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Mr. Rick Casson

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● (1535)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): We'll call the meeting to order. We're meeting today pursuant to Standing Order 108(2) and the motion adopted Tuesday, November 20, 2007, on the study of health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

Today we have a two-part meeting. The first part is the witnesses, and I'll introduce them shortly. The second part is to consider the third report of the subcommittee on agenda and procedure that we held Tuesday to deal with future business. We'll give these two gentlemen as much time as we can, but we'll try to switch over probably at 5, 5:10, or somewhere in there.

Today we have General Gauthier, commander of the Canadian Expeditionary Forces Command, and Colonel Bernier, director of health services operations.

Do you both have presentations to make?

Lieutenant-General Michel Gauthier (Commander, Canadian Expeditionary Forces Command, Department of National Defence): Yes, we do.

The Chair: General, are you going first? Please take as much time as you need, and then when we get into the questions, we will start with a seven-minute round for each party and then switch to five minutes, and we'll get as deep into that as we can.

LGen Michel Gauthier: Thank you very much, Mr. Chair and honourable members. I will try to keep my remarks relatively short and stick to the comments I have in front of me. I can't guarantee the same approach to answers to questions, of course. We'll see how that works out.

[*Translation*]

Good afternoon.

I am pleased to have this opportunity to speak with you about Canadian Forces health services in support of deployed operations.

As you know, as Commander, Canadian Expeditionary Force Command, I am responsible for all Canadian Forces personnel deployed on international missions. I take strategic direction from the Chief of Defence Staff, produce plans, and oversee the resulting operations. In current Canadian Forces language, I am a Force Employer. The Force Generators, most notably the Navy, Army and Air Force, have the task of producing, equipping and making ready their personnel for both domestic and international assignments. These are then assigned under my operational command while employed overseas consistent with direction provided by or on behalf of the CDS.

Currently, there are a total of 16 overseas missions, involving roughly 3,000 Canadian Forces personnel, both regular and reserve. Overseas missions have varied widely in the past several years. They have included traditional peacekeeping, maritime interdiction, evacuation of non-combatants, and humanitarian assistance. The missions vary widely in terms of local conditions, but, in general, all assigned personnel serve in environments that pose heightened personal risk and hardship.

● (1540)

[*English*]

Clearly, the Canadian Forces' largest, highest profile, and most demanding mission is the one in Afghanistan. This mission is not as large as some of the missions of the past 15 years, notably the mission in Bosnia at its height. But it is clearly the most intense, in that it involves counter-insurgency operations against the determined enemy. Of course, this means our personnel in Afghanistan experience psychological stresses associated with physical hardship, violence, and danger on a significant scale.

Command authority over personnel during periods when they're undergoing mission-specific training prior to deployment rests with the appropriate force generator, principally, commander of the army, commander of the navy, and commander of the air force. It also reverts back to them, of course, once these forces arrive home for recuperation and preparation to resume their normal duties. Therefore, I will focus my remarks on how I discharge my command responsibilities for the provision of health services to personnel deployed overseas and concentrate on Afghanistan, the largest effort.

For any potential overseas task, CEFCOM conducts an analysis process to determine the composition and size of forces necessary in relation to the assessed operating environment, the mission, tasks, and the concept of operations. Force protection, logistics support, and health care requirements are all specific red-line imperatives for which the CDS must be satisfied that the deploying force has what it needs to assure mission accomplishment.

As the mission evolves, force composition is scrutinized in great detail between ourselves and force generators every six months to ensure it remains relevant and appropriate to the mission requirements. Likewise, through a relatively robust lessons learned framework, lessons are captured on a continuing basis in-theatre and analysed by force generators to adapt and improve doctrine, equipment, training, and operating methods for those deploying on future rotations in a very dynamic way.

[*Translation*]

In Afghanistan, our medical and dental presence is the most comprehensive we have deployed since the Gulf War, with a total of 166 health service personnel, a small number of civilian contracted clinical augmentees and a further 21 in direct support at other forward locations. A tiered system, based on progressively larger and more diversified levels of care, addresses the needs of our in-theatre personnel inside and outside the wire.

At the basic level, all troops are Combat First Aid qualified and able to provide immediate rudimentary care. Many are trained to a more specialized standard of Tactical Combat Casualty Care. Though clinically non-professional, these individuals provide an initial and potentially critical first response. The first level of professional medical expertise is defined as role 1. At this level, medical technicians, the equivalent of civilian paramedics, deploy on high-risk patrols and provide emergency stabilization in situ. Role 1 also includes physician assistants and medical officers at forward operating bases providing routine medical care and care beyond the scope of a medical technician. This ability to provide urgent initial treatment is extremely important to increasing survival chances and more complete recovery.

[*English*]

Where the seriousness of the injury requires more complex care, the patient is rapidly evacuated to our Role 3 medical facility in Kandahar, which is capable of surgical and other specialist interventions. This world-class facility, which I believe a number of you have seen, is multinational in composition, but is led and predominantly staffed by Canadian Forces personnel. Through the skilful and dedicated application of modern battlefield medicine, these individuals have saved many lives. I make a point of visiting the Role 3 facility just about every time I go into theatre.

Patients whose conditions are serious enough to preclude continued involvement in the mission are repatriated to Canada after undergoing a limited period of advanced care and stabilization at the United States military's Landstuhl Regional Medical Center in Germany, another world-class facility, where a number of Canadian lives have been saved.

With over 20 visits into theatre now over the last six years, I have a very positive view of the health support foundation we have in place in Afghanistan, in terms of health care professionals, trained soldiers, and a chain of command that's absolutely seized with the importance of looking after our men and women. I believe our soldiers have a strong sense of confidence that wherever they happen to be in harm's way, they will be looked after quickly and with the best of care.

In addition to the physical injuries our personnel can sustain, those related to operational stress receive equal attention and commitment of resources. I can assure you that leaders at all levels of the chain of command, from the section or crew level right up to the chief of defence staff, are acutely aware of the high-risk character of operations in Afghanistan and are absolutely mindful of their responsibility to ensure that the necessary in-theatre support framework is in place and the units, as coherent teams and as individuals, are as well prepared as they can be to face the associated challenges.

In this whole area, the Canadian Forces in general has made significant strides in the past decade, in that operational stress injuries are increasingly viewed in the same context as physical ones.

During force generator-conducted pre-deployment training, every effort is made to simulate, as realistically as possible, the conditions under which our troops will operate. Knowing what to expect can enhance an individual's ability to cope with stressful situations. But the training also includes educating leaders at all levels to detect signs of undue stress and pressure in their subordinates and means of providing support and referring to professional mental health workers who are part of our health services component in-theatre.

Once referred, patients are carefully screened to determine if treatment is required and, if so, whether that level of treatment would restrict them from continuing the mission. These assessments are only made by competent clinical professionals, while keeping the chain of command apprised of any consequent employment limitations and patient requirements. You will hear more from Colonel Bernier about the health services infrastructure in-theatre as it relates to mental health.

I would simply add to this that the first layer of both response and protection is the team that surrounds each soldier, whether it's a vehicle crew or an infantry section, together with the leaders at each level, all of whom see themselves as having a central role to play in looking after each other.

● (1545)

[*Translation*]

Under my direction, an interim post-deployment decompression activity is an integral part of the return process for all deployed personnel. The purpose of this program is best thought of as an inoculation against reintegration stress by providing an interim venue between the dangerous, fast-paced, rigid structure of the combat theatre, and the domestic home environment. Designed to provide a positive environment away from the pressures of the operational treater, troops are able to socialize, relax, reflect on their experiences and receive educational briefings on stress-related injuries. This process has been well received by our personnel, though the true measure of its effectiveness will only be apparent over time.

[*English*]

With respect to health issues in general, and mental health issues in particular, information is maintained by our CF health care professionals, and it is analyzed and discussed with the operational chain of command as appropriate.

In my experience of a bit more than two years of commanding operations in Afghanistan, I can say that operational stress injuries have not been identified by any of the three theatre commanders—General Fraser and then General Grant and then General Laroche—at any time as having either a detrimental effect on operations or in posing them with a challenge that was beyond their capacity to handle. The most obvious indicator of mental health issues adversely affecting operations would be the number of personnel who need to be repatriated from theatre for operational stress-related injuries. So far these numbers have been extremely low. It is indicative of the success of our mental health provider footprint and pre-deployment training.

From a very practical point of view, the health and well-being of our people is essential to mission accomplishment. Naturally, confidence in our ability to provide necessary health care is an important contributor to strong morale among deployed forces.

Finally, there's a much more general principle in the ethos of military leadership that exercising diligent care for those under one's command is a moral and ethical necessity and commitment, especially in light of the acceptance of ultimate risk that those individuals have taken.

As commander responsible for the mission in Afghanistan and other deployed forces, I'm confident that our personnel who are deployed in harm's way are receiving an excellent standard of attention and care. Given the challenges they face in Afghanistan in particular, they deserve nothing less.

I'd be happy to take any of your questions, though I caution that I'll defer to Colonel Bernier on matters of a specific medical nature. Of course, I'll hold off on answering your questions until Colonel Bernier has spoken.

● (1550)

The Chair: Thank you very much, General.

Colonel, go ahead.

Colonel Jean-Robert Bernier (Director, Health Services Operations, Department of National Defence): Good afternoon, Mr. Chairman, ladies and gentlemen. Thank you for the opportunity to appear before you today with General Gauthier.

I'm the director of health services operations in the Canadian Forces health services group. In addition to providing medical advice to the strategic joint staff, my directorate works through the Canadian operational support command to support the operational commands in planning, preparing, and executing all aspects of health service support to military operations.

[*Translation*]

Among others, my key responsibilities include: assessing the health threats specific to an operation; determining and organizing the appropriate health measures and capabilities necessary for the health protection of deployed forces and for the treatment and evacuation of casualties from point of wounding all the way back to Canada; organizing the appropriate professional and technical training of deploying health services personnel and units; coordinating with the health services of host nations and allies to maximize the efficient employment of coalition resources; ensuring that deployed health services elements are provided with whatever professional support and health services resources they need during the mission, and evaluating and coordinating modifications to the training, capabilities and capacity of deployed health services according to the most current health needs of the force.

[*English*]

As you know, the nature of many military operations makes the development of some mental health conditions unavoidable, even with the best preventive and treatment efforts. I would, however, like to summarize the preventive and treatment efforts that are relevant to mental health in operations.

Regarding prevention and early identification, health screening occurs at enrollment, during periodic health assessments throughout a member's career, and at pre-deployment to identify those whose past or current health status might place them at increased risk of having inadequate operational capability or of suffering a serious health problem during operations.

Realistic training at enrollment with units and before deployment helps our members develop confidence in their skills, weapons, equipment, colleagues, and leaders. This is important because strong unit cohesion, social support, realistic training, and good leadership have been associated with lower rates of combat stress and are thus amongst the best preventive medicine efforts.

Stress awareness is briefed during pre-deployment training and is being integrated into officer and non-commissioned officer courses. In combination with the various chief of military personnel programs to promote good mental health, these efforts form a strong foundation for a deployable force that's as mentally fit as possible.

[*Translation*]

Determination of the mental health and other treatment capabilities to be deployed for particular missions is based on consultation between my staff, the operational commands, and senior health specialists. They take into account the threat, the nature of the mission, previous experience, medical evacuation timelines, host nation and allied health services resources, and many other factors.

Mental health staff currently in southern Afghanistan include several primary care physician assistants and physicians, two social workers, one mental health nurse and one psychiatrist. Canadian troops are also supported by a cadre of chaplains for pastoral counseling and by some US and UK mental health staff. Visits to forward operating bases by mental health specialists are conducted routinely to provide education and early intervention.

Wait times for care are negligible and emergency cases are seen immediately. Surge support in the event of mass casualties is available from other NATO health service facilities in Afghanistan, and higher level care is available at the US military's Landstuhl Regional Medical Centre in Germany.

The adequacy of the deployed Canadian capability is continually reassessed. This is based on a weekly review of patient visit statistics, regular reports and recommendations of the task force surgeon, periodic staff assistance visits from Canada, detailed biennial after-action reports, expected future operations, regular consultation with allies and many other factors.

● (1555)

[*English*]

Early identification and treatment of problems is pursued with the aim of returning members to duty, but repatriation is necessary if it's in the best interests of the member's health or if the duration and type of any employment limitations or treatment would adversely impact his or her operational capability.

As for all health conditions, these determinations are not based on blanket policies but on a professional assessment of each individual's condition and health needs. It is, for example, possible for a soldier with a well-managed condition in the maintenance phase to carry on doing all duties if doing so is in the patient's best health interests and if there are no significant risks related to the condition or prescribed medications. Among the clinical considerations is that studies have demonstrated that mental health casualties taken away from their units do not do as well and are at higher risk of developing chronic conditions such as PTSD.

As the Surgeon General previously noted, patients with acute mental health conditions would not be employed in combat duties. Normal psychiatric and occupational medical practice and Canadian Forces policy would preclude their return to such duty without a deliberate determination by competent medical staff that it was medically and operationally safe to do so.

Transient spikes in visits to medical staff may occur after high-tempo operations and traumatic incidents, but the vast majority of patients quickly recover and return to duty. The number of operational stress injuries manifesting during operations has so far not had a significant operational impact.

[*Translation*]

At the end of their deployment, members must complete a declaration of injury or illness listing potentially harmful exposures or health conditions they sustained. They undergo an initial post-deployment health screening and those with potential mental health problems are identified to their home base medical staff for follow-up. An enhanced screening is conducted three to six months later that focuses specifically on mental health concerns.

A Third Location Decompression Program also occurs over a few days in Cyprus before returning to Canada. This is an effort to ease the reintegration process by providing members an opportunity to rest and readapt to western comforts, to achieve a sense of closure by having relaxed time in a safe environment with their comrades, to provide access to mental health professionals for counseling if needed, and to provide education about operational stress injuries, common reintegration problems and how to get help.

Though not a medical intervention shown to impact the burden of operational stress injuries, there is some evidence that its educational component is contributing to the earlier presentation for care of members with mental health concerns.

Following the enhanced health screening in Canada, all members continue to have access to the pastoral, health promotion and treatment programs mentioned by previous witnesses. Individual health also continues to be monitored through periodic health assessments that include mental health screening elements.

[*English*]

In summary, the mission in Afghanistan may potentially have a significant long-term mental health impact, but the Canadian Forces strives to improve, and has improved, a robust program to deploy forces that are mentally ready, to support them well in-theatre with mental health resources, and to maximize the early identification and treatment of conditions that manifest after deployment.

Though not predictive of the ultimate toll on our members' mental health, the caseload in-theatre today has not been unexpected, is well within our deployed medical management capabilities, and has not had a significant operational impact.

Thank you for your patient attention. I would be pleased to answer your questions.

The Chair: Thank you very much.

Our opening round will be seven minutes. Before we get into that, I'd like to welcome Mr. Wilfert to the committee and congratulate him on his new duties with the official opposition.

It looks like you get first run, sir, at the seven minutes.

Hon. Bryon Wilfert (Richmond Hill, Lib.): The vice-chairman isn't here, so I guess I do. Thank you, Mr. Chairman.

I'd like to welcome our witnesses. It's good to see you again, General.

I have two questions. First, I certainly congratulate you on what you're doing in the field. When I was in Afghanistan a couple of years ago, I heard nothing but very positive comments from the rank and file there about the medical facilities provided.

If someone comes home, if they leave the military—some leave earlier than others—then with regard to provincial health care plans or health care facilities for both them and the family, what kind of coordination, if any, is done in that regard in terms of support?

Second, in terms of the issue of potentially the long term that you'll be evaluating with regard to Afghanistan, what types of assessments do you put in now in order to prepare for that? As we know, in the past this used to be called shell shock or battle fatigue. We didn't understand it as well then as we do now. How do you do an assessment to look at whether there's the potential to prepare for that? What kinds of resources do you need, or would you need, in order to do that in case that impacts in the longer term—in three to five years, say?

That's through you, Mr. Chairman, to the general or the colonel.

● (1600)

The Chair: Colonel.

Col Jean-Robert Bernier: Those are areas that are outside my lane, but I can answer generally. Far greater detail on them can be provided to you. Because it's such an important area, we have a specific deployment health section whose only purpose for existence is to do a long-term follow-up and evaluation study of all of the most current literature and to conduct original studies following up our troops.

With respect to your first question about what happens when troops retire from the armed forces, there's an extensive collaboration between DND and Veterans Affairs, and specifically between the medical elements of both those departments. There are progressive efforts that are improving continually, which the chief of military personnel, I believe, mentioned in his initial testimony to this committee, relating to that. But there's good coordination.

I don't know all of the details, but there's a common centre, for example, for the care of injured soldiers to enhance that kind of coordination. There are various efforts to ensure there's a smooth transition of all the clinical care records to Veterans Affairs. There's the involvement of the military medical staff in ensuring that Veterans Affairs and the soldier get information required for medical records to support whatever applications they have to Veterans Affairs to access additional services. There are efforts in our periodic health assessments to ensure that all of this is recorded as well for the long term, both for individual clinical mental health and for other physical disabilities, as well as for occupational exposures or environmental industrial exposures that may in the future result in some kind of harm.

All of that is either centrally recorded and/or in individual medical records. Those records are accessible to any CF member for provision to Veterans Affairs.

With respect to your second question, long-term evaluation post-Afghanistan is conducted primarily by this deployment health section that I've mentioned. Some of the records and some of the statistical data collection will end up having to be conducted by a different directorate, called the directorate of health services delivery. There's an effort that's progressively improving, that will be improving substantially once we have an automated information management tool in place, called the Canadian Forces health information system, that can permit the automated collection and aggregation of the data for analysis.

In the meantime, we have enhanced post-deployment health assessments that I mentioned earlier, which occur at three to six months post-deployment. Because we know that some operational stress injuries will manifest after that six-month point, we also have a periodic health assessment based on the Canadian task force on preventive health, those guidelines. Because those guidelines for younger populations were only once every five years, we determined that wasn't enough, particularly for mental health surveillance. So we will be compressing that down to doing it once every two years. That periodic health assessment includes mental-health-specific questions, validated questions, to help identify earlier mental health problems. So every two years, unrelated to the deployment, we'll also be able to carry on evaluating and to pick up earlier cases that might have been missed because they didn't manifest themselves before the six-month point.

Finally, there's a health and lifestyle information survey that we conduct once every four years. Again, it's conducted by another directorate, so I won't go into too much detail about it. I'll try to stick within my lane. There's a directorate of force health protection that looks after most of the preventive health programs, except for mental health, which is so important that it has a separate organization.

The health and lifestyle information survey, conducted once every four years, specifically asks questions from members, and the accuracy of that data is fairly well validated by other sources. The last one was conducted in 2004 and the next one will be in 2008. That will give us significant additional data. It will help us validate. It'll give us a better picture in a number of areas, including mental health. It's mailed out to thousands, or even tens of thousands, of Canadian Forces members, and there's a reserve component as well, so it involves a substantial number of reservists.

● (1605)

In addition to that, periodically, depending on the issue, there are ad hoc additional studies that are conducted. For example, there was a very extensive Gulf War series of studies conducted for the Gulf War veterans. So we have a whole series of efforts to try to follow up epidemiologically and to do health surveillance on individuals after they return from Afghanistan or any deployment.

Hon. Bryon Wilfert: Thank you for that.

The Chair: You have about one minute and 25 seconds. Do you want to save it for the next round?

Hon. Bryon Wilfert: I'll transfer it to my colleague, please. Thank you very much.

The Chair: We'll get around to you folks again.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Mr. Chair, I would like to welcome the general and the colonel.

Could you describe the process of an incident in an operational theatre, for example in a forward base, starting from the moment a soldier falls victim to an attack? How do things unfold? First, who determines the severity of the wound? You said that everyone has basic training. When the wound is more serious, who on the ground decides that the person who has stepped on a mine, or been attacked or shot needs additional care? Who in the group is responsible for deciding how serious the wound is and if it can be treated on the spot? How do you proceed under those circumstances? Where do you take the wounded soldier first? Do you take him to Kandahar and, from there, if he needs more care, do you transport him to Germany?

LGen Michel Gauthier: The process is very clear, but we must be careful, for security reasons, not to reveal all the details of how we care for our soldiers on the ground in an emergency. Colonel Bernier will handle that challenge.

Mr. Claude Bachand: Are you telling me that things like that are classified?

LGen Michel Gauthier: They are classified in the sense that if I paint you a detailed picture of how we react to enemy action, it could provide an advantage to those who oppose our efforts in Afghanistan. To a certain extent, that is a serious concern. However, I think we can give you a good idea of the way it works.

Col Jean-Robert Bernier: The assessment of the severity of the wound and the steps to be taken, knowing whether the person can be treated on site or whether he should be transferred to a higher level of care, those decisions are always made by the medical personnel.

Mr. Claude Bachand: Are there medical personnel at each forward base?

Col Jean-Robert Bernier: Yes, and not just there. There are medical personnel in most patrols up to a certain level of deployment. Even our medical technicians are trained to identify mental health problems to a certain extent.

LGen Michel Gauthier: Each separate element has a basic medical capability and personnel.

Mr. Claude Bachand: To determine the severity of wounds.

One thing troubles me, and I read an article about it. I hope that you will be in a position to answer my question. We know that the Taliban are listening to us, more or less live. We are often told so, and I am inclined to believe it. A forward base can be located 200 or 300 kilometres from Kandahar. I have been told that, if the designated person decides to evacuate a casualty, travel by road may be out of the question because of the severity of the situation. A helicopter evacuation is needed and these are done by the American army. So there is not much we can do if American authorities tell us that they are sorry but they do not have a helicopter available.

Do I understand that we give our soldier first aid until an American helicopter is available?

● (1610)

LGen Michel Gauthier: To my knowledge, the only limitation involving helicopters was a direct result of weather conditions that prevented the helicopter from flying. That is the only example I am aware of. Perhaps Colonel Bernier can give other examples or a more direct answer.

Col Jean-Robert Bernier: When operations are planned, we always make sure that we have a way to evacuate patients. This is always factored in by the chain of command.

At the moment, the Americans provide the service, but everything is directed by the medical team at NATO regional headquarters. They determine where evacuation resources will go, according to the need. So, if other troops—the Dutch, the British or the Americans—needed them, that is, if their cases were more serious, they would have priority. Likewise, when the troops come back, the wounded are taken either to a Canadian hospital, or another country's hospital, whichever is most appropriate. In no way is this giving the control over to the Americans. They are very generous and they provide us with exceptional service. Things are not as they are because we cannot provide the service ourselves but because they offered it to us when the operation was being planned.

If needed, we have the capability to provide the personnel required. In that case, the responsibility would lie with the operational commander of the Canadian Expeditionary Force.

Mr. Claude Bachand: Is there a threat assessment? If we are considering sending a patrol to a place that we know is very dangerous, do we make sure that, before we send them into that theatre, that helicopters are available in case something happens?

LGen Michel Gauthier: Absolutely. Medical evacuation capability is part of the checklist as the operation is being planned. There is a series of other important capabilities in support of an operation. As for threat assessment and management, the commander of the tactical group would decide to proceed with or without those resources, according to the threat level. I assure you that this is always part of the planning process.

[*English*]

The Chair: Thank you.

Ms. Black.

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

I also welcome you both to our committee. It's nice to see you again.

A report was released today by the DND/CF ombudsman—ombudsperson, I suppose—into the medical treatment for reservists. I'm sure you've had a chance to go through it. It was really very scathing I think in its observations and some of its conclusions as well. In reading the report, it was pretty clear that there's not a significant level of tracking going on with the care with respect to reservists.

I want to ask you why there would be this gap in services between what a reserve soldier would receive and what a regular forces soldier would receive. I don't understand why it would be this way. Part of the report said, for instance, that for the loss of a limb, a reservist may get 40% entitlement compared to what a regular soldier might get.

I'm sure you've read the report. There were some very troubling kinds of conclusions and statements made with the report.

I just want to ask you why there would be this different level of medical services to reservists. Clearly, it's gone on a long time. What's the basis for it? How did it come to be this way? And what's going to be done to correct it?

● (1615)

LGen Michel Gauthier: Both of us are squarely focused on operations outside the country and health care support to operations outside the country. The issue you've just referred to actually has to do with treatment and entitlements back in Canada as opposed to in our theatres of operation, so it's not really something I have the expertise to comment on at all, unfortunately.

I assume Colonel Bernier will have the same comment.

Col Jean-Robert Bernier: I would have to defer to others. It's a Veterans Affairs issue, in some ways, as far as entitlement—

Ms. Dawn Black: No, it's not Veterans Affairs.

Col Jean-Robert Bernier: Is entitlement for a pension what you were referring to?

Ms. Dawn Black: No, it wasn't. It was medical care and tracking of the medical health of reservists when they return.

Col Jean-Robert Bernier: You mentioned 40% for loss of limb pension.

Ms. Dawn Black: Less benefit, yes.

Col Jean-Robert Bernier: Those kinds of things, such as benefits, some elements within DND, are under the purview of elements of the chief of military personnel outside the health services completely, and other elements are not operations.

I can say, however, that all reservists—because we know it's harder for us to follow up on them after deployment—specifically get an interview with a medical officer before returning out of the theatre at the end of the deployment. They also, policy-wise, are required to undergo the same six-month post-deployment enhanced screening. Their entitlements for care are the same as for regular force members for injuries they suffered as a result of military service.

One of the problems you'll note in the ombudsman's report is that there's been inconsistency of application and incomplete application—that kind of thing. There are many reasons why it's been that way historically, but one of them is that there's a point when a reservist reverts back to part-time service, as a class A reservist, when the mandate for his health care is the provincial government's, so there's an element of stepping into another jurisdiction's mandate and prerogative.

I can assure you that the armed forces will be taking it very seriously. I know this has been an issue that's been discussed internally for some time over the years.

Ms. Dawn Black: Clearly, when more and more reservists are being sent now to Afghanistan—the proportion is going up compared to other missions—it's something that absolutely must.... I think Canadians will be horrified when they read this report. I was.

I mean, really, a soldier is a soldier. I'm not part of the military, so I don't understand why there'd be a difference in the culture. I take what you said, that you're responsible for treatment while they're on the mission, but I would certainly urge anybody who has any influence to fix this. It seems totally unfair.

LGen Michel Gauthier: I have absolutely no doubt that CDS, the chief of military personnel, and the Surgeon General will all receive the ombudsman's report with great interest. For our purposes—being focused overseas—what we can say is there's absolutely no difference between how a reservist and a regular force soldier is supported, cared for, and looked after. They're all soldiers deployed.

Ms. Dawn Black: While they're on mission, yes.

The other question I have follows up on Mr. Bachand's question. He asked about injuries at forward operating bases. I want to ask you specifically about operational stress injuries and post-traumatic stress disorder at forward operating bases. How is that dealt with? Have you had to return soldiers from a forward operating base because of operational stress injuries? How would that process work without contravening any of the information you don't want to contravene?

● (1620)

Col Jean-Robert Bernier: Physician assistants at forward operating bases, or other medical people—including medical officers or medical technicians—have training and can identify individuals who are having problems. Individuals can also approach a chaplain, if there is one, or their chain of command. There are peer counsellors who are trained, non-medical people who have specific training in helping to identify and support individuals who are suffering normal stress reactions after a traumatic incident.

At any point, should one of those individuals need to be, or want to be, seen at a higher level—or it's determined by any of the health care providers that they should be—then they can be referred for further assessment by a medical officer or by the mental health people. Either while they're at the forward operating base or once their subunit rotates out of it and they're back in Kandahar, they can be assessed at any time. They can access things directly. They don't have to be referred by a medical officer; they can go directly to the social worker or directly to any of the mental health professionals.

Ms. Dawn Black: Has anybody had to leave a forward operating base because of an OSI?

Col Jean-Robert Bernier: I don't know the answer to that question. People have had to be extracted in the middle of a...but that's something—

LGen Michel Gauthier: This is not something that would naturally get reported up the chain back to Ottawa on a regular basis nor even be kept track of. I can tell you I am aware of situations where that has occurred.

The Chair: Thanks.

Ms. Dawn Black: Is that it?

The Chair: Yes, that's it. When you ask good questions and get good answers, time flies.

Mr. Hawn, and then we'll go back over to the official opposition.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Chair, and thank you both for being here.

Just as a bit of a point of clarification and information on Ms. Black's first question, the department has already actioned some of the recommendations from the ombudsman's report, and there is a proposal before Treasury Board to standardize the compensation, regular and reserve. Where that is in terms of the timeframe, I don't know, but they have taken some action in that area. It is ongoing.

General, I want to ask you a question. This relates back to Mr. Bachand's question.

Can you describe our level of cooperation, mutual support, and attitude between allies in moments of duress—i.e., an attack, injuries, and so on—and tell us whether they think of themselves as Americans, Canadians, Brits, Dutch, or just us? Can you comment on that?

LGen Michel Gauthier: The thought brings a smile to my face because I've seen some of this during visits overseas, especially when it comes to lives being at stake. The attitude, the working environment, the spirit inside the Role 3 facility, for instance, where there aren't just Canadians but other nations that are involved, in the teams that come together, whether they are American helicopters, British helicopters, Dutch helicopters, or whatever it might be, is that they are over there to support mission accomplishment and they are over there collectively to support soldiers. There is absolutely nothing more important than providing that support to individual soldiers.

There is no bureaucracy. There are no walls or international barriers that would say we are not going to provide that support because this is ours and we don't want to share it—absolutely not—especially in cases where life and limb are at stake.

Mr. Laurie Hawn: You two are more on the staff side, obviously, at the moment. I know operators hate to hear that. With a lot of things going on, with actions that are on the field, how have you found the flow of information from commanders in the field up through commander of CEFCOM as the force employer? Up to the force generators out there and getting back down to the field, is the flow of information effective and timely, and are there things you are looking at to make improvements there?

LGen Michel Gauthier: I'll speak from an operational perspective and a command perspective, and then Colonel Bernier can give a sense of his own perspective.

The fact is, as the commander, I have a staff that sifts through all the information that flows. Clearly lots of information flows up and down the chain. They bring me the important nuggets, which either they know I will naturally be interested in or they need my help with to steer things in a certain way.

In this area, I would say I get as much of my information by doing commander things as I do because information flows up; in other words, by going in to visit Afghanistan and talking to soldiers, talking to platoon commanders, company commanders, and battalion commanders, hearing their stories, and going into the Role 3 and the Role 1 and talking to them and getting their sense of how things are going.

In this particular area, the area of operational stress and mental health, we all understand that it's not black and white. It's very grey in terms of the dividing line between what is an injury and what is just normal wear and tear. There are a lot of stresses and strains in-theatre. The troops come together—and General Laroche and I had this conversation in the not-too-distant past—and there is a natural reaction in response to difficult things that happen over there. Elements of that are fear, stress, and various other things. How do they overcome that? At the first level, the immediate level, the team they're part of comes together—and we all understand this well in the military—and they draw strength from that. They, together, find a way to step up and face the next challenge.

There have been very few instances reported to me up the chain in which there's been a red flag—none, in fact, I would say—for a significant issue associated with operational stress that would demand my attention. At the same time, I understand that in that very tough environment, operational stress is high. There are a number of different ways that it needs to be dealt with. Some of them are medical, professional, and technical. Some of them are just soldiers getting together and responding in the right way. Some of them are associated with leadership, and so on.

So there's a rambling answer to your question. I will say that I think I have a good sense of the demands in-theatre, the challenges, and whether or not there are problems on a range of issues, of course. There's a system in place that can let me know if there's a red flag that should be raised and if I need to deal with a specific issue, and we do that regularly.

● (1625)

The Chair: You have less than a minute left.

Mr. Laurie Hawn: All right.

Col Jean-Robert Bernier: I'll just quickly mention that we have weekly reports of certain types of clinical visits, and that ives us a good idea of what kinds of trends are taking place and where the demands are.

There are multiple daily contacts by the staff to the staff in the Role 3 and the health service support unit, and multiple daily contacts between the unit and General Gauthier's medical advisor, the CEFCOM surgeon. There are visits by staff. The most important thing is, once a week for one to two hours, I'll speak directly by telephone to the CO of the health service support unit, and that gives me a lot.

There's a big pile of other things we do—regular after-action reports—so we have a very good feel of what's going on day to day.

Mr. Laurie Hawn: The focus is on Afghanistan, but there are a lot of other missions, as you said, out there. Are there any other areas of concern coming up from those other missions? We tend to forget them because Afghanistan takes all the attention. Are there any unique sorts of concerns that are coming from any of those other missions?

The Chair: If you don't mind, we'll have to get back to that. Time has expired.

That ends the opening seven-minute round. We'll go to five minutes, starting with the official opposition, the government, and then the Bloc.

Mr. Murphy, or whoever, you have five minutes.

Mr. Alan Tonks (York South—Weston, Lib.): I have a very quick question. It's pursuant to the reports you receive and any flags that come up. With respect to post-traumatic stress disorder, you've gone over very carefully the psychiatric and occupational medical practice routine in your overview. Have any flags gone up with respect to the inordinately high use of drugs in the psychiatric treatment of stress disorder?

Col Jean-Robert Bernier: I'm not aware of anything related to an inordinately high rate of drug use.

You're speaking of in-theatre use?

● (1630)

Mr. Alan Tonks: Yes, in the treatment regimen.

I underscore this question, Mr. Chairman, just from a very peripheral knowledge of how post-traumatic disorders are treated, that there have been issues raised in civilian life today with respect to everything from the treatment of Down's Syndrome—and wrong treatments, in some cases—to nursing homes. There's this capacity, it seems, to rely too heavily on drugs. I was interested if this had a relationship to treatment at home, and the implications of it, because I can just imagine the pressures our forces are under. I just wondered if the military was flagging this issue, because this does have some inherent other issues associated with it.

Col Jean-Robert Bernier: We have not detected any problem with excessive prescription of drugs. All of our practices are evidence-based; whatever use of drugs occurs is based on good evidence.

In particular, in our circumstance, there's a very selective use of drugs because of the potential side effects and the potential for occupational impact. So we have an even greater incentive than most to ensure that we minimize the use of drugs in the treatment of our casualties.

Everything we do, everything our mental staff does, is based on best practices, supported by evidence.

The Chair: Mr. Murphy, for five minutes.

Hon. Shawn Murphy (Charlottetown, Lib.): I have one question involving the whole issue of the increased use of reservists.

Bear in mind that I'm not a regular member of the committee, but I do have a significant number of military families in my community. In all my experience, I've never heard any complaints or concerns about the medical treatment in-theatre. Your testimony today I think supports that, and you are to be congratulated. Of course, we as Canadians would not expect anything less, and we are proud of it.

But the situation I see on the ground is that the men and women who are coming back—and probably significantly more among the reserves than the regular forces—are not adjusting well on their return to society. They don't make a self-diagnosis when they come back; it usually comes from their partner or, more likely, from their parents that the person is not adjusting well. Sometimes a job is lost or there are alcohol issues, or just adjustment issues.

In a lot of cases they're disappointed with the follow-up treatment from the Department of National Defence. I know this is not within your bailiwick, but going forward, because we're obviously going to be in-theatre for another couple of years anyway—three years—do we run the risk of having more reservists with this problem and much more severely than now?

I'm making a comparison between a reservist who perhaps was an accounting clerk and goes into theatre for six months and comes back, but doesn't adjust, as opposed to a career force member who perhaps doesn't experience the same level of readjustment coming back to Canada—and I don't know this; that's why I'm looking for your advice.

That's what the situation is on the ground, speaking as a member of Parliament, but in-theatre, I've never heard anything but compliments.

The Chair: I'm sorry, you only have a minute or so to respond. I apologize.

LGen Michel Gauthier: I can't comment; it's certainly outside my focus.

Col Jean-Robert Bernier: I would just mention that we have recognized for a long time that there's a difference in social support, because they are taken away from the unit and the troops they are deployed with, so there are fewer supports in their home units when they get back to their home towns. So they don't get as much benefit from peer support as regular force members would, and there is the issue of the distance of access.

But there are outreach efforts that we're making, and we're progressively increasing them. I'm not sure if CMP has mentioned any of them, but I know some of them have been publicly mentioned, including the possibility of establishing enhanced outreach through link nurses with reserve field ambulances or medical companies to increase their ability to stay on top of these individuals and their problems, and to enhance and remove barriers to their access to Canadian Forces treatment should they need it.

● (1635)

The Chair: Ms. Gallant, and then back over to Mr. Bouchard.

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

Through you to our witnesses, what are the top three injuries suffered by soldiers deployed to Afghanistan? I mean serious injuries, not blisters or twisted ankles.

Col Jean-Robert Bernier: It depends on the phase of the operation and what rotation has occurred. It has been different with each one.

Mrs. Cheryl Gallant: Okay, IED casualties.

Col Jean-Robert Bernier: Currently, for example, because of IEDs, the greatest burden has been lower leg, pelvic, and head injuries.

Mrs. Cheryl Gallant: Thank you.

What I would like to see is a graph, a bar graph, with the most common injuries along the X axis—dismemberment, above the leg, below the knee, arms, hands, and so on—and then on the Y axis, the number of incidents, just so that we have an idea of the types of injuries.

You mentioned the pelvic area and the leg area for IED injuries. I understand that some of the forces have a special groin protector. In other militaries, that's part of their normal kit. Is there a program or a project under way to procure these groin protectors for our army personnel in theatre?

LGen Michel Gauthier: The short answer is yes. You could get more details of that from the army. The commander of the army could speak to that. Or we can get you that information.

Mrs. Cheryl Gallant: Are they being issued now?

LGen Michel Gauthier: The last time I was in-theatre, I was told they were just being introduced.

Mrs. Cheryl Gallant: Introduced in the trial stage?

LGen Michel Gauthier: Into theatre.

Mrs. Cheryl Gallant: So they are available.

LGen Michel Gauthier: That's what I was told, but we will get you more specific information.

Col Jean-Robert Bernier: There are other efforts under way that are much more expansive than that. They're all classified efforts because of the operational security, but there are many things that are probably going to be even more protective than that.

Mrs. Cheryl Gallant: So the everyday soldier going into a LAV or doing patrols on foot does have access to this type of equipment, or will have access in a short length of time.

LGen Michel Gauthier: They will. How soon I couldn't say. The more general answer to the question I think is that we follow this quite precisely in-theatre and back in Canada, from a medical perspective, from an equipping perspective, from any number of different perspectives.

We've been making adjustments to both the vehicle set that we have, in terms of how they are protected, and to personal protective gear, based on the results of this analysis we do. And that evolves over time. It's very dynamic. So we could take this one example of the groin protector, but it actually applies much more broadly than that.

Mrs. Cheryl Gallant: Thank you.

For any soldiers who want the throat protector part that goes onto the front of their collar, any deployed Canadian personnel who want that protection, do they have it accessible in-theatre?

LGen Michel Gauthier: I can't answer that question. I don't have that detail. I can take that on notice.

Mrs. Cheryl Gallant: Would you be able to follow up with us?

Lastly, would you describe, step by step, the process a soldier goes through in order to, first of all, try to remain in the military if there's an amputation involved? Let's say it's a leg amputation. And then, if there is no way to accommodate the soldier, what are the steps this soldier must take in order to obtain all the compensation that he or she is entitled to receive through the military, through DND, SISIP, and Veterans Affairs? Please walk me through it.

● (1640)

LGen Michel Gauthier: Unfortunately, I have to respond in the same way that I have to a couple of other questions. I'm just the wrong person to ask that question to. They're very good questions, and I don't have the answers to those. It would be the chief of military personnel who would have the responsibility to provide you with those answers.

Mrs. Cheryl Gallant: Thank you.

I'll share the rest of my time with my colleague.

The Chair: No, you've used it all up, I'm afraid. You'll have to straighten it out with your colleague.

Mr. Bouchard, you have five minutes.

[*Translation*]

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

Thank you also, Lieutenant-General Gauthier and Colonel Bernier, for being here with us.

My question is a general one, so it goes to the general, of course.

We are aware that we have a large number of military personnel on missions overseas. The most significant mission is in Afghanistan. Soldiers are deployed there by a rotation system. Some leave and others are recruited. We know that recruiting is not easy and has some constraints. The fact that soldiers are deployed repeatedly or more frequently in the rotation could have health implications.

Is the number of military personnel serving in foreign missions sufficient, most specifically in Afghanistan?

LGen Michel Gauthier: Once again, I am not necessarily an expert on the implications of recruitment and attrition in the Canadian Forces, or even in the army. The Chief of Military Personnel or the Army Commander would be in a better position to answer those questions. To date, at my level, the army has not indicated any problem with the ability of the Canadian Forces to supply troops to accomplish its mission. Nor do we foresee any up to 2011.

Mr. Robert Bouchard: Thank you.

You told us about your health care personnel deployed in the mission in Afghanistan, in Kandahar. You also said that wait times were not long. Can you give me specific examples of what that might mean for a soldier needing a health care service. Are we talking days or weeks?

Col Jean-Robert Bernier: Normally, we are talking hours, or a few days at most. For acute problems, service is immediate, 24 hours a day, seven days a week.

Mr. Robert Bouchard: For DND, how important is the rehabilitation of soldiers who have been treated for psychological wounds that are classified as severe or moderately severe and who want to get back to the operation?

LGen Michel Gauthier: I would say that it is of utmost importance.

I will let Colonel Bernier talk more specifically about our health system.

Col Jean-Robert Bernier: All available resources are provided to maximize rehabilitation. It can take years, but we keep those people in the army. At a certain point, if we are sure that no further improvement is possible, we conduct an assessment to see if the person can continue to serve as a soldier. The decision on whether the Canadian Forces can continue to employ him is made at that point.

● (1645)

Mr. Robert Bouchard: So there are several stages, and the assessment is simply one of them.

Col Jean-Robert Bernier: We are continually re-evaluating, and, as long as it is possible, with rehabilitation treatment, for the person to resume military service in a way that the Canadian Forces deem acceptable, that person remains in the army.

LGen Michel Gauthier: For us, that is a basic principle. Absolutely nothing should be more important than taking care of those who have been wounded in the service of their country overseas. Be assured that this is how we see things.

[*English*]

The Chair: Very good. Thank you.

We'll go to Mr. Tonks and then back to Mr. Lunney.

Mr. Alan Tonks: Thank you.

Colonel Bernier, I don't sit on this committee and haven't heard previous witnesses, so I'm coming from an information vacuum, to say the least.

Some personnel come back from active operations and are decommissioned, which in my mind means they leave the forces. Do they have the same ongoing monitoring for traumatic and post-traumatic stress disorder, and ongoing mental health treatment? Do they have the same opportunities as troops who have simply come back and may be redeployed? In other words, do they continue in the forces?

Col Jean-Robert Bernier: For those who are released from the armed forces, the responsibility for their military service-related care becomes the responsibility of Veterans Affairs Canada. We no longer have a legal mandate to carry on with providing them health care. We do everything we can to smoothly transition their care to Veterans Affairs and ensure they get all the benefits necessary. I don't know all the details of that. It's outside my area. We don't carry on monitoring them, except in some cases where we do ad hoc studies and try to find the records for those people after they've left.

We did one particular study, for example, a mortality study of Gulf War veterans. We had tremendous effort and collaboration with Statistics Canada to follow up on veterans who had long left the armed forces to try to get as many records as possible, as much information as possible, to assess what the long-term impact was. There are various collaborations with Veterans Affairs, but generally, once they leave the armed forces we no longer have a legal or other mandate to carry on with providing their care.

Veterans Affairs has its own series and whole template of services that are offered. In some cases, they are more expansive. I don't know all the details of them, but they're very generous as far as the treatment that's available to soldiers who've suffered any kind of military service-related injury.

Mr. Alan Tonks: Has any statistical analysis been done on those who were diagnosed in a professional and disciplined medical regime, came home, and continued in the forces? Have any statistics been gathered as to the remediation rate of those who have overcome post-traumatic stress and are back in so-called mainstream activity to be redeployed back to active service?

Col Jean-Robert Bernier: I don't know what studies there have been, if any. I mentioned the directorate of medical policy, which has a deployment health section that does that kind of research. As far as I know, no....

One thing I can say is that some studies have been done on symptomatology three to six months after deployment, starting six years after the Gulf War—deployment in Kabul in the early days of the mission and most recently deployment in Afghanistan. They looked at the percentages of troops who've returned and undergone this post-deployment enhanced screening. But remember, this is just screening, not diagnosis, and so far what we're finding is not alarming. In some cases, it's reassuring, in that it suggests that people are presenting much earlier. In other words, we're starting to beat the stigma, obstacles, and various disincentives to present for care early. That's a good thing, because the earlier they present for care, the less likely they'll carry on and develop a chronic condition.

● (1650)

Mr. Alan Tonks: Right. Thank you.

Thank you, Mr. Chairman.

The Chair: Mr. Lunney, five minutes.

Mr. James Lunney (Nanaimo—Alberni, CPC): That's a good segue into where I wanted to pick up, and that's on the comments made by General Gauthier about post-deployment decompression activity as an integral part of the return process.

I'll quote from your remarks:

> The purpose of this program is best thought of as an inoculation against reintegration stress by providing an interim venue between the dangerous, fast paced, rigid structure of the combat theatre, and the domestic home environment.

It's so designed, anyway.

I understand, General Gauthier, that was under your direction. I just want to say that we've heard testimony about the importance of this decompression time. I understand that's where peer counsellors are employed. I think that relates back to remarks by Colonel Bernier about the fact that people are coming forward earlier and their results are improving. So I just want to commend you for that initiative. It seems to be a very good one.

This leads into my question, though. Earlier you mentioned that about 85% come home fine. About 15% may experience some sort of operational stress injury, most of which people recover from fully, I understand. We have allies over there, some 26 nations in Afghanistan. Not all of them are tasked as our troops are, but with the U.S. and British troops you have more counter-insurgency tasking. Would the numbers we're describing here on these types of injuries be compatible with those of our colleagues from other nations?

Col Jean-Robert Bernier: Some of the numbers, yes, are quite compatible. Some are different because of differences in the way we deploy troops.

For example, in terms of the Americans in Iraq, recently one of their studies found that they had a significantly higher rate of symptomatology suggestive of PTSD six months after their deployment. But that was for 12-month deployments as opposed to six-month deployments.

So there are enough differences that it makes it very misleading and often invalid to compare the results.

Mr. James Lunney: Apples and oranges.

Col Jean-Robert Bernier: Yes.

Mr. James Lunney: I certainly respect that response.

I'd like to pick up on Mr. Tonks' earlier question about the drugs. I think what he's referring to is this international concern about not best practices related to military practice but just in treating depression in a global sense, with the failure and disappointing results worldwide in anti-depression.

But I'm pleased to say—I'll just throw this in quickly for Alan's benefit—that other options are being explored. EMDR, an eye movement desensitization and reprogramming initiative, is a natural or mechanical type of treatment that helps them revisit the trauma. They seem to be getting good results with that. I think at committee here we'll be hearing from at least some soldiers who've benefited from that.

With that comment, I'll just pass it over to my colleague,

[*Translation*]

who has been patiently waiting to ask a question.

Mr. Steven Blaney (Lévis—Bellechasse, CPC): You are very cruel, my dear colleague.

[*English*]

Two minutes is my intro, actually.

[*Translation*]

Thank you, my dear colleague.

Thank you, Mr. Chair. Perhaps I will leave it to your discretion.

First of all, I would like to thank you for coming to meet us. I listed to your presentations and heard you speak about the military hospital at the base in Kandahar. Like several members of the committee, I had the opportunity to travel there, and to witness the professional standard of care that is provided. More recently, a regular Forces nursing assistant from my constituency came back from there. Of course, the things he saw disturbed him greatly.

That brings us to the subject of an illness inherent to the profession, post-traumatic stress disorder. You described it to us quite well, but naturally, we want to hear more. As we listen to you, we understand the environment in which the illness develops. We know that its effects can last for decades. Things that happen over a few months or a few years can have repercussions. You mentioned long-term effects. Mr. Lunney said that 15% of soldiers can develop psychological difficulties after events like these. If 25,000 soldiers have already served in this one mission in Afghanistan, that could be 3,000 to 4,000 people.

In the field, do soldiers diagnose each other? Do they, for example, report any of their comrades who are having problems? How do those things happen? I also want to point out that that we met the chaplain when we were in Afghanistan and he told us about the challenges.

For example, is it not time for the Canadian Forces also to think about setting up long-term care facilities, given how long the aftereffects of these disorders can last?

● (1655)

[*English*]

The Chair: Just before you respond, I am going to tell you how I am going to do this, because the next five minutes is for the official opposition and then we go back to the government side. So I'm going to use that five minutes to allow you to respond to his two questions.

Go ahead, you have five minutes, and you guys are next.

[*Translation*]

LGen Michel Gauthier: I am going to give you a quick answer to your first question and I will let my colleague answer the second.

In an infantry section, an armoured vehicle, or any vehicle for that matter, each individual sees his comrades and watches their behaviour very closely, what they say and do every day. The interaction between pairs of individuals is very personal, though it depends on the individuals. If it is more serious, someone is going to put a word in the ear of the deputy section commander and ask what he thinks. At some stage, according to how serious the situation is, either the chain of command becomes involved, or health professionals are asked to look after the situation.

You should ask General Grant, General Laroche and Colonel Hetherington that question. You are going to have them here in the next few weeks. They can give you a precise idea of how things are handled on site.

Col Jean-Robert Bernier: Exactly. We get wounded members referred to us by their peers, by on-site medical personnel, by chaplains, and some come to us on their own.

Mr. Steven Blaney: Can you comment on the long-term effects?

Col Jean-Robert Bernier: Do you mean psychological trauma?

Mr. Steven Blaney: Yes, because there are going to be long-term effects. Canadian troops are going to have to have bases that are able to treat these conditions that develop and to stay with people outside the operational area for quite long periods.

Col Jean-Robert Bernier: General Semianiw has described the structures that exist to follow and support them, whether it be socially, medically, in aftercare or anything else. We even have structures to provide long-term support for families. But we do not have enough data to determine how big a problem this will be over time. As I explained a little earlier, we are encouraged by the fact that people are coming forward earlier. So there is reason to suppose, if we consider the way in which the treatment works and the natural progression of the conditions, that this will increase our chances of reducing the extent of the problem in the long term.

● (1700)

Mr. Steven Blaney: Very good.

Col Jean-Robert Bernier: Of course, as long as the mission lasts, and especially if future operations involve a lot of combat, we will continue to have casualties of this kind.

[*English*]

The Chair: Good. Thank you very much.

To finish up this second round, are there any more questions from the opposition? No.

That's probably a good spot to end then, before we deal with our report from the steering committee.

If the committee will allow me, I have a couple of questions. On the issue of lessons learned, could you quantify how long it takes to implement change in routine, change in protocol, when something like that happens, when it feeds back up the chain? Does it happen quickly? Is it a matter of days or weeks? Does it have to be studied forever or can you make a pretty quick decision?

LGen Michel Gauthier: I think it's anywhere from, quite honestly, minutes to years, depending on the nature of the issue. In response to IED events in-theatre, we will have someone on the scene very quickly—I'm talking minutes—and they will do an initial evaluation and a follow-on evaluation. Thanks to the information age we live in, we're able to propagate the results of that analysis very quickly—within theatre to subject matter experts in-theatre who will look at what can be done immediately, back to Canada, to the army, to ADM(Mat), to the Canadian Forces writ large. What materiel-like fixes need to be put in place? Can those be done quickly? Can they be done in-theatre? Can they be done? Will it take more time? Do we need to buy a new piece of kit that will take a little bit longer? It's the same thing with tactics, techniques, procedures, and so on.

So the system is very responsive in terms of getting the information out there. For some of it, depending on the nature of the question that's being examined, of course, the analysis will take a little bit longer in delivering, so a solution will take longer. But it can be very responsive.

The Chair: Very good.

I have one more. When there's a physical or a mental injury, who's responsible for making the call to say that a soldier cannot be deployed any more? Whose decision is that? Does it have to work up the chain of command that a soldier is done here and has to go home, or is that done at the platoon level?

LGen Michel Gauthier: I think there are two elements to that. If the medical professionals say he's not fit for duty, he's not fit for duty, and there's no further discussion, quite frankly. If, from a chain-of-command perspective, there's a view that he's not deployable, that decision can be made at any one of a number of levels.

The Chair: Good.

Thank you both very much. We have to do a bit more business here, but we'll let you disentangle yourselves. Keep up the good work. We appreciate everything you do. We're going to try to get to Wainwright to see some of the training given to our people before they go, to enable them to handle some of the situations you talked about. That will prove to be pretty interesting, I would think.

Thank you.

We'll just suspend for a minute.

●

(Pause)

●

● (1705)

The Chair: We'll come back together and deal with the report.

The subcommittee met on Tuesday and came up with a plan to go forward. The first issue we came up with is based on the witness list that was supplied by members. We've come up with a budget of $57,800 to carry on this study and have the witnesses come in.

The second issue is a visit to Wainwright. This is where the troops go through the last phase of preparing to be deployed. The best time Jim could squeeze out was May 9 to May 11. That would be a pretty active time to be there and see some good things happening.

Then there is a visit to Valcartier on June 2 to June 4.

Also, Mr. Cannis asked for a briefing on the North Atlantic Treaty Organization summit in Bucharest, and that is planned for April 15.

We have the rest of the meeting dates filled up with witnesses until the break, and if we get this passed here today, then we can move ahead. I can get the budget approved at Liaison next week, and then work on getting these travel documents put together.

Are there any comments?

Mrs. Cheryl Gallant: I didn't hear what you said about Bucharest.

The Chair: There's been a request for an update on what happened at the NATO summit, just from a Canadian perspective.

Mr. John Cannis (Scarborough Centre, Lib.): Mr. Chair, I'd like to inform the members of the committee that we proposed—I'm not going to say we agreed, but we proposed—that we would utilize our members' travel points to keep the costs down in terms of our travel to Wainwright, and the same would apply to Valcartier. That was just a proposal, of course. If everybody is in agreement, we'll make sure it's done.

The Chair: Yes. We thought if everybody could use one of their 64 points, it would sure help with the budgeting. I don't think we all use all of them every year. Is everybody all right with that?

Mr. James Lunney: Is money an issue on this one? I'm just asking, because of Afghanistan.

The Chair: I think if we show some initiative and that we're trying to.... I don't know if it would be an issue, but we got some money to go on our other trip, we've got this request, and now we're going to go back for another travel request.

Mr. James Lunney: Did we get the money for Afghanistan?

The Chair: Yes.

Mr. John Cannis: Are there any suggestions? On the visits to Wainwright and Valcartier, it's not just the members. I think support staff has to join us. Perhaps the clerk could do a rough calculation, because you'll probably have to go to the liaison committee and ask for that.

The Chair: If we can get this through, that's what we'll do. We'll get it all detailed as to what it should be as far as the dollars are concerned.

May 9 to 11 is not during the week; it's the weekend, but they've indicated that would be the best time for us to go. There are some other options. There is one from the 11th to the 14th. That would be during the week. It's option three, actually. The preferred option is May 9 to 11, for the action on the ground.

Mr. Blaney.

● (1710)

Mr. Steven Blaney: I would like to comment on this very last point, Mr. Chairman.

I think there's nothing like walking the field, I would say, as an engineer. When you're on the ground, you really get a grasp. You get a better result. I think these two trips will benefit the report and the depth of our recommendations.

One of my concerns is that I just looked at my schedule, and on that very weekend, the Saturday, there is a special event organized with the *6e Régiment d'artillerie de campagne*. I want to acknowledge the contribution of the reservists who took part in the last rotation on behalf of my constituents. I wonder whether there are special events on that very weekend in Wainwright. I am curious. Why is there travelling on the Friday, Saturday, and Sunday?

The Chair: I'll get Jim to explain the different scenarios. He's actually got three different ones he can talk about.

Mr. James Cox (Committee Researcher): There are three options. On the first option, there is training at the level of a company, which is good to see. Then on the second option, there is training at the level of a company as well, which is good. As well as that, there is planning for a larger operation, and that's the period over the weekend. The other option after that is to stay and observe this larger operation.

So you have the company in training on its own, or you have the option of the company in training and the planning for the higher operation, or you have the option of observing the higher operation.

The Chair: So the third option would be during the week.

Mr. James Cox: During the week.

And frankly, in terms of training to observe, all of them are valuable. There isn't a choice that is a bad one.

The Chair: If the committee prefers, we could try to make it during the week instead of on the weekend.

Ms. Gallant.

Mrs. Cheryl Gallant: I have two questions. First of all, is there live fire?

Mr. James Cox: No. They have completed all that, and the big exercise in the States. Although live fire is concluded, the troops will have the sensors on their helmets, and lasers. If you are visiting then, the advantage is that all of you are capable of getting close and being involved in the training, as opposed to having to stand off as people are shooting.

Mrs. Cheryl Gallant: Okay. With respect to the bigger exercise, I'd like to comment that Wainwright is a unique place to be able to observe something like that. It's very difficult on your local base to see the entire orchestration happening. As much as I love being in the Chamber, I would forfeit that week so we could all observe the grand exercise, as well as the debriefings and lessons learned afterwards.

The Chair: And that would be May 12, 13, and 14.

Go ahead, Mr. Lunney.

Mr. James Lunney: Mr. Chair, that week...is it May 5 to 11, in Wainwright? I'm scheduled to travel to Israel with a group, the Canada-Israel group, regrettably. So if it is possible to reassign that, it would be great for me. If not, I'm afraid I'll be reading the minutes or report.

The Chair: John, do you have anything?

Mr. John Cannis: Those are the only dates, James, that you've given us?

Mr. James Cox: That's all that's available in terms of training activity.

Mr. John Cannis: I was going to comment after I heard this, Mr. Chairman.

With all due respect to the members in our committee who are not here, for example, the critic, Claude, and Dawn, I just want to echo Cheryl's comment. For me, this is such a unique opportunity. From what I've heard, I think it's an opportunity we must not miss, and we must see cooperation on it. I understand James has a commitment already to be away that week. Is that correct, James?

● (1715)

Mr. James Lunney: It may or may not happen, depending on what's going on.

Mr. John Cannis: I think we should base it on, number one, the fact that it's imperative that we go.

Number two, Mr. Chairman, through your efforts, it's imperative we get cooperation from all parties for those days, given the strong collective support of our military. Nobody is here to say, well, they're going to stay back because something might happen and they're not going to go, which I think is what Cheryl was saying: it's imperative that we get there. I think you'll find full cooperation on our side in terms of the dates, but I can't speak for the NDP.

The Chair: I think everybody is fairly flexible, particularly if we were able to go during the House session. That's what we're paid to do, and we can make that work. We might have to go in on Sunday, the 11th, and be done on Wednesday or Thursday morning, so that might just work out fine. Is that everybody's preference? Good.

Could I have somebody move this?

Mr. John Cannis: [*Inaudible—Editor*]...on the scheduled trip to Afghanistan, Mr. Chair?

Mrs. Cheryl Gallant: We're not in camera, no.

[*Translation*]

Mr. Steven Blaney: I so move.

[*English*]

The Chair: It is moved that the report be adopted.

(Motion agreed to)

The Chair: Thank you for that.

Are there any more comments? We'll have to carry on with your initiative.

Is there anything else? The meeting is adjourned.

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