HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 049 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Wednesday, April 5, 2017

Chair

Mr. Neil Ellis

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● (1635)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I call the meeting to order. Pursuant to Standing Order 108(2) and the motion adopted on September 29, the committee resumes its study of mental health and suicide prevention among veterans.

I apologize on behalf of the committee. We had a vote and we are a little late, but thank you for sticking in with us. We're going to start with the panel with 10-minute statements, followed by some Qs and As.

We'll start with the presentation “A Project for Life”, with François Joyet and Andrée Roberge.

The floor is yours.

Mr. François Joyet (President, Canada Company, Quebec Chapter, Project For Life):

Good afternoon, ladies and gentlemen. I am François Joyet, president of the Quebec chapter for Canada Company, and a board member.

As fast as I can I'll say that over the last two years our organization has been sponsoring a respect campaign spearheaded by Steve Gregory and Doug Bellevue, which has brought us to meeting a lot of different people, different organizations, throughout Quebec, Ontario, and the west, to come to a very basic conclusion.

Being from a business mindset and not a medical mindset, in business, we often say that we are as strong as the weakest link of our chain. We've noticed that there are many people doing many different things and millions of dollars being invested to help our veterans find solutions to what I think is generally agreed, that PTSD is a mental illness, and homelessness comes from it, as does suicide.

We started wondering how we could find a way to fix this. We had the pleasure of meeting people from the Saguenay region who were in contact with les Frères Maristes, which has an old school congregation site. We started asking questions of how we as a group could put everyone together and offer one complete service, with the end result being the reinsertion into Canadian society of our veterans becoming productive Canadian citizens again.

I don't think I can go over everything here with you today, but one of our asks was how we can get formal approval to putting these various organizations around the table to come to a complete and formal proposal. We've met the people from l'Hôpital Sainte-Anne. We've met people from the Old Brewery Mission in Montreal. We haven't met with the people from OSI yet, but we have identified them as people we need to be sitting down and talking with.

We do not have an interest in reinventing anything. Everything is out there. You have people doing zootherapy with dogs. You have Wounded Warriors financing programs with equestrian centres in the west. You have True Patriot Love, which is even financing a program at the University of Southern California—I'm searching for my words because I got off my text; I was told to be very short and sweet and to the point—which brings the person into a simulator where they're revisiting what caused the PTSD.

When you go across Canada and you start meeting all these different people, everyone is doing something, but no one is doing it together. No one is doing it under one roof, offering a complete service. How do we bring the person to an end result, which is back into society as a productive citizen? This is something we'd like.

I sent my text, so I think you will have it. There's a lot of work to be done. I do not have a formal proposal to give to you, but I think if we, as an independent voice, business leaders, were able to put all these people around the table to come up with a formal project, we could do something like that.

Rapidly, that's it.

● (1640)

The Chair: Thank you.

Madame Roberge.

[*Translation*]

Dr. Andrée Roberge (President, The Neuro Group Inc., Project For Life): Hello. Thank you for meeting with us today.

As a scholar at the Medical Research Council of Canada, I had the opportunity to work in the neuroscience field and to study various structures of the nervous system. I did research on neurodegenerative disorders and stress, in particular post-traumatic stress, but also other types of stress. I also did research on depression, schizophrenia and psychiatric disorders.

Through the Project for Life, we offer individuals suffering from post-traumatic stress and their families access to all the resources under one roof. This starts with the medical file, which contains the information about the diagnosis and explains the different therapeutic approaches used. We include blood tests that quantitatively measure the entry and exit of information in the brain and that help distinguish between all conditions, including diagnoses related to anxiety or depression, cognitive disorders or psychiatric disorders. Based on the result, we can look at the situation with the doctor and the individual, and start providing care.

To follow our program, individuals must understand that they've experienced a difficult situation, in this case post-traumatic stress. They must accept this fact in order to receive care, find a way to reintegrate into society and get back the quality of life they had before and they had chosen. We're talking about an integrated approach that groups together everything under one roof and that's based on the medical file and the family, meaning the spouse and children.

Thank you.

[*English*]

The Chair: Next we have Dr. Ken Lee, medical consultant at Parkwood Institute's Operational Stress Injury Clinic.

Welcome.

Dr. Ken Lee (Medical Consultant, Parkwood Institute's Operational Stress Injury Clinic, Canadian Mental Health Association, Middlesex-London Branch, As an Individual): Thank you very much.

Just by way of background to let you know what I do in my practice, I've been working at the Parkwood OSI Clinic for about 10 years, since 2006, as a part-time medical consultant, but my main area of practice in London is in addictions and mental health with the CMHA London and Addiction Services. I've been a member of the Ontario Minister of Health's advisory committee on addressing the opiate crisis in Ontario. That's some of the background I want to give you so that you know where I'm coming from.

The mental health care provided in OSI clinics has always been focused on PTSD. Significant time and resources are spent in those clinics to filter out the diagnosis of PTSD as distinct from other mental health conditions that are not necessarily treated in OSI clinics.

If we're going to make an impact on reducing veterans' suicide and improving their mental health, I think it's important that these OSI clinics broaden their scope and treat other mental health conditions. Depression is a large component of what we see, but the veterans do not necessarily qualify for treatment within these clinics unless there's an identified service-related PTSD condition. We make the diagnosis of sub-threshold PTSD to allow people to be qualified for treatment.

The other big impediment that I see in my experience in these clinics is that there's a significant problem with alcohol and substance abuse in the population of patients we see in the OSI clinics. Alcohol use disorder is tracked, but other substances are not necessarily tracked that closely.

We don't have the capacity in the OSI clinics to address these problems. We refer people to treatment programs and residential rehab programs, such as Homewood, Bellwood, and other programs in the province, but we do not actually have the capacity to address these problems in the clinic. We do not have an addiction counsellor in our clinics. The main treatment in PTSD is not pharmacotherapy; it is mainly psychotherapy by psychology. Psychotherapy and trauma exposure therapy do not work that well, if at all, in the background of alcohol abuse and substance abuse.

It would be nice to broaden the scope of the OSI clinics to address whatever mental health concern the member presents with. These are people who need care otherwise anyway, whether related to their service or related to transitioning to civilian life. Whether they get the care through the federal OSI clinic system or through the provincial health care system, I think it's important that the care be delivered in a timely fashion. My philosophy is that we deliver the care that's needed and worry about the funding later, whether it's provincial or federal. That could be worked out later, at a committee elsewhere.

That's the gist of what I want to say. I think we owe a duty of care to veterans who have willingly risked their lives, life and limb, to serve and protect our country. The least we can do is give back and provide the service they need after their service to our country.

Thank you.

● (1645)

The Chair: Thank you.

Now we will have Ms. Paris, psychologist.

Thank you for coming today.

Ms. Céline Paris (Psychologist, As an Individual): Thank you very much for the invitation. I'm honoured to be here. I'm very aware that I have only 10 minutes, so I will fly through my text. My apologies to the interpreters.

My name is Céline Paris. I'm a psychologist. I've been working with soldiers and veterans since 1990. I started within the CF system. Since 2005 I have been in private practice. At first I did mainly diagnostics, and now I do mainly treatment.

I want you to know at the start that I was drafted to speak with you today. I was drafted by a brilliant young veteran. He said, “Céline, you have to tell them about hope.” I take hope very seriously, so here I am.

I like positive psychologist Rick Snyder's definition of hope. It's more than optimism or a general positive outlook on life. For Snyder, hope is made up of agency and pathways. You have hope when you believe you can achieve your goals through your own efforts, “agency”, and when you have a plan to achieve them, “pathways”. Hope is about being goal-oriented and staying that way through the highs and lows of life. I think hope has left the hearts of too many veterans, and as a society we're not doing all we can to stop the bleeding.

My message of hope will be in two parts. The first is fact and the second is opinion.

The fact is that therapy works. There is scientific research that shows objectively, repeatedly, that psychological treatments for PTSD work. Science is the solid foundation that every other strategy builds on. I hope you will listen to Dr. Hector Garcia's TED talk or read the transcript I've provided to you. The title of his talk says it all: “We train soldiers for war. Let's train them to come home, too.” His message is that today we know how to eliminate PTSD.

Yes, he uses the word “eliminate”. This is a very strong claim, so I came with proof. These are not scholarly articles, although I have some here, if you like. These are three graphs. I hope you have the graphs. I'm going with *moins mais mieux*.

SUDS, subjective units of distress, is a scale used to measure progress in therapy. A score of 10 means extremely distressed and a score of one means perfectly comfortable. When a person with PTSD is going through this active part of therapy, which means reliving their trauma story every day to finish processing it, their psychologist asks them to track their SUDS each day.

I'll turn now to my three graphs. Page 1 shows the progress over two weeks of a soldier still on active duty. I'll call her Marie. She was brutally assaulted by her partner and left for dead. Pages 2 and 3 show the progress of a young Afghanistan veteran who faced grave dangers and horrors. He lost friends to the Taliban and later to suicide. He stayed fully engaged in love and work, but, boy, was he suffering. Let's call him John. As it happens, both Marie and John completed their trauma therapy for their worst event just this month.

The third case, on page 4, is from 2013. He is a sailor in his seventies who was almost killed in a fire at sea in 1969. He left the navy as soon as he got off the ship. By the time he heard there was such a thing as PTSD, more than 40 years had passed. He came to therapy because his wife wanted to go on a cruise, and setting foot on a boat was unthinkable.

As you can see, their SUDS ratings start high and go down from day to day and week to week. Like Carlos, Dr. Garcia's Vietnam vet, after a few weeks of hard work their trauma was truly in the past. The whole idea behind prolonged exposure is that it will stay there.

Are these three individuals different from most? Maybe. You might guess that they had more courage, but I don't think that's it. Soldiers are brave. What they did have was hope. They refused to let a diagnosis determine how they were going to live their lives. Without hope, they would not have been willing to summon and confront their worst memories, any more than a cancer patient would sign up for the cruelties and indignities of chemo.

To explain to our patients why they need to face their traumas, we tell them that all emotions have a function. They are a signal, like hunger, pain, or cold, that something needs attention. Ignore them and they get worse. If we haven't eaten, it doesn't occur to us to label our hunger as the problem, because if we did, we could just take an appetite suppressant rather than eat.

With anxiety it is trickier. Unlike hunger, our first instinct is the wrong one. The first thing we all try is to push the bad memories out of our minds. Avoidance is addictive, because it works wonderfully in the short term. In the long term it makes the problem worse. The alternative is exposure.

● (1650)

[*Translation*]

What I flee follows me, and what I face is erased.

[*English*]

So, therapy works, and now for the opinion.

Hope is in crisis, and we have to do something soon. Why is PTSD portrayed as a chronic condition, necessarily, by default? Why are newly diagnosed soldiers like Marie, who is just starting out in life, being told by clinicians and peers that managing their symptoms is all that they can hope for? It looks to me like hope needs a lobby group.

For every new effort of support, I ask that we remind ourselves that a safety net can catch, but it can also entangle. The short answer to why soldiers and veterans choose suicide is not PTSD, it's not depression, and it's not lack of support. It's hopelessness. Support without hope creates victims, not survivors, and soldiers don't make good victims. They don't need their struggles to be glorified. The antidote to shame is not honour, anyway; it's self-compassion, remembering our common humanity, the idea that there but for the grace of God go I. When they understand what they need to do to get past PTSD, they just get on with it, but first they need to grasp that they do have agency, and there are pathways, well-worn pathways, in fact.

No societal change is all positive. PTSD has become a household word, but awareness has come at a price. A treatable psychological condition has somehow become equated with a chronic disability, a life sentence, and an identity. Yet, a diagnosis is something you have, not something you are.

I don't love the term “OSI”, operational stress injury, mainly because I haven't found the analogy of injury terribly useful. I know the idea is to combat stigma, but I'm just not convinced it's lived up to its promise. I like analogies that hint at agency—what you can do yourself to recover—analogies that contain the seeds of hope. My favourite for anxiety is a wave that you can't control, that could very well engulf you, but that you can learn to surf or ride. That's why I chose it for the cover of my book.

Besides, a diagnostic label is a useful thing. I was so excited to read that our government is opening new centres of excellence and using the term “PTSD” in their name. A precise diagnosis is crucial, like you were saying, because it dictates the treatment. Just as in medicine, everything starts with the right diagnosis and stalls with the wrong one. Sticking with medical analogies, we know that cancer is not one illness. Choosing the best treatment protocol depends on an exact diagnosis.

I do know the word “eliminate” is scary. We certainly don't want to give false hope or, heaven forbid, leave those who didn't respond to therapy feeling like they didn't try hard enough. Believe me, I share those fears. Then I wonder, if we were talking about cancer, wouldn't I be grateful for any hope I was given? In medicine, it's natural to treat hope as the precious gift that it is. Sure, the risk of relapse does exist, especially if there are more traumas in my future, but then I can be PTSD-free, like we say cancer-free.

Of course, the cancer metaphor is not perfect either. You don't need hope to recover from cancer. A great surgeon could be enough. With anxiety, passive won't work. Someone like me has to convince you to take the scalpel bravely in hand and show you how to use it.

To sum up, support has a crucial, vital role to play before, during, and after treatment. It's protective and it's healing, but it's not treatment any more than support is a treatment for leukemia, diabetes, or a broken leg. When it's coupled with the message that this is all you can hope for, a beautiful safety net becomes a trap.

There is a controversial book that has come out this year called *Against Empathy*. In it author Paul Bloom argues that empathy can be a bad strategy for caregivers because it can lead to burnout and neglect of evidence-based solutions to people's problems. This stance has been criticized as being too extreme, and I tend to agree. Empathy without reason is blind, but reason without empathy is empty.

Good therapy is based on reason, and support is based on empathy. Our soldiers and veterans need and deserve both—oh, and also, hope.

[*Translation*]

Thank you.

● (1655)

[*English*]

The Chair: Thank you.

We've saved some time, so I think we'll be able to do the first round and extend them to six minutes now.

We'll start with Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you, all of you, for coming.

I apologize for the tardiness on our part. Hopefully we'll get through, and we can all get a good response to some of our questions. This has been something we've been following quite extensively, and we've learned a lot about it. This committee is working very well together and we look forward to hearing what you have to say.

A lot of the things that we've heard about on the issue of mental health and suicide are around that transition from being a solider to becoming a veteran. In our previous study, we looked at some of those aspects, and we hope to have some answers. We've come up with some recommendations. Likewise, we will come up with some good recommendations through this study.

One of the things we've heard about is that we train our soldiers to fight. We indoctrinate them from day one, the moment they join the forces, and we keep them that way, and they learn to march based on the order of the hierarchy of the system. When they're finished, we don't decommission them. We don't train them to be civilians. Would you agree with that? This question is for anybody who'd like to respond.

Mr. François Joyet: We run a program at Canada Company called the military employment transition program, which deals with a big piece that I think relates to what you're talking about, which is called education.

One of the issues they have during their military career is that they're basically living in a society within a society. They have their own language. They walk out of there and they basically talk a language that is completely different from what they find in the civilian community, so they need to learn how to express everything they've learned.

We also work with the business community to try to get them to understand the reality of what they went through and what they were, because they have a whole set of skills that are comparable to those in our civilian communities, but it's just a matter of how they communicate. One of the attributes of that program is helping them with that, so I would agree with what you're saying. It's a big piece of education.

Mr. Robert Kitchen: Dr. Roberge.

[*Translation*]

Dr. Andrée Roberge: I agree with what you said.

We're offering an integrated project. This means that we take into account what the soldiers were and what they should keep being. We know that they went through a dramatic situation, in this case post-traumatic stress, the key word for everybody. Post-traumatic stress can manifest itself on a neuropsychological level through anxiety issues and depression, which can lead to suicide.

We're proposing an integrated program where we provide care for individuals by taking into account their medical file, diagnosis and all the therapeutic approaches prescribed to them. We then conduct blood tests that measure the entry and exit of information in the brain. These tests help the clinicians and the employer, the Canadian Forces, confirm that the individuals can be rehabilitated and reintegrated into society.

● (1700)

[*English*]

Mr. Robert Kitchen: Dr. Lee.

Dr. Ken Lee: I absolutely agree that reintegrating into society is a big issue. What they've learned is that their behaviours in the military do not work well in civilian life. They don't know quite how to fit in, and they lose that sense of belonging in normal civilian life.

For example, if you're working in a job in civilian life, you can't be giving orders the same way you give orders in the military. People get angry and you get charged with harassment, and you end up losing your job, etc., and it goes down the line. I think it's quite important to teach people how to cope with that, absolutely.

Mr. Robert Kitchen: Ms. Paris.

Ms. Céline Paris: I'll focus mainly on helping people reintegrate when they have PTSD. That's exactly what the TED talk from Hector Garcia is about. He says that we train soldiers for war, so let's train them to come home, too. The psychological therapies that help with PTSD have a lot in common with training. They involve repetition, as does the training. He says that if you put a gun in somebody's hands, you train them how to use it. In the same way, when you reintegrate someone coming home, you need to do some things. If some of your experiences are now associated with PTSD, it's about the stress response becoming stuck, and you need help to become unstuck, and you need training in order to do that.

Mr. Robert Kitchen: Thank you.

Dr. Roberge, I have your presentation and it intrigues me. I'm a very black-and-white person. I'm a scientist. I believe that I need facts, and when you talk about blood tests, that's a factual thing that people can grasp.

You talk about the HPAS axis. We've heard in committee how proper training may be helpful in terms of the exposure they get. Where do you see that fitting in, from a scientific point of view, when we're dealing with somebody? We train them to do this, basically on the responses that you have when we detrain them. Can you comment on that and on how you see that fitting into your presentation?

The Chair: I apologize, but you'll have to provide your answer in about 30 seconds, if you could, please. Thanks.

Mr. Robert Kitchen: Sorry, I've asked you a technical question. Answer as quickly as you can.

Dr. Andrée Roberge: Just in a few words, according to the results that we have from the first test, we could go to the axis, the relationship between the brain and the adrenal and the hypothalamus glands. We know exactly which situation the person is in from a neurophysiological point of view. We could through our way of taking care of the person—because he or she has to understand and accept that according to the result we have on the axis, the test, we know there is a profound type of psycho-effective type of situation, which they have to live with first. They have to deal with the family. They have to live with the socio-environmental situation. That's why we have this three-way kind of thinking

[*Translation*]

to reintegrate individuals into society.

[*English*]

It takes about six to nine months to be sure the person is able to go back to work—

The Chair: Thank you.

Dr. Andrée Roberge: —and be able to make a choice to be in the army or outside of the army. We have some workshops that give the opportunity for the person to make a choice.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, Mr. Chair, and thank you to all of you for your insights today.

Céline, you talk about support and hope. Where does hope come from?

● (1705)

Ms. Céline Paris: Sometimes it comes with the person. In the case of Marie, she walked in having always been a very hopeful person. She had that combination of agency and pathways. Many military people have it; they just lose it along the way.

In the case of John, at the beginning he had multiple issues that I would prefer not to get into, but when I told him that I thought we could treat this, he said, “That's not what I have been hearing. Are you sure about this?” He struggled with that. I said, “Isn't it nice that you have a therapist who's hopeful? I'll carry the hope for a while.” He appreciated that. Eventually he took it on and continued.

It's interesting, though; it remained an issue throughout the whole treatment. I met them both last week, and they both said that when their SUDS were hitting peaks, they didn't believe the treatment would actually work. The only reason they continued to do it was not that I was such a wonderful therapist that I had convinced them, but that they wanted to be able to say that they had done absolutely everything. It was just real stubbornness on their part that they got through it.

That they had hope to begin with carried them. I think it's something we need to work on all the time as therapists.

Mrs. Alaina Lockhart: I find this interesting. I can see among the witnesses we've had here who have struggled that quite often they've lost hope. They want really badly to be better, but they've lost hope.

Can you tell me a bit about exposure therapy and what you do?

Ms. Céline Paris: Sure. There's a whole chapter in my book that makes it pretty easy, so if you want to know more, I can lend you that later.

Essentially, you have the person do the exact opposite of what they already have been doing. It's very hard to convince them to do it. That's the hardest part. What you do is have them tell their worst trauma story in every detail, using all the senses: what they saw, what they smelled, what they felt, what they heard. It's not so much the fact but rather the impact.

Once we have a written story in great detail, they either tape it or we read it in one session of therapy, and after that they read it every day. There are rules. They have to read it for 45 minutes, and they have to read it for five days a week. If they have to read it more than once, that's okay. That's how you see that graph go down.

What I can say is that everybody who has done it has graphs just like the ones I've shown. However, the tricky thing is that there's research that has just came out that says that of Afghanistan and Iraq veterans, 70% drop out of this kind of therapy because it's so difficult. You're asking them to go back and do the opposite of what's natural: face the worst thing. You need to have a really good explanation and a good relationship with them and to really work on that hope all along, if you want them to continue to do this.

Mrs. Alaina Lockhart: I think of General Dallaire. When he was here he talked about his struggle with two types of therapy, one to try to shut down the memories and one to bring them back. I know there are those two conflicting things. I'm sure some would argue that you probably shouldn't be doing both at the same time.

Ms. Céline Paris: I'd love to talk to General Dallaire about hope.

General Dallaire, if you're listening, give me a call.

Mrs. Alaina Lockhart: How many patients have you treated who have become...can you say they're symptom-free?

Ms. Céline Paris: Yes. I'm not a researcher, so I'm not the one to give you numbers. I can tell you that, as I said, everybody I've seen who does PE, prolonged exposure, has a graph just like those. They move on, and then I lose them. I don't see them anymore; they just move on.

John and Mary are too recent, but I'm sure it's going to work for them, too. In the case of the sailor in his seventies, he was reassessed a year later by an independent person and was found to be still symptom-free. It really works.

Mrs. Alaina Lockhart: How important is it to have the correct diagnosis of PTSD before undertaking this therapy? Is that a problem? Are people misdiagnosed?

Ms. Céline Paris: I think they are. That's why I was saying that I'm not keen on the term “OSI”, because I find that it's too broad an umbrella. It's too specific and too broad at the same time.

Because it's made a psychological injury a battle wound, if you have any kind of psychological symptom and you're a soldier, naturally you're going to want to fall under that umbrella because there is some honour to that. The problem with this is that the therapy has to be specific. Even within PTSD, if all you have is PTSD, which is rare and not that common, the degrees of the symptoms are going to be different and there are different strategies for each configuration of symptoms, the same as you would say about a medical condition.

Diagnosis, to me, is the first step to everything. The correct diagnosis is essential.

● (1710)

Mrs. Alaina Lockhart: Thank you.

The Chair: Ms. Benson.

Ms. Sheri Benson (Saskatoon West, NDP): Thank you, Mr. Chair.

I'm going to start with a general comment. When we're talking about mental health and suicide prevention and we're talking about a transition for an individual from military life to non-military life, many people are going to have individualized experiences of that. Some will do it well. Some will need some support. Some will need more support. In the comments about all the different groups popping up in reaction to some of the struggles of military personnel, is the community saying that there are gaps? That's why you get all those groups coming around all over and it becomes a very complicated map because people have been trying to get help and they couldn't, so they've tried to do it on their own.

I liked your comment that now it's time to bring those pieces together.

Dr. Lee, I wonder if you could comment. I was taken by your comment. When people walk through the door they need to be treated as individuals and they need to be able to have the myriad of therapies available depending on what they need. I wonder if you might expand a bit on your comments about people getting only one kind of thing in this place and this is all that's authorized, and if they need something else, or if it's a family issue and that kind of thing, they have to go somewhere else. I would like to hear your comments on that.

Dr. Ken Lee: It's something I feel quite passionately about. Because of my other work in addictions and mental health, I work at the CMHA, and we see civilians with mental health issues and we treat them very differently there compared to the way the OSI clinic does.

The way we treat it is, people come into the CMHA, whether they come through addiction services, CMHA, a homeless shelter, or whatever; no door is the wrong door for someone to come in and we will provide the services. We will work out where that person gets their services, the exact funding issue, and where they go and all that. The patient doesn't need to know about that and we just direct them through and get the service.

It's different working in the OSI system. You have to qualify for an OSI-related condition to qualify for treatment at the OSI clinic. Now, honestly, we do stretch the definitions of what we're allowed to treat and we try to give as much service as we can, but in reality, the service is not as timely as people would need. From the time they are referred to the time they do an intake there is a waiting time to see a psychologist and a waiting time to see a psychiatrist. The wait times can appear deceivingly good, but in reality they may not be as good as you think they are.

If we treat them basically the same way as we treat other mental health conditions and other people, regardless of whether one has served in the military or not.... The OSI clinics really need to broaden their scope to treat whatever comes in that door, and the member should not have to worry about applying, worry about funding, and whether they qualify or not. We can work that out later among ourselves.

Ms. Sheri Benson: Does anyone else want to comment?

I worked in community mental health and the biggest problem often is not having a wrong door. People come for help and it shouldn't matter where they walk in. If someone has asked for help, the community or the system needs to help them find a therapy that works or a service that works.

I was intrigued with your one-stop shop. I'm sorry. That might sound a little like a 7-Eleven or something, but it's shorthand for people being able to walk through one door and not 16 doors. I wonder if you might—

● (1715)

Mr. François Joyet: That's the whole basis of the project because that's what we found is the problem. I was having a discussion from a gentleman from the—

Ms. Sheri Benson: Sometimes the system needs help, not necessarily, you know....

Mr. François Joyet: Yes. You have the TSO clinic in Quebec City, which is responsible for all of eastern Quebec. If someone in Rimouski has a one-hour meeting they take a four- or five-hour bus ride. They come to their one-hour meeting, and then they go back. Do we honestly believe that works? No.

That's why our project came about, saying let's try to pool everything. But if you're pooling everything, you're not just pooling psychological support and medical support. You need to get these people to become productive again. That is why we pulled together all the different elements we believe need to be pooled to be able to offer these services. The advantage is being a national organization speaking with the religious congregation. They used to manage our health care and education systems. They have these properties across the country, and they're willing to give them up for a buck. You people spend a good part of the day talking about a budget. No one ever wants to talk about money, but unfortunately, you need to talk about money. You need to create something that is going to be financially sustainable. There needs to be a beginning, an end, and a person being a productive person. That's why our project came about.

The Chair: Next, we'll split Mr. Lemieux's time with Mr. Eyolfson.

Mr. Lemieux, you're up.

[*Translation*]

Mr. Denis Lemieux (Chicoutimi—Le Fjord, Lib.): Thank you, Mr. Chair.

I'm fortunate to be a member for the Saguenay region, where the Bagotville military base is located. I'm very concerned about prevention when it comes to the mental health of our soldiers and the well-being of our veterans.

My question is for Dr. Roberge.

Do you think veterans have trouble asking for help at first? I'm very concerned about this. Second, do you know about the new artificial intelligence systems to help veterans in a preliminary consultation, before the first contact with a therapist is established? You seem very nice, but nonetheless, the therapist may be a barrier for a soldier who has trouble asking for help.

I want you to comment on this.

Dr. Andrée Roberge: I must answer yes to your question.

I told you I was a scholar at the Medical Research Council of Canada. At the time, I did all my research at the Laval University faculty of medicine. I did research on stress and the hypothalamic-pituitary-adrenal axis. I thought that my colleagues and I could go to the Valcartier base to establish a partnership in this area. I was told that “No, he's in a dark place, we're not dealing with this anymore.” I retorted that we had the ability to look at what happens before, during and after.

It's now 2017. Nevertheless, it's still difficult for soldiers who aren't amputees, but who have a psycho-affective injury, to say they're suffering. It takes time. Quebec's motto is “I remember”. In that sense, soldiers will always remember what they experienced. However, it will be less painful for them when a professional family, in a place completely separate from their biological family, has helped them understand that they experienced a special situation. When they return to their family, they'll have accepted what they experienced and who they are. Their family must also understand this, which is why our project must integrate this entire approach under one roof.

Therefore, the answer to your question is yes.

Mr. Denis Lemieux: At that point, do you think an artificial intelligence tool to take the first step, which consists of asking for help, could be useful to these people?

Dr. Andrée Roberge: Yes. This approach is part of one of our workshops.

Mr. Denis Lemieux: Is any artificial intelligence software currently being used by the armed forces?

Dr. Andrée Roberge: Yes. Different types of software can be used.

Mr. Denis Lemieux: Thank you.

I'll give the rest of my speaking time to Mr. Eyolfson.

● (1720)

[*English*]

The Chair: Thank you.

Mr. Eyolfson, you have three minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you.

Dr. Paris, you've been treating people with PTSD for about 20 years now, I understand. Over time, with regard to the numbers of patients you're seeing presenting with it, is it increasing? Is it decreasing? Is it changing? What is the trend?

Ms. Céline Paris: Again, I'm a clinician, not a researcher, and the numbers would be obtainable through research. My practice—

Mr. Doug Eyolfson: No, I mean the numbers that you're—

Ms. Céline Paris: My practice is full and there are always....

Mr. Doug Eyolfson: Yes, okay.

Ms. Céline Paris: I hear that there's a waiting list for people to receive treatment for PTSD, and that waiting list is quite long in certain places.

Mr. Doug Eyolfson: We've heard some talk about stigma in the armed forces regarding personnel seeking help. Are you finding in your experience with your patients that they're describing the stigma being a barrier to their seeking help?

Ms. Céline Paris: Absolutely, unfortunately, despite the amazing efforts that the CF has been making. I have friends and colleagues who've worked on the road to mental readiness program. There are incredible efforts to battle the stigma and change attitudes, but I can't say that I see.... Mind you, remember that I see a very biased group. I see the people who are not well. They tell me that the stigma is alive and well and is not really changing all that much.

I think we have to do something else, something different. What I propose is that we communicate that PTSD is treatable and you can resolve it through treatment. If it stops being a life sentence the way the media has been portraying it lately, and the way patient groups have been portraying it, I think the stigma might then change. If it means that you go into treatment for a few months or maybe a year shortly after the time you've experienced the difficult events, then the whole face of this problem changes.

I don't think the information is out there that there are treatments that work. In fact, I feel like turning the tables around and asking you if you've been hearing from psychologists, because it's in psychology that these treatments have been developed and researched. Have you been hearing from psychologists? Have you been hearing this message that treatments do work, they exist, and we have them now? We've had them for many years.

Mr. Doug Eyolfson: All right. Thank you very much.

The Chair: The bells are going to ring in about two minutes, so this ends today's meeting. Again, I do apologize.

Mr. David Sweet (Flamborough—Glanbrook, CPC): Mr. Chair, may I use a minute just to get something good on the record?

The Chair: Sure. We could run a one-minute round with everybody, if that's okay.

Mr. David Sweet: It's just to see if we can get something that I think is good on the record.

Thank you very much, all of you, for your good work.

Mr. Joyet, please tell Stephen Gregory thanks very much for making sure every Canadian knows about Operation Husky.

This is for the two clinicians who are here. We've talked a lot about rehabilitation. We've talked a lot about training for the military. What kind of research is going on right now for prevention? Is there research that's happening to make sure that someone has the capability to deal with traumatic situations, so that not only are we treating after the fact but we actually have some resilience before the fact?

Dr. Ken Lee: That's not my area of expertise, so I don't think I can answer that question.

Perhaps my colleague would know more about that.

Ms. Céline Paris: Because I still have colleagues who are within the CF, I know there are great initiatives to train people, and those training efforts are now being spread throughout society as well and are helping first responders. In another job that I have I work with the RCMP. I do training for resilience to help people face new challenges.

The big thing is that we don't know that it's actually protective. No research yet has shown that. There are resilience programs, hundreds of them, throughout North America, but so far, I'm not aware of any research that has shown that this is protective.

The Chair: The bells are ringing, so I need a motion to adjourn.

First of all, I'd like to thank everybody for coming today. If there's anything you would like to add to the testimony, you could email it to the clerk and he'll get it to the full committee. Again, thanks to all of you for coming today.

I'd like to thank the members who filled in for other MPs today.

We have a motion to adjourn from Mr. Samson.

(Motion agreed to)

The Chair: The meeting is adjourned.

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