.

LCol Gerry Blais: For the most part, yes, sir.

Hon. Denis Coderre: Okay. How do you make your checks and balances to see that the people who deserve to have an answer get the right answer? I ask because sometimes, because of all the red tape, it falls through the cracks. How do you manage to make sure you have better service yourself under the people who are working for you?

LCol Gerry Blais: As I say, now—since September—we have people throughout the country. Earlier we didn't have that. Obviously it's hard to get information if you don't have people on the ground, because geographically we're so dispersed.

[*Translation*]

Hon. Denis Coderre: However, is data centralized here? For example, if you wish to manage the case of a CF member with specific problems, is the data on file at the base, at the command to which the member is assigned or here? Or, are two copies available?

LCol Gerry Blais: The information is on file at the base and the detachment located on the base handles the member's case. However, if these members need additional help or authorizations, for example authorizations for funerals, they turn to us for help. With BlackBerries and other similar devices in use today, authorizations are given within an hour in all cases.

Hon. Denis Coderre: Everything is computerized. How do you manage all of the data?

LCol Gerry Blais: Recently, we issued our first report. Since the detachments began operating only in September, last week, we issued an initial list of all CF members who had either been injured or had experienced a health problem. We estimate that the list is 95% accurate. As a result, we can monitor these members regardless of where they may be.

Hon. Denis Coderre: And this is handled by DND, not by an outside service. Correct?

LCol Gerry Blais: It is handled by DND.

[*English*]

The Chair: Thank you, sir.

We'll go over to the government and then back over to the Bloc.

Mr. Hawn is next.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

Thanks, gentlemen, for being here.

I have a couple of quick questions. I met a civilian doctor at Massingar at Christmas. He was the head of trauma for one of the Toronto hospitals—I forget which—and he was over there for a two- or three-month period. Is he unique? Are we getting more like that? Are we going out to try to find them? His story was that he came to us and said that he wanted to do that. Are we getting more like that?

● (1620)

Col David Weger: Again, for exact numbers, the director of health services operations would be best placed to provide those, but we use a number of mechanisms. Certainly the fact that we have most of our military specialists embedded within civilian facilities creates an awareness that the opportunities are out there. We do have individuals who, as in the case of this gentleman, step forward and say that it's something they would really like to do—that it appeals to them, that they see it as a way to contribute to the country, and that they would like to take some time and go over there.

In fact, at least two individuals we had on contract as civilians who were sent over for a tour have subsequently come back to Canada and enrolled in the Canadian Forces. It is far more frequent than it was half a decade ago. It will, with luck, become far less frequent as the overall health of our medical speciality occupations improves, but it will certainly always be an option that's out there for those individuals who do indicate that they have an interest in doing this to support us.

Mr. Laurie Hawn: Great, and that brings me to retention. You talked about retention in terms of a percentage of folks. Define retention. Are we talking about an extra three years, five years, two years? How do you define retention?

Col David Weger: For general duty medical officers, it is that they stay within the forces after their initial four-year obligatory service period is up. In most instances that means they stay until the end of their initial engagement, which now, in the new terms of service, is 25 years.

With the specialists it's actually linked more closely to how close they are to the 25-year window once they have finished their obligatory service: if they have less than five or six years, they tend to stick it out; if they don't, then they tend to move on.

Mr. Laurie Hawn: I think it was you, Colonel Blais, who talked about the transition aid program, or perhaps you just mentioned it. What are the mechanisms they use? What kinds of agencies are you working with and what kind of success are you having?

LCol Gerry Blais: Actually, the transition assistance program is growing by leaps and bounds. The support we're getting throughout the country for injured servicemen is actually quite amazing.

In this program we have a website where we post job opportunities in excess now of 300 companies throughout the country. The individuals who are going to be released for medical reasons place their resumé on the site and matches occur that way. Now we are more active. We're pursuing job matching to assist the individuals in finding the right job. For example, TD Canada Trust sent three of their vice-presidents to us. Just before Christmas we had a meeting, and they just recently hired three military members who were leaving because of fairly serious injuries.

So the program is becoming very, very successful.

Mr. Laurie Hawn: Obviously the whole program is expanding because of the need and because of what we're doing as a country.

This is to either one of you or both of you. In your area, what is the biggest single challenge you think we could do something about?

Col David Weger: In my realm—and to be frank, I'm not sure how much this committee can help us on it—we essentially face the same challenges as the civilian health care environment does.

Number one, we're competing for the same already limited pool of health services human resources.

Number two, not entirely but to a very significant extent, we are victim of the vagaries of the civilian health services training establishments. At the universities, for example, programs are constantly expanding time-wise. It's what we call credential creep, which is the idea that now, for example, the baseline employability credential for social workers is now a master's degree. We are forced in this situation to follow those same dictates with respect to education and training in order to ensure that our personnel are provided with the appropriate level of care, the equivalent Canadian level of care. We are, to a certain extent, held hostage by the governing bodies as they change requirements for entry-level education and training.

Lastly, we tend to be, from time to time, our own worst enemies. Due to shortages in uniformed providers, we have to hire civilians. We hire them at rates that make it very attractive for existing uniformed providers to get out and be hired back as civilians, which again creates greater demands to hire civilians. To a certain extent, it's the proverbial catch-22. But certainly our success with the physician attraction and retention initiative shows us that with specific focus in an area and the right motivation we can turn that around.

● (1625)

The Chair: Thanks, Mr. Hawn.

We go now to Mr. Bouchard, back to the official opposition, and then back to the government.

Go ahead, Mr. Bouchard.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chairman.

Thank you to all of the witnesses for joining us. I understand that your responsibilities extend to social spheres. Do they also extend to cases of operational stress?

LCol Gerry Blais: We manage a social support program for members dealing with operational stress.

Mr. Robert Bouchard: That is excellent.

The authorities had been informed that one hundred or so soldiers from Valcartier who had been deployed to Kandahar were scheduled to return earlier because of injury. After six months of field duty, 68 injuries can be attributed to combat operations. Of this total number, 14 cases of depression can be attributed to operational stress. After six months, 20% of the injuries are linked to mental health problems. As mentioned earlier, 17 % of all soldiers who have returned from Kandahar since the mission first began are experiencing mental health problems.

If the data on the Valcartier troops is correct, then it would seem the numbers have been increasing recently. Would you not agree? In the past, the percentage of CF members with mental health problems was said to be 17%. After six months, the number has climbed to 20%. According to my sources, the incidence of post-operational mental health problems has increased rather significantly.

Col David Weger: The figures cannot tell us if we are seeing a trend. The best person to answer that question is our analyst with the forces protection directorate, Dr. Mark Zamorski. I know that he is on your witness list. He will be able to answer your question.

LCol Gerry Blais: Sir, it is still too early to say how the CF members returning to Valcartier compare to soldiers who have been on other missions. Unfortunately, it sometimes takes a while—perhaps even several years—before returning members exhibit symptoms of the disorder.

Mr. Robert Bouchard: I read that there is a shortage of personnel, particularly in the mental health field. Since the start of the Canadian mission to Afghanistan, some thirty soldiers have contacted the post-traumatic stress disorder military victims group.

Can you in fact confirm if there is a shortage of personnel to attend to soldiers with mental health issues, given that 30 soldiers have filed complaints with the PTSD victims group?

Col David Weger: After they returned to Canada?

Mr. Robert Bouchard: Yes, since the start of the mission.

● (1630)

Col David Weger: Our priority is making sure that in Kandahar and in every theatre of operations, we have all of the mental health personnel we need, regardless of their particular area of expertise. We acknowledge that we need to expand mental health services in Canada. We are developing a program to do precisely that. The Director, Health Services Delivery could give you more details about this program, including the number of service providers.

[*English*]

The Chair: Thank you, Mr. Bouchard.

Are there questions from the official opposition? No.

We'll go back to the government and Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Mr. Chair.

Thank you, gentlemen. It's great to have you here with us today.

I'm interested in the discussion about the limited pool of health services and health service providers that we have in the general health care system in the country. It's a very astute observation, in response to the question from the parliamentary secretary.

With a limited pool...I want to ask about musculoskeletal injuries, for example. You mentioned that you have pharmacists, medical doctors, and nurses. If anybody wants chiropractic care they have to go off the base to get it, and I'm sure there are members who access those services where they're available.

We have a group of chiropractors on the Hill today presenting to the industry committee.

Given the shortage of resources and medical manpower to deal with some of these injuries, is there any consideration given to using other health care professionals, who may be very well qualified, to take some of the burden off those medical doctors? About 30% of the cases presenting to traditional medical offices are musculoskeletal—sprain, strain, joint-related injuries that can be managed very well by a non-medical practitioner such as a chiropractor. Has any consideration been given to expanding the range of services available on the base to help to take the pressure off those officers who are overworked?

Col David Weger: If you're referring specifically to having them in uniform or to being uniformed members of the Canadian Forces, our guiding principle essentially is that unless there is a direct operational employment for them, i.e., an overseas deployment, we normally will not put a profession or occupation into uniform. That, at the end of the day, is the primary purpose of having a uniformed health service. It's to provide the care where normally you cannot buy it or procure it in some other manner, either from a host nation or, potentially, allies.

Again, I am not a clinician, so I can't really speak from that perspective with respect to whether or not chiropractors can or cannot deal with more acute injuries. Our entire focus, when it comes to delivering operational health services—that is to say deployed health services—is on timelines. If an individual can be returned to full operational duty within a specific period of time, then they stay in theatre and are treated. If they cannot be, then they are evacuated out of theatre to Canada or another location where they can receive the appropriate level of care.

Mr. James Lunney: I wasn't particularly implying that to be as a first responder. When you have serious, potentially life-threatening bleeding injuries and so on, you need a different type of response. But when you're managing those injuries, if they are not managed properly, they can lead to long-term disability in many cases and shorten somebody's career.

Putting that aside and going back to our subject at hand—and forgive me for the little diversion there—as you're expanding the services for people with operational stress injuries and the mental health services, I understand there's quite a large increase in budget to attract more personnel and expand the services available and the number of personnel providing services. Is there any kind of task force or anybody looking at what other outside-the-box approaches there might be for helping people with operational stress-type injuries, or are we just looking at providing more of the same?

● (1635)

Col David Weger: All of the initiatives under Rx2000 were put together over a significant period of time. That included broad-range consultation, specifically with respect to the mental health initiative, which is where this particular one lies. I cannot really speak to how far outside the box they got. Again, Lieutenant-Colonel Richard Pucci, who is our director of health services delivery, under whom the mental health initiative falls, would be in a much better position to address that question.

LCol Gerry Blais: I guess I can say, though, that one thing we do provide on the social side is peer support for people with operational stress injuries. We have people who were once in uniform, who have suffered an operational stress injury themselves, who have healed to a large degree. They report to a doctor, and once he says they're good to go, they join the public service and provide peer support to injured members. We offer that service, as well, to families of those suffering from operational stress injuries.

Mr. James Lunney: We have a study going on in Alberta right now of people using vitamins and minerals for a serious form of depression, bipolar depression. Neuroscience specialists have been looking at it, and it's actually getting some surprising results with small clinical trials. But it seems to be that in Canada where we have, among our soldiers, an increased number of post-traumatic stress disorders and of course operational stress injuries, one can set the stage for another, you might say. People with operational stress injuries back in the theatre could be exposed.

Maybe it's too much to expect the military to actually lead in something avant-garde, but we have a new phenomenon with more soldiers, more of our personnel coming down with these types of injuries. There might be room to take a look at whether some of those soldiers might benefit from simply expanded nutritional support, not just more food as in more to eat, but more concentrated nutritionals that actually support the nervous system and might reduce the number of injuries.

The Chair: Could we have a short response to that, please? It was more of a statement than a question.

Col David Weger: I read the transcript from the meeting with General Jaeger. You brought forward the question at that time as well, and I do know that she has approached our director of force health protection to ask him to start looking into exactly this point.

As a guide, we focus on delivering evidence-based medicine. There is very little that would likely lie within a realm that is defensible, from that perspective, that at some point somebody might not be willing to try. It's difficult to say, but certainly General Jaeger intends to get back to the committee. I believe she made a commitment to get back to the committee with respect to that point.

The Chair: We're back over to the official opposition, but they're good.

It's back to the government for five minutes.

Ms. Gallant.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

When an injured soldier is well enough to return home, but not well enough to go to work and, say, he's living in a PMQ, what provisions are made to ensure that the residence is handicapped accessible? Are the families required to move off base into accommodations that are handicapped accessible?

LCol Gerry Blais: What we endeavour to do is provide what the soldier wants. I know of one specific case in Petawawa where the individual preferred to live on the base, then a married quarter was modernized in such a manner that it became fully accessible.

However, if a person is living off the base and would like to continue to live off the base, we have occupational therapists assess if it's possible to do that in the current residence. If it's not, benefits are in place where another residence can be purchased and the required modifications can be made there.

Mrs. Cheryl Gallant: I understand that, where possible, the Canadian Forces want to retain the experience of the soldiers even though they may not be able to go to active duty; they're in teaching capacities. What improvements are being made to infrastructure or building entrances, for that matter, to accommodate these people, who may not be able to walk up stairs any ?

LCol Gerry Blais: I'm not an infrastructure expert, but I know for a fact that on bases they endeavour to provide handicapped-accessible entrances to all buildings. Of course, with bases being so large and some of these buildings being a little older in a lot of places, that presents different challenges, but I know the intention is definitely there to do it in any manner possible.

● (1640)

Mrs. Cheryl Gallant: As the need arises, these changes are being made. Is there not a special program in place to make everything accessible?

LCol Gerry Blais: I'd defer that one to the infrastructure people.

Mrs. Cheryl Gallant: Okay.

Upon receiving a diagnosis of PTSD, is a soldier automatically given a medical release?

LCol Gerry Blais: Anybody who suffers from basically any injury, be it mental health or physical health, is first given what is known as a temporary medical category. They are given up to three of those, during which time the doctor has a chance to say, okay, are we making progress here or are we stabilizing? If that's the case, then they continue on temporary categories as they progress through the system.

If at some point it's obvious the member is not going to get better, they're assigned permanent employment limitations. At that point, a career review is conducted and the member is told that either the limitations allow him or her to remain in the Canadian Forces or ultimately they may be released. They also have the opportunity, at that point, to provide input into the process, as to whether they agree or think that things should be looked at in a different manner.

Mrs. Cheryl Gallant: There is the real fear, aside from just the embarrassment or stigma attached to a mental illness, that they will be automatically booted out of the forces if they admit to some sort of mental strain. If that is not the case, is it then in the best interest of the soldier to overcome that fear and have the injury put into the medical record so that if there's a delayed reaction, as we've heard from a previous member, at least it was on the record and they would be able to receive benefits if it's necessary at a future point in time?

LCol Gerry Blais: I would say it's extremely important. First of all, we want the individual to get treatment. If they don't see a doctor they're not going to be treated, and it's going to be difficult for them to get better if they're not getting the medication and the psychiatric or psychological assistance they require.

As you rightly state, if there is no documentation that the person has suffered an injury, then when they apply to Veterans Affairs for benefits, of course, it will be more difficult for them to access.

Mrs. Cheryl Gallant: Are we embedding people or designating people in theatre, in a platoon, to be on a specific lookout for mental injuries while they're in the action?

LCol Gerry Blais: As was mentioned earlier by Colonel Weger, the only ones who can actually make a diagnosis that there has been a mental injury is a psychiatrist.

What we do, as was touched on, is provide training in all Canadian Forces leadership courses to help individuals recognize behaviours that might indicate there might be some type of mental health or other issue, and then encourage the leaders to refer these individuals in question for proper medical assessment.

Within the health services, our junior medical technicians are provided with much the same general behavioural recognition stuff. Is something going on that's out of character for an individual? At our senior paramedic level, they undertake roughly 17 hours of training specifically oriented towards the recognition of indicators of mental health problems or issues. At the physician assistant level, they undertake 33 days of training, as well as a four-week residency in a mental health facility, to provide them with the skill sets they require not only to recognize the signs and symptoms, but also to assist in actual treatment of mental health problems.

The Chair: That ends the second round. We're now getting into the third round.

The official opposition have indicated they're fine. Does the government side have any questions?

Go ahead, Mr. Blaney, you have five minutes.

● (1645)

[*Translation*]

Mr. Steven Blaney: My question is for the Lieutenant Colonel and touches on a subject broached by my colleague Ms. Gallant. You explained that when a solider was unable to resume his regular duties, his career was re-evaluated. Therefore, it is possible that if nothing suitable is found for him in the Canadian military, he may have no choice but to resign.

Could you elaborate further on that and also explain to us how the transition to veterans' status is made and whether disability payments are awarded?

LCol Gerry Blais: Are you talking about one type of benefits in particular?

Mr. Steven Blaney: I am drawing a parallel of sorts with the civilian sector where a person may be declared disabled as a result of a workplace accident. How does it work in the military?

LCol Gerry Blais: When a solider is injured, he remains a CF member. In the case of a member of the Reserve Force, we operate a program similar to the civilian program. For example, if a person is injured while in the service of the military, whether it be while exercising to stay in shape, repairing a vehicle or some other thing, the military continues to pay the member the same salary he was earning prior to being injured. The member is evaluated by a doctor every six months to determine whether or not the injury is healing. However, until such time as that member is ready to go back to work or to school —since many of our reservists are students— he is eligible for a rehabilitation program.

Mr. Steven Blaney: Obviously, with mental health problems, the hope is that the situation will resolve itself. However, if that does not happen, what then?

LCol Gerry Blais: Occasionally a Regular Force member may not be able to resume his regular duties. He will then have to resign from the Canadian military. However, before that happens, members receive help with submitting applications to VAC, which subsequently does an assessment. In fact, retiring members have access to a range of programs designed for them.

Members receive a lump sum for the injury sustained. Subsequently, they are eligible for other income protection programs.

Mr. Steven Blaney: Is there a connection between post-traumatic stress disorder and drug use?

LCol Gerry Blais: Yes.

I am not a doctor, so I can't speak with total certainty, but we do know that there is a link here. Comorbidity does exists, in the case of alcohol, drugs or other addictive behaviours.

Mr. Steven Blaney: Thank you very much.

[*English*]

The Chair: Thank you.

We're now down to Ms. Black.

Ms. Dawn Black: Last, but not least.

Thank you very much. I have a couple of questions.

We're very focused at this committee, as I think the nation is, and as the Canadian Forces are, on the mission in Afghanistan. But obviously you do more than that, and you have more responsibilities than that. I'm wondering about the whole issue of post-traumatic stress disorder or occupational strain injuries in terms of the three different forces. Do you have data that show there may be different triggers depending on which force people are in, and does it manifest itself differently depending on whether it's the air force, the army, or the navy?

The other question I have is in terms of someone who's badly injured and needs to be brought home. For instance, if they're on one of the ships in the gulf and they can't be treated on the ship or anywhere near by, how does that process happen, and how is the family kept in the picture?

Col David Weger: The first question is one that really needs to be asked of our mental health professionals. I am completely outside of my realm in trying to address that particular question, as I'm sure is Colonel Blais.

● (1650)

Ms. Dawn Black: Fair enough.

Col David Weger: With respect to medical evacuation, it really depends on where the individual is undertaking operations. If they are injured in Kandahar or southern Afghanistan, there's a medical evacuation process to the U.S. military hospital in Landstuhl, Germany.

Ms. Dawn Black: I understand. That's why I talked about the ship.

Col David Weger: That process could be very similar to somebody on one of the ships. They would be landed, probably by helicopter, to the most appropriate and closest medical facility.

Ms. Dawn Black: Where would that be from the gulf?

Col David Weger: It could be one of the civilian hospitals in the United Arab Emirates. It could be in Qatar. It could conceivably be a hospital in Pakistan. Depending on the injury, it would be wherever the most appropriate type and level of care is available.

There's a process that kicks in from there, involving 1 Canadian Air Division in Winnipeg as well as the medical personnel, to arrange for the evacuation of the individual. If it's a minor injury they tend to be booked on commercial airlines, either with or without an escort. If it's something more serious that requires medical care while they're in flight, then for single individuals it tends to be the Canadian Forces Challenger aircraft. Occasionally we will lease air medical evacuation capabilities. They do exist in the commercial sector.

More specific examples are probably best addressed by the director of health services operations.

Ms. Dawn Black: If the injury was very serious, would a family member be taken to the person and then brought home with them?

Col David Weger: It's entirely dependent on the timelines involved. If the individual can be stabilized quickly, then they will be moved more quickly, and there's often little to be gained by moving next of kin. In Landstuhl we do it frequently, because there tends to be a longer recovery time in those particular air medical evacuations.

Unless it's a very serious injury where the individual may not make it back, as a rule we tend to wait for the individual to get back to Canada.

LCol Gerry Blais: If the medical officer recommends that a family member be with the individual, then we act on that recommendation immediately and send a family member.

The Chair: Thank you, Ms. Black

Thank you, gentlemen. We appreciate your being here.

Committee, on Thursday we have the medical advisers to the chief of the air staff, chief of the land staff, and chief of the maritime staff. Hopefully they'll be able to answer some of the questions you have. Ms. Black, I believe you have a specific question on the navy.

Does somebody have a point before we adjourn the meeting?

Hon. Denis Coderre: Yes.

I'm very thankful for your contribution.

I think the most important thing, as a start, if I may say respectfully, is to get to know the disease itself and the condition of the situation. So I would suggest also not only to have people from DND, but I would like, as soon as possible, early in the process, to have some medical experts, maybe from outside, to provide us with a one-two punch. It's important also to see both sides of the coin. Of course we need to know what's going on in the department, but it's important at the same time.... If you remember the question I asked at the last meeting regarding bringing back some troops under medication, there are different schools of thought.

So it's important to take a look at this. I'm not saying it's right or wrong; we need to understand it, and it would be important to have some medical experts from outside, such as psychiatrists, to give us their side of the story.

The Chair: We've taken the witness list and the researcher and the clerk have tried to formulate with DND the panels that come and the timing. Do you think it's useful for the committee, in order for us to focus more and get on the track we want, to have a brief meeting to discuss that? Does anyone have a thought on that?

Hon. Denis Coderre: What I'm suggesting is, first of all, that we need to understand the disease and the conditions where they're living. Of course, what we are doing afterwards for the troops who are suffering is important, and we're providing some services. But I think we should do first things first, because most of the questions—and it's normal—were clinical.

So that's why it's important first to manage and understand what we're talking about at a certain level, because there are a lot of innuendoes, and then proceed to discuss what we are going to do to help them to surmount the problem.

● (1655)

The Chair: Ms. Black.

Ms. Dawn Black: Did you want to respond to that?

The Chair: No, go ahead.

Ms. Dawn Black: I mentioned to you earlier that I had been approached by a couple of family members of Canadian Forces personnel who had returned from Afghanistan. They expressed some frustration with going through the system. One in particular would like to come and testify, and perhaps another one.

So should I give those names to the clerk so they can participate in this?

The Chair: Bring them forward. I might have some comment on it.

Mr. Hawn.

Mr. Laurie Hawn: With the greatest respect for the people who are going through that, sometimes they don't make the best, most objective witnesses, because obviously they're focused on their situation and can tend to get fairly emotional and a little off track. I understand where they're coming from. Perhaps a good summary of their situation in their own words, and then present that to some people who would be equipped to answer those kinds of concerns.... We'd feel free to challenge them on it, and so on. It might be a little easier to get good answers if it isn't what might turn out to be fairly emotional and not very objective.

That's just a suggestion. Those kind of stories do have a place.

The Chair: Yes, the successes and failures are important to hear about.

I'm concerned, too, about making sure we can do it in an objective way. I mentioned this to Ms. Black before we started. I hope they would be prepared for what could happen in this situation, under the microscope they'd be under if they came here, and the attention that would be drawn to them. We all have cases that have been brought to us of this person or that person. It would be really something to get it opened up if it got out of hand on us, so I think we have to be really careful how we deal with it.

Hon. Denis Coderre: But I would suggest, too, that it's important to see if some people live with the problem. If you want to cure it, it's important to do so.

So I would suggest that some associations already exist, and maybe both those families are part of that. I know that in Quebec, specifically in the Outaouais, there is one. Of course they have grievances, but what I believe, though, is that we should do it in a manner that does not get too emotional, because we don't know how that will end. But I think it's important for the record to share their experiences, to see if they're suffering, because it's not just prevention. If you want to cure a situation, it's important to understand it.

The Chair: It's just been brought to my attention that we should be in camera for this discussion. What I'd like to—

Ms. Dawn Black: Can I respond, though, since I raised it?

It's very important that we hear from the people who are faced with this right now. If they're willing to come...I don't think we should be afraid of emotion, for heaven's sake. People are getting hurt, and getting seriously hurt. We can't run away from that.

The Chair: I think the indication is that we need to have a bit of a discussion, but we already have the witnesses lined up for Thursday, and I don't want to cancel them. Possibly it can be next week. I'll discuss this with the clerk and see what we have lined up. For the people who are coming, I hate to say no.

It seems to me that we need to have further discussion on this issue alone, and we'd like to do that in camera at some point in time. But I'd like to do it with a notice going out. So possibly next Tuesday, if we don't have a full witness list, we will have time to flesh this out and get it sorted and see who we want.

An hon. member: You mean February 26.

The Chair: Yes, it's not next week but the week after, as we move forward. As a committee, I know that all of us want to do the best job we can, and we want to make sure we get the right information.

We'll conclude this meeting. The meeting is adjourned.

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