HOUSE OF COMMONS
CANADA

DOING WELL AND DOING BETTER: HEALTH SERVICES PROVIDED TO CANADIAN FORCES PERSONNEL WITH AN EMPHASIS ON POST-TRAUMATIC STRESS DISORDER

Report of the Standing Committee on National Defence

The Hon. Maxime Bernier, P.C., M.P.
Chair

JUNE 2009

40th PARLIAMENT, 2nd SESSION

Also available on the Parliamentary Internet Parlementaire: http://www.parl.gc.ca

Available from Communication Canada — Publishing, Ottawa, Canada K1A 0S9

DOING WELL AND DOING BETTER: HEALTH SERVICES PROVIDED TO CANADIAN FORCES PERSONNEL WITH AN EMPHASIS ON POST-TRAUMATIC STRESS DISORDER

Report of the Standing Committee on National Defence

The Hon. Maxime Bernier, P.C., M.P.
Chair

JUNE 2009

40th PARLIAMENT, 2nd SESSION

STANDING COMMITTEE ON NATIONAL DEFENCE

CHAIR

Hon. Maxime Bernier, P.C., M.P.

VICE-CHAIRS

Hon. Bryon Wilfert, P.C., M.P.
Claude Bachand, M.P.

MEMBERS

Steven Blaney, M.P
Ray Boughen, M.P.
Hon. Denis Coderre, P.C., M.P.
Cheryl Gallant, M.P.
Jack Harris, M.P.
Laurie Hawn, M.P.
Hon. Anita Neville, P.C., M.P.
Pascal-Pierre Paillé, M.P.
LaVar Payne, M.P.

OTHER MEMBERS OF PARLIAMENT WHO PARTICIPATED

Dawn Black, M.P.
Rick Casson, M.P.

CLERK OF THE COMMITTEE

Paul Cardegna

LIBRARY OF PARLIAMENT
Parliamentary Information and Research Service

James Cox, Wolfgang Koerner

THE STANDING COMMITTEE ON NATIONAL DEFENCE

has the honour to present its

SECOND REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied health services provided to Canadian Forces personnel with an emphasis on post-traumatic stress disorder.

TABLE OF CONTENTS

INTRODUCTION

If there was ever a subject that merited non-partisan attention, this is it.

If there was ever a time to make it better, it is now.

The Canadian Forces Health Services (CFHS) is among the best of its kind in the world. Particularly on battlefields like those in Afghanistan, our wounded soldiers, sailors, airmen and airwomen are provided with the most dedicated, professional and effective medical treatment Canada can provide, from the point of injury, all the way back to a hospital near home in Canada. The Canadian Forces also recognize that the well-being of military families is a crucial cornerstone of troop morale, operational effectiveness and personnel retention. It therefore continues to offer a growing number of health and social support programs for military families.

As effective as current Canadian Forces health care and social support programs are, there is room for improvement. Concern has been expressed over the ability of the Canadian Forces to meet the needs of soldiers recovering after being injured in combat in Afghanistan and in other operations. Of particular worry is the ability of the military health care system to care for the growing number of those suffering operational stress injuries (OSI), including post-traumatic stress disorder (PTSD).

The Standing Committee on National Defence (hereinafter the Committee) examined the provision of health services to the Canadian Forces, with a focus on PTSD. This report concludes that renewed leadership efforts and program improvements are required. However, unlike other reports dealing with these issues, we suggest the provision of adequate health care services for Canadian military personnel and those family members who need it, as a result of military activity conducted at the direction of government, is not only a Canadian Forces issue. It is a whole-of-government responsibility. There are others that can and should help.

Our study was an objective examination of the root causes of main difficulties facing military health care in Canada today. Our overall objective is to offer government credible and workable recommendations to remedy the challenges identified. We hope they will be implemented effectively and efficiently, in a spirit of teamwork across all departments.

Within the military, effective casualty treatment and handling is a significant morale enhancer. If Canadians expect our troops to do what we ask of them, it is only fair that those troops be confident they will be taken care of, should they be injured in the course of doing their duty. Moreover, should they be killed, or injured, physically or psychologically, they must know that their family will be cared for too.

The vast majority of injured personnel receive excellent care. However, there have been instances in which wounded personnel, or members of their families, have not received adequate treatment. Some prior reports, from the Department of National Defence and Canadian Forces Ombudsman and the Auditor General of Canada have highlighted examples of wounded soldiers 'falling through the cracks' and not receiving the care and treatment to which they or their families were entitled.[1]

We emphasize our desire to identify root causes, those fundamental reasons why such things as inconsistent policy application, lack of follow-up treatment and a prevailing perception of a negative 'stigma' might exist. The Committee feels that simply throwing money at problems will not prevent them from happening again. Moreover, just because a problem appears in the Canadian Forces does not necessarily mean that is the only place such difficulties exist. Shortages of medical professionals and negative attitudes toward psychological disorders are found in the general population too. Simply directing the Canadian Forces to take action does not always work either, particularly when the Canadian Forces has neither the capability, nor the mandate, to solve the problems identified. Many of the well-intentioned recommendations in past studies do little more than address symptoms of more deep-rooted challenges. This Committee was determined to look diligently for fundamental causes.

We think we found them.

1 Throughout the remainder of this report, for convenience, the terms 'soldier' or 'troops' will occasionally be used to mean all sailors, soldiers, airman and airwomen. We do so with great respect to all Canadian Forces personnel.

EXECUTIVE SUMMARY

The CFHS is among the best of its kind in the world. Particularly on battlefields like those in Afghanistan, our wounded soldiers, sailors, airmen and airwomen are provided with the most dedicated, professional and effective medical treatment Canada can provide. The Canadian Forces also sponsors important social support programs for military families.

As effective as current Canadian Forces health care and social support programs are, there is room for improvement. Concern has been expressed over the ability of the Canadian Forces to meet the growing needs of soldiers injured, both physically and psychologically, in combat in Afghanistan and elsewhere.

The Committee found three over-arching issues that seemed to be at the root of much that is troubling the Canadian Forces health care system.

First, the Committee heard evidence that attitudes toward mental health issues in the Canadian Forces remain largely negative. Such attitudes exist far beyond the Canadian Forces and can be found throughout Canadian society. Worse still, the stigma experienced by people with mental illness can be more destructive than the illness itself.[2]

We think the Canadian Forces can lead by example in the field of appropriate attitudes toward mental health. Proper attitudes lead to positive practices that treat psychological injuries with the same relative urgency and respect given to physical injuries. Once any injury is inflicted, there is no time to waste. The Committee suggests that, as an example to all Canadians, the Canadian Forces initiate and embed a modern, enlightened view of mental health issues that is scrupulously adhered to by all ranks.

This is the one major step that allows effective improvement in all other areas.

Second, there is a problematic policy-implementation gap. For every senior officer or departmental official who told us of initiatives being taken to improve military health care generally and mental health diagnosis and treatment in particular, we heard at least one junior rank who told us the system was not working for them.

Based on evidence heard, the Committee thinks the main difficulty resides in front-line clinics that are under-resourced and with case managers who are over-worked.

2 See the Canadian Mental Health Association website at http://www.cmha.ca/bins/content_page.asp?cid=3&lang=1.

Well-meaning health care providers are being 'burned out'. Somehow, in the midst of such strain, the Canadian Forces must find a way to deliver consistent quality and continuity of care.

We recognize however, the inherent challenges involved when resources are in short supply. This is the third principal issue we discovered. There is a chronic shortage of professional health care providers in Canada.[3] When Canadian Forces patients are referred to civilian health practitioners for treatment, they compete for already limited access to care with the existing civilian patient population. Waiting for treatment can be even longer in areas of the country, such as many isolated or rural regions, where there is already a severe shortage of resident medical professionals. As well, Canadian Forces health services compete, just like any other employer, with provinces and established medical institutions for the talents of graduating medical students. A study by the Federal Healthcare Partnership (FHP) noted that the shortage of physicians is reaching "crisis proportions".[4]

The main issue here is recognition of the fact that the shortage of medical professionals is not only a Canadian Forces problem and therefore cannot be solved simply by providing more money and directing the Canadian Forces to recruit more healthcare providers. What is needed here is a whole-of-government approach to mobilize, deploy and sustain sufficient medical health professionals to meet the growing needs of injured Canadian Forces personnel and their families.

From these over-arching issues flow a number of consequential challenges that we have identified and addressed at the individual, family, Canadian Forces, Department of national Defence and government levels.

All the challenges identified by the Committee are solvable. It will take teamwork.

3 See the CMA website at http://www.cma.ca/index.cfm/ci_id/55125/la_id/1.htm.

4 Canadian Medical Forum Task Force on Physician Supply in Canada, November 1999.

RECOMMENDATIONS

RECOMMENDATION 1

The Minister of National Defence and the Chief of the Defence Staff should jointly make a public announcement to all ranks of the Canadian Forces, outlining a high-profile effort to pursue a modern, enlightened and unequivocal view of mental health issues in the Canadian Forces. All commanders of commands, formations and units should also deliver complementary declarations to their personnel, to reinforce implementation at the local level.

RECOMMENDATION 2

The Department of National Defence should cause an independent audit to be conducted of military patient case management practices to determine the extent to which a gap exists between expressed Canadian Forces policy and the actual practices applied to the continuing treatment and care of injured Canadian Forces personnel. Once defined, appropriate measures should be taken, throughout the chain of command, to eliminate the gap and improve patient care.

RECOMMENDATION 3

The Department of National Defence should cause a second audit to be conducted by an independent body, to examine the administrative burden imposed on Canadian Forces health professionals, with a view to determining whether any such administrative duties adversely impact the delivery of effective patient care.

RECOMMENDATION 4

It is recommended that Government recognize, despite the shortage of healthcare professionals in Canada, that the Canadian Forces has an obligation to provide necessary and adequate medical treatment to its members including returning soldiers with continuing need for treatment and services.

Just as the Canadian Forces is expected to provide treatment for physical injury, the Canadian Forces should also be expected to provide soldiers suffering from OSI with the necessary mental health and related services. Related services include, but are not limited to, addictions counselling, marriage and family counselling, occupational therapy and recreational therapy.

Recognizing that the Canadian Forces cannot implement effective remedies alone, a strategy for providing adequate and comprehensive treatment for OSI will require cooperation and support from other government departments. But regardless of the challenges, the Canadian Forces—with assistance from the appropriate government partners—must make every effort to mobilize, deploy and sustain sufficient mental health and related professionals to meet the needs of members of the Canadian Forces and their families.

RECOMMENDATION 5

It is recommended that the Government establish, within one year of the presentation of this report, a National Health Care Resources Monitoring Council, led by Health Canada, composed of health representatives from the Canadian Forces, the Royal Canadian Mounted Police, other appropriate government departments and agencies, other appropriate levels of government and other relevant stakeholders. This Council should meet regularly, at least semi-annually, to review the disposition of all health care capabilities in Canada, review health care needs in various client communities such as the Canadian Forces and military families, identify gaps and consult on measures that could be taken to remedy them.

RECOMMENDATION 6

It is recommended that Health Canada, supported by the Department of National Defence and Veterans Affairs Canada, complete a detailed audit of health care services available to the Canadian Forces in Canada and around the world, to identify the nature and scope of gaps. In Canada, this would be done in cooperation with provincial, territorial and appropriate municipal authorities. The Committee recommends particular attention be paid to large rural bases, which seem most at risk for lack of health infrastructure. Abroad, it would be done in cooperation with nations in which Canadian Forces personnel are located.

RECOMMENDATION 7

The Canadian Forces should expand recruitment incentive programs for mental health professionals, including the use of student debt relief, grants, bonuses, tuition payment and the purchase of more medical placements at universities, providing provincial assurances can be gained that the money so spent would indeed go to educate nominated Canadian Forces mental health care students.

RECOMMENDATION 8

The Canadian Forces should include treatment for substance abuse and addictions as part of the services offered to sufferers of OSI and PTSD.

RECOMMENDATION 9

The Canadian Forces should ensure that members and their families are provided with information about the risk of domestic violence that is associated with OSI and PTSD, and should provide services to family members who are at risk of or suffering from domestic violence as a result of OSI or PTSD.

RECOMMENDATION 10

The Canadian Forces should develop a formal outreach program to educate contracted health care professionals about the unique nature of military experiences encountered on international missions, particularly those involving any degree of combat.

RECOMMENDATION 11

The Canadian Forces should formally recognize the requirement to include, where appropriate, selected family members in the treatment regime of psychologically injured personnel and take measures to ensure they are consulted and included in treatment plans, to the extent it is helpful to do so.

RECOMMENDATION 12

Where injured Canadian Forces members require continuing assistance in navigating an administratively complex programme of treatment and care, the Canadian Forces should facilitate the use of a designated advocate chosen by the member and provide an appropriate level of cooperation with such advocate. Canadian Forces members should be advised of their right to an advocate. Given the concerns of additional stresses on family members, potential advocates could include retired members of the Canadian Forces and other professionals (e.g. medical doctors, psychologists, spiritual/religious advisors).

RECOMMENDATION 13

The Canadian Forces should give primary consideration to the continuity of quality care for recovering soldiers, over career development options.

RECOMMENDATION 14

The Canadian Forces should monitor the mental health of its members for five years after deployment on operational missions, to ensure effective treatment and tracking of mental health issues.

RECOMMENDATION 15

The Canadian Forces must recognize there still exists a certain culture, perhaps even a prejudice, regarding how mental illness is perceived among its rank and file.

RECOMMENDATION 16

The Canadian Forces should continue its efforts to educate all military personnel on the nature, processing and treatment of OSI, with a particular effort to eliminate any stigma associated with the condition.

RECOMMENDATION 17

The Canadian Forces should embed in all leadership training courses, at all levels, material on identifying and processing personnel with OSI. Enhanced material, for commanders at all levels, should be included in all pre-deployment training too.

RECOMMENDATION 18

The Department of National Defence and the Canadian Forces should move to co-locate all medical facilities on military bases, in a manner that supports the concept that all injuries and ailments will be treated with equal respect and that works to eliminate any lingering stigma associated with mental health issues.

RECOMMENDATION 19

The Department of National Defence should ensure that adequate resources are allocated to the establishment of a sufficient number of the Joint Personnel Support Units and Integrated Personnel Support Centres to provide this level of support and service nation-wide.

RECOMMENDATION 20

Reserve unit chains of command must be intimately and proactively involved in ensuring their returning personnel complete the post-deployment process on time, including all necessary administration, interviews and medical appointments. Where individual Reservists are undergoing continuing care and treatment after full-time service, Reserve unit chains of command must remain in regular contact with CFHS case managers and take an active interest in the soldier's treatment programme.

RECOMMENDATION 21

The Canadian Forces must continue their efforts to inform and educate military members and their families about the nature and treatment of OSI, but with an enhanced focus on Reserve Force commanders, personnel and their families, particularly those who reside at some distance from a military installation.

RECOMMENDATION 22

The Committee encourages the Minister of National Defence and the Canadian Forces to continue to strive for the compassionate application of existing regulations regarding universality of service and minimum operational standards, to allow the continued employment of recovering soldiers, as long as such employment contributes to Canadian Forces operational requirements.

RECOMMENDATION 23

The Department of National Defence should immediately provide enhanced transportation resources (such as modern multi-passenger vans or highway cruiser buses and drivers) to isolated military bases to ensure that military personnel and family members have adequate transportation for access to out-of-town health care services and medical appointments.

RECOMMENDATION 24

The Canadian Forces has an obligation to remind personnel that they have an obligation to keep their families fully informed of medical and social support services available to them. The Canadian Forces must continue to encourage military families to engage those medical and social support services.

RECOMMENDATION 25

In conjunction with other Federal Healthcare Partnership stakeholders, the Department of National Defence, Veterans Affairs Canada and the Canadian Forces should hold an annual national conference on best practices and advancements in military health care overall, with special emphasis on mental health care.

RECOMMENDATION 26

The Canadian Forces should ensure that personnel in units returning from operational tours of duty are exempt any further non-operational deployment away from their unit for the defined duration of the post-deployment reconstitution phase, unless to do so would negatively affect patient well-being according to mental health professionals.

RECOMMENDATION 27

The Canadian Forces should ensure continuity in the chain of command in units returning from operational tours of duty, particularly at lower levels, remains in place, as much as operational requirements allow, during the post-deployment reconstitution phase.

RECOMMENDATION 28

The Canadian Forces should develop health services doctrine to cover the care and treatment of Canadian Forces casualties from the point of evacuation to recovery or release and transfer to Veterans Affairs Canada support.

RECOMMENDATION 29

The Canadian Forces should ensure their extended health services doctrine includes measures addressing OSI from recruitment through to retirement, with particular emphasis on the preparation of soldiers to endure psychological traumas before they engage in combat operations. The Canadian Forces should investigate best practices in psychological preparation for OSI and PTSD.

RECOMMENDATION 30

The Department of National Defence and the Canadian Forces should institute a program, in concert with Provincial and Territorial governments, to monitor best practices for the cooperation and integration of Canadian Forces health services with local community health and social services, and implement common high standards.

RECOMMENDATION 31

The Canadian Forces should ensure that a military padre or contracted religious/spiritual advisors are available at any third location decompression centre and are included in the Canadian Forces strategy on mental health care.

RECOMMENDATION 32

The Canadian Forces should regularly review the composition of the Operational Trauma Stress Support Centre multi-disciplinary teams and remain open to the addition or use of clinical professionals not traditionally found in the military health care system, such as registered marriage and family therapists and that the services thereof be added to the dependents' Extended Health Care schedule of covered benefits.

RECOMMENDATION 33

The Canadian Forces should provide this Committee, the Auditor General of Canada and the Department of National Defence and Canadian Forces Ombudsman with a full, unclassified update of the status of the Canadian Forces Health Information System, along with a meaningful explanation of when it will reach full operational capacity.

RECOMMENDATION 34

The federal government should move immediately to provide the necessary resources to reach full operational capability of the Canadian Forces Health Information Systems project, with the assistance of a database.

RECOMMENDATION 35

The federal government should initiate cooperative programs with provincial and territorial governments, to offer incentives to qualified professional health care workers, to provide their services to Canadian Forces personnel and their families, in locations where there is a shortage of such services.

RECOMMENDATION 36

The federal government should continue to work in cooperation with provincial and territorial governments to enhance relationships between local community health and social services to enhance and Canadian Forces health care services.

BACKGROUND

After the end of the Cold War, Canadian Forces operations in Croatia, Bosnia, Macedonia, Somalia, Rwanda, Cyprus, and elsewhere produced casualties, some of whom are only being identified now. Throughout the 1990s, as operations increased in both number and intensity, the Canadian Forces was downsized, including health systems and health services. The result was a dramatic reduction of military health care capacity, leaving only those services deemed necessary for future operations.

A government decision was taken to reduce in-garrison health care in Canada and use the civilian health care system where it could. Military in-patient capabilities, all with a psychiatric care capacity, were closed in Ottawa, Valcartier, Halifax and Esquimalt. In-patient addiction rehabilitation services were closed in Valcartier, Kingston, Winnipeg and Esquimalt.

At the same time, the civilian health care sector was under severe financial pressures and in some areas it could not easily accommodate additional Canadian Forces patients. By the late 1990s a Chief of Review Services report confirmed that the Canadian Forces health care system was in trouble. As a result, the Canadian Forces launched a health care project called *Rx 2000*. Its initiatives continue today.

When the Canadian Forces returned to Afghanistan in 2003 and started to suffer combat casualties, there was increasing public awareness that effective military medical services were required on the battlefield, at home and at many points in between. As casualties mounted, particularly after the redeployment of Joint Task Force Afghanistan from Kabul to Kandahar in 2005, wounded soldiers were being evacuated from combat locations, treated at a military hospital in theatre and sent home for further care and recovery. Some of the more grievously wounded were first sent to the world-class United States (US) military hospital in Landstuhl, Germany, for emergency critical care and stabilization, prior to being evacuated to Canada.

Canadians also learned, as they had during the First and Second World Wars, the Korean War and many of the more intense UN missions during the Cold War, that in addition to physical wounds, our troops were also liable to sustain a range of psychological injuries. While the vast majority of our injured military personnel received excellent care at all stages of treatment and recovery, there were a small, but unnerving number of casualties coming forward to reveal that they had not received the level of attention and care to which they were entitled. There were particularly poignant cases found among those suffering psychological wounds.

In February 2002, the Department of National Defence and Canadian Forces Ombudsman published a comprehensive special report entitled *Systematic Treatment of Canadian Forces Members with PTSD.*[5] It found there was a need for improved procedures dealing with the identification, treatment and administration of Canadian Forces members suffering from PTSD, as well as a requirement for more attentive care for their families. At the same time, it noted that the Canadian Forces recognized these challenges and was being proactive in dealing with them.

An initial follow-up report was published in December 2002. It reported on improved deployment related procedures, enhanced social support mechanisms and renewed commitment and determination on the part of senior leaders to improve the quality of all medical care. On the other hand, it expressed disappointment at continuing negative attitudes, at lower levels, about psychological injuries and the continuing lack of low-level unit support.

Beginning in 2006, a number of media stories discussed cases of soldiers returning from combat operations in Afghanistan suffering from PTSD.[6] Moreover, in May 2006, a Senate Standing Committee complimented Canadian Forces mental health care initiatives and provided some helpful recommendations for improvement.[7]

Shortly thereafter, in 2007, the Auditor General of Canada produced a report on the military health care system.[8] It raised a number of procedural concerns within the military health care regime and offered recommendations for improvement. The government agreed with all of them.

This and continuing media coverage of the death and injury of Canadian troops in Afghanistan attracted the attention of the Standing Committee on National Defence, which then decided to conduct a detailed study of health services provided to the Canadian Forces, with a focus on PTSD. The study was conducted between February 2008 and February 2009.

---

5 PTSD — Post Traumatic Stress Disorder. See Marin, André. *Report to the Minister of National Defence: Systematic Treatment of Canadian Forces Members with PTSD.* Ottawa: DND and Canadian Forces Ombudsman, February 2002, at http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/pts-ssp/index-eng.asp.

6 *The Canadian Press*. "Canadian soldiers' health at risk after deployment". October 29, 2007, at http://www.cbc.ca/health/story/2007/10/29/soldiers-study.html

7 Senate of Canada. *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. The Senate Standing Committee on Social Affairs, Science and Technology, May 2006, http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06high-e.pdf,

8 Auditor General of Canada. "Military Health Care". *2007 October Report.* Chapter 4, at http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23828.htm.

In the course of our study, three more relevant reports were published by the Department of National Defence and Canadian Forces Ombudsman. The first, in April 2008, examined the treatment of injured Reserve Force members.[9] It found significant inequities in four areas: provision of health care to Reservists; inconsistent standards of care; inadequate benefits for Reservists; and a lack of timely administration of Reserve medical releases. The second report specifically examined the state of mental health services at CFB Petawawa.[10] It generally found that there was a shortage of mental health resources at the Base. Finally, the Ombudsman published a special report in December 2008, which constituted a second follow-up review of the original 2002 special report on PTSD.[11] Notable among its findings were that some Canadian Forces members suffering from OSI and their families were still not receiving the care and treatment they needed and that over half of the 31 recommendations in the 2002 report, had not been implemented.

The Committee was cognizant of the fact that while concern for wounded military personnel has tended to center on those injured in Afghanistan, Canadian Forces personnel are sometimes injured in the course of normal garrison or training duties at home in Canada, as well as occasionally in the conduct of other Canadian Forces missions abroad, at sea, in the air or on land.[12]

---

9 McFadyen, Mary. *Special Report to the Minister of National Defence: Reserved Care, An Investigation into the Treatment of Injured Reservists.* Ottawa: DND and Canadian Forces Ombudsman, April 2008, at http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/rc-str/index-eng.asp.

10 McFadyen, Mary. *Assessing The State of Mental Health Services at CFB Petawawa.* Ottawa: DND and Canadian Forces Ombudsman, November 12, 2008, at http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/asm-ees/index-eng.asp.

11 McFadyen, Mary. *A Long Road to Recovery: Battling Operational Stress Injuries.* Second Review of the Department of National Defence and Canadian Forces' Action on Operational Stress Injuries, Ottawa: DND and Canadian Forces Ombudsman, December 2008, at http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/osi-tso-3/index-eng.asp

12 See the full list of current Canadian Forces operations at http://www.forces.gc.ca/site/operations/current_ops_e.asp.

CONTEXT

In any study of the Canadian Forces, it is important to recognize certain contextual factors affecting how the Canadian Forces is governed, organized, operated and adapted. These factors are important because they provide much of the rationale as to why some things are as they are and, of importance to this study, provide clues as to how improvements can be made.

PROFESSION OF ARMS IN CANADA

First among the principal contextual factors is the existence and influence of the profession of arms in Canada, which exercises the use of military force on behalf of government and people of Canada. All members of the profession willingly accept unlimited liability, the notion that they may be ordered into harm's way in conditions that could lead to the loss of their lives. Their highest duty is to Canada and is embodied in the tenet, "service before self". Canadian Forces members adhere to the principle of primacy of operations and military leaders are taught to act in accordance with the professional priorities of, "mission, troops, self".[13]

Familiarity with the concept of the profession of arms in Canada is helpful in understanding why obligatory physical standards are imposed on military employment and in understanding why, if those standards cannot be met, military personnel must be reassigned or released from the Canadian Forces. In keeping with the tenet "service before self", no Canadian Forces member is entitled to serve as long as they may want to, nor do they have a right to promotion. Continuing service and promotion are based on merit. That said, the Canadian Forces currently interprets existing regulations in a compassionate way to allow injured soldiers the time they need to recover or prepare for life after military service.

CHAIN OF COMMAND RESPONSIBILITIES

Command is the legal authority to direct action of subordinate units and issue orders to subordinate personnel. The military chain of command holds the professional, legal and moral responsibility for the care and well-being of military personnel under its command.[14]

---

13 Canadian Forces. *Duty With Honour: The Profession of Arms in Canada*. Ottawa: Canadian Defence Academy, 2003.

14 "Command", Chapter 3 of *Queen's Regulations and Orders.* Available on the DND and Canadian Forces website at http://www.admfincs.forces.gc.ca/qro-orf/index-eng.asp.

Chapter 4 of *Queen's Regulations and Orders*, dealing with the general responsibilities of officers, specifically states that officers *shall* "promote the welfare, efficiency and good discipline of all subordinates".[15] Officers in command of a base or other unit are expected to exercise command over all officers and non-commissioned members, at the base or other unit.[16] Commanders at all levels are required to be familiar with the personal and professional circumstances of personnel under their command,in order to control and administer them appropriately, in the pursuit of assigned missions.

The military chain of command extends from the Chief of the Defence Staff (CDS) down through all ranks, with two notable aspects. First, no chaplain shall exercise command over any officer or non-commissioned member. Second, "no officer who is not a medical officer shall exercise command over a medical officer in respect to his treatment of a patient."[17]

COMMANDING OFFICER RESPONSIBILITIES

Also in the context of this study, Commanding Officers have the following duties:

a) to assist health care providers in understanding the performance requirements and conditions that normally apply to a particular military member, so that the most appropriate medical employment limitations (MEL) can be assigned;

b) to inform health care providers when other employment exists within the unit that the Canadian Forces member may be able to perform in accordance with assigned MEL;

c) to inform health care providers when assigned MEL appear vague or inappropriate in a particular working environment;

d) to raise concern about imposed MEL with the health care provider or Base Surgeon as required;

e) in consultation with a medical officer, to identify those unit supervisors who are authorized to receive additional information on MEL; and

15 *QR&Os*, Chap. 4, Art. 402(1)(c).

16 *QR&Os,* Chap. 3, Art. 3.23(1).

17 *QR&Os*, Chap. 3, Art. 3.33.

f) to ensure information about a MEL assigned to a Canadian Forces member is handled in confidence within the unit, without disclosure to unauthorized personnel.

CANADIAN FORCES MEMBER RESPONSIBILITIES

In the context of this study, we note that every Canadian Forces member has the following duties:

a) to self-report as sick, without delay, when suffering from or suspecting he or she might be suffering from a disease;

b) to report to his or her chain of command, any medically based inability to perform duties;

c) to inform his or her chain of command, when required, any MEL specified by his or her health care provider;

d) to follow those imposed MEL;[18] and

e) to follow prescribed medication and treatment regimes.

Serving personnel also have a responsibility to convey information on available support facilities, programs and resources to their families.

CANADIAN FORCES HEALTH SERVICES RESPONSIBILITIES

The Chief of Military Personnel (CMP) is directly responsible to the CDS for the conduct and quality of health care in the Canadian Forces. The head of the clinical practice of medicine in the Canadian Forces is the Surgeon General, who has the right of direct access to the CDS on medical matters.

Also subordinate to the CMP is the Canadian Forces Health Services Group (CFHSG), sometimes referred to as part of Canada's "14th medical system", the organization that actually delivers health care to the Canadian Forces and exercises command and technical control over all military health care facilities in the Canadian

18 Chief of the Defence Staff, *Disclosure of Medical/Social Work Info to Commanding Officers,* CANFORGEN 039/08 CMP 039 131851Z, Feb 08.

Forces.[19] It includes both medical and dental branches. CFHSG is composed of uniformed and civilian health care providers working in approximately 120 different units of varying sizes in different areas around the world. The units can range from a large group of about 300 health service personnel on bases such as Canadian Forces Base (CFB) Valcartier or CFB Petawawa, to two personnel providing health care support on any of Her Majesty's Canadian ships (HMCS) or at Canada's most northern military station at Alert.

Medical professionals within the Canadian Forces health services system are responsible to the chain of command for the quality of health care given to military personnel.[20] Their primary obligation to service personnel is to maintain their health and mental well-being, prevent disease, diagnose or treat any injury, illness, or disability and facilitate their rapid return to operational fitness. This is an important concept. Canadian Forces health care works to put soldiers 'back into the fight'. The Canadian Forces health care system is not intended, nor is it fundamentally designed to provide continuing, long-term care to personnel who will never recover to the point of returning to full duty.

The obligation medical professionals have to the chain of command entails sustaining or restoring service personnel to operational effectiveness and deployability. Medical professionals are responsible for keeping the chain of command informed of the medical status of those under its command, to the degree necessary for optimal employment of those personnel in the attainment of assigned missions. While medical advice should always be treated with respect, the chain of command retains the authority and responsibility to employ personnel under command in a manner appropriate to the circumstances.[21]

Canadian Forces personal medical records are confidential, known only to a Canadian Forces patient and Canadian Forces medical professionals dealing with that patient. In keeping with Canadian privacy laws, military health care providers have a professional duty to safeguard patient medical information from inappropriate disclosure, but they must exercise due diligence in the context of supporting operational effectiveness, while respecting the legal and regulatory framework in which they work. While specific information such as diagnosis and detailed treatment should not be disclosed, an open dialogue, on a need-to-know basis, between medical professionals and the chain of

---

19 The Canadian Forces health services website can be found at http://www.forces.gc.ca/health/engraph/home_e.asp.

20 Chief of the Defence Staff, *Disclosure of Medical/Social Work Info to Commanding Officers,* CANFORGEN 039/08 CMP 039 131851Z, Feb 08.

21 *QR&Os*, Chap 4, Art. 4.20(1), which reads: "A commanding officer is responsible for the whole of the organization and safety of the commanding officer's base, unit or element, but the detailed distribution of work between the commanding officer and subordinates is left substantially to the commanding officer's discretion."

command, is essential to maintaining the integrity of the Canadian Forces health care system and to ensure that neither the individual nor the mission is compromised.

Military health care providers have the following specific duties:

a) To provide clear, detailed and relevant MEL information on sick report forms;

b) to disclose to a Commanding Officer, limitations on a Canadian Forces member's ability to use weapons, complex machinery or equipment;

c) to disclose additional non-clinical information necessary for the Commanding Officer to assign appropriate duties to the psychologically or physically injured soldier;

d) to disclose prescribed information to appropriate authorities when required by federal and applicable provincial laws; and

e) to inform the Base or Area Surgeon when the health care provider has indications that a Commanding Officer is not providing the required support to the patient or is not respecting assigned MEL;[22] and

f) to supervise Canadian Forces patients and ensure they follow prescribed medication and treatment regimes .

FEDERAL, PROVINCIAL AND TERRITORIAL RESPONSIBILITIES

At the federal level, Health Canada's responsibilities for health care include setting and administering national principles for the health care system through the *Canada Health Act* and delivering health care services to specific groups (e.g. First Nations and Inuit). Working in partnership with provinces and territories, Health Canada also supports the health care system through initiatives in areas such as health human resources planning, adoption of new technologies and primary health care delivery.[23]

The Canadian constitution does not address health and health care as a single subject nor does it explicitly allocate responsibility to one order of government or another. Both provincial and federal governments have varying degrees of jurisdiction over different

22 Chief of the Defence Staff, *Disclosure of Medical/Social Work Info to Commanding Officers,* CANFORGEN 039/08 CMP 039 131851Z, Feb 08.

23 Health Canada website at http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php.

aspects of the health care system.[24] However, through a number of court cases and legal interpretations, it is now well accepted that the provinces have primary jurisdiction over the organization and delivery of health care services in Canada. In contrast, Yukon, Nunavut and the Northwest Territories do not have formal constitutional powers over health care, although they have assumed these responsibilities.

While the provinces and territories have primary responsibility for health care delivery, the federal government has constitutional authority and responsibility in a number of very specialized aspects of health care (e.g. the approval and regulation of prescription drugs) and in critical areas of publicly funded health care, including the protection and promotion of health.

The *Canada Health Act* specifically excludes members of the Canadian Forces from the definition of "insured persons" and thereby effectively prohibits Canadian Forces personnel from care and benefits provided by provincial health care systems.[25] Responsibility for their healthcare falls upon the Minister of National Defence.

The *Constitution of Canada* bestows responsibility for "Militia, Military and Naval Service, and Defence" in the hands of the federal government.[26] The *National Defence Act* (NDA) assigns the Canadian Forces to the Minister of National Defence, who "has the management and direction of the Canadian Forces and of all matters relating to national defence."[27] The CFHS provides health care to Regular and Reserve Canadian Forces personnel and represents the Department of National Defence in the Federal Healthcare Partnership (FHP), an umbrella group of federal departments and agencies that provide health services to specific groups of Canadians, including First Nations and Inuit peoples, members and veterans of the Canadian Forces and members of the Royal Canadian Mounted Police (RCMP).[28] Where medical treatment might not be available within the Canadian Forces, it can be acquired from the civilian sector. As explained by Major-General Walter Semianiw, the Canadian Forces Chief of Military Personnel:

> Canadian Forces personnel are offered a full range of health services, from health promotion and illness prevention to treatment and rehabilitation. If the health care clinic on a particular base cannot offer a required service, then that service is purchased from

---

24 This section is taken from Roy Romanow, *Building on Values: The Future of Health Care in Canada*, Ottawa: Final Report of the Commission on the Future of Health Care in Canada, 2002.

25 *Canada Health Act*, R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11.

26 *Constitution Act of 1867*, Section VI, Article 91.7.

27 *National Defence Act*, R.S., 1985, c. N-5, s. 4; R.S., 1985, c. 6 (4th Supp.), s. 10.

28 See the Federal Healthcare Partnership website at http://www.fhp-pfss.gc.ca/fhp-pfss/home-accueil.asp?lang=eng.

the civilian health care sector. Arrangements have been made across the country to ensure that regional care is provided close to the member's immediate family and support system, which is a foundation of the conceptual construct that we have in place.[29]

STATISTICS

To provide perspective on the scope of the issues being discussed in this report, the following statistics are offered. According to Department of National Defence information received in March 2009, the Canadian Forces casualty summary for Afghanistan in 2008 is as follows:

Year	Killed In Action (KIA)	Non-Battle Deaths (NBD)	Wounded In Action (WIA)	Non-Battle Injuries (NBI)
2002	4	0	8	1
2003	2	0	3	0
2004	1	0	3	5
2005	0	1	2	7
2006	32	4	180	84
2007	27	3	84	298
2008	27	5	124	170
SUB-TOTALS	93	13	404	565
TOTALS	106		969	

Table 1 — Canadian Forces Casualty Statistics as of December 31, 2008[30]

29 Semianiw, Major-General Walter, Chief of Military Personnel. *Evidence*. Standing Committee on National Defence, Meeting No. 11, February 7, 2008.

30 E-mail from the Office of the Minister of National Defence to the Library of Parliament, March 3, 2009. Note that the wounded and injury figures reflect only physical injuries.

The Canadian Forces has deployed Rotation Number 7 (ROTO 7). There have been more than 27,000 Canadian Forces personnel deployed to Afghanistan since 2002. Applying the casualty statistics to that number produces the following death and casualty rates, as of the end of 2008:

a) Killed in Action (KIA) 0.34% (1/3 of 1%);

b) Non-battle deaths (NBD) 0.05%;

c) TOTAL DEATH RATE 0.39%;

d) Wounded in action (WIA) 1.5%;

e) Non-battle injuries (NBI) 2.1%;

f) TOTAL WOUNDED RATE 3.6%

These statistics do not include psychological injuries, or OSI, the number of which remains largely unknown. However, to provide a general idea, Brigadier-General Hilary Jaeger, the Canadian Forces Surgeon General, told the Committee that the Canadian Forces now have results from over 8,200 completed screening questionnaires, which show 4% responding in a manner consistent with PTSD, 4.2% consistent with depression, a total of 5.8% consistent with either or both of these conditions, and 13% consistent with any mental health diagnosis.[31] Applying these percentages to the approximately 27,000 Canadian Forces personnel who have served in Afghanistan since 2002 it would seem that:[32]

a) approximately 1120 Canadian Forces members could exhibit symptoms of PTSD;

b) approximately 1176 Canadian Forces members could exhibit symptoms of depression;

31 Jaeger, Brigadier-General Hilary, *Evidence.* Meeting No. 4, Session 40-2, February 25, 2009. It is important to note that the risk of displaying symptoms of any type of OSI increases with the number of individual deployments to stressful missions.

32 For interest, according to information received from the Canadian Forces in April 2009, about 23,500 have served one tour of duty in Afghanistan; about 4,000 have served two tours; about 400 have served three tours; and about 20 have served four tours. No one has served five tours of duty in Afghanistan.

c) approximately 1624 Canadian Forces members could exhibit symptoms of either or both PTSD and depression; and

d) approximately 3640 Canadian Forces members could exhibit some sort of mental health concern.

The Committee knows these statistics are not exact, nor are they precise enough to begin drawing any specific conclusions. The same individual may be counted in more than one category. Furthermore, symptoms of OSI or PTSD may not be a result of service in Afghanistan. Perhaps a trauma suffered years ago during a tour of duty in the Balkans, or Somalia, or Rwanda could be the root cause. But these issues might be beside the point. The numbers are presented here only to get a general feel for the size of the problem being discussed.

It must be noted however, that the overwhelming majority of Canadian Forces personnel are fit and healthy. They come through the rigours of difficult deployments without difficulty. As noted by Brigadier-General Jaeger, "…it is worth emphasizing that 87% of those screened reported doing well." Nonetheless, this fact in no way diminishes the importance of addressing issues associated with those who have some degree of OSI.

It should also be pointed out that the Committee realizes there are other Canadian Forces personnel suffering from some form of OSI, sustained at home, in other theatres of operation, or in conditions of work other than combat. In focussing on Canada's military mission in Afghanistan we do not intend to neglect these other people who also require help. In fact, we feel that concentrating attention on Afghanistan-related OSI issues will inherently help all Canadian Forces personnel, including those who are veterans of past Canadian Forces missions, and their families who have been touched by any injury—physical or psychological.

In the course of our efforts to understand the numbers involved, we persistently reminded ourselves that the real issue is one of people. Sailors, soldiers, airmen and airwomen and their families are the centre of gravity in this report. We recognize they need and deserve our attention, while they deal with injuries, both physical and psychological, and the effects of those injuries, no matter how large or small.

THE CENTRAL ISSUES

The Committee closely examined all evidence placed before it and identified three central issues that seemed to be at the root of most, if not all, the difficulties facing the Canadian Forces health care regime. The first was the lack of a positive, aggressive, established attitude toward the diagnosis and treatment of OSI. Second, we identified a problematic gap between policy enunciation at senior levels and its implementation at the unit and clinic level. Finally, the Committee recognizes the chronic shortage of health care professionals available to meet the needs of Canadian Forces members and their families, which requires a whole-of-government effort to solve.

ATTITUDE

The Committee heard evidence that attitudes toward mental health issues in the Canadian Forces remain largely negative. Although discussion tended to remain focussed on soldiers suffering from PTSD, we realize, upon further reflection, that such attitudes also exist far beyond the Canadian Forces, amongst some Canadians.

According to the Canadian Mental Health Association (CMHA), mental illness is common. Statistics show that one in every five Canadians will have a mental health problem at some point in their lives. Mental illness is feared by many people and, unfortunately, still carries a stigma—a mark or sign of disgrace. Because of this stigma, many people hesitate to get help for a mental health problem for fear of being looked down upon. It is unfortunate that this happens because effective treatment exists for almost all mental illnesses. Worse, the stigma experienced by people with a mental illness can be more destructive than the illness itself.[33]

There are many myths about mental illness. Within the aggressive and competitive military environment it is sometimes believed that mental illness is caused by a personal weakness. In truth, it is in no way a character flaw. It is an illness, and it has nothing to do with being weak or lacking will-power. Although people with mental illness can play a big part in their own recovery, they did not choose to become ill, and they are not lazy because they cannot just ‘snap out of it’.

33 See the Canadian Mental Health Association website at http://www.cmha.ca/bins/content_page.asp?cid=3&lang=1.

The Committee recognizes that men and women may be equally liable to mental illness, but we also acknowledge a growing body of research on men's mental health issues that seems particularly relevant to the military culture in Canada.[34] Beliefs about masculinity encourage men's general lack of interest in health issues. Western society's view of the value of men is seen as an important factor affecting men's mental health. Dr. Michael Myers a psychiatrist and clinical professor in the Department of Psychiatry at the University of British Columbia, says, "In men, mental illness can be masked. We've known for decades that women are more apt to recognize illness of any sort and go to their doctor. This doesn't mean women are healthier, but that some men just repress it."[35]

Evidence presented to the Committee makes it clear that Canadian Forces leadership is working hard to instil appropriate attitudes toward mental health in the Canadian Forces, but perhaps not high or hard enough.[36] As will be discussed later, such efforts do not seem to gain much traction at lower levels.[37] The Canadian Forces has led Canadian society by example in the past, on issues of gender equality, eliminating discriminatory practices and implementing an enhanced ethical framework. We think the Canadian Forces can again lead Canadian society by example in the field of appropriate attitudes toward mental health.

Proper attitudes precede appropriate action. An attitude that accepts psychological injury in the same way that physical injuries are accepted, will lead to positive practices that treat any psychological injury with the same relative urgency that is given to physical injuries. Once any injury is inflicted, there is no time to waste. To provide an example to all Canadians, we suggest that the Department of National Defence and the Canadian Forces simply, 'get on with it' and initiate a high-level, high-profile, public declaration to establish and embed a modern, enlightened and unequivocal view of mental health issues to be scrupulously followed by all ranks. If done properly, such a declaration will serve as an example for parallel initiatives in other sectors of Canadian society.

---

34 Ibid.

35 Cited in Canadian Mental Health Association at http://www.cmha.ca/bins/content_page.asp?cid=3-726&lang=1.

36 Priorities of The Chief of the Defence Staff, shown on his website at make no mention of health care at all. The Canadian Forces Military Human Resource Strategy 2020 contains the term 'mental health' only once in its 50 pages, DND. *Military Human Resource Strategy 2020,* Ottawa: NDHQ/ADM HR (Mil), 2002, at http://www.cmp-cpm.forces.gc.ca/pd/hrs-smr/doc/hrs-smr-2020-eng.pdf.

37 See the Canadian Forces Mental Health website at http://www.forces.gc.ca/health-sante/ps/mh-sm/default-eng.asp.

RECOMMENDATION 1

The Minister of National Defence and the Chief of the Defence Staff should jointly make a public announcement to all ranks of the Canadian Forces, outlining a high-profile effort to pursue a modern, enlightened and unequivocal view of mental health issues in the Canadian Forces. All commanders of commands, formations and units should also deliver complementary declarations to their personnel, to reinforce implementation at the local level.

THE POLICY-IMPLEMENTATION GAP

The second principal issue was captured in this passage from one Committee meeting:

> The testimony we heard in camera was very troubling testimony about mental health services and the lack of timely diagnosis or the lack of treatment that Canadian Forces members and their families felt they had a basic right to expect.
>
> …At the same time, we've heard from people of higher rank within the military who clearly are committed to trying to treat mental health issues properly and effectively. …But there seems to be this gap between what we're hearing from the upper echelons of the Canadian military and what we've heard from soldiers, not all of whom have been soldiers who returned from Afghanistan. Some were soldiers from our time in Bosnia.
>
> My question to you is about this gap in perception and the gap between the testimony we heard from the individual soldiers and their families, who felt they didn't receive timely attention to their mental health issues, and the reports and testimony we heard about the desire in the higher levels of the military to ensure that they will.
>
> Dawn Black, M.P.
> June 17, 2008[38]

38 Standing Committee on National Defence, *Evidence*, Meeting No. 33, June 17, 2008.

For every senior officer or departmental official who told us of initiatives being taken to improve military health care generally and mental health diagnosis and treatment in particular, we heard at least one junior rank who told us the system was not working for them. The phrase ‘falling through the cracks’ was heard so often it lost its notoriety. The apparent policy-implementation gap was a persistent issue that has not faded, even in the face of new initiatives by Department of National Defence and the Canadian Forces.

The Committee recognizes the fact that recent Canadian Forces patient satisfaction surveys show the vast majority of Canadian Forces members and their families think the provision of Canadian Forces health care services met their needs.

Successful care and treatment is the norm within the Canadian Forces. However, we also recognize that the number of dissatisfied people cannot be ignored and that more effective efforts must be made, at lower levels, to eliminate instances of inadequate care.

The Committee also heard evidence that Canadian Forces medical personnel are overburdened with administrative duties, spending up to 40% of their time on administrative and policy issues. While higher administrative overhead in a relatively small organization can be expected, Canadian Forces medical personnel should be focused on their primary task—front-line care for patients.

More details follow in later sections, but the main problems, according to what we heard, seem to reside in front-line clinics that are under-resourced and with case managers who are over-worked. However, at this point, the Committee is comfortable in recommending that an independent audit be conducted to determine the degree to which the policy implementation gap and administrative overhead problems exist and measures needed to eliminate them.

RECOMMENDATION 2

The Department of National Defence should cause an independent audit to be conducted of military patient case management practices to determine the extent to which a gap exists between expressed Canadian Forces policy and the actual practices applied to the continuing treatment and care of injured Canadian Forces personnel. Once defined, appropriate measures should be taken, throughout the chain of command, to eliminate the gap and improve patient care.

RECOMMENDATION 3

The Department of National Defence should cause a second audit to be conducted by an independent body, to examine the administrative burden imposed on Canadian Forces health professionals, with a view to determining whether any such administrative duties adversely impact the delivery of effective patient care.

SHORTAGE OF PROFESSIONAL HEALTH CARE PROVIDERS

There is an enduring shortage of professional health care providers in Canada. In January 2008, the Canadian Medical Association (CMA) announced a major campaign to draw public attention to the growing physician shortage. According to the CMA, almost 5 million Canadians do not have a family physician and 5 million more could be in the same situation by 2018. Canada needs 26,000 more doctors to meet the Organisation for Economic Co-operation and Development (OECD) average of physicians per population.[39]

There are two important points here. First, when Canadian Forces patients are referred to civilian health practitioners for treatment, they compete for already limited access to care with the existing patient population. Waiting for treatment can be even longer in areas of the country, such as many isolated or rural regions, where there is a severe shortage of resident medical professionals. Second, the recruitment of health care professionals for service in the Canadian Forces does not enjoy an independent source of recruits. The Canadian Forces health services compete, just like any other employer, with provinces and established medical institutions for the talents of graduating medical students. Despite attractive signing bonuses, competitive salaries and a 'distinctive' lifestyle, not all doctors or nurses seek a military career.

The Committee was also made aware of a study by the FHP, entitled, *Study on Recruitment and Retention of Federal Physicians*, published in 2007. The report made clear the increasing pressure of meeting demands for health care services in Canada, along with the fact that the decreasing number of professionals in this field has touched both the private sector and the government at all levels. The FHP noted that the shortage of physicians is reaching crisis proportions as "projections to 2021 suggest the number of

39 See the CMA website at http://www.cma.ca/index.cfm/ci_id/55125/la_id/1.htm.

physicians per 1,000 population will reach an alarming ratio of 1.4/1000".[40] Adding to this crisis is the additional estimate that retirements of Canadian physicians will accelerate over the next 10 to 15 years leaving an even greater shortage.

In view of these facts, the FHP thinks it imperative that the federal government address its inability to recruit and retain sufficient qualified medical personnel. In the course of the study leading to the report, several common challenges were identified and four main themes emerged:

a) Compensation. Federal salary levels have not kept pace with provincial and private sector realities;

b) Pressing Operational Requirements. The negative impact of contracting services, the increasing need for specialists and experienced physicians, the high turnover of physicians and, the difficulty of managing heavy workloads due, in part, to the lack of administrative support;

c) Pressing Administrative Requirements. Problems with regards to classification of positions and compensation level, the onerous and inflexible staffing process for the physicians population, and increasing budgetary constraints;

d) Pressing Qualitative Requirements. Limited opportunities for career development, limited scope of practice and the clash between departmental and medical cultures.

The main issue here is recognition of the fact that the shortage of medical professionals is not only a Canadian Forces problem and therefore cannot be solved simply by providing more money and directing the Canadian Forces to recruit more health care providers. The challenge exists at both the federal and provincial levels. Solutions are beyond single department initiatives. What is needed here is a concerted approach to mobilize, deploy and sustain sufficient medical health professionals to meet the growing needs of injured Canadian Forces personnel and their families.

40 Canadian Medical Forum Task Force on Physician Supply in Canada, November 1999, available at http://www.physicianhr.ca/reports/PhysicianSupplyInCanada-Final1999.pdf.

RECOMMENDATION 4

It is recommended that Government recognize, despite the shortage of healthcare professionals in Canada, that the Canadian Forces has an obligation to provide necessary and adequate medical treatment to its members including returning soldiers with continuing need for treatment and services.

Just as the Canadian Forces is expected to provide treatment for physical injury, the Canadian Forces should also be expected to provide soldiers suffering from OSI with the necessary mental health and related services. Related services include, but are not limited to, addictions counselling, marriage and family counselling, occupational therapy and recreational therapy.

Recognizing that the Canadian Forces cannot implement effective remedies alone, a strategy for providing adequate and comprehensive treatment for OSI will require cooperation and support from other government departments. But regardless of the challenges, the Canadian Forces—with assistance from the appropriate government partners—must make every effort to mobilize, deploy and sustain sufficient mental health and related professionals to meet the needs of members of the Canadian Forces and their families.

RECOMMENDATION 5

It is recommended that the Government establish, within one year of the presentation of this report, a National Health Care Resources Monitoring Council, led by Health Canada, composed of health representatives from the Canadian Forces, the Royal Canadian Mounted Police, other appropriate government departments and agencies, other appropriate levels of government and other relevant stakeholders. This Council should meet regularly, at least semi-annually, to review the disposition of all health care capabilities in Canada, review health care needs in various client communities such as the Canadian Forces and military families, identify gaps and consult on measures that could be taken to remedy them.

RECOMMENDATION 6

It is recommended that Health Canada, supported by the Department of National Defence and Veterans Affairs Canada, complete a detailed audit of health care services available to the Canadian Forces in Canada and around the world, to identify the nature and scope of gaps. In Canada, this would be done in cooperation with provincial, territorial and appropriate municipal authorities. The Committee recommends

particular attention be paid to large rural bases, which seem most at risk for lack of health infrastructure. Abroad, it would be done in cooperation with nations in which Canadian Forces personnel are located.

RECOMMENDATION 7

The Canadian Forces should expand recruitment incentive programs for mental health professionals, including the use of student debt relief, grants, bonuses, tuition payment and the purchase of more medical placements at universities, providing provincial assurances can be gained that the money so spent would indeed go to educate nominated Canadian Forces mental health care students.

Almost all injured military personnel who appeared before the Committee highlighted three principal concerns—their sense of abandonment by their unit; the long, frustrating wait for diagnosis and treatment; and, the uneven quality of treatment provided by medical professionals and case managers.

LACK OF UNIT SUPPORT

Soldiers with injuries or OSI who appeared before us all felt a clear and disappointing sense of abandonment by their unit, that began when they were evacuated from the battlefield, returned from post-deployment leave after returning from Afghanistan, or were transferred to the Service Personnel Holding List (SPHL).[41]Indeed, in 2002, the Ombudsman found there was inadequate contact between Canadian Forces members with PTSD and their units, particularly once the soldier had been placed on the SPHL.

In much of the evidence heard by the Committee, little mention was made of any attention being received from non-commissioned officers (NCOs) and junior officers. Few of the soldiers mentioned anything about the chain of command below Commanding Officers. They felt they had been left to navigate the medical system on their own. One reservist felt he was purposely being shunned by his unit. Another soldier, who had served with valour in Afghanistan and sustained both physical and psychological injuries, was so upset at the lack of attention from his unit he ended up moving home with his parents while undergoing treatment that he felt was too long in coming. He wanted nothing further to do with the Canadian Forces.

There are two aspects here. First, based on the cases before the Committee, once a soldier leaves ‘unit lines’ and is waiting for medical treatment, they seem to be forgotten by their sub-unit and unit level chain of command. This is explained, in part, because those organizations remain focussed on operations, with attention necessarily devoted to tasks at hand. Second, a problem arises when soldiers are moved back to Base locations to await treatment, beyond their immediate chain of command. It appears that no other group steps in to take over. This is where the feeling of abandonment starts, particularly for a young Private or Corporal who cannot find their way around or, if they are already exhibiting symptoms of OSI, are in no state to be wandering around unsupervised anyway.

41 The SPHL was an administrative measure to manage and monitor those military personnel who were not yet fit enough to return to full duty with an operational unit.

The Committee heard of injured soldiers being left on their own for days in Kandahar Airfield, before being able to fly home to Canada, having food and drink brought to them in their accommodation trailers because they could not walk to the dining facility. This type of story was not unique. It was all the more troubling because all these young soldiers came from established regiments that pride themselves on being able 'to take care of the troops'. Clearly, they must do better.

One witness suggested that some sort of 'holding unit' for injured personnel, other than the purely administrative SPHL, should be established on major Canadian Forces Bases and other locations where there are significant number of injured troops undergoing treatment. This unit would provide trained staff to exercise daily supervision of recovering soldiers and shepherd them through the maze of appointments and treatments associated with their recovery programme. However, the Committee thinks the recent announcement of the Joint Personnel Support Unit (JPSU) addresses the issue of providing adequate supervision and help to recovering soldiers.

The Committee heard ample evidence that OSIs and PTSD are often found in co-morbidity with addiction to drugs and/or alcohol. Addiction co-morbidity can further complicate OSIs and PTSD and present other problems, including legal, for Canadian Forces members.

RECOMMENDATION 8

The Canadian Forces should include treatment for substance abuse and addictions as part of the services offered to sufferers of OSI and PTSD.

RECOMMENDATION 9

The Canadian Forces should ensure that members and their families are provided with information about the risk of domestic violence that is associated with OSI and PTSD, and should provide services to family members who are at risk of or suffering from domestic violence as a result of OSI or PTSD.

QUALITY OF CARE

While the Committee was made aware of a number of examples of excellent care being provided to Canadian Forces members suffering OSI, we also heard from many Canadian Forces personnel and military family members who were critical of the lack of empathy and understanding shown by civilian health care professionals. The most common complaint was that civilian mental health professionals simply did not understand the nature of activity or traumas experienced by Canadian Forces personnel in Afghanistan, particularly those who engaged regularly in combat operations.

In one in-camera session, the Committee heard from an experienced soldier with PTSD that all he wanted was the chance to sit and talk over his experiences with fellow soldiers. Wounded soldiers with symptoms of OSI need to talk over their experiences with a person who understands what they went through, has an evident degree of empathy and is willing just to listen. Apparently some civilian contract medical health professionals are not. On the other hand, some civilian mental health professionals informed us of their concerns about inappropriate military practices and impediments to quality care for Canadian Forces members with OSI.[42]

RECOMMENDATION 10

The Canadian Forces should develop a formal outreach program to educate contracted health care professionals about the unique nature of military experiences encountered on international missions, particularly those involving any degree of combat.

The mother of a Canadian Forces soldier suffering from PTSD told the Committee that she thought many overworked military medical and mental health professionals were burdened by 'compassion fatigue' and therefore found it difficult to summon up the strength to be caring and empathetic in every case.

Throughout all this, there was clear consensus from all parties that personnel suffering OSI would benefit from some degree of contact with, or participation of, selected family members in their treatment program.

The Committee was told by both families of Canadian Forces members and medical professionals, such as Dr. Greg Passey that family members are susceptible to both care-givers stress and secondary PTSD.[43] This makes navigating an administratively complex program of treatment and care difficult for them.

RECOMMENDATION 11

The Canadian Forces should formally recognize the requirement to include, where appropriate, selected family members in the treatment regime of psychologically injured personnel and take measures to ensure they are consulted and included in treatment plans, to the extent it is helpful to do so.

---

42 See the testimony of Dr. Joyce Belliveau and Dr. Robin Geneau, *Evidence*, Standing Committee on National Defence, Meeting No. 26, May 8, 2008.

43 Passey, Dr. Greg. *Evidence.* Standing Committee on National Defence, Meeting No. 28. May 29, 2008.

RECOMMENDATION 12

Where injured Canadian Forces members require continuing assistance in navigating an administratively complex programme of treatment and care, the Canadian Forces should facilitate the use of a designated advocate chosen by the member and provide an appropriate level of cooperation with such advocate. Canadian Forces members should be advised of their right to an advocate. Given the concerns of additional stresses on family members, potential advocates could include retired members of the Canadian Forces and other professionals (e.g. medical doctors, psychologists, spiritual/religious advisors).

CONTINUITY OF CARE

When recovering soldiers are posted from one unit to another, their continuing care is sometimes interrupted or adversely affected in some other way. The Committee heard from a number of witnesses who had experienced a problem with continuity of care after a move, particularly if that move sends them to an area with a shortage of professional medical specialists.

We recognize the inherent challenges of balancing the operational requirements of the Canadian Forces, the treatment regimen of a recovering soldier and the preferred employment of that soldier. In recalling that the aim is to allow injured soldiers to recover and heal, in order to return to full duty, the Committee suggests that, in the absence of overriding reasons to do otherwise, continuity of care and quality treatment considerations should take priority over career development considerations.

RECOMMENDATION 13

The Canadian Forces should give primary consideration to the continuity of quality care for recovering soldiers, over career development options.

RECOMMENDATION 14

The Canadian Forces should monitor the mental health of its members for five years after deployment on operational missions, to ensure effective treatment and tracking of mental health issues.

THE STIGMA

The issue of a 'stigma' came up frequently. Mental health disorders are viewed pejoratively in the public at large. For many years, it was widely noted that within the military environment psychological injuries were viewed as a sign of weakness. Those who suffered a mental disorder were, sometimes harshly, judged as being 'not tough enough' to be a soldier. The 2002 Ombudsman's report found that those with PTSD are often "stigmatized, ostracized and shunned by their peers and the chain of command." Six years later, the Ombudsman's second follow-up report in 2008 found that the "negative stigma" associated with PTSD and other OSI remained a problem. However, it noted that a number of education initiatives had been launched in the intervening years, but that stronger leadership was needed at the local level.

The Committee heard anecdotal testimony from a number of witnesses, usually of junior rank, that described how, in the military culture, physical wounds that could be seen were more readily accepted, even respected, than psychological wounds that could not be seen and were often thought to be somehow less deserving of respect and might even be considered a sign of weakness, or even more devastating, a lack of courage ('guts'). To be fair, we also heard considerable testimony, mainly from senior ranks, that such views are changing and that all wounds, whether they be physical or psychological, are coming to be seen, and accepted as 'injuries'.

The Canadian Forces has recognized for some time that the stigma surrounding mental illness is a leadership issue. There is evidence that significant improvement is being made. Conducted between 2006 and 2008, a recent survey of Canadian Forces personnel returning from Afghanistan, who had completed their decompression period, clearly shows that over 80% of respondents disagreed with stereotypical stigmatization. They rejected views that people with mental health disorders are weak, that their careers would be adversely impacted and that there would be difficulty getting time off work for treatment. An overwhelming 93.5% said they would not think less of anyone receiving mental health counselling.[44]

Moreover, at a US-Canada Forum on Mental Health and Productivity meeting in November 2008, the Canadian Forces was praised for its success in reducing the stigma associated with mental illness, which has become a significant workforce and productivity issue throughout North America in general.

---

44 Canadian Forces Survey. *Stigma and Other Barriers to Mental Health Care in Canadian Forces Members Returning from Deployment to Afghanistan.* Anonymous data collected following Third-location Decompression in Cyprus 2006-2008. More than 9000 respondents. Response rate greater than 90%.

The Canadian Forces Mental Health and Operational Stress Injury Joint Speakers Bureau has developed a national education campaign to increase general mental health literacy among all ranks of the Canadian Forces and to remove social barriers to care. To date, over 8,000 military members have received training and education through the campaign.[45]

The Committee believes that remnants of this stigma thrive largely because of the absence of an appropriate, over-arching attitude towards mental health issues in the Canadian Forces, which, as discussed at the beginning of this report, is one of the root causes of many difficulties facing the military health care system.

RECOMMENDATION 15

The Canadian Forces must recognize there still exists a certain culture, perhaps even a prejudice, regarding how mental illness is perceived among its rank and file.

RECOMMENDATION 16

The Canadian Forces should continue its efforts to educate all military personnel on the nature, processing and treatment of OSI, with a particular effort to eliminate any stigma associated with the condition.

RECOMMENDATION 17

The Canadian Forces should embed in all leadership training courses, at all levels, material on identifying and processing personnel with OSI. Enhanced material, for commanders at all levels, should be included in all pre-deployment training too.

But, there are also other, more subtle things that sustain the stigma.

Well-meaning concern over the fact that Operational Trauma Stress Support Centres, located on major Canadian Forces Bases, apparently fail to provide enough privacy is one example. We heard from a number of witnesses who said those seeking mental health help at an Operational Trauma Stress Support Centre cannot do so anonymously because others, including perhaps peers and supervisors, can see a Canadian Forces member going in and out of the building. They fear being ostracized,

45 See DND Backgrounder at http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2844.

talked about, or worse, enduring adverse career action. The answer, according to some witnesses, is to move mental health clinics off-base, where confidentiality and privacy can be achieved.

Apart from the fact that no evidence exists to support the idea that off-base clinics provide improved confidentiality, this type of move might simply ignore or reinforce the real problem. There are medical professionals who think moving mental health facilities off-base only reinforces the perception of stigma. If psychological injuries are to be treated the same as physical injuries, perhaps Operational Trauma Stress Support Centres should be co-located with other medical services on the base to encourage the equivalency. This issue is discussed further in a later section.

RECOMMENDATION 18

The Department of National Defence and the Canadian Forces should move to co-locate all medical facilities on military bases, in a manner that supports the concept that all injuries and ailments will be treated with equal respect and that works to eliminate any lingering stigma associated with mental health issues.

The physical separation of those who suffer OSI from their unit and peers is another issue that feeds the stigma. Often such patients are left idle at home, with their family, only to venture out when treatment demands it. As comforting as being at home with family might be, it is not 'normal' for a soldier, who usually fills a day on duty within the unit, among peers, where daily routine is largely managed. The Committee thinks that any stigma would be further reduced if, like those with a physical injury, OSI sufferers were engaged in at least a near-normal, supervised daily routine among peers. The establishment of the JPSU will help in this regard.

JOINT PERSONNEL SUPPORT UNIT

On March 2, 2009, the Canadian Forces announced that, over the coming months, a network of eight support centres will open (Vancouver, Edmonton, Shilo, Toronto, Petawawa, Valcartier, Gagetown and Halifax), known as Integrated Personnel Support Centres (IPSCs), which are all to be subordinate to the JPSU, located in Ottawa.[46] The JPSU and its satellite IPSCs, are to respond to requests for support and report, through the chain of command, on issues of concern raised by ill and injured CF personnel. They

46 See the JPSU Backgrounder at http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2880.

aim to improve the quality of health care and services, to ensure military personnel have access to a consistently high standard of care and support across the country, and reduce gaps, overlaps and confusion, so no one 'falls through the cracks'.

The JPSU will coordinate Canadian Forces and Veterans Affairs Canada health care services for military personnel and their families; support serving and releasing Canadian Forces personnel, both Regular and Reserve Force; cater to both referrals and walk-in clients, to long-term injured personnel and to members considering retirement. It responds to queries from family members regarding support services and programs for ill and injured personnel, and provides referrals as appropriate.

RECOMMENDATION 19

The Department of National Defence should ensure that adequate resources are allocated to the establishment of a sufficient number of the Joint Personnel Support Units and Integrated Personnel Support Centres to provide this level of support and service nation-wide.

RESERVISTS

The Department of National Defence and Canadian Forces Ombudsman's report on the inequities of Reserve Force benefits as a result of injury confirms the administrative challenges that have long been facing the Reserve Force. During our study, the Committee acquired evidence that Reserve units are unable to complete necessary administration relating to mental health post-deployment screening. One witness described how he received no contact or support from his small city-based regiment.

In another area of the country, post-deployment screening of 57 soldiers in a strong Reserve regiment was not completed in the six-month time frame defined for the activity. During that period:

a) 35 of 57 had completed the required medical follow-up;

b) 14 of 57 had completed the tuberculosis skin test; and

c) 36 of 57 had completed the Enhanced Post-Deployment Screening survey.[47]

47 Information received from DND on March 19, 2009.

In practice, most returning Reservists are simply given instructions to fill out certain forms at specific times and that they must contact, on their own, a local contracted social worker, to arrange an appointment for and interview. Some of these contracted civilian social workers have been described as having no idea what Reservists did in Afghanistan, no empathy and little interest in digging too deeply into the psychological state of soldiers.

When Reservists come home from an overseas operation, they can be effectively supervised for the duration of their full-time service contract, which may (usually) expire between 60 to 90 days after their return. During that time, injuries or ailments that become apparent can be addressed. In cases where those injuries and ailments are not remedied during the period of the full-time service contract, the contract can be extended until the military member has recovered, or until the soldier wishes to terminate the contract. In either case, Canadian Forces supervision of care and treatment continues.

Difficulties arise in two ways. First, some injuries, particularly OSI, may not become apparent during the life of the full-time service contract. So after about 90 days the Reservist returns to civilian life and at some later point, when they start to have difficulty, they may or may not seek help on their own. The Reserve unit may never know about the problem.

Second, it is a fact that some Reservists, even upon being instructed to complete forms and make appointments, simply do not. Off duty, they cannot be compelled to do so. Reserve unit efforts to organize and complete such administration can face frustrating delays. In some Reserve units, a more proactive approach seems to work, whereby contract civilian social workers are brought to the armouries on a parade night and all returning personnel (usually not a large number in any one Reserve unit) are interviewed individually and the necessary forms completed. Reserve units that take a more passive approach and leave it up to individual Reservists to complete the forms and make interview appointments themselves tend to get less satisfactory results.

RECOMMENDATION 20

Reserve unit chains of command must be intimately and proactively involved in ensuring their returning personnel complete the post-deployment process on time, including all necessary administration, interviews and medical appointments. Where individual Reservists are undergoing continuing care and treatment after full-time service, Reserve unit chains of command must remain in regular contact with CFHS case managers and take an active interest in the soldier's treatment program.

RECOMMENDATION 21

The Canadian Forces must continue their efforts to inform and educate military members and their families about the nature and treatment of OSI, but with an enhanced focus on Reserve Force commanders, personnel and their families, particularly those who reside at some distance from a military installation.

CONTINUING SERVICE

One of the more emotional points that came before the Committee was the issue of whether and how an injured soldier might be allowed to continue serving in the Canadian Forces. It was sometimes amazing to hear from wounded servicemen and women who, no matter what their malady, wanted desperately to remain in uniform, in some capacity. Emotion aside, in the profession of arms in Canada, no one is owed a long military career and no one has a right to promotion. Nonetheless, the issue deserves sober discussion.

Department of National Defence Departmental Administrative Order and Directive (DAOD) 5023-0 spells out the policy on Universality of Service in the Canadian Forces.[48] The principle of universality of service or 'soldier first' principle holds that Canadian Forces members are liable to perform general military duties and common defence and security duties, not just the duties of their military occupation or occupational specification. This may include, but is not limited to, the requirement to be physically fit, employable and deployable for general operational duties. All Canadian Forces personnel must meet the Minimum Operational Standards.[49]

To execute its mission the Canadian Forces must be given broad authority and latitude in utilizing Canadian Forces members and their skills. The statutory basis for this authority is Section 33 of the NDA, the essence of which is recognized in the *Canadian Human Rights Act* which provides that the duty to accommodate is subject to the principle of universality of service.[50] Under this principle, Canadian Forces members must at all times and under any circumstances perform any functions that they may be required to perform. This open-ended nature of military service is one of the features that distinguish it from the civilian notion of employment governed by a contract.

---

48 See DAOD 5032-0 at http://www.admfincs.forces.gc.ca/dao-doa/5000/5023-0-eng.asp.

49 See DAOD 5023-1, *Minimum Operational Standards* are found at http://www.admfincs.forces.gc.ca/dao-doa/5000/5023-1-eng.asp.

50 *Canadian Human Rights Act*, Subsection 159 at http://laws.justice.gc.ca/en/ShowFullDoc/cs/H-6///en.

Injured personnel whose prognosis leads to eventual full employability again are retained in the Canadian Forces while they recover. Some however, whether they suffer from a physical or psychological wound, may still meet Minimum Operational Standards, but will not regain full employability in their former trade because they cannot meet the medical standards for that particular trade. Rather than being released from the Canadian Forces, they may be offered an occupational transfer (OT) to another, less demanding trade.

During testimony, the Committee heard that OT bureaucracy needed to be streamlined to allow transfers to happen quickly, particularly in the cases of OSI sufferers who were eager to get back into familiar, but less demanding surroundings. While we did not pursue this issue in detail, we do wish to note that OT is not entirely the panacea some make it out to be. Recalling the mission orientation of the Canadian Forces, it must be remembered that only personnel who can fully meet employability standards can be retained for their full period of service. All Canadian Forces trades ultimately have an operational role. Postal clerks, cooks and infantrymen find themselves side by side in Afghanistan.

The OT process is not merely a trade reassignment activity. There is more to it than that. Complex considerations are involved related to medical status, qualifications, operational requirements, training schedules etc. Without explicit evidence to the contrary, the Committee cannot find any fault with the existing system. We are confident that the Canadian Forces will continue to take necessary steps to achieve any further efficiency that may be required to allow the timely transfer of injured soldiers to another military trade, in keeping with operational requirements.

Some Canadian Forces personnel are injured so badly and suffer so grievously from physical injury or OSI/PTSD that they will not recover to a level of employability, even in a less strenuous trade. In accordance with universality of service regulations they will usually be released from the Canadian Forces and responsibility for their continuing care will be taken up by Veterans Affairs Canada. Today however, the Chief of Defence Staff applies a good deal of compassion and common sense to the application of existing regulations in order to allow injured soldiers the time and support they need to heal and come to their own decisions about continuing service.

RECOMMENDATION 22

The Committee encourages the Minister of National Defence and the Canadian Forces to continue to strive for the compassionate application of existing regulations regarding universality of service and minimum operational standards, to allow the continued employment of recovering soldiers, as long as such employment contributes to Canadian Forces operational requirements.

THE FAMILY

It is widely recognized in the Canadian Forces that the well-being of military families is crucial to operational effectiveness. Soldiers in battle should not have to worry about their loved ones at home.

Since 1992, the Department of National Defence has supported a network of more than 40 Military Family Resource Centres (MFRC) in cities and on military bases across the country.[51] When troops deploy on operations, Canadian Forces Bases also mobilize Deployment Support Centres (DSC), populated by military personnel dedicated to supporting families left behind.[52]

In 2008, the Canadian Forces held the first annual Families Summit, at which MFRC and military family representatives gathered with senior military leaders to discuss how family support services can be enhanced. A national campaign championing the role and importance of military families has been developed, under the title *Military Families: The Strength Behind the Uniform* and there are plans in progress to establish a national Canadian Forces Family Advisory Board that will report twice a year to the Armed Forces Council, to provide advice on military family issues directly to senior Canadian Forces leaders.

Families of military personnel with mental health concerns currently have access to a range of Canadian Forces and Veterans Affairs Canada services and programs, including counselling available through the Member Assistance Program and the Operational Stress Injury Social Support (OSISS) network.[53] Support is also provided by the joint Department of National Defence/Veterans Affairs Canada Centre for the Support of Injured Members, Injured Veterans and Their Families (known as 'the Centre') and the National Operational Stress Injuries Centre in Saint Anne de Bellevue, Quebec.[54] Crisis intervention is available through the network of MFRCs across the country, in the US and in Europe.

---

51 See the Director of Military Family Support at http://www.cfpsa.com/en/psp/dmfs/index.asp.

52 For example, see a DSC website at http://www.army.forces.gc.ca/DSC_Petawawa/index-eng.html.

53 See The Centre's website at http://www.cmp-cpm.forces.gc.ca/cen/atc-slc/index-eng.asp. Also see the OSISS website at http://www.osiss.ca/engraph/index_e.asp?sidecat=1.

54 See the website of the National Centre for Operational Stress Injuries at http://www.vac-acc.gc.ca/clients/sub.cfm?source=steannes/stann_ctre.

ACCESS TO CARE

The provision of health care services to military families, like civilian families, is a provincial responsibility. However, access to that care is uneven. In relatively isolated or rural military bases such as CFB Cold Lake and CFB Petawawa, few, if any, military families have family doctors, due to shortages of medical health professionals in the area, although they do have access to nearby hospitals and emergency clinics. Families that have a family doctor in one location will not necessarily gain another when they move to a different location in the country or overseas.

The Committee heard evidence that even where health care services are available, there may be challenges in getting to it, once again particularly in isolated or rural areas. Family members are sometimes required to travel a considerable distance to attend specialist medical appointments, but do not have regular or reliable means to get there. In this way, what was described to us as an access to care issue, might, in some cases, be just a transportation issue. This is one issue that can be solved by the Department of National Defence and the Canadian Forces.

RECOMMENDATION 23

The Department of National Defence should immediately provide enhanced transportation resources (such as modern multi-passenger vans or highway cruiser buses and drivers) to isolated military bases to ensure that military personnel and family members have adequate transportation for access to out-of-town health care services and medical appointments.

RESPECT AND EMPATHY

Some family members, particularly parents, expressed clear disappointment at the apparent lack of respect and empathy they got from some Commanding Officers, or their representatives, when they sought to intervene on behalf of their son or brother, who, in the cases we heard, held the rank of Private and Corporal.

Also, the operational chain of command apparently has little tolerance for the interest of family members in the administration and care of an injured soldier, particularly if that soldier feels unattended to. Mid-level commanders may chafe at the notion that parents might have an opinion and role in influencing treatment to be given to their son, the soldier. We have already provided a recommendation related to this issue.

BECOMING ENGAGED

The Canadian Forces provide a plethora of military family social support services, many through the network of MFRCs, but others through unit and Base programs. MFRCs are located on major Canadian Forces Bases to support the mainly Regular Force families that reside there. There are other MFRCs, like the one in Calgary, that serve a clientele mainly composed of reserve families. Some, like the MFRC in Ottawa, serve a collection of families from various backgrounds, the only common element being the fact that they have a family member deployed on an operation somewhere.

The Committee is aware of evidence that some military families, both Regular and Reserve, do not take full advantage of MFRCs, or other family support programs. There appear to be two reasons for this. First, serving soldiers, who receive information about family support services during their pre-deployment training, are less than diligent in passing that information on to their spouses. Second, some spouses, particularly those raising a family in a larger urban area and not on a military base, prefer not to get engaged with military family support services, apparently feeling they can do just fine on their own.

These circumstances are particularly prevalent in families with deploying Reserve Force members. In one appearance before the Committee, the parents of one young Reservist, one of whom is a medical doctor, acknowledged they did not act on the family support information provided to them, by their son and his unit, prior to deployment.

While families cannot be compelled to participate in social support programs offered, the Committee does feel they should be respectfully reminded that becoming engaged will help them cope with the absence of their loved one and provide the comfort in knowing the range of help available should they need it. Moreover, it is also important that military spouses and families realize that even if they do not require help during the tour, they may in a position to help another family who is less fortunate. If military families expect to benefit from the myriad of social support programs provided by the Canadian Forces, they have a responsibility to become engaged.

RECOMMENDATION 24

The Canadian Forces has an obligation to remind personnel that they have an obligation to keep their families fully informed of medical and social support services available to them. The Canadian Forces must continue to encourage military families to engage those medical and social support services.

THE DEPARTMENT OF NATIONAL DEFENCE AND THE CANADIAN FORCES

THE MENTAL HEALTH NETWORK IN THE CANADIAN FORCES

Over the last ten years, the Department of National Defence and the Canadian Forces have established a range of programs and initiatives to contribute to the identification, prevention and treatment of mental health problems.

The Enhanced Post-deployment Screening Process, a survey conducted 90 to 180 days after the return of deployed troops to Canada, tracks personnel experiencing deployment-related mental health problems. The five Canadian Forces Operational Trauma Stress Support Centres in Esquimalt, Edmonton, Toronto, Ottawa and Halifax have been joined by six Veterans Affairs Canada Operational Stress Injury clinics in Montreal, Fredericton, Quebec City, London, Winnipeg, and Calgary. The Operational Stress Injury Social Support (OSISS) network provides peer support, family counselling and bereavement services across the country.

A Special Advisor to the Chief of Military Personnel (CMP) oversees the management of non-clinical matters related to OSI. An Operational Stress Injury Steering Committee, which includes key senior leadership of the Canadian Forces, studies innovative ways of dealing with OSI, while an arm's-length joint Department of National Defence/Veterans Affairs Canada Mental Health Services Advisory Committee (MHSAC) reports to the CMP and to Veterans Affairs Canada leadership on mental health issues.

These are all admirable initiatives, but as has been covered elsewhere in this report, the real challenges are found in effectively implementing higher policies and direction. To ensure that state-of-the-art practices are available to all Canadian Forces chain of command appointments and mental health professionals the Committee thinks that more strategic advantage can be taken of Department of National Defence and Canadian Forces involvement in the FHP.

RECOMMENDATION 25

In conjunction with other Federal Healthcare Partnership stakeholders, the Department of National Defence, Veterans Affairs Canada and the Canadian Forces should hold an annual national conference on best practices and advancements in military health care overall, with special emphasis on mental health care.

THE MORAL RESPONSIBILITY

Civilian military family members are covered by provincial health care programs. The Canadian Forces has no formal or legislated mandate to treat civilian military family members. Canadian Forces resources are budgeted and allocated on military requirements alone and do not formally take into account the health requirements of military families because the Canadian Forces have no mandate to do so.

Nonetheless, the Committee heard much about the moral responsibility of the Canadian Forces to care for military families. We note however, that the Canadian Forces itself was the first to assume this responsibility many years ago. The Canadian Forces has always offered care and support to its military families *in keeping with the resources available and what it could do.*

Some non-military witnesses arbitrarily spoke of this moral responsibility not only as though it was something new, but in a way that exceeded the Canadian Forces mandate and resources. In recent testimony, a representative of the Department of National Defence and Canadian Forces Ombudsman said, "First, as mental health injuries are the result of military service, and the direct cause of family stress, the Canadian Forces have a moral responsibility to ensure that care and treatment are provided to families."[55] Not only can the Canadian Forces not *ensure* care and treatment that is beyond their mandate, they also certainly cannot do so if it involves interfering in legislated provincial affairs.

NOT ENOUGH PEOPLE

The central issue facing the Canadian Forces is the shortage of personnel, almost everywhere, almost all the time. This is not a new phenomenon. It has been a significant impediment to all Canadian Forces activity for generations. Despite government authorization and funding that allows an increase in Canadian Forces personnel strength to nearly 100,000 Regular and Reserve personnel, the net growth has been weak.[56] In many ways, this too is a whole-of-government issue, but it is beyond the scope of this study. What is relevant here is the fact that the extended impact of this chronic shortage is instrumental in thwarting the ability of low-level chains of command to supervise and care for their soldiers.

---

55 McFadyen, Mary, *Evidence*, Standing Committee on National Defence, Meeting No. 004. February 25, 2009.

56 The CF Regular Force strength has grown by less than 3300 in the past five fiscal years. See the DND Backgrounder at http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2865.

Personnel growth is also hindered by the steady attrition of mid-level senior officers and senior non-commissioned officers (Sr NCOs), partly as a result of a relentless tempo of operational training and deployment, particularly in Afghanistan.

One consequence of this chronic personnel shortage is the fact that, because of the 'operations primacy' approach in the Canadian Forces, many training establishments have less personnel than they need. To provide the necessary instructional, support or administrative staff required to conduct training activity, military personnel from other units are temporarily assigned to military schools and training activities.

Throughout every year, but mainly during the spring and summer training periods, hundreds, if not thousands of junior military leaders, particularly in the Army, are removed from their units and 'tasked' to instruct, support or administer a variety of training activities at other locations. The bulk of these 'taskings' fall on the Master Corporal, Sergeant, Warrant Officer, Lieutenant and Captain ranks—the very ranks that provide close supervision of soldiers. These 'taskings' usually require the tasked individual to be away from home (again) for up to two months at a time.

Concurrent with the summer 'tasking' period is the annual posting cycle during which many Canadian Forces personnel and their families are re-assigned to new duties elsewhere. Such moves normally come every two or three years over the course of a career.

The case of one Army battalion is instructive. It returned from a seven month tour of duty in Afghanistan in the spring of a year. Their time in Afghanistan had been marked by some of the largest ground combat operations in the history of NATO and in the history of Canada since the Korean War. They had sustained many killed and wounded, but they had fought well and were now home for a rest.

After about three days back in garrison, where necessary administration was completed and equipment turned in, unit personnel were allowed to depart on some well-deserved leave. Most went home to families, living either in garrison, or in other towns across Canada. Some young single soldiers remained on their own, in their quarters, on-base.

In effect, everyone became unsupervised and beyond the observation of their peers and unit chain of command who knew them best. In the nearly three weeks of leave, a few soldiers succumbed to symptoms of OSI, some disruptively and violently so. The problem was, this all happened at home, or beyond the view of the unit chain of command. Families began to suffer too.

When the period of post-deployment leave was finished and unit personnel returned to duty, those soldiers suffering to various degrees from the symptoms of OSI tended not to step forward and self-report their difficulty. Instead, many of the problems came to light

in the form of disciplinary issues resulting from inappropriate behaviour. They became identified as ‘problem soldiers’

At this time, being the beginning of the summer training period, the inevitable ‘taskings’ started to come in. Unit Junior NCOs, Senior NCOs, Warrant Officers and junior officers started to depart for temporary training assignments elsewhere. Young soldiers, a few of whom now obviously suffered from a variety of OSI were increasingly supervised by a dwindling cadre of junior leaders, some of whom had their own post-deployment issues, but who could not escape the increasing workload. All this was happening during the period that the Army theoretically identifies as a post-operation ‘reconstitution’ phase.

It must be remembered too, that this is now also the ‘active posting season’ and some of the battalion’s leadership personnel are packing up and moving their families to a new location, as the military member is re-assigned to a new job.

Just when an experienced, familiar chain of command is needed to bring all unit personnel through the post-deployment phase, part of which involves mental health screening, it is dissipated by the burden of ‘taskings’ and postings. In an interview, a Commanding Officer, who arrived on posting and the Regimental Sergeant Major, who remained in the unit, lamented the circumstances of a chain of command ravaged by ‘taskings’, recalling their deep regret at not being able to do more, but also recalling their feeling of frustration and helplessness in being unable to stem the tide of ‘taskings’.

This brief vignette illustrates that, while no one argues with the pre-eminence of ‘operational primacy’ in the Canadian Forces, there is a requirement to reflect upon what might come second. From what we have seen and heard, the Committee feels that concern for the health, particularly mental health, of personnel in units returning from operational tours of duty should, to the extent and duration required, be given primacy over other considerations. Put bluntly, the continuing health of soldiers should outweigh training challenges of the moment.

RECOMMENDATION 26

The Canadian Forces should ensure that personnel in units returning from operational tours of duty are exempt any further non-operational deployment away from their unit for the defined duration of the post-deployment reconstitution phase, unless to do so would negatively affect patient well-being according to mental health professionals.

RECOMMENDATION 27

The Canadian Forces should ensure continuity in the chain of command in units returning from operational tours of duty, particularly at lower levels, remains in place, as much as operational requirements allow, during the post-deployment reconstitution phase.

PREVENTION AND EXTENDED DOCTRINE

The Committee heard evidence from various professionals that there are few to no preventative diagnostics available at this time for mental health problems before people join the Canadian Forces. Similarly, it would present legal and human rights difficulties to implement a recruitment screening mechanism based on psychological diagnostic tools. Current Canadian Forces training is some of the best in the world and ably provides many soldiers with the tools they need to psychologically prepare them for the stresses they will encounter. Pre-mission training is also some of the best in the world (see Annex on Prevention). However, the Committee believes that more needs to be done to prepare soldiers for the battlefield stresses they could encounter. Research on how to adequately prepare soldiers and prevent OSI and PTSD needs to be a focus—i.e. an 'ounce of prevention' is certainly worth a 'pound of cure'. Current and ongoing advancements in 'Battlemind' training in the United States may prove especially fruitful and deserves attention by Canadian Forces medical personnel and policy officers.

As mentioned earlier, the Committee heard a considerable amount of evidence to the effect that operational casualty care on the battlefield is second to none and that all involved are nothing short of courageous, professional and dedicated. Concern over the efficacy of medical care and treatment begins after injured personnel leave the battlefield. Recognizing that the Canadian Forces have proven doctrine covering Health Services Support to Operations, we suggest further effort be devoted to developing extended doctrine covering the period from battlefield evacuation to recovery or transfer to Veterans Affairs Canada support upon release. This doctrine might include such subjects as:

a) a standardized regimen of continuing care for both physical and psychological injuries, from point of injury to recovery or release:

b) care and administration upon assignment to the SPHL;

c) role and responsibilities of the operational chain of command;

d) role and responsibilities of the medical chain of command;

e) role and responsibilities of injured personnel undergoing care; and

f) role of the family in continuing care.

RECOMMENDATION 28

The Canadian Forces should develop health services doctrine to cover the care and treatment of Canadian Forces casualties from the point of evacuation to recovery or release and transfer to Veterans Affairs Canada support.

RECOMMENDATION 29

The Canadian Forces should ensure their extended health services doctrine includes measures addressing OSI from recruitment through to retirement, with particular emphasis on the preparation of soldiers to endure psychological traumas before they engage in combat operations. The Canadian Forces should investigate best practices in psychological preparation for OSI and PTSD.

THE CLINIC

A number of witnesses who appeared before the Committee, including Dr. Greg Passey and Senator Romeo Dallaire, a noted psychiatrist and former Canadian Forces officer respectively, recommended that military mental health clinics should be located off-base, so that those seeking help would not be seen by friends, peers and the chain of command. The same point was made by some personnel participating in a Canadian Forces Patient Satisfaction Survey in January 2009. They wanted a more discreet location.

Another view holds that moving mental health clinics off-base would only aggravate the issue of stigmatization. Besides, going off-base in a small town like Petawawa would not necessarily provide a more discreet location, unless the clinic was placed at some distance. If psychological injuries are to be thought of and treated the same as physical injuries, it stands to reason that they would be attended to in the same facility. Having the Operational Trauma Stress Support Centres remain on base is not only economical and efficient, it is one way of mitigating any inappropriate stigma.

RECOMMENDATION 30

The Department of National Defence and the Canadian Forces should institute a program, in concert with Provincial and Territorial governments, to monitor best practices for the cooperation and integration of Canadian Forces health services with local community health and social services, and implement common high standards.

THIRD LOCATION DECOMPRESSION

Most troops returning from a tour of duty in Afghanistan are required to undergo a short period of 'decompression' in Cyprus, a location specifically chosen to provide a safe and 'normal' atmosphere for a few days, where soldiers can rest and relax after enduring the operational environment of combat in Afghanistan. This period of decompression lasts from three to five days, depending on arrival and departure times of military flights. During their stay in Cyprus, troops are provided with a few hours of briefings about the challenges of reintegration back home. They are given information on OSI and provided with social support contact information should they need it.

It is important to note that while decompression may be useful in identifying some who might display symptoms of OSI, this is not the primary aim of the decompression activity. Decompression is primarily aimed at assisting personnel to ready themselves for reintegration into their family, either as a returning spouse, or returning son or daughter. Families in Canada have managed their lives during the soldier's absence in Afghanistan, but the returning soldier might be expecting to 'pick up where he left off' before his departure. There may be a period of readjustment for both parties. Decompression briefings aim to help the returning soldier understand some of the readjustment challenges he or she may face. It should also be noted that equivalent briefings are made available to spouses and families through MFRCs at home.

The Committee also notes that holistic health and spiritual care are vitally important to many Canadians, including the Canadian Forces. Military padres and/or privately contracted religious/spiritual advisors provide an important service for Canadian Forces members who request and rely on their services. The Committee heard testimony that these religious/spiritual professionals provided excellent services to Canadian Forces members during the decompression state—not to mention at bases across Canada.

RECOMMENDATION 31

The Canadian Forces should ensure that a military padre or contracted religious/spiritual advisors are available at any third location decompression centre and are included in the Canadian Forces strategy on mental health care.

OPERATIONAL TRAUMA STRESS SUPPORT CENTRES

These centres were established in 1999 and are located in Edmonton, Esquimalt, Halifax, Ottawa and Valcartier.[57] They provide assistance to serving members of the Canadian Forces and their families dealing with stresses arising from military operations. Operational Trauma Stress Support Centres holistically address a myriad of psychological, emotional, spiritual and relationship problems, with a multi-disciplinary team of medical professionals, including a psychiatrist, a psychologist, a social worker, a chaplain and a community health nurse.

Although not mandated to treat civilian family members, Operational Trauma Stress Support Centres, as part of their holistic approach, do sometimes treat families, particularly where the military members has an OSI, or when both spouses are having relationship difficulties.

The Committee notes that relationship and family stress is a further contributor to retention problems and an additional stressor for those suffering from OSIs and PTSD. We heard evidence that suggested the Canadian Forces hire registered marriage and family therapists to be included on the Operational Trauma Stress Support Centre multi-disciplinary team. We feel however, that while such relational treatment might be needed, the Canadian Forces should retain the flexibility to decide whether such professionals need to be hired permanently, or whether there services can be contracted in the local area. Nonetheless, the idea does represent the need to be open to new and alternative treatments that have not traditionally been part of the military health care system.

RECOMMENDATION 32

The Canadian Forces should regularly review the composition of the Operational Trauma Stress Support Centre multi-disciplinary teams and remain open to the addition or use of clinical professionals not traditionally found in the military health care system, such as registered marriage and family therapists and that the services thereof be added to the Dependents' Extended Health Care schedule of covered benefits.

57 See the OTSSC website at http://www.forces.gc.ca/health-sante/ps/mh-sm/otssc-cstso/default-eng.asp.

KEEPING TRACK OF HEALTH INFORMATION

It seems that the CFHS does not know how exactly how many Canadian Forces members suffer from OSI. Such records are not aggregated. Past reports of both the Auditor General of Canada and the Department of National Defence and the Canadian Forces Ombudsman were critical of the CFHS for its inability to collate health care information at the national level. A Canadian Forces project to field an information system that could maintain such records was expected to have been completed before now. In the second follow-up report published in December 2008, the Ombudsman remained pointedly critical of the Canadian Forces' apparent lack of success in getting such a system up and running.

Although there are, in fact, a number of processes by which the Canadian Forces can track personnel with particular health issues, they are not precise or disciplined enough to compile and sustain up-to-date information on all patients, all the time.

However, Canadian Forces health records are being computerized, in concert with a national effort to develop electronic health records across Canada. In fact, the Canadian Forces Health Information System (CFHIS) is nearing completion. CFHIS is an electronic health record solution that will securely share information and coordinate care for Regular and Reserve force personnel, anytime, anywhere. It creates a complete health record for every Canadian Forces member by integrating a number of software applications that support a wide range of Canadian Forces health services and functions including: centralized patient registration and scheduling; computerized physician order entry and clinical notes; pharmacy information system; laboratory information system; a radiology information system; and a dental information system.[58]

CFHIS project began rolling out electronic patient registration, scheduling and immunization tracking capabilities to medical and dental clinics across the country in April 2005 and by September it reached the half way point, with 21 sites and 438 trained users accessing new applications. There seems to be no further, current information available on the project and when presented with the opportunity when she appeared before the Committee, the Surgeon General offered no details on the project, leaving Committee members under the impression that little, if anything was being done to address the recommendations of both the Auditor General and Ombudsman. We continue to wonder why the Canadian Forces remains so reticent about what seems to be positive news.

58 See the CFHIS website at http://www.forces.gc.ca/health-sante/proj/cfhis-sisfc/default-eng.asp.

RECOMMENDATION 33

The Canadian Forces should provide this Committee, the Auditor General of Canada and the Department of National Defence and Canadian Forces Ombudsman with a full, unclassified update of the status of the Canadian Forces Health Information System, along with a meaningful explanation of when it will reach full operational capacity.

RECOMMENDATION 34

The federal government should move immediately to provide the necessary resources to reach full operational capability of the Canadian Forces Health Information Systems project, with the assistance of a database.

ENGAGING GOVERNMENT

As has been mentioned, concerns over the care and treatment provided to injured Canadian Forces personnel or their families have been aired in a variety of fora in the past two years. In almost all instances, recommendations have been directed at the Canadian Forces or Department of National Defence, both of which readily acknowledge and accept their lead role in providing treatment and care for military personnel and their families. We note, however, that, in exercising their health care responsibilities, both the Canadian Forces and the Department of National Defence will require the assistance and support of other government departments.

For example, the second recommendation in Department of National Defence and Canadian Forces Ombudsman's report on mental health services at CFB Petawawa calls upon the Canadian Forces to:

> ...establish and properly resource an organization—at the national level—responsible for working with external agencies and all levels of government, as required, to ensure that military families and individual members of the families of military personnel have access to the broad spectrum of services and care they need.[59]

The Committee knows of no Canadian Forces organizations with such a broad mandate and, to our way of thinking, it is inappropriate to direct the Canadian Forces to lead inter-governmental activity. Such a responsibility is political, not military. Recalling that care and treatment of civilian military family members is the legal responsibility of provincial health care plans, the Committee suggests that recommendations such as this require participation beyond the Canadian Forces and Department of National Defence, to engage the Government as a whole.

59 McFadyen, Mary. *Assessing the State of Mental Health Services at CFB Petawawa*. Ottawa: Ombudsman for National Defence and the Canadian Forces, December 2008. p. 15.

FEDERAL/PROVINCIAL/TERRITORIAL/MUNICIPAL COOPERATION

The Committee heard numerous witnesses say how impressed they were with the cooperative arrangements made between the Canadian Forces and provincial and some municipal health institutions in Edmonton and Calgary, Alberta and Valcartier and Quebec City, Quebec. Conversely, the apparent absence of equivalent cooperation in Petawawa, Ontario and Oromocto or Fredericton, New Brunswick was also frequently noted.

We know however, that the Petawawa Centennial Family Health Centre (PCFHC) was established in July 2005 and has provided care for thousands of patients, including those from military families.[60] It is partnered with the CFB Petawawa MFRC and the Canadian Forces Personnel Support Program. Mental health services for military families are provided by the Pembroke Phoenix Centre.

At CFB Gagetown, the Base Medical Clinic (BMC) has six in-patient beds and a well-equipped emergency department, including X-ray, laboratory, pharmacy, physiotherapy and mental health services.[61] Civilian medical facilities in the local area include the Oromocto Public Hospital, the Dr Everett Chalmers Hospital in Fredericton and the Saint John Regional Hospital.

The Committee is also aware of the substantial partnership established between the CFHS and the Montfort Hospital in Ottawa.

RECOMMENDATION 35

The federal government should initiate cooperative programmes with provincial and territorial governments, to offer incentives to qualified professional health care workers, to provide their services to Canadian Forces personnel and their families, in locations where there is a shortage of such services.

RECOMMENDATION 36

The federal government should continue to work in cooperation with provincial and territorial governments to enhance relationships between local community health and social services to enhance and Canadian Forces health care services.

60 See the PCFHC website at http://www.pcfhc.ca/about/index.html.

61 See the BMC website at http://www.army.forces.gc.ca/cfb_gagetown/english/bservices/medical/index.asp.

ANNEX A:
OPERATIONAL STRESS INJURIES AND POST TRAUMATIC STRESS DISORDER

OSI AND PTSD

The term Operational Stress Injury (OSI) is used by the Canadian Forces to include all types of psychological injuries resulting from the myriad stressors encountered in the course of military duty. Post-traumatic stress disorder (PTSD) is but one kind of OSI.[62] An OSI is any persistent psychological difficulty resulting from operational duties performed in the course of military service. It re-characterizes these conditions as injury, which is more in keeping with current thinking. OSI is not a legal or a medical term. Unlike PTSD, it is a strictly military term, used by Canada and NATO.

Mental health problems are no less real or legitimate than physical health problems. The brain is the most complex organ in the body and like other parts of the body it can be injured as a result of illness or injury. These injuries and the degree to which they affect brain functions are not a matter of personal will and not within an individual's ability to control. Just as individuals vary so too does the range of severity of their symptoms.

PTSD is a psychological injury caused by the reaction of the brain to a very severe psychological stress such as feeling one's life is threatened. In life threatening circumstances, the brain automatically kicks into 'emergency mode.' The fight or flight or freeze response is activated. The problem that arises in PTSD is the repeated reliving of the trauma leading to a continuous reactivation of this response. This can lead to difficulty functioning personally or professionally.

PTSD, one of the operational stress injuries, is a legitimate medical condition, like any other affecting the human body. It is considered a mental illness and is caused or aggravated by psychological trauma. PTSD often occurs in combination with other personal, social, spiritual and mental health difficulties. Associated problems may include depression, anxiety, alcohol and drug abuse, and difficulty dealing with family, friends, and co-workers.

62 See the DND Backgrounder on OSI and PTSD at http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2871.

It should also be made clear that there are a variety of other medical conditions that manifest very similar symptoms as PTSD but which are not PTSD. Symptoms of PTSD include: re-experiencing the event, sometimes by vivid dreams or through flashbacks; avoidance of situations or things that trigger memories of the event; difficulty enjoying or being interested in things the way they used to be, difficulty with intimate feelings; hyper-arousal symptoms such as irritability, the tendency to startle easily and to anger easily, (when these were not present before the event).

PTSD can be accurately diagnosed and effectively treated. As with other health problems, it is more effectively treated if identified early. Delay in treatment of PTSD can lead to aggravated symptoms and can also impede recovery.

Comprehensive care is best provided by skilled and experienced mental health care providers. Once PTSD is formally diagnosed treatment can include both therapy and medication. Medication is helpful and can help control symptoms, but the most effective therapeutic approach in most patients is Cognitive-Behavioural Therapy. The therapy deals with thoughts, feelings and behaviours that have been affected by the trauma. Literature supports this form of therapy as being the most effective.

The great majority of Canadian Forces personnel, approximately 87%, returning from deployment will not have to deal with any mental health issues. Some members, however, will have experienced symptoms of operational stress.

Overseas deployments expose military personnel to events that can cause psychological injury. Modern terms for the different kinds of operational stress are PTSD and OSI.

PTSD is an anxiety disorder. Other anxiety disorders are phobia, panic disorder and obsessive-compulsive disorder. PTSD is not an exclusively military phenomenon, and it is experienced by people regardless of their vocation or workplace. It is caused by an experience in which serious physical harm or death occurred or was threatened. This includes the serious harm or death of a friend or colleague, the viewing or handling of bodies, exposure to a potentially contagious disease or toxic agent, and the witnessing of human degradation (such as sexual assault).

PTSD is a complicated disorder with a wide range of symptoms:

- panic or anxiety (sweating, increased heart rate, muscle tension);
- mood swings, irritability, sadness, anger, guilt, hopelessness and depression withdrawal or difficulty expressing emotion;
- loss of interest in previously enjoyable activities;

- loss of intimacy;

- a preoccupation with the traumatic experience in the form of daydreams, nightmares and flashbacks;

- difficulty concentrating, disorientation and memory lapses, disturbed sleep or excessive alertness (sometimes called hypervigilance);

- erratic behaviour (in an attempt to avoid reminders of the traumatic experience); and

- alcohol or substance abuse.

The CMHA estimates that one in ten people suffers from an anxiety disorder. Many Canadian Forces members dealing with PTSD have developed the disorder as a result of non-military traumatic experiences such as accidents, assaults and natural disasters. Canadian Forces personnel experience of PTSD is, however, coloured by factors that do not always apply outside the realm of military operations. These include isolation from home and loved ones; unfamiliar or hostile populations and climates; extended periods of medium- and high-level stress; and, in many cases, the inability to leave the source of the stress.

Diagnosis of PTSD is complicated by the fact that it is not uncommon for a person who has the disorder to experience another anxiety disorder or a physical ailment at the same time. Diagnosis of PTSD requires that a person experience significant impairment in functioning and that this impairment persist for over a month.

PREVENTION

Primary prevention of mental health problems is in its infancy as a field of study. There is extensive ongoing research into understanding the root causes of stress disorders and “resilience,” or resistance to their effects. This research will guide the continued development of Canadian Forces prevention programs. CFHS has identified several ways to reduce the risk of personnel experiencing service-related mental injuries.

There are programs in place to enhance the self-help skills of Canadian Forces personnel. These initiatives cover healthy living, stress management, anger management, addiction awareness and family violence prevention. For those personnel deploying on stressful operations and missions, good mission preparation and training is critical. This includes education on stress-coping skills, unit cohesion and social support, and awareness of the potential effects of stress. Training is realistic and is designed to bolster confidence in both individual and team capabilities.

Personnel undergo a mental health screening as part of their pre-deployment physical assessment. Deploying personnel also undergo a psychosocial screening by either a chaplain or a mental health professional.

Canadian soldiers about to return to Canada after a lengthy deployment are required to experience a five-day decompression stop on the way home (commonly called Third Location Decompression, (TLD). At the TLD site, each member has the opportunity to speak with a mental health professional privately and to raise concerns that they may have at that time. Personnel are educated about PTSD/OSI. The mental health team provides information about home, work and community life back in Canada in order to make reintegration less stressful.

The Canadian Forces screening and reintegration policy requires that all personnel returning from an international operation of 60 or more days duration undergo the Enhanced Post-deployment Screening Process between 90 and 180 days after their return to Canada. This screening is meant to better identify those with deployment-related problems, with a particular focus on psychological problems. The Canadian Forces member completes a detailed health questionnaire and has an in-depth interview with a mental health professional. The interviewer completes a form recording a clinical impression and a recommendation for follow-up care. Regular periodic medical check-ups continue the mental health assessment of the Canadian Forces member.

TREATMENT

CFHS, in conjunction with military and civilian partners, is researching treatment options for stress disorders. At present, treatment of PTSD/OSI typically involves a combination of medication and psychotherapy.

The Canadian Forces maintains numerous sites for treatment of PTSD/OSI. The first point of contact for most military personnel who are experiencing mental health problems is the primary care physician at a Base Medical Clinic, who will either provide the required assistance or refer the member to the most appropriate resource. In the case of an emergency, personnel can access a physician during daily sick parade.

Mental Health Programs (MHP), specialized mental health services, are available at the larger Canadian Forces Bases. Elements of these programs will be available at smaller bases depending upon population size and local resource availability. Psychiatrists, psychologists, social workers, mental health nurses, addictions counsellors and Health Services chaplains normally staff the multidisciplinary teams of the MHP.

Operational Trauma Stress Support Centres located across Canada employ a mixed military and civilian staff of psychiatrists, psychologists, social workers, mental health nurses and chaplains. The Operational Trauma Stress Support Centres use a multidisciplinary treatment model to provide assessment, educational outreach, treatment

and research. In addition to providing direct service to Canadian Forces personnel, these centres are involved in consultation with other treatment facilities around the world, and in reviewing the professional literature on trauma, stress and PTSD/OSI. There are five centres: in Halifax, Valcartier, Ottawa, Edmonton, and Esquimalt.

Veterans Affairs Canada operates six operational stress injuries clinics to serve veterans, members of the Canadian Forces and former Royal Canadian Mounted Police officers who have suffered OSI as a result of their service. These clinics are located in Fredericton, Montreal, Quebec City, London, Winnipeg, Calgary, and Vancouver.

SUPPORT

Canadian Forces members, Regular and Reserve, in need can call a 1-800 hotline number to contact the Member Assistance Program, 24 hours a day, from anywhere in the world, for a confidential referral to someone who can help them. The program provides external, short-term counselling for members seeking assistance outside military health services. Family can also receive treatment through the program if this would influence the member's well-being. The program is civilian-based in that it uses professional counsellors provided by the Employee Assistance Services of Health Canada, but it is funded by the Canadian Forces.

OSISS

The Operational Stress Injury Social Support (OSISS) program was established in 2001[63] to provide one-on-one support, peer support groups for serving military personnel, veterans, and families, and social support to bereaved families. This program has grown into a robust partnership between the Canadian Forces and Veterans Affairs Canada. Within the Canadian Forces, OSISS is backed up by an educational campaign to help increase general awareness of mental health, provide information on how operational stress can affect individuals, their peers, their subordinates, and those around them, and teach military personnel what they can do to assist those with mental health issues. The goal is to enable Canadian Forces members to recognize early signs of mental health challenges and issues and to take positive action. This educational campaign has been expanded to include Canadian Forces families too, to help them, help them support their loved ones and help them better deal with the effects of mental health problems in their home.

63 See the OSISS website at http://www.osiss.ca/engraph/peer_sn_e.asp.

The National Operational Stress Injuries Centre in St. Anne de Bellevue, Quebec, enable close cooperation between the Canadian Forces and Veterans Affairs Canada medical staffs, particularly in cases governing the transition of Canadian Forces members being released to civilian status and the continuity of their care. The centre provides assessment, treatment, prevention and support services to currently serving personnel, veterans and their families who are suffering from mental health problems related to operational stress.

The Military Family Resource Centres located at all major Canadian Forces Bases are able to provide information on a wide range of subjects of interest to military families, including mental health. Staff at these centres can direct family members in greater need to appropriate service providers.

APPENDIX A:
LIST OF WITNESSES

39th Parliament, 2nd Session

Organizations and Individuals	Date	Meeting
Department of National Defence	2008/02/07	11
BGen Hilary Jaeger, Commander of the Canadian Forces Health Services Group, Director General of Health Services and Canadian Forces Surgeon General		
MGen Walter Semianiw, Chief of Military Personnel		
Department of National Defence	2008/02/12	12
LCol Gerry Blais, Director, Casualty Support and Administration		
Col David Weger, Director, Health Services Personnel		
Department of National Defence	2008/02/14	13
Cdr R.P. Briggs, Medical Advisor to the Chief of Maritime Staff		
Capt(N) M.E.C. Courchesne, Medical Advisor to the Chief of Air Staff		
Col A.G. Darch, Medical Advisor to the Chief of Land Staff		
As an individual	2008/03/04	15
Alain Brunet, Researcher at the Douglas Institute, Associate Professor, Department of Psychiatry, McGill University		
Department of National Defence		
LCol Theresa Girvin, Psychiatrist, Mental Health Services, CFB Edmonton		
Department of National Defence	2008/03/06	16
LCol Joel Fillion, Senior Staff Officer, Mental Health		
BGen Hilary Jaeger, Commander of the Canadian Forces Health Services Group, Director General of Health Services and Canadian Forces Surgeon General		
Office of the Auditor General of Canada		
Sheila Fraser, Auditor General of Canada		
Wendy Loschiuk, Assistant Auditor General		
Department of National Defence	2008/03/11	17
Cyndi Greene, Peer Support Coordinator, Calgary and Alberta South		
Shawn Hearn, Peer Support Coordinator, Newfoundland and Labrador		
Maj Mariane Le Beau, Manager,Operational Stress Injury Social Support		

Organizations and Individuals	Date	Meeting
Department of Veterans Affairs Canada	2008/03/11	17
Kathy Darte, Manager, Operational Stress Injury Social Support		
Col (Retired) Donald S. Ethell, Chair, Joint Department of National Defence and Department of Veterans Affairs Canada Operational Stress Injury Social Support Advisory Committee		
Department of Veterans Affairs Canada	2008/03/13	18
Doug Clorey, Director, Mental Health Policy Directorate		
Rachel Corneille Gravel, Executive Director, Ste. Anne's Hospital		
Raymond Lalonde, Director, National Centre for Operational Stress Injuries		
Department of National Defence	2008/04/03	19
Col Jean-Robert Bernier, Director, Health Services Operations		
LGen Michel Gauthier, Commander, Canadian Expeditionary Forces Command		
As individuals	2008/04/08	20
Robert Ayres		
Sylvain Chartrand		
Cindy Coady		
Maurice Coady		
Stacey-Lorraine Daza		
George Dumont		
Ann LeClair		
Cindy Smith-MacDonald		
Department of National Defence	2008/04/10	21
LCol Roger R. Barrett, Commanding Officer, 3rd Battalion, The Royal Canadian Regiment		
LCol Stephen M. Cadden, Commanding Officer, Royal Canadian Dragoons		
LCol Craig L. Dalton, Commanding Officer, 2nd Regiment, Royal Canadian Horse Artillery		
Col Dean J. Milner, Commander, 2nd Canadian Mechanized Brigade Group		
Gagetown Military Family Resource Centre	2008/04/15	22
Beth Corey, Executive Director		
Halifax and Region Military Resource Centre		
Colleen Calvert, Executive Director		

Organizations and Individuals	Date	Meeting
Military Family Services Program		
Celine Thompson, Director		
Petawawa Military Family Resource Centre	2008/04/15	22
Theresa Sabourin, Executive Director		
Department of National Defence	2008/04/17	23
MGen Timothy Grant, Deputy Commander, Canadian Expeditionary Force Command		
LCol Simon Hetherington, Executive Assistant, Chief of the Land Staff, Former Commanding Officer, Provincial Reconstruction Team		
Col Omer Lavoie, Task Force Commander, Counter Improvised Explosives Task Force, Former Battle Group Commander, First Battalion, The Royal Canadian Regiment Battle Group		
As individuals	2008/05/01	24
Paul Franklin		
Audra Franklin		
Jesse Larochelle		
Randall Larochelle		
As an individual	2008/05/06	25
Col (Retired) Pat Stogran, Veterans Ombudsman		
Canadian Forces Grievance Board		
Caroline Maynard, Director, Legal Services		
James Price, Acting Chairperson		
Department of National Defence		
Mary McFadyen, Interim Ombudsman, Office of the National Defence and Canadian Forces Ombudsman		
As individuals	2008/05/08	26
Joyce Belliveau		
Kathrine Carswell		
Michael Kent Carswell		
Chris Clark		
Robert Ferrie		
Robin Geneau		
Tammy Greene-Clark		
Jonathan Shay		
As individuals	2008/05/29	28
Hon. Roméo Dallaire, Senator		
Fred Doucette		

Organizations and Individuals	Date	Meeting
Greg Passey		
Allan Studd		
Department of National Defence	2008/06/05	29
Cmdre J. Bennett, Commander, Naval Reserve		
BGen G.J.P. O'Brien, Director General, Land Reserve		
MGen D.C. Tabbernor, Chief, Reserves and Cadets		
BGen E.B. Thuen, Director General, Air Reserve		
Department of National Defence	2008/06/12	31
LCol H. Flaman, Surgeon, Land Force Western Area, CFB Edmonton		
Maj S. West, Base Surgeon, Canadian Forces Health Services Centre Ottawa		
Cdr D.R. Wilcox, Regional Surgeon, Joint Task Force Atlantic		
Department of National Defence	2008/06/17	33
LCol Stéphane Grenier		
Gen Rick Hillier, Chief of the Defence Staff		
Capt(N) Hans Jung, Deputy Surgeon General		
MGen Walter Semianiw, Chief of Military Personnel		

40th Parliament, 2nd Session

Organizations and Individuals	Date	Meeting
Department of National Defence	2009/02/25	4
Col A. Darch, Director, Mental Health		
Col (Retired) D. Ethell, Chair, Mental Health Advisory Committee, Veterans Affairs Canada and Department of National Defence		
LCol S. Grenier, Special Advisor , Operational Stress Injuries, Post-Traumatic Stress Disorder		
BGen Hilary Jaeger, Commander of the Canadian Forces Health Services Group, Director General of Health Services and Canadian Forces Surgeon General		
National Defence and Canadian Forces Ombudsman		
Mary McFadyen, General Counsel		

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings (Meetings Nos. 3, 4, 8, 9, 10, 11, 12, 13, 16, 17, 21, 25 and 26) is tabled.

Respectfully submitted,

Hon. Maxime Bernier, P.C., M.P.
Chair

Dissenting Report on the Report on *Health Services Provided to Canadian Forces Personnel with an Emphasis on Post-Traumatic Stress Disorder*

Presented by the Bloc Québécois

The Bloc Québécois contributed significantly to the report on *Health Services Provided to Canadian Forces Personnel with an Emphasis on Post-Traumatic Stress Disorder.*

Although the report contains recommendations we endorse, the disregard for Quebec's jurisdiction for health is a major stumbling block.

We do not want to unduly criticize the federal government's actions with regard to health as long as it acts within its areas of jurisdiction. However, there has been a consistent trend at the federal level: its lack of expertise in health care provision. The federal government is closely involved in providing health care to Aboriginal peoples and military personnel, and we note a serious limitation in the quantity and quality of services. The federal government has the worst record with respect to Aboriginal peoples, and similar difficulties have been noted with regard to the Canadian Forces.

The Canadian Forces must often compete for the limited supply of health care professionals, leading to duplication. This is harmful for both levels of government.

Competition is proof that the federal government is not self-sufficient and must rely on the provincial public sector to meet its demand for services.

The federal demand for services also impacts the provincial government. Increased demand due to significant military presence in a region directly affects physician supply for civilians. The waiting list and wait time for taxpayers in hospitals are increasing.

We know that the department currently plans to increase recruitment efforts and strengthen retention measures, which will inevitably increase the number of military personnel. Moreover, the war in Afghanistan has a huge impact on the health of military personnel. It is certainly at higher risk given the difficutly of the work. Inevitably, the demand for health services will increase and the Canadian Armed Forces will have to rely on new personnel to meet their needs.

As stated in the *Constitution of Canada*, the federal government has jurisdiction over the "militia, military, naval service and defence"[64]. With respect to restructuring health care services provided to Canadian Forces personnel, the goal should not be to impose a new way of managing the health system on the provincial government. It already has a well-established health care system. We support the provincial government in retaining full control of its internal management.

At this time, the two levels of government must proceed by way of administrative agreements. There are two departments, two public services, one pool of services for both levels, which creates duplication as well as more red tape and bureaucratic rivalry. In our opinion, the federal government should instead provide the provinces with the financial resources required to meet their real needs.

The Bloc Québécois nevertheless regards recommendations 3, 4, 5, 18, 24 and 29 as clear interference in the jurisdiction of Quebec and the provinces for health. In reading this report, it appears that the Committee did not take into account the specific characteristics and jurisdiction of Quebec and the provinces for health care services. We accordingly object to this report since the federal government has not demonstrated respect for the jurisdiction of Quebec and the provinces for health.

64 *The Constitution Act, 1867*, Part VI, section 91.7.

Supplementary Report of Committee Member Jack Harris

I would like to make the following four points as a supplemental to the report of the committee:

1) While the important recommendations made in “Doing Well” continue to have my support, I remain uncomfortable with the overly positive tone that runs throughout the text of the report. The motivation of my New Democrat predecessor on this committee, Dawn Black, in seeking this study was the serious concerns coming from the members of the Canadian Forces and their families concerning the inadequacy of treatment and support for those suffering from Operational Stress Injuries (OSI), such as Post-Traumatic Stress Disorder (PTSD). For this reason, I feel it unnecessary to continually praise the Department of National Defence for its efforts when, in the case of Operational Stress Injuries, it has failed Canadian Forces members and their families.
2) While it is recognized that cooperation with other government departments and agencies is, of course, needed in dealing with OSI, the *overriding responsibility* must remain with the Department of National Defence to *ensure* that Canadian Forces members and their families receive the necessary resources, treatment and support. Operational Stress Injuries are complex and affect the lives of members in a variety of ways. Though providing OSI treatment poses challenges and is unique from the treatment of physical injuries, Canadian Forces members suffering from OSI are as deserving and entitled to the same standard and level of adequate treatment as those members suffering from physical injury alone.
3) Recommendation Twelve facilitates the use of an advocate to help Canadian Forces members and their families navigate both the Canadian Forces bureaucracy as well as the complex treatment regime required in many cases of OSI. While I am pleased that the use of an advocate, initially proposed by my colleague Dawn Black, is provided for in the recommendations, I would prefer the recommendation went further and included the establishment of an advocate program. By this I mean that the Canadian Forces would recruit and provide training for individuals who would be assigned to OSI cases to work as advocates on behalf of the members. These could be, for example, former CF

members, as they understand the Canadian Forces culture and system, or professionals from an appropriate field, such as healthcare or social work.

The recommendation for an advocate arose from witness testimony heard during the committee's study. The committee heard from family members of Canadian Forces members, including the father of a member who is himself a former member of the Canadian Forces, of the difficulty they faced in trying to help their loved one navigate the system. The Committee also heard from professionals specializing in the area of post-traumatic stress disorder. These individuals, such as Dr. Greg Passey who is a leading expert in the field and runs a PTSD clinic at Vancouver General Hospital, testified that family members can suffer from secondary PTSD, making it even more difficult to aid their loved one suffering from PTSD. Given the recommendations from both people affected by PTSD and professionals in the field, I believe there is ample evidence supporting the need for an advocate program.

4) The new and welcome initiative of Joint Personal Support Units (JPSU), are currently only available in places where major bases exist. While acknowledging this is a beginning only, and is satisfactory for many returning soldiers, it is inadequate for transferred soldiers and for reservists who return to their home communities. It is therefore hoped that the JPSU system will soon be expanded so as to ensure adequate service is available to all returning Canadian Forces personnel.

Respectfully submitted by:

Jack Harris, St. John's East