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Chair

Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): This is our 26th meeting in our study of health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

Today we have two different panels. Our first set of witnesses includes Joyce Belliveau, Robin Geneau, Robert Ferrie, and Jonathan Shay.

We'll allow each witness an opportunity to make an opening statement, and then we'll go to a round of questions. We have an hour and a bit to deal with these folks, so hopefully we can keep within our time constraints and get the answers to our questions.

We'll start with Ms. Belliveau and move across.

The floor is yours. Go ahead.

Dr. Joyce Belliveau (As an Individual): Thank you. I'd first like to express my appreciation for the opportunity to appear before this committee.

My name is Dr. Joyce Belliveau, and I'm a clinical psychologist in private practice in Fredericton, New Brunswick. I specialize in the treatment of trauma-related disorders.

For over 12 years, a significant portion of my client base has been active members and veterans of the Canadian Forces. Ninety-five per cent of those referrals has been for the treatment of operational stress injuries and post-traumatic stress disorder.

I have worked with men and women from every peacekeeping, humanitarian aid, or combat-related tour, post-Korea. I have also worked with CF clients involved in the Oka crisis, the Gander incident, the Swiss Air disaster response, ice-storm relief, and even an earthquake relief in Italy in the 1970s. I also provide treatment for police officers, firefighters, and civilians across a range of trauma experiences.

The combat or tour-related PTSD and OSI that I treat in my military clients differs in very special ways from civilian-based trauma, even trauma experienced by police officers and firefighters. At the end of the day, no matter how traumatic the experience, a police officer or firefighter can go home. A soldier on tour is there for the duration. Home can be months away, and for many there's no respite during their tours. They maintain constant hypervigilance for months and may experience subsequent trauma incidents.

Those in positions of authority may be even more compromised by traumatic events. Not only are they personally affected; they also carry added care and concern for their troops.

I have reviewed the transcripts of the proceedings to date. Without question, the way the Department of National Defence has responded to the needs of those with OSI has improved over the years, particularly in response to the Afghanistan tours. Decompression, post-deployment screening, medical and psychological evaluation every two years instead of five are all steps in the right direction.

The stigma of seeking treatment for OSI is less, but it is still present. A number of my clients would not have sought treatment if they had known their only choice was to be treated on the base or at the mental health clinic, even though it is now located off the base. The fear of losing one's job or potential for career advancement is diminishing, but it is still a problem that delays seeking treatment.

I will now address issues related to my experiences with CFB Gagetown mental health services, which were, prior to March of 2006, absolutely excellent.

The clinic at CFB Gagetown operated at one time as a satellite clinic under the direction of Dr. Rakesh Jetly of the Halifax OTSSC. Members were assessed and provided with treatment in a timely manner. There was ongoing communication between all the health providers involved in the client's care. This included case conferences, exchange of progress notes, and direct phone contact with medical officers in emergency situations.

Community-based service providers like me met periodically with the CFB Gagetown mental health team for educational seminars, as well as to promote the cohesiveness of this unique team. Accountability was built into the system, and the progress of clients was easily tracked.

One person facilitated all client referrals. The focus was on evidence-based practice that followed the multi-phase, multi-modal, cognitive behavioural therapy protocol accepted as the standard for treatment at OTSSC centres across Canada. This consists of three phases: stabilization, trauma processing, and a final phase involving maintenance, relapse prevention, and termination of therapy.

There are numerous techniques and skills for which clinicians can and should be trained in order to provide effective treatment for OSI. No one technique is the be-all and end-all.

Until a few years ago, my experience as a community-based service provider for CFB Gagetown mental health had been entirely positive, with one exception—being disparagingly referred to as "one of those chicks in town" by one of the former medical officers on the base who did not believe in PTSD.

When the satellite clinic ceased to be in 2006, for reasons unknown to us, the dynamics of the clinic changed. In May 2007, I wrote to the military ombudsman's office after a number of unsuccessful attempts to communicate with staff at CFB Gagetown's mental health services about issues that were compromising care for Canadian Forces personnel. I will identify my concerns and present a few of the numerous examples fuelling those concerns.

I'm concerned about confidentiality of client information. Under the previous system, I would first be contacted via the liaison person to see if I had openings. If not, I would be asked when I would have openings, whether I would hold some slots for them, and when I would be able to take new clients.

At this point, in order to protect the confidentiality of the client, I was not given any identifying information about the client, other than the treatment issue. If I were able to take a new referral, only then would the client be identified and the necessary documentation would be sent.

● (1540)

The current system consistently violates client confidentiality. For example, despite telling the clinic director and referral person from CFB Gagetown mental health clinic that I could only take two referrals, I was sent five via mail in early February from three different sources within the clinic. Identifying information was on all of them. I was able to take three of the five and was instructed to return the other two to the base, even though I knew my colleague was available to take these cases immediately.

I returned the referrals. Since then I have received two phone calls, from two completely different people at the mental health clinic, to follow up on one of those clients for whom I had returned the referral. One was calling to see, about two weeks later, why I had not contacted the client. About ten days after that, I received a call from yet another staff member who was trying to find out why this client was not being seen yet, as he was getting very frustrated with the wait.

I don't know what happened to that particular client, but I know I spoke to five different people within the mental health clinic about a client that I had never seen or spoken to. I should not even have known this client's name.

This not only raises concerns about confidentiality but speaks to my second concern—namely, what appears to be a total lack of organization at the administrative level. The current system does not appear to have any effective mechanism for referring and tracking progress.

I received a phone message last spring from one of the staff at mental health wanting to know the progress of one of my clients. This client had been released from the Canadian Forces about one year earlier. My termination report had been sent in within weeks of this client's release. He had transitioned to Veterans Affairs for his last few sessions of therapy. This case had been closed for months.

As recently as last week, I received a voice mail message from the person who is, to my understanding, in charge of referrals. She stated that she was responding to my call to her, the day before, about my client, whom she identified by name. She then proceeded to discuss the case.

The problem here is twofold. I had not called her and the person named was not my client. When I responded to her voice message to let her know this, her response to me was, "Well, I wonder who *is* seeing this person."

We are consistently hearing from our clients not only about their frustrations in navigating that system in order to get assessed and treated but also about the stories of their friends and colleagues who are falling through the cracks.

Also of concern is whether client issues are being addressed in a timely manner. In January of 2008, a former OSI client of mine was refused authorization to return to see me. He was quite distraught when he called me. He could not believe he would have to go through yet another screening and be assigned to a counsellor at the mental health clinic when I already knew his story and the therapeutic relationship was already established. Retelling the story to yet another person and building trust in a therapist can be very challenging and time-consuming. I saw this client for two sessions, pro bono, and his issue was resolved. This would have taken weeks had it been handled on the base.

In August 2007 I requested a case conference. It was scheduled for October and subsequently cancelled. I was not informed of the cancellation. I requested rescheduling as soon as possible, because it had implications for this client's treatment. The case conference was held in March of this year, seven months later. In the old system, case conferences were usually held within two weeks of the request.

I have concerns about the mandate of the mental health clinic regarding clinical focuses being only on the identified issue. I have not really understood this directive, but I know it is the philosophy of the brief therapy model, which does not have any evidence-based efficacy for complex PTSD. How this translates into practical reality is that the extension of treatment has been denied if the therapist identifies an issue that the authorizing agent perceives as not related to the original identified referral issue.

PTSD and OSI affect the whole person, their families, and their jobs. The comprehensive package is the identified issue. Past trauma prior to military trauma needs to be addressed in order for successful resolution of PTSD.

Life continues for these clients while they are in treatment. l've had clients in treatment who have lost parents or siblings, clients whose spouses have been diagnosed with cancer or other serious illness. I have clients in treatment for OSI who are also dealing with chronic pain conditions. I have experience in treating chronic pain, bereavement, and other issues that impact on their recovery.

I am not going to tell my client that we can't address these things because they are not the identified issue. We have to treat the whole person, not approach the issues in a piecemeal fashion.

As the situation deteriorated between the base and the community-based service providers, I was becoming increasingly concerned about the adequacy of training and/or supervision of some of the staff providing mental health services.

● (1545)

Clinical psychologists are trained in a scientist practitioner model. We are committed to evidence-based practice, not only by our training but by our code of ethics.

There is a clear directive from Veterans Affairs in both the U.S. and Canada that benzodiazepines are contraindicated in the treatment of PTSD, particularly because they exacerbate symptoms. Despite that, a number of my clients were overmedicated on benzodiazepines. One client was on five of these medications, all of them at double the standard dosage. We were no longer receiving clinical notes from the psychiatrist on the base at that time, Dr. Hanley, and we had no way of tracking medication protocols. This is important, because medication can impact treatment efficacy. Clients are rarely knowledgeable about medications and do not question the experts. My attempts to have this and similar situations addressed were met with brick walls.

Please note that with the new psychiatrist who has been on the base since Dr. Hanley lost his licence, benzodiazepines are no longer an issue. However, I am still not receiving assessment reports or psychiatrist's notes.

One of my current clients with complex PTSD was seen by two different counsellors on the psychosocial team at the mental health clinic for over a year before he was referred to me, despite having been identified as having PTSD. His response, after our second session, was that he knew more about PTSD after two sessions with me than he had learned in over a year of counselling on the base. He had not received any education about PTSD, nor had he been taught any strategies for coping or for reducing symptoms.

I am concerned about the timeframe for treatment. When I read Brigadier-General Jaeger's statement of February 7 that the maximum for treatment is about 20 sessions, or, in the best-case scenario, seven to 10 sessions, l was alarmed. The military personnel I am treating from the Afghanistan tours have experienced multiple tours and multiple traumas. Afghanistan has merely been the catalyst for seeking treatment.

In the years that I have provided services to DND clients, I have treated only one client with only one trauma event. The rest of my clients have experienced multiple traumas related to multiple tours. For some clients, 20 sessions are required just to build trust in the therapist and the process before we can start processing the trauma events, particularly if the client is experiencing secondary wounding because of the process involved in getting into treatment. Having seven to 20 sessions has been my experience in cases of single-incident trauma, but even those are client specific and may exceed 20 sessions. The sooner a person with OSI gets into treatment, the better. However, each case must be dealt with in the manner best suited to that client within an evidence-based framework.

As one of the “chicks in town” who has extensive training and experience in assessing OSI and PTSD and treating them, I do have some recommendations for this panel.

First, I would recommend that the CFB Gagetown mental health service return to the OTSSC model that was working so effectively and efficiently in identifying, tracking, and providing therapy services. Accountability, evidence-based practice, and a coordinated team approach are the foundation of the OTSSC model.

Second, I would recommend increased communication and collaboration with the community service providers. We are not the enemy. I do not see DND clients because I need the money. My caseload will not decrease if I no longer receive referrals from the base. My wait-list for new clients is usually two to four months. I work with clients who have trauma issues because it is the most gratifying work I ever do as a clinical psychologist. In areas like CFB Gagetown, with the scarcity of trained mental health professionals to treat OSI and PTSD, alienating the community-based service providers who have the experience and expertise seems counter to any mandate to provide appropriate services.

Third, I would recommend that a clinician with training and experience in evidence-based methods for treating OSI and PTSD be hired at the mental health clinic and be in charge of making treatment-related decisions.

Finally, I would recommend an external evaluation of the administrative aspect of the clinic and the implementation of an organized system to refer and track client progress.

Operational stress injury and post-traumatic stress disorder are treatable. Not everyone will go into full remission, but their quality of life can be improved substantially with proper evidence-based treatment provided by properly trained and qualified mental health professionals in a system that treats each person with the dignity and respect they deserve.

Thank you.

● (1550)

The Chair: Thank you very much.

Robin, are you ready? Go ahead, please.

Dr. Robin Geneau (As an Individual): My name is Robin Geneau, and I'm a licensed psychologist. Joyce Belliveau is a colleague of mine. We've been doing this work together for a long time.

I've been treating combat PTSD for about 10 years now. I have a lot of specialized training for that. I've taken specialized training in cognitive behavioural therapy. I've also taken a lot of specialized training in EMDR. It's one of the treatment approaches I use quite frequently.

I'm going to repeat what Joyce said about what happened to the program in Gagetown. We had been working for several years with this OTSSC satellite clinic in Gagetown, which was shut down. When the clinic was shut down, the treatment for OSI fell under the mental health clinic.

Everything this panel has heard about the OTSSCs does not apply to Gagetown. There is no OTSSC in Gagetown. The standards and qualifications that the OTSSC staff have are not applicable in Gagetown. A Gagetown social work program took over mental health, and they have been running it since March 2005.

As Joyce said, prior to the satellite clinic shutting down, we had a wonderful working relationship with the OTSSC. We all did training together—Gagetown staff, Halifax staff, the private practitioners. We had free clinic case conferences. We were very successful in treating members with combat PTSD and getting them back to work—back into their careers. Things were going very well.

When the satellite clinic shut down, and that was in March 2005, the program started to deteriorate then. But the next spring—that would have been about April 2006—there was new management at the mental health clinic in Gagetown. That new management was blatantly hostile to civilian therapists. We got the impression that their intention was to do all the treatment themselves and that they didn't want to hear from us or talk to us or have any involvement with us any more.

As a result of that change in attitude, there started to be problems with our clients. To give you some examples, clients were being cut off in the middle of treatment for no clinical justification. I ended up seeing clients—serving soldiers—for free: one soldier for three months, a couple of soldiers for a couple of sessions, and I did a group session. All of those were done at no charge because of difficulties with authorization processes at Base Gagetown.

The one client who was cut off from treatment had to do with what Dr. Belliveau spoke to. We would always receive referrals for treatment of PTSD, but this new model the mental health clinic had was that you would treat a client by issue. This particular client had been referred to me for tour-related trauma. We were dealing with issues to do with his workplace, and it was related to Afghanistan. Basically the clinic decided that I had changed topics and they were no longer going to support his treatment. He was the one I ended up seeing for free for about three months.

They changed the rules about all different kinds of things, about how reports were to be submitted. Basically communication really shut down. Because I advocated for my clients, I was punished by having my name taken off the provider list for the psychosocial team. I expect to be punished further for being here today, and I'm prepared to deal with that if that's the case. But certainly any attempts we've made to address client issues with the clinic have been very unsuccessful.

There are other issues with this new mental health system in Gagetown. I had sent a request for one client to see the psychiatrist and it was denied. I was told that the client was already seeing the psychiatrist, which wasn't true. The client was not seeing the psychiatrist and he needed to, and they seemed to be unable to identify that the psychiatrist was not seeing him. It took increased networking on my part to get him an appointment with the psychiatrist.

● (1555)

I requested that a client of mine see the case manager because he was concerned about his medical release, and it was denied.

In a letter he sent me, the clinic manager told me there's no such thing as an OSI or an OSI program. He said that OSI was an old medical term that is no longer used; it's an inappropriate term, and it is not to be used by external service providers.

The other thing that was happening as things were falling apart was that nobody was checking on cases. There was supposed to be a BF system under which clients would be checked every several months to see the progress of their treatment. That just completely stopped. It went by the wayside.

I requested case conferences and was told no. I was denied case conferences to deal with treatment issues. I requested clinical reports on the clients I was treating, and I didn't receive them. I asked about the mental health clinic's standards of care. This committee has heard about evidence-based practice, and as a psychologist, I engage in evidence-based practice, so I attempted to get the clinic to clarify what their standards of care were. I didn't receive any response to that at all. To my knowledge, there are no standards being used in the clinic at all for PTSD treatment.

This past February I received a referral in the mail. It just showed up in the mail, and when I called the client that day to come in for an appointment, he told me he'd been waiting for me to call him since December. He was on sick leave, at home, waiting for me to call, and the only delay was for that referral to come to me in the mail. It took two months for them to send the referral so that I could make an appointment. I could have easily started the treatment in December.

In addition, I want to talk a little bit about the spouses, because I treat spouses as well. I think this committee has already heard a little bit about the experience of spouses when a member is ill with PTSD. It's very frustrating for the spouses. I've gone to the OSISS support group to give presentations to the spouses, and I've heard horrendous horror stories about how the members are not getting treatment. Supposedly they were to be treated in-house, but they're actually seeing mental health nurses or bachelor-level social workers, and they're not actually receiving treatment.

What ends up happening in that system, in which they have non-mental health professionals seeing the clients, and not doing treatment, is that the client just ends up getting screened and screened and screened and never actually gets any treatment. That's what the spouses are complaining about. That's what their experience has been, that the serving members aren't getting treatment.

After these problems had developed, Dr. Belliveau and I decided we would contact the ombudsman. We had attempted for over a year to resolve issues with the mental health clinic and were met with nothing but hostility, so we contacted the ombudsman, and we felt quite desperate about that at the time. One of the things we were concerned about, which Dr. Belliveau mentioned, was the over-prescription of benzodiazepines, which are not even supposed to be prescribed for PTSD. There were all these other issues of clients not getting therapy or having treatment cut off.

So when we complained to the ombudsman, their response was that our complaint was not within their mandate and that they hadn't heard of any problems in Gagetown. They forwarded our complaint to the Surgeon General in August 2007, and we never received a response to that particular complaint.

Another issue is the medical release. When soldiers are released with PTSD, ideally they are in treatment at the time they are being medically released. I saw in the evidence for this committee that this committee was told that the forces would follow the treatment through the release process until the member was set up with service providers in the community. That's not happening. People are just being released, and they're told to find their own doctor, find their own therapist, find their own psychiatrist. There's no transitioning being done there at all.

So they're struggling once they are released, and they're usually in the midst of treatment. Our clients have been fortunate, because we've been able to help connect them to a psychiatrist in the community who they could see, and we have connections now with the OSI clinic, but the base mental health clinic is doing nothing to prepare the soldiers for release.

● (1600)

I had a soldier who was released in February, and the only contact the base mental health clinic made was when the Blue Cross lady called me and left a message that as of such and such a date, I was not to bill them because the client was no longer theirs. That was the sole contact that was made with regard to the follow-up care.

There is a mental health team at the mental health clinic that has some highly qualified people on it, but they don't seem to be making any of the decisions. The decisions that we're still having difficulty with are not coming from the team; they're coming from non-clinicians. We're not allowed to have any access whatsoever to the mental health team. We don't even know who the case manager is for individual clients, and we haven't been allowed to know that since March 2005.

We did have a meeting with SAV in January. They came to do their visit in Gagetown. They knew we had concerns, so they came and met with us. That was a very satisfactory meeting. They seemed to understand our concerns. We felt they had listened, but nothing has changed since. I had a soldier cut off from treatment again last week. I had recommended that he have six sessions of follow-up over the next year, because he's in maintenance and I felt that would be sufficient, and it was denied. The person who decided to deny it felt that he didn't need the follow-up sessions. The soldier was not told that the treatment was denied, so it was left to be my responsibility to tell him that—and he has submitted a complaint about it, as far as I know. So despite our going to the ombudsman and talking to the SAV and trying to deal with the clinic, the same problems are continuing.

PTSD needs to be treated early, and ineffective treatment makes it worse. In the end, this is our ultimate concern. The mental health clinic on the base has a lot of people seeing the clients, but they are not doing treatment. I can't convey to you enough how frustrating and discouraging it is to be a soldier and to meet with this person and that person, to tell the same story over and over again, but not get treatment. One of my recent clients who was referred to me for treatment had seen seven mental health people in Gagetown before he came to me, and he was just frustrated from having to repeat his story over and over again.

This idea that PTSD can be treated in six or seven sessions, maximum 20, is just astounding to me. I've been treating primarily complex PTSD cases. You can't put a limit on it because you really don't know how long the treatment is going to take. I'm very concerned that the CF would think of putting some kind of arbitrary maximum limit on treatment, rather than go with the clinical recommendations of the people who are doing the treatment.

The other thing is that the treatment needs to be done by specially trained clinicians. It can't be done by mental health nurses. It can't be done by counsellors. It has to be done by people who have advanced graduate training and actual training in PTSD treatment. The base mental health clinic has very few people who have the qualifications and training to do that kind of treatment.

We've complained about these things over and over again to the mental health clinic. They seem to believe that they're not accountable to anyone and they don't have to answer to our complaints or concerns. So I hope by participating in this process something can be done to help develop a more effective program there. In particular, they need some clinical leadership, because there isn't any clinical leadership there by anyone who has the expertise in PTSD.

That's it. I'm finished.

● (1605)

The Chair: Thank you very much.

Mr. Shay, welcome. The floor is yours.

Dr. Jonathan Shay (As an Individual): Thank you.

I am Jonathan Shay. I am a psychiatrist by trade, and for 20 years I have worked with psychologically injured combat veterans in the United States Department of Veterans Affairs.

Two books have come out of this: *Achilles in Vietnam* and *Odysseus in America*. The latter draws attention to preventing psychological and moral injury in military service. This book gives the “what” and the “why” of this prevention, and some of the parochial U.S. forces' “how” in a policy sense.

United States Senators John McCain and Max Cleland, a Republican and a Democrat respectively, jointly wrote the foreword to this book endorsing the preventive mental health agenda. I'm very pleased to hear that in the Canadian Parliament, psychological injury has not become a partisan issue in the way it has in the U.S. Congress.

I have done a good bit of work with the U.S. forces over the years, and some work with the Canadian Forces and Bundeswehr, always emphasizing the sovereign importance of three things: peer cohesion, ethical and expert leadership, and excellent training in prevention and recovery from combat trauma. I have also been appointed critic of the American Psychiatric Association's diagnostic construct, PTSD, post-traumatic stress disorder, as inherently stigmatizing for military forces, as well as deeply flawed in other respects.

I am very happy that the Canadian Forces have led in adopting the mode of speaking of this as psychological injury or operational stress injury. This way of speaking about it is now being followed by the United States Marine Corps. As recently as last week—although I haven't seen this on the computer myself—I heard that the Secretary of the Army went on and on about this being an injury, not a disease, disorder, malady, or illness.

I welcome your comments and questions. Since I cannot grasp what you want from me, I will wait for you to tell me.

● (1610)

The Chair: Thank you.

Mr. Ferrie.

Dr. Robert Ferrie (As an Individual): Honourable members, I'm a medical doctor. Twenty-four years ago I began working in psychotherapy, and 12 years ago I confined my practice to PTSD. I, too, have treated a number of different groups with post-traumatic stress disorder, such as train engineers, police officers, firemen, victims of rape and childhood abuse and neglect, and veterans of World War II and Afghanistan.

Today I wish to make three points, which have been partly made.

There are effective treatments for PTSD. These treatments are psychotherapeutic. PTSD is caused when the psyche is overwhelmed by severe trauma, and it can only be cured or healed by psychological interventions.

Nutraceuticals and nutritional supplements are extremely helpful.

Point three is that the antidepressants, mistakenly called selective serotonin re-uptake inhibitors, have been shown to be no better than a placebo.

Regarding point one, there are a number of effective treatments for PTSD, but they're all trauma-focused. They're formally recognized, and I'm certified in one of these, EMDR, eye movement desensitization and reprocessing. The published research, which empirically validates EMDR, arose largely from its application to soldiers traumatized in combat. The practice guidelines of the U.S. Department of Defense/Veterans Affairs place EMDR in the highest category, recommending it for all trauma populations at all times. But it's one of a certain number of trauma-focused therapies. It's not talk therapy, because actually its efficacy has been shown using talk therapy as a control.

A Canadian veteran from Afghanistan, who recently appeared before this committee as a witness, was a patient of mine. He suffered from severe PTSD, but I should mention that prior to his trauma he was normal; he had no childhood trauma or neglect. Before he came to me, the Veterans Affairs staff were trying to help him with his debilitating symptoms from PTSD, and they repeatedly suggested he take antidepressant medication. He refused this and went to a naturopath, who subsequently referred him to me. In this case, after only three months of EMDR he now no longer satisfies the official criteria for PTSD.

My second point concerns the use of nutritional medicine for PTSD. I'm a member of the International Society of Orthomolecular Medicine. I started to use therapeutic doses of B vitamins, essential fatty acids, magnesium, tryptophan, and especially inositol in order to help wean my patients off antidepressants and help them deal with high levels of anxiety.

With regard to PTSD, I found that high doses of inositol, 12 to 18 grams, as documented by the Israelis, is very helpful for anxiety. Most brain and central nervous system and insulin-related functions depend upon inositol, and under extreme or prolonged stress the body does not synthesize sufficient amounts, hence supplementation helps in those cases.

My third point has to do with the SSRIs and the newer so-called antidepressants. I'll explain why I call them “so-called” in a minute. These are recommended in a number of practice guidelines for PTSD. All current guidelines were written before the latest revelations were published, which show that the SSRIs are no better than a placebo. They have serious, sometimes irreversible, side effects and they may be based on fraudulent research. I refer you to Paul Taylor's excellent article in the April 26 edition of *The Global and Mail* and I quote:

> ...it became apparent that the trials were stacked in favour of the corporate sponsors right from the start.

In a 2007 study demonstrating the difference between the response to Prozac and to EMDR, Bessel van der Kolk, a renowned researcher in this field, ran a trial involving 88 subjects. He compared EMDR, Prozac, and a placebo. At six months follow-up after the termination of the study, 75% of the EMDR group of adult-onset PTSD had achieved a symptom-free functional state. None in the Prozac group achieved this. I have performed a single-design case study that had similar results.

● (1615)

The problem with the so-called antidepressants, and SSRIs in particular, is fourfold. First, the serotonin hypothesis upon which they are based has no verifiable foundation. I refer you to the article entitled “Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature”. No wonder, then, that PTSD cannot be cured simply by redefining it as an illusory problem, a serotonin malfunction. PTSD, the psyche, and depression are just not that simple.

This study I'm going to mention right now has caused a great furor in the British press. It was published in March of this year, and they reviewed the original FDA data that gave approval for the SSRIs a number of years ago. They reviewed the data on approximately 5,000 subjects, and what they showed was that the drug was then known to be no more effective than a placebo.

Thirdly, these drugs came to market because the experts reviewing the raw data for the regulatory process were duped. One of these experts, Dr. David Healy, a British pharmacologist and psychiatrist, helped to expose this fraud and wrote the famous book, *Let Them Eat Prozac*. In January 2004, he presented his findings here in Ottawa.

The medical profession and the public continue to prescribe and take these drugs, because of the observable short-term placebo effect and because they may be difficult to discontinue once they're started. With PTSD, as with all mental disorders, the placebo effect is on the order of 80%. This is an important point to consider.

Fourthly, the side effects are very serious and eventually are felt to a greater or lesser extent by almost all who take the drugs. The side effects are often deadly or irreversible. David Healy concluded this from a review of the raw data of the clinical trials he obtained when he was an expert witness in a suit against Glaxo-SmithKlein. He found that the rate of suicide in subjects in those studies was up to 10 times higher on SSRIs than on placebo.

The *Compendium of Pharmaceuticals and Specialties*, the CPS, which is found in every doctor's office and every pharmacy in Canada, now warns us:

> There are... reports with SSRIs and other newer anti-depressants of severe agitation-type adverse events coupled with self harm [suicide] or harm to others [violence and manslaughter].

I also refer you to the website www.ssristories.com. It provides public information on many of the school shootings and other violent events that during the past three decades were caused by people on these drugs.

You might ask why some patients have the early onset of significant adverse effects while others have no effect whatsoever from the same dose of the drug. Since the 1970s, we have known the answer to this question, owing to our knowledge of the variation in certain liver enzymes in the super-family cytochrome P450.

Some people are slow metabolizers and some are fast. The rest are in a so-called normal range. The slow metabolizers get the adverse effects very quickly. However, long-term use of most of these drugs will eventually overload the ability of the liver to metabolize them, precipitating adverse events, or blunt the ability of cell receptor sites, rendering the drug ineffective.

● (1620)

Careful reading of the literature and clinical experience shows that PTSD is most effectively treated and has the best chance of long-term improvement or cure with trauma-focused psychotherapy, such as EMDR.

Nutraceuticals should be used because extreme and prolonged stress causes nutritional deficiencies. They have no major side effects and can be managed by anyone with less knowledge than it takes to manage self-medication with aspirin. They don't require regulation.

In PTSD patients, psychotropic drugs should not be used because they're not effective and their side effects are unacceptable. If anything, they prolong the illness.

The CBC reported on April 19 of this year that the rate of suicide in Canadian soldiers doubled in 2007 compared to the year before. This corresponds with the move from Kabul to Kandahar, where the Taliban is more active. Undoubtedly, one would expect an increase in PTSD cases from intensified combat, but PTSD does not have to automatically lead to suicide.

How many of Canada's soldiers who committed suicide were exposed to an increased risk because they were prescribed one or more antidepressants? This committee could seek an answer to that question. If a substantial number were on these medications, the logical conclusion is that a different approach is urgently needed. Funding for this class of drugs should also be questioned. They have been shown to be ineffective and to cause disastrous side effects. More trained trauma therapists are, of course, vitally necessary.

Thank you.

The Chair: Thank you very much.

We'll get into our opening round of questions, and that might be all we have time for. Make your questions short and to the point, and hopefully the answers will be as well.

We'll start with the official opposition. Mr. Wilfert.

Hon. Bryon Wilfert (Richmond Hill, Lib.): Thank you, Mr. Chairman.

Thank you all for coming. You've certainly given us a great deal to think about.

At the end of the Second World War, it was said that Canada was the best country in the world in providing for its veterans. We want to continue to ensure that happens and that soldiers are getting the help they need. Clearly we have heard today that they're not. Regardless of what we have heard from the higher ranks, there seems to be a failure to understand that there is a major problem here, and there's a failure to communicate that effectively. Clearly there's a failure to diagnose it, as many of you have mentioned, and a failure to respond effectively to this operational stress injury situation.

Dr. Belliveau mentioned earlier that she wanted to see an audit at Gagetown. The Minister of Veterans Affairs seemed to be supportive, but has not come out officially in support of the need for transparency. Can you tell us why there would be reluctance to do that?

On the adequacy of services, you've indicated that services are not there. We hear this all the time, and people are falling through the cracks. The fact is we're up to 11,000 people who are suffering, from 3,500 just five years ago. We don't have the infrastructure in place to respond. I assume you're telling us that the situation in Gagetown is not dissimilar to those in other places across the country. We need to respond effectively in our recommendations to that.

Can you comment on this transparency issue?

I will give the Minister of Veterans Affairs credit, in that he is responding, but obviously he's not able to respond as quickly or effectively as we need, given the load.

The Chair: Dr. Belliveau.

Dr. Joyce Belliveau: I will attempt to respond to both within the limits I have.

I wish I could tell you why they are not responding to the requests for an audit. There is certainly enough evidence, from our perspective, to demonstrate a need for somebody to come in and do an external audit to understand particularly—and I can only speak to Gagetown and my experience there—what has happened with this program.

In any attempts to understand the organizational structure, the referral process, how clients are being tracked, we are getting different answers from different people. People within the system, I think, are trying to perhaps protect themselves and may not want the external audit. Certainly, there have been some attempts.

We also know that certain staff members have been effectively silenced—have been told they were not allowed to speak out.

I'm hoping the Minister of Veterans Affairs does come through with some way to provide some sort of evaluation of what is going on. I don't understand why it hasn't been done to this point. There certainly is enough evidence.

The adequacy of services is probably a problem across Canada. The response to the upcoming Afghanistan tours.... There certainly was an awareness that treatment providers were going to be needed; however, there didn't seem to be any standards set as to the criteria for hiring staff. There certainly have not been a lot of efforts towards training.

Both Robin Geneau and I have offered on many occasions to go to the base and not only train but supervise staff. That has met, again, with resistance. We don't feel we are the ones who have to do the treatment, but we would like to see adequate service providers. Training is available. We are both trained in many of the techniques and strategies, and we utilize them in our own practice. And we've gone out of our way not only to use the strategies, but to train.

● (1625)

Hon. Bryon Wilfert: There seems to be a stigma associated with this situation, and because of that stigma and the view we've heard from some witnesses that there is still this macho view within the armed forces, they don't want to be seen as.... In fact, one person said he was told, “Just suck it up”.

Would that be a fair assessment?

The Chair: Go ahead.

Dr. Joyce Belliveau: That attitude is slowly changing, but really where it's changing is at the grassroots level. The soldiers who actually come for treatment are the ones who are spreading the news to each other that treatment isn't such a bad thing and that there are some pretty decent people out there who can help them. The stigma is slowly changing, but I don't know if there's enough being done in terms of the education component to help people realize they're not going to lose their jobs, they're not going to be stigmatized by their peers, by their supervisors. However, that still is the case. It's not as bad as it used to be, but it is there.

Hon. Bryon Wilfert: Certainly, we'll try to follow up with regard to the issue of the audit at Gagetown.

Dr. Joyce Belliveau: Thank you.

Hon. Bryon Wilfert: Mr. Chairman, if I have some time left I'd like to share it with my colleague, Mr. Rota.

The Chair: Go ahead, Mr. Rota. You have two minutes.

Mr. Anthony Rota (Nipissing—Timiskaming, Lib.): Thank you, Mr. Chair.

Thank you for coming out today.

It's interesting, when we hear the accounts from, say, a command point of view and then we hear the rest, there is a little bit of a contradiction there. That's one of my concerns.

I'll ask a question, and then I'll get into the other questions and you can answer them all. It will be my way of getting around the time limit, if that's okay with the chair.

The Chair: You're not going to be able to do that.

Mr. Anthony Rota: Okay. I'll go right to my question.

When clients are cut off and they're in the middle of therapy, are they supplied with an alternative? Second, who decides when they're cut off? What qualifications do those people have, and what reasons do they give you for determining that situation in particular?

The Chair: Go ahead.

Dr. Robin Geneau: It's one of the problems. We don't know who decides, because who decides today might not be who they tell us decides tomorrow.

Mr. Anthony Rota: If I could clarify that, is it an administrative decision or is it a clinical decision?

Dr. Robin Geneau: It could be either.

Mr. Anthony Rota: You don't know.

Dr. Robin Geneau: It's just a big jumble. It could be a doctor one time, it could be a manager one time, it could be anyone. And the reasons could be any. But the decisions are not being made by qualified clinicians and they're not being made on a clinical basis.

In fact, one of the soldiers said to me that he felt the decision to cut him off from his treatment was made for financial reasons.

Mr. Anthony Rota: Is this something you find is particular to your area, or do you find it spread across? We've had different witnesses. I've heard that Alberta has wonderful service for people who have different issues.

I come from northern Ontario. It's very sparsely populated, very similar to your area.

Is this something that happens mainly in rural areas or on bases that are not near major centres, or do you have knowledge of any other areas that see the same situation?

Dr. Robin Geneau: Are you referring specifically to treatment being cut off?

Mr. Anthony Rota: I mean the cutting off of treatment and the overall service that's provided to the individual soldiers who have health issues.

Dr. Robin Geneau: I'm not sure. I really don't know what's going on in other areas of the country, but in our area it's a control issue. It's the mental health clinic's decision to control everything. They choose to disregard the opinion of the treating clinicians and just make their decisions on their own, and they don't have to account to anyone for that. That seems to be specific to what's happening in Gagetown, and it's never happened before. This is a very recent development that we would have that, and I want to make it clear that it has nothing to do with Veterans Affairs.

In my role as a service provider for Veterans Affairs I have no complaints with at all. We have complete support from Veterans Affairs for doing treatment. It's only the CF.

● (1630)

The Chair: Thank you very much.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Welcome. I will start with you, Dr. Geneau. In your presentation, you said that you could suffer retaliation or be punished for having testified before the committee.

Mr. Chair, does the committee have a witness protection program, or does that only apply when their lives are threatened?

Some hon. members: Oh, oh!

Mr. Claude Bachand: You do not want to answer? Let us talk about it again later.

[*English*]

The Chair: We'll have to deal with that if it happens.

[*Translation*]

Mr. Claude Bachand: What do you mean by “punished”? Surely they are not going to put you in front of a firing squad and shoot you. What can they do to you if they are not happy?

[*English*]

Dr. Robin Geneau: At this time, I'm receiving a small number of referrals for clients who are under the mental health team, but my name was taken off the provider list for the psychosocial team, I believe, in retaliation for previous efforts of mine to advocate on behalf of clients. I suspect I may be taken off the list completely for the whole clinic now as a result of being here. That's what I expect. There was no threat made, of course, but it has happened. My name was literally taken off the list as a provider, and they didn't inform me or discuss it with me; they just took me off.

[*Translation*]

Mr. Claude Bachand: You are a civilian practitioner. If your name is taken off the list, you will simply have all civilian patients. Your income will not be reduced. The people who consult you from now on will be civilians. That is not a severe punishment. It is just that soldiers will not be referred to you any more. Is that right? OK.

You asked the department to hold an enquiry into what happened and you have not received an answer yet. The committee is sort of thinking of asking the Auditor General to conduct a formal inquiry. What are your thoughts about that?

There are two schools of thought. On the one hand, people in uniform who have sat where you are sitting say that there are hardly any problems. On the other hand, soldiers say, as you do, that the problems are many. Would asking the Auditor General to report on what is really happening be a solution that you would consider?

[*English*]

The Chair: Go ahead, Dr. Belliveau.

Dr. Joyce Belliveau: I think it would be an excellent source of an audit. I think you're going to get varying comments across different bases. We can only speak to our own experience. I could say it depends on who you're asking the question to. I've read all the proceedings, and I agree that what we're hearing from the powers that be is not the experience. There is quite a contrast.

Our hope is that there is going to be some sort of external investigation, whether it's by the Auditor General's Office or Veterans Affairs.

[*Translation*]

Mr. Claude Bachand: One of the reasons that is frequently mentioned is that General Yaeger might get bad information because they want to hide the truth from him. Do you believe that that is the case?

Instead of painting a very negative picture for the general by telling him that things are not going at all well and that a lot of people have fallen through the cracks in the system, the officers around him tell him that the situation is not that bad, that they are trying hard, that they will get there, but that it will take time. In turn, the general tells the committee that they are trying hard and that they will get there.

Is that a reasonable explanation?

● (1635)

[*English*]

Dr. Robin Geneau: May I comment? When we did the ombudsman's complaint, there was an article about that in the newspaper. The manager of the Gagetown mental health clinic was interviewed at the time, and what was reported in our local newspaper was that they had 12 to 15, I believe the number was, fully qualified staff in their clinic to provide treatment. I would assume that that's the same information that was passed on up the line of authority as well.

The fact of the matter is, he must have been counting the cleaning lady, because they really didn't have that many staff; the reality is they only had a couple who were actually qualified to treat PTSD, and that hasn't changed. They still only have a couple of staff. I don't know the exact numbers now; they might have a dozen staff now, but they only have a couple who have the qualifications. He said to the newspaper that there were more than a dozen qualified staff to treat PTSD, so I would guess the same thing was going up through the line of command.

[*Translation*]

Mr. Claude Bachand: We are told what procedure is followed for a physical wound. If someone has a foot cut off or loses an arm, we know what will be done. I can agree with that. I would like to have asked Dr. Shay how he differentiates between a wound and an illness, but it is a subtle distinction.

Whatever the case, it seems that no procedure is followed in the case of mental illness or post-traumatic stress disorder. Do you agree that the Canadian Forces simply do not know what to do, that no one keeps track, that things can vary from one region to another? Do you notice a lack of procedures in the treatment of mental health problems? Caring for the soul is different from caring for the body and it is sometimes more complicated.

[*English*]

Dr. Joyce Belliveau: We initially started this process because there was a procedure in place. The OTSSC model has very clear procedures, from the entry-point level for the soldier in terms of assessment—how that process goes—right through the whole treatment process. Our concern was that that procedure was abandoned at Gagetown. So there are very strong procedures in many clinics across Canada, particularly Halifax.

The Chair: Mr. Comartin.

Mr. Joe Comartin (Windsor—Tecumseh, NDP): Thank you, Mr. Chair.

Thank you for being here. Dr. Shay. I'm going to apologize in advance. We brought you all this distance and I get the sense we're not going to get an advantage of your skills. I'm going to come back to you in a minute, because I have to ask some questions of our two witnesses here.

What is the current status of Dr. Hanley? I know he's suspended, but—

Dr. Joyce Belliveau: He has lost his licence in both Newfoundland and New Brunswick.

Mr. Joe Comartin: Do you know how he got hired in the first place?

Dr. Joyce Belliveau: No. We're not privy to that information.

Mr. Joe Comartin: I assume that would be part of the audit. You'd want that covered in the audit.

Dr. Joyce Belliveau: Certainly.

Dr. Robin Geneau: Could I add something?

Mr. Joe Comartin: Yes, please.

Dr. Robin Geneau: He did continue to work at the base for several months after he lost his licence. He was technically not seeing patients, but he was participating in mental health team meetings—which we're not allowed to participate in—and he was involved in case conferencing and decision-making about patients. He worked there for three months after he lost his licence.

Mr. Joe Comartin: Can you tell us who made the decision to allow him to continue?

Dr. Joyce Belliveau: No.

Mr. Joe Comartin: With regard to the complaint you sent—I guess, Dr. Belliveau, it was you who sent the complaint to the ombudsman. Is that correct?

Dr. Joyce Belliveau: We both sent individual complaints.

Mr. Joe Comartin: Was it suggested to you that you in fact had to present a complaint from a soldier?

Dr. Joyce Belliveau: We were told that they actually did not have the mandate to pursue our complaint, but because it had impacted on soldiers, they were going to look at it. However, it is typically the soldiers who do have to file the complaints.

Mr. Joe Comartin: I'm sorry, I should have made the question clearer.

Were you told by the ombudsman that that was necessary and suggested that, yes, that's one of the...? Was that recommended to you?

Dr. Joyce Belliveau: Yes, it was.

Mr. Joe Comartin: Were you able to do that?

Dr. Joyce Belliveau: To encourage soldiers? We have encouraged many of the soldiers to come forward, based on our experience with the ombudsman's office, and I think more of them are. We hear the complaints, and they want us to act as advocates for them. We don't have the means to do that, other than in situations like this. The ombudsman's office is not mandated to listen to anybody other than the soldiers.

● (1640)

Mr. Joe Comartin: Can you say in all honesty that you're certain that some of them did complain to the ombudsman?

Dr. Robin Geneau: We were told by the soldiers they had complained. That's the degree of our certainty.

Mr. Joe Comartin: Have there ever been any complaints made about the services you provide? Is there anything on the record anywhere of your being castigated for improper services?

Dr. Joyce Belliveau: Not that I'm aware of.

Mr. Joe Comartin: And you're operating under some discipline body?

Dr. Robin Geneau: Yes.

Mr. Joe Comartin: Have there been any complaints to the discipline body by Gagetown?

Dr. Robin Geneau: No. We would have heard about that if there were.

Mr. Joe Comartin: There is a story in the newspaper articles about a clinic being opened by Veterans Affairs in Fredericton, an OSI clinic. Have you had any involvement? Were you consulted on how the clinic should be established?

Dr. Robin Geneau: Not on the establishment, but once the psychologists got there they made contact with us, and we're doing joint training with them, which is wonderful. This is the way we used to work with the CF. We're participating in joint training. We have a lot of cooperation, and we expect to have a very good working relationship with the OSI clinic once they get off the ground.

The Chair: Go ahead. You still have four minutes.

Mr. Joe Comartin: So I have some time to get back to Dr. Shay.

The Chair: Yes.

Mr. Joe Comartin: I haven't read your books, but I've read reviews of your books and other material on you. Could you give the committee any indication as to whether there's a model for treatment of OSI elsewhere in the world that you could point us to that the Canadian military should look at in terms of developing the model for Canada?

The Chair: Go ahead, sir.

Dr. Jonathan Shay: I hope it's clear that I have been down in the bottom of the ocean, in the trenches with the veterans, for 20 years, but my heart has really been with the active forces in preventing psychological and moral injury in active duty forces. I am not a big literature hound, and I don't pretend to be an expert on the treatment of psychological injury once it's happened. I'm very proud of what I've been doing with the veterans I've been working with, but this is not evidence-based, other than my testimony, my satisfaction.

There is a very rigorously developed evidence-based algorithm for treatment, which was mentioned earlier by one of the witnesses. I apologize for not remembering who. The joint Department of Veterans Affairs and Department of Defense clinical treatment guidelines for PTSD and acute stress disorder and operational stress reaction—I forget the jargon, sorry—but even earlier than acute stress disorder.... This algorithm and the echelons of studies behind it are all on the web under clinical practice guidelines for PTSD of the Department of Defense and Department of Veterans Affairs. I was part of the clinic that was involved with drafting that because of my involvement in prevention, but I wish I could claim more expertise in responding to your question.

Mr. Joe Comartin: Let me ask Dr. Belliveau basically the same question. Are there any other models we should be looking at for treatment?

I'm going to come back to Dr. Shay, because I want you to answer the question about prevention as well.

Dr. Joyce Belliveau: The centre of excellence, I believe, in terms of treatment issues, is Ste. Anne's Hospital. This is the basis of the OTSSC model, which is a multi-phase, multi-modal, cognitive behavioural model, with all sorts of research evidence with efficacy. It involves a number of different strategies and techniques, including EMDR in the trauma processing phase, but it is evidence-based and there is a very clear algorithm or procedure in place following this model.

● (1645)

Mr. Joe Comartin: Ste. Anne's? I don't know where it is.

Dr. Joyce Belliveau: It's in Quebec, in Ste-Anne-de-Bellevue.

The Chair: I'm sorry, Mr. Comartin, you've run out of time.

Mr. Hawn.

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

We're going to try to spread the time amongst the three of us, so I'll make fairly quick points, if I could.

Clearly there's a problem at Gagetown, but we should be careful not to generalize that across the military, because we've heard evidence otherwise. I think we also need to be careful about numbers. We talk about going from 3,500 to 11,000. That 11,000 includes peacekeeping vets, and it goes as far back as Korean War vets. It's not necessarily Afghanistan-related.

With respect to the situation in Gagetown—you may be uncomfortable answering this question, so feel free not to—are we talking about the same people who are involved in this? Is there a continuity of people who are causing the problem, or is there a continuity of attitude that goes from commander to commander or supervisor to supervisor?

Dr. Robin Geneau: There is some continuity of people involved, but primarily it's a structural issue. They lack clinical expertise and they lack an efficient administrative process. It's completely lacking. Structural changes, systemic changes, need to be made.

In the context of the lack of structure, individuals can engage in empire building or control or whatever they want to do, and that can be rampant. This is the reason why we say there needs to be an audit. We believe, as a result of that lack of structure and the lack of administrative effectiveness, there are clients out there in our community who are not receiving services, and we want them found.

Mr. Laurie Hawn: To Dr. Ferrie, just quickly, the suicide rate for soldiers in fact has dropped. The suicide rate that was quoted included other non-soldiers, so I would challenge that source a little bit.

EMDR appears to be pretty valid treatment, and I think the nutraceuticals area bears some more investigation and work, in a positive sense. EMDR and nutraceuticals—have you seen evidence of their use in other countries, such as the U.S., the U.K., Australia?

Dr. Robert Ferrie: If you go through the bibliography I've submitted here, you'll find that they have done studies in Israel using nutraceuticals for anxiety and depression. They found that they're more effective than a placebo, which is more than you can say for the SSRIs.

Mr. Laurie Hawn: Okay.

I'm going to pass it on to Mr. Goodyear.

The Chair: Mr. Goodyear.

Mr. Gary Goodyear (Cambridge, CPC): Thank you, Mr. Chair.

Through you, I would like to congratulate the witnesses. In my past life I was a health care provider as well, and I can tell you, it's not such a bad thing to be accused of being an advocate for your patient.

I can also tell you, and perhaps my colleagues, about my experience with the insurance industry. I worked for them and would give them opinions. If they liked the opinion, they would refer more patients to me. If they didn't like the opinion, they would stop referring. Of course, I had other sources of referrals so I didn't really suffer.

At the end of the day, though, what happens when you allow that to continue is that the insurance company—I'm assuming Gagetown has the same philosophy—eventually ends up with only the practitioners who provide only the opinions they like. That tends not to be based on the best interests of the patients. In the insurance industry's case, it would be based on profits. That's never a good thing. You end up with poor-quality providers and profitable insurers. So I have to congratulate you on keeping that advocacy going.

I want to ask some hopefully very quickly answered questions.

I would like to ask our psychologists, if I may, Joyce and Robin, is this type of therapy regulated in Canada? Is it under any supervising authority? Is there a regulatory body outside of the psychotherapy profession?

Dr. Joyce Belliveau: Certainly psychologists and social workers have regulated bodies. I'm sure in the OTSSC model there is ongoing evaluation—

Mr. Gary Goodyear: So the psychotherapy association and profession recognize the therapy, and they regulate it, through you.

Dr. Joyce Belliveau: We are bound, as psychologists, by evidence-based practice, so the techniques and strategies we use are monitored.

Mr. Gary Goodyear: Can you tell me approximately how many practitioners of this type of therapy there might be in Canada?

Dr. Joyce Belliveau: I have no idea.

Mr. Gary Goodyear: Is there a guess? Would it be over 100, under 100, over 1,000...?

Dr. Robin Geneau: Are you specifically referring to trauma therapy?

● (1650)

Mr. Gary Goodyear: Correct, the eye movement desensitization and—

Dr. Robin Geneau: My guess is that in New Brunswick there are fewer than 20 practitioners.

Mr. Gary Goodyear: Okay. I know it's difficult to tell us how many treatments are necessary, because patients aren't Chevrolets; they respond differently to the same therapy. But can you tell the committee how many treatments are needed before you start seeing a benefit? And what would be the average number for complete recovery? I'm again asking our psychologists. Is there any way to answer that?

Dr. Joyce Belliveau: It is so dependent on how they come in. We have done a lot of work with people from every tour. We're getting some people who have come in 11 years post-tour. By that time, you know it's going to take a long time.

I think perhaps with Afghanistan we may be able to get some idea of that. But again, we're getting people coming in who have had multiple tours and multiple traumas, so it is very case-specific.

Mr. Gary Goodyear: All right. I'm going to leave the rest of my time to my colleague. Thank you very much.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): I'm going to make some comments and ask questions at the end, in the interest of time.

It seems that if a soldier is identified for potential medical release, it makes more sense for a community-based practitioner to be taking care of the patient. After all, once they are released they have to go through the screening business all over again.

You mentioned that the number of visits were curtailed at a certain point and that help is most effective the sooner the patient receives help. That is a big concern. I am the MP for Petawawa, and the broken soldiers are telling me that it has been 18 months and they still haven't seen a provider for the very first time. In fact, one day our committee for veterans affairs visited. One man had been waiting 18 months, and it just so happened that he was going to see a provider for the very first time that day.

I am told that there is a new centre standing at CFB Petawawa, but I haven't been able to verify that for myself.

I have a question for Dr. Geneau. You mentioned that you also see the families of military personnel. Does the member's insurance plan cover the treatment when you see dependants?

Dr. Robin Geneau: Dependants are covered under Sun Life. They have a $1,000 entitlement under their Sun Life plan. They have to pay, though, and get a receipt and send the receipt in through the mail and wait maybe four to six weeks for reimbursement. It is a complaint among those people that they do not find it a reasonable way of receiving services.

The Chair: Sorry, Ms. Gallant, but we're out of time. I apologize. We have another panel. That is very unfortunate. This has been a good session, and we could sure use some more questions, but we're going to have to suspend for a minute to move in camera for our next panel.

I want to thank you all very much. You have come a ways. Some of you answered more questions than others, but we will use your testimony in our report, I am sure.

[*Proceedings continue in camera*]

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