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CANADA

# CARING FOR CANADA'S ILL AND INJURED MILITARY PERSONNEL

## Report of the Standing Committee on National Defence

**Rick Norlock**
**Chair**

**JUNE 2014**

**41st PARLIAMENT, SECOND SESSION**

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# THE STANDING COMMITTEE ON NATIONAL DEFENCE

has the honour to present its

**FOURTH REPORT**

Pursuant to its mandate under Standing Order 108(2) the Committee has studied the Care of Ill and Injured Canadian Armed Forces Members and has agreed to report the following:

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# CARING FOR CANADA'S ILL AND INJURED MILITARY PERSONNEL

> The health and well-being of Canadian Forces members is the shared responsibility of leaders, health care providers and the members themselves. That includes a whole-of-government approach to ensure that those who serve their country and are called upon to serve with unlimited liability are provided with the care and support they and their families need in the unfortunate event that they become ill or injured. This is the social contract.
>
> Rear-Admiral Andrew Smith, Chief of Military Personnel, 22 November 2012

## Introduction

The House of Commons Standing Committee on National Defence ("the Committee") has had a long-standing interest in the care of ill and injured Canadian Armed Forces (CAF) personnel. Our last report on the issue entitled *Doing Well and Doing Better: Health Services Provided to Canadian Forces Personnel with an Emphasis on Post-Traumatic Stress Disorder* was released in 2009. The report concluded that although the CAF health care system and social support programs were effective, there was room for improvement — particularly with respect to the care of CAF members suffering from operational stress injuries (OSI), including post-traumatic stress disorder (PTSD). In the report, the Committee made 36 recommendations to the Government of Canada.

The care of ill and injured CAF personnel is still of interest to us, and we embarked on this study to examine improvements that have been made over the course of Canada's mission in Afghanistan with respect to the treatment of physical and mental injuries, and the challenges that remain. Throughout our study, the Committee identified a number of recurring themes, including prevention, treatment and support services for ill and injured CAF members, research and innovation, and support for military families. The Committee firmly believes that in caring for its members, the Department of National Defence (DND) and the CAF must continue to improve on all of these aspects throughout the various stages of a CAF member's career: at recruitment, in the pre-deployment phase, in-theatre (during deployment), during post-deployment recovery, and during his or her transition to civilian life. Although the report covers all aspects of a CAF member's career, the majority of the testimony we received focussed on the deployment and recovery stages. As well, much of the testimony focussed on OSIs, which means that this report focuses much more on mental illness than it does on physical injuries.

Since October 2011, the Committee held 24 hearings regarding the care of ill and injured CAF members. The Committee heard from CAF personnel living with physical and/or mental injuries, family members of ill and injured CAF members, the CAF leadership and health care practitioners, DND officials, the DND/CAF Ombudsman, various external health care professionals and associations, and charitable organizations. The Committee also spent a day at Garrison Petawawa visiting the health care facilities, meeting with health care professionals and administrators as well as with ill and injured CAF members and their families.

Despite the wide range of witnesses we heard from, the Committee faced certain challenges when trying to gather evidence. Unlike studies conducted internally by DND/CAF, Statistics Canada, and the DND/CAF Ombudsman, the Committee does not have unfettered access to the CAF population of ill and injured members, nor does it have access to confidential internal DND/CAF documentation. There are privacy laws regarding health care that would limit our knowledge of individual cases — and rightly so. We therefore had to rely on the reports that have been publicly released by these organizations and on the testimony of their representatives. In addition, certain individuals we wanted to hear from chose not to appear before us or could not as a result of ongoing grievances or litigation against DND and the CAF regarding the very issues we were intent on hearing about. This was an ongoing frustration. We did, however, hear from some ill and injured CAF members who came forward to present their concerns to us. Some of them expressed considerable exasperation with certain aspects of the health care and support system that they felt compelled to appear before the Committee for an opportunity to be heard. Furthermore, we were concerned that one witness in particular faced intimidation by his superiors for choosing to appear before us. We thank all of them for sharing their difficult experiences with us so matter-of-factly and at times with a sense of humour — which was particularly surprising given their circumstances. We admire their resiliency, and wish them all the best on their road to recovery and in accomplishing their future goals.

Based on the testimony it received and on publicly available information, the Committee agrees to report the following findings to the House of Commons.

**Context**

During the defence budget cuts of the 1990s, CAF health services faced very deep reductions, which included the elimination of CAF hospitals and other services provided to ill and injured CAF members, such as rehabilitation. In 2000, DND, through the Canadian Forces Health Services Group, launched the Rx2000 project to modernize and enhance the standard of care provided to CAF personnel. However, when Rx2000 was planned and approved, "Afghanistan was not on anybody's mind."[1] Therefore, it was more or less based on a "peacetime requirement to provide health care."[2] Canada's mission in Afghanistan (2001–2014) — Canada's largest military deployment since the Second World War and the armed forces' first major combat operation since the Korean War — required improvements to the CAF's existing health care programs and services. The CAF also recognized the need to develop new programs, particularly with respect to mental health care and rehabilitation, to meet the growing needs of CAF personnel returning home with various physical and/or mental injuries. According to Commodore (retired) Hans Jung, former CAF Surgeon General, Rx2000 provided the basic foundation on which to expand

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1 Cmdre (Retired) Hans Jung, NDDN *Evidence* (Standing Committee on National Defence), 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

2 Ibid.

and improve CAF health programs and services during the Afghanistan years. Rx2000 was "well thought out and methodically executed," he told the Committee, adding that the CAF is today "a leading organization and model of care" in a number of areas because of it.[3]

For example, the CAF operates Canada's first and, at the moment, only pan-Canadian electronic health records system — the Canadian Forces Health Information System (CFHIS) — another key outcome of Rx2000. It permits military clinicians to access the health records of all CAF personnel anywhere in the world, on land or at sea. Once Canada's provinces and territories develop their own electronic health records systems, these should be able to integrate into the CFHIS. As another example of achievement, with respect to mental health care, the CAF has "shorter overall wait times for care and more mental health care providers per capita than any other Canadian institution."[4]

In relation to our NATO allies, CAF health services made a considerable difference on the ground in Afghanistan. The trauma hospital in Kandahar, NATO's first ever Role 3 Multinational Hospital[5] in combat operations, was established and led by CAF health services, from 2006–2009. For that, in 2012, Canada was selected as the recipient for the Dominique-Jean Larrey Award for the greatest medical contribution to the Alliance. In addition, the CAF "Deputy Surgeon General was selected by NATO to chair its research committee on health, medicine, and protection," and CAF Health Services personnel have a "leadership role in virtually all its mental health-related research activities."[6] In 2013, NATO requested that a CAF medical service expert "co-chair its international symposium on best practices in post-combat rehabilitation and reintegration of patients suffering physical and mental injuries."[7]

We were also told that the CAF is a global leader in de-stigmatizing mental health illnesses and injuries in the military. We heard that the CAF has made a significant effort to treat physical and mental injuries with the same legitimacy. This includes using the terminology "operational stress injury" or OSI, which is not a medical term, but one used by the CAF to encourage its members to come forward for treatment. Lieutenant-Colonel (retired) Stéphane Grenier, former OSI advisor to the Chief of Military Personnel, coined

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3 Ibid.

4 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

5 "Role 3 support is normally provided at the division level and above. It includes additional capabilities, such as specialist diagnostic resources, specialist surgical and medical capabilities, preventive medicine, food inspection, dentistry and operational stress management teams when not provided at level 2." Col Ronald Brisebois et al., "The Role 3 multinational medical unit at Kandahar Airfield 2005–2010," *Canadian Journal of Surgery*, December 2011.

6 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

7 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

the term in 2001. He developed the term strategically to move away from the term "combat stress injury" used by the US Marine Corps, which "gives the impression that people need to participate in combat to experience the consequences of an overseas deployment."[8] In 2007–2008, four causes of OSIs were developed in cooperation with the US Marine Corps. The first is trauma. The second is fatigue, particularly from "cumulative wear and tear on the soul."[9] The third is grief – individual grief for fallen friends and also institutional grief, for every time a coffin came home to Canada. And finally, the fourth is moral conflict, when military members question the morality of what they did or did not do, and what they witnessed. For instance, according to Brigadier General Jean-Robert Bernier, current CAF Surgeon General, the latter is the prevalent cause of OSIs stemming from CAF operations in the 1990s, where the mandate and rules of engagement of certain missions did not allow CAF personnel to respond when atrocities were being committed.[10]

Although Canada's mission in Afghanistan came to an end in March 2014, and the operational tempo for many arms of the CAF has slowed, "this is not the case for the health services," particularly with respect to mental health.[11] BGen Bernier told us that "many trauma-related mental health cases take years to present," and CAF health services has "challenges that require ongoing aggressive effort and focus." This is also recognized in the Minister of National Defence's initiative of 2012 "to increase the military mental health budget by an additional $11.4 million, for a total of $50 million annually, despite the need for all defence department elements to contribute to national deficit reduction."[12]

In 2012, the CAF launched *Caring for Our Own*, a "comprehensive approach" for the care of ill and injured CAF members and their families. It "organizes the programs and services offered to CAF ill and injured members and their families into an integrated system of care that ensures they receive the care and support they require through the successive phases of recovery, rehabilitation, and reintegration."[13] This is known as the 3Rs approach. Under *Caring for Our Own*, DND publishes and regularly updates a *Guide to Benefits, Programs, and Services for Serving and Former Canadian Armed Forces Members and their Families*, which provides "serving and retired Regular and Reserve Force members as well as their families with an overview of benefits, programs and

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8 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013

9 Ibid.

10 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

11 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

12 Ibid.

13 Department of National Defence, *Caring for Our Own*.

services to which they may be entitled in the event of a member becoming disabled, ill, injured or deceased while serving in the Canadian Armed Forces (CAF)."[14]

In October 2013, the *CAF Surgeon General's Mental Health Strategy* was released. Based on a number of internal and external studies, the Strategy gives an assessment of the current state of mental health in the CAF, and provides guidance for the delivery of services and the prioritization of resources and research over the next five years. It is important to note that Afghanistan-related OSIs are a minority of the mental health conditions present within the CAF population. According to the Mental Health Commission of Canada, one in every five Canadians will experience a mental health condition in their life time. The *Canadian Community Health Survey – Mental Health and Well-being – Canadian Forces (CCHS-CF)* conducted by Statistics Canada in 2002 showed that CAF members exhibited double the risk of depression, both related and unrelated to military operations, as compared to the Canadian population.[15] Therefore, CAF health services must have the ability to treat "a far greater" mental illness burden that is not related to combat or deployment operations.[16] Unfortunately, the Statistics Canada survey did not capture data with respect to determining whether the OSIs suffered by CAF personnel were specifically related to deployments to Rwanda, Bosnia, or other locations.

The only mission-specific OSI data the CAF holds is from its report entitled *Cumulative Incidence of PTSD and Other Mental Disorders in Canadian Forces Personnel Deployed in Support of the Mission in Afghanistan, 2001–2008*. The report, by David Boulos and Dr. Mark Zamorski, indicates that out of about 30,000 CAF personnel deployed to or in support of Canada's mission in Afghanistan before 31 December 2008, 13.2% were diagnosed with an OSI in the 5 years following that deployment. This included 8% diagnosed with PTSD and more than 5% with other types of deployment-related OSIs, such as depression and anxiety disorders.[17] BGen Bernier informed us that once extrapolated to approximately 9 years post-deployment, the percentages increase to 20% for OSIs and 11.8% for PTSD. In comparison, the lifetime prevalence of PTSD in the general population is 7% to 9%.[18] The report also indicates that when deployment *and* non-deployment related mental illnesses within the cohort are taken into account, the figure rises to 18.9% for PTSD. Another report by the same authors extrapolates that those who deployed to Kandahar specifically have close to a

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14 Department of National Defence, *Guide to Benefits, Programs, and Services for Serving and Former Canadian Armed Forces Members and their Families*, November 2013 Edition.

15 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

16 Ibid.

17 Department of National Defence, *Cumulative Incidence of PTSD and Other Mental Disorders in Canadian Forces Personnel Deployed in Support of the Mission in Afghanistan, 2001–2008*, Canadian Forces Health Services , November 2011.

18 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

30% possibility of developing an OSI nine years post-deployment.[19] The limitations of these studies include the inability to capture those who have not sought care, who have sought care outside CAF health services, or who were released shortly after their deployment.

The DND/CAF Ombudsman has also been engaged in CAF mental health issues since 2002. He has released 5 different reports and almost 50 recommendations intended to improve the care and treatment received by CAF members suffering from OSIs, including PTSD. The 2012 report *Fortitude Under Fatigue*, concluded that the CAF made considerable progress in implementing previous recommendations with respect to the identification, prevention, and treatment of OSIs. The report also identified a number of broader areas of improvements, including the evolution of the CAF's mental health capability from an ad hoc system to one that is better structured to deliver integrated care to CAF members suffering from OSIs, including PTSD. The challenges that remain are addressed in this report.

CAF health services are the primary health care provider for all CAF personnel whether their health concerns are duty related or not. If necessary services are not available within the CAF system, military members are reliant on civilian provincial/territorial health authorities. Every military member is insured by a third-party insurer, currently Blue Cross, which covers the cost of external health care treatments for DND. Since the closure of CAF hospitals, and given that 80% of military members and their families live off military bases, there is an increased dependence on provincial/territorial health care services and support systems than ever before. This is an overarching challenge that touches not only the care of ill and injured CAF personnel, but also the care of their family members and reservists.

**Stage 1: Recruitment**

"… forewarned is forearmed …"

Mr. Gregory Woolvett, Father of an Injured Soldier, 3 June 2013

An individual wanting to join the CAF needs to be both physically and mentally fit. Physical fitness can be tested with fairly clear results. Evaluating an individual's mental fitness, however, is more challenging. Committee members were interested in understanding what kind of psychological screening is conducted at the recruitment stage. The Committee also investigated whether it was possible to measure mental resilience and susceptibility to mental illness as a result of chronic stress and/or trauma before an individual is accepted into the armed forces. The Committee also learned that, as a prevention strategy, the CAF now educates all military members on mental resiliency from

19 David Boulos and Mark A. Zamorski, "Deployment-related mental disorders among Canadian Forces personnel deployed in support of the mission in Afghanistan, 2001–2008," *Canadian Medical Association Journal*, 6 August 2013.

the moment they are recruited and through every stage of their professional lives in the armed forces.

Lieutenant Colonel Alexandra Heber, senior psychiatrist and clinical head of the Ottawa Operational Trauma and Stress Support Centre (OTSSC) and Cmdre Jung informed the Committee that a medical history, including a psychological history, is taken at the recruitment stage by either a family doctor or physician's assistant. Cmdre Jung indicated that if this history raises any red flags, the CAF could request additional information before the individual's file is finalized. LCol Heber confirmed that individuals with serious and persistent mental illnesses like schizophrenia or bipolar disorder are generally screened out at the recruitment stage. However, Cmdre Jung further noted that if an individual's file "is clean or the person never sought out anything and therefore doesn't know what he or she doesn't know, or is actually hiding it, that person will squeak through."[20] In these instances, LCol Heber stated that, given the rigours of military life and that the CAF community is quite small "even for people who wouldn't tell us, if they're going to have a psychotic episode early in their career, they're going to come to our attention fairly soon."[21]

While some measures can be taken to uncover existing mental illness at the recruitment stage, it is not currently possible to determine a person's mental resilience or susceptibility to mental illness as a result of trauma, though research on these issues is ongoing. Dr. Marc Fortin, Assistant Deputy Minister for Science and Technology at DND, told the Committee that Defence Research and Development Canada (DRDC) is currently investigating "any kind of indicator that will allow us to identify predisposition to trauma through stress leading to trauma."[22] This, in turn, would also help the CAF better diagnose and treat mental injuries and illnesses when they do arise. Dr. Sanela Dursun, Director of Research Personnel and Family Support at DRDC, indicated that DRDC is also conducting a study that will follow military members from recruitment to release in order to tease out certain personality dimensions that are "possible risk factors under stress in the theatre that might trigger or have a higher likelihood of PTSD."[23] Using the recruit health questionnaire, DRDC will study the linkages among certain personality dimensions as members progress through their career, including during deployment. According to Dr. Harvey Moldofsky, Professor Emeritus in the Department of Psychiatry at the University of Toronto, the American military is also studying possible predictors for PTSD. He informed the Committee that the Americans are looking at personal and family history of predisposition to mental illness as one factor, and also at genetic profiles.

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20 Cmdre (Retired) Hans Jung, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

21 LCol Alexandra Heber, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

22 Marc Fortin, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

23 Sanela Dursun, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

### Mental Resilience and Readiness at Recruitment

Given the inability to predict an individual's mental resilience when confronted by chronic stress and/or a traumatic event, the CAF has recognized the need to educate military members about mental health from the time they are recruited into the forces. The *Road to Mental Readiness* (R2MR) training and resilience program is an important component of the CAF's overall mental health strategy. As explained by Colonel Rakesh Jetly, CAF Mental Health Advisor, "the idea from resilience isn't to have a shield against stress; it's more that stress is inevitable in life and in deployment, and you can bounce back."[24] Committee members were given a pocket-sized R2MR booklet which serves to educate military members on how to identify their own, their subordinate's, or their buddy's stress levels, and to give the appropriate leadership and intervention guidelines for each of these levels, from coping with stressful situations to suicide prevention strategies. The booklet also lists the mental health resources and support services available to CAF members. A similar, wallet-sized pamphlet is available to CAF family members.

Witnesses highlighted the importance of starting mental health education at recruitment, while emphasizing that waiting to educate CAF members on mental health right before deployment is too late. Heather Allison, mother of an injured soldier, argued passionately that mental health awareness and education should start at basic training. She stated: "It's something that should be incorporated into boot camp – that this is a part of being a soldier and this is what could happen."[25] Cmdre Jung further justified the need for mental health awareness and education from recruitment onwards as a way to de-stigmatize mental health more generally in the armed forces. Incorporating mental health education at various levels of leadership training for both non-commissioned members and officers will "inculcate" CAF members "into the new, enlightened way of looking at mental health."[26]

According to Colonel Scott McLeod, CAF Director of Mental Health, a research study is being conducted to assess the benefits of R2MR not just on deployment or post-deployment, but also its impact on training success, and the way in which CAF members cope with daily stressors that occur through all levels of military training and throughout the career cycle. Col. Jetly also informed the Committee that R2MR has drawn considerable attention domestically and internationally for its best practices. For instance, the RCMP and the Ontario Provincial Police have approached the CAF with respect to implementing a similar program in their respective police forces. As well, a NATO group is adapting this model for use across the Alliance.

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24 Col Rakesh Jetly, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 60, 6 December 2012.

25 Heather Allison, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

26 Cmdre (Retired) Hans Jung, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

**Recommendation 1**

**The Committee recommends that the Government of Canada conduct rigorous mental health screenings during the recruitment period of a Canadian Armed Forces member.**

**Recommendation 2**

**The Committee recommends that the Government of Canada, through Defence Research and Development Canada or other entities, expand its research into the pre-susceptibility of operational stress injuries.**

### Stage 2: Pre-Deployment

A considerable amount of training and preparation occurs in the pre-deployment stage of a military member's career. In recent years, this has included mental resiliency and readiness. The Committee heard about the training required for military members at the pre-deployment stage, and the component designed to prepare their families for deployment. We also learned what research was ongoing with respect to resiliency and OSI prevention.

LCol Heber informed us that before military members are deployed, they go through a medical exam, whereby a family physician makes an evaluation based on their medical history, including their psychological history. Both LCol Heber and Marie Josée Hull, a clinical social worker who has worked with ill and injured CAF members, explained the difficulty in screening a person for risk factors associated with OSIs before deployment. As Ms. Hull elaborated: "I've found that sometimes you can get the best qualities in soldiers who have had previous trauma in their lives: they have been resilient and they've learned coping skills that will make them terrific soldiers."[27] Others with the same background may not be able to cope with further trauma, whereas those who have never been exposed to high stress or trauma also may or may not turn out to have robust coping skills. LCol Heber noted that there are many people "who have those risk factors but never develop PTSD."[28] The fact that individuals react differently to stress and trauma makes pre-screening very difficult. Further, LCol Heber believes that denying members who are deemed fully fit an opportunity to deploy because they have those risk factors "would be a disservice to them."[29]

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27 Marie Josée Hull, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 54, 1 November 2012.

28 LCol Alexandra Heber, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

29 Ibid.

### Pre-Deployment Mental Resiliency and Readiness

Given that pre-screening is a limited tool, more focus has been placed on resiliency training and mental readiness. According to Dr. Judith Pizarro Andersen and colleagues from the University of Toronto, "a growing body of evidence points to prevention and preparation as a key step in reducing the negative effects of trauma exposure and the risk of PTSD and other OSI."[30] Similarly, LCol Heber informed us that according to research, "no matter how terrible the situation is going to be, it seems that the more prepared people are ahead of time, the less traumatized they are." She further explained that "surprise in and of itself produces trauma."[31] To elaborate, Andersen et al state that "preparation reduces the unpredictability and uncontrollability" military members may face, and also "helps them respond appropriately to threatening situations, and reduces negative reactions."[32] The R2MR is based on such research and does have a pre-deployment component. LCol Heber informed us that in the same way that the CAF prepares its members for combat, it also prepares them mentally "by teaching them some techniques they can use when they find themselves feeling overwhelmed or getting very anxious as well as some things that will help them to calm themselves and calm their bodies down."[33]

The effect of sleep on mental readiness is another aspect of resiliency that is part of a growing body of research. The Committee heard from researchers who study the link between sleep and mental health. Dr. Anne Germain, Associate Professor of psychiatry at the University of Pittsburgh, School of Medicine, informed us that sleep disruption is a real threat to mental readiness and operational performance in military settings. She also argued that sleep disturbances preceding exposure to stress or a traumatic event are a predictor of poor psychiatric outcomes. Further, sleep disturbances or vulnerability to sleep disturbances can be detected before people deploy. She explained that "sleep is a modifiable behaviour," and therefore people can be trained ahead of a deployment to get better quality sleep. She stated "there are different strategies that are applicable well before deployment, during training, to enhance not just sleep health, but also mental readiness."[34] Military members often do not get enough quality sleep and are, in fact, trained to be able to continue functioning with relatively little sleep. Research presented by Dr. Germain showed that even in non-deployed military members, 70% of them chronically sleep for a short duration, less than 6 hours a night. In comparison, only 30% of the civilian population have the same issue. However, if military members can be trained to get more

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30 Judith Pizarro Andersen et al., "The Use of Resilience Programming to Improve Health and Prevent PTSD among Military Personnel," University of Toronto, distributed to Committee members on 11 April 2014.

31 LCol Alexandra Heber, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 78, 1 May 2013.

32 Judith Pizarro Andersen et al., "The Use of Resilience Programming to Improve Health and Prevent PTSD among Military Personnel," University of Toronto.

33 LCol Alexandra Heber, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 78, 1 May 2013.

34 Anne Germain, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 6, 26 November 2013.

consolidated sleep when the opportunity presents itself, this would have an improved effect on mental readiness and overall mental health.[35]

The OSI Joint Speakers Bureau (JSB) is another component of pre-deployment mental health preparation. A group of speakers, including military members with OSIs, share their personal experiences, and provide a peer support element; while mental health clinicians educate members on recognizing the signs and symptoms of OSIs, and encourage members to seek help early if necessary. Further, the JSB serves to de-stigmatize mental health responses to stress and traumatic experiences. Based on testimony from Gregory Woolvett, a father of an ill and injured CAF member, it appears as though his son did not have access to such resiliency programs before his deployments. He told the Committee: "They're taught how to staunch bleeding, tie tourniquets, all that kind of stuff, but they're not given any tools to deal with the mental aspect of combat, or the terror, because often it was more terror than combat."[36]

The Committee acknowledges that the CAF has come a long way over the last decade with regard to resiliency training and mental readiness. It was, however, distressing to hear from family members that their loved ones serving in uniform may not have had access to such training given that it was unavailable until a few years ago. There are, no doubt, many others who are also victims of timing and past insufficiencies. The fact that the CAF has adapted its requirements to meet operational demands shows that it is implementing the lessons it is learning. The Committee hopes that the CAF continues on this trajectory so that these programs are continually improved and already in place for whenever the Government of Canada requires CAF members to deploy to conduct difficult tasks on behalf of Canadians.

### Preparing CAF Families

The R2MR training and resilience package also has a family component. The CAF, through the Military Family Resource Centres (MFRCs), delivers a pre-deployment course as well as a "Home Location Decompression" course a few weeks before the military loved one returns home from operations, and a joint follow-up meeting upon return. Ms. Allison told the Committee that when her daughter deployed, she attended a pre-deployment meeting for family members at her local MFRC. When she asked about PTSD, she was informed by counsellors that they were not going to discuss PTSD at that time, and such a discussion would take place "a couple of weeks before your soldier comes home,"[37] during the Home Location Decompression course. In her opinion, this was not satisfactory. She recommended that family members be prepared earlier for the impacts of PTSD, particularly parents, who often live in a different city than their military sons and daughters.

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35 Ibid.

36 Gregory Woolvett, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

37 Heather Allison, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

Though mental readiness is a critical component of a military member's pre-deployment training, the Committee was reminded that it will not always be possible to prepare all military members to deal with every type of trauma, particularly given that unexpected traumatic events will likely occur in insecure and unstable environments where CAF personnel operate. Mark Ferdinand, National Director of Public Policy with the Canadian Mental Health Association (CMHA), noted the importance of recognizing that "just under 10% of people" who experience trauma will have their lives impacted so seriously "to the point where they can't cope with daily living."[38] Others may suffer from other symptoms and reactions on the mental health spectrum. Dr. Mark Zamorski, Head of the Deployment Health Section at DND, cautioned that he has not yet seen any gains in terms of prevention that have had a transformative effect. "Preventative measures," he noted, "will be, at most, of modest efficacy." Furthermore, the CAF will continue to see OSIs. He did not believe that there will be "the reliable prevention of PTSD" in his lifetime, as it is "just too big of a task."[39] Cmdre Jung stated that in terms of resilience, "no one knows whether you can actually instill resilience."[40] He noted that more research is needed to show that resilience training prevents the development of OSIs, and to ensure that the CAF is moving in the right direction.

Although resiliency and readiness training may not prevent every member from developing an OSI, the Committee believes the programs are of benefit particularly in de-stigmatizing the subject of mental health and encouraging members needing treatment to self-identify and seek treatment early.

**Recommendation 3**

**The Committee recommends that the Government of Canada enhance education provided to military families for mental health issues prior to deployment of a CAF member through the *Road to Mental Readiness* program.**

**Recommendation 4**

**The Committee recommends that the Government of Canada enhance the preparation and training for potential operational stress injuries amongst CAF members before they deploy, and improve methods to train CAF members to self-assess for potential mental health issues.**

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38 Mark Ferdinand, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 5, 21 November 2013.

39 Mark Zamorski, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 77, 29 April 2013.

40 Cmdre (Retired) Hans Jung NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

## Stage 3: In-Theatre

> "After the rocket struck, I was unconscious. When I awoke, I found myself pinned inside the wreckage and I was on fire. I had to pull myself out while on fire and through gunfire try to extract my dead and dying brothers in arms. Without trying to sound shocking, I had to wade through human soup while on fire to get everyone out."
>
> Corporal Glenn Kirkland, 5 June 2013

Such was the reality many of Canada's men and women in uniform encountered during the mission in Afghanistan. Ill and injured CAF members in-theatre relied on each other, on their medics, and on the CAF medical professionals at the Role 3 hospital in Kandahar. The Committee gained an appreciation of the innovations being developed to increase the survivability of CAF personnel in-theatre, and the care available to CAF personnel for both physical and mental injuries during a deployment. Most examples shared with the Committee derived from Canada's most recent and considerable contribution to the NATO-led International Security Assistance Force (ISAF) mission in Afghanistan.

### Tactical Combat Casualty Care

The Committee heard that the CAF is continually striving to increase the survivability of its military members and improve in-theatre injury prevention. Over the course of Canada's mission in Afghanistan, life-saving measures evolved in response to the nature of the threat, particularly the effects of improvised explosive devices (IEDs). In addition, personal protection equipment was enhanced and DRDC focussed its work on reducing the impact of IEDs on CAF vehicles.

A number of witnesses testified to the considerable success of the CAF's delivery of pre-hospital trauma care, also known as tactical combat casualty care, in saving many lives on the battlefield. We were told that the biggest threat to Canadian lives in Afghanistan was the IED. Canada lost 158 brave men and women in uniform during that mission. Major Ray Wiss, a doctor and infantryman who served in Afghanistan, informed us that "only eight of them were from direct fire by the Taliban." "Canadians," he said, "do not die in gunfights."[41] The devastating effects of IEDs required advanced initial life-saving care to be "pushed forward" as close as possible to the frontlines. BGen Bernier informed us that medical technicians and combat arm soldiers were trained to do a number of "specific procedures that, in Canada, may often only be done by an emergency room physician."[42]

According to BGen Bernier, two key life-saving tools were added to a soldier's kit: the self-tightening tourniquet and a concentrated powder substance called QuikClot.

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41 Maj Ray Wiss, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 77, 29 April 2013.

42 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

The latter was eventually replaced by a clotting gauze that did not cause a chemical burn and could be "inserted into areas where bleeding cannot be stopped by compression because of the depth or the extent."[43] Medics receive additional advanced battlefield and traumatic injury-focused training, such as providing a needle decompression for a collapsed lung. Colonel Homer Tien, Canadian Military Trauma Surgeon and Military Trauma Research Chair at Sunnybrook Hospital, informed us that CAF medics have been trained within this paradigm of tactical combat casualty care since 1996, but it truly came into practice in 2001–2002 with the start of Canada's mission in Afghanistan. Having served in Bosnia in the 1990s and then in Afghanistan over the last decade, he stated that "the medical technicians have really come into their own. They have a defined mission … No one provides better pre-hospital trauma care than they do."[44]

Cmdre Jung stated that the greatest cause of preventable death on the battlefield remains exsanguination, and noted that those intervention techniques used by CAF soldiers and medics within the crucial first 10 minutes, "the platinum 10," prevented several casualties from bleeding to death. They also gave the in-theatre medical team flexibility. According to the joint theatre trauma registry, which was widely used in Afghanistan to collect data regarding the in-theatre care of ill and injured military members, those techniques "extend[ed] the time to do necessary surgery by up to two hours", while still maintaining the same life-saving capability.[45]

Personal protection equipment, worn by CAF personnel, was critical to preventing life-threatening physical injuries. Major Wiss showed us how the Kevlar vest and metal bulletproof plates worn by CAF personnel were integral to protecting the "death box" — the heart and major blood vessels — from AK-47 bullets. Ballistic glasses worn by CAF personnel prevented shrapnel fragments from explosions caused by IEDs or rocket-propelled grenade attacks from damaging their eyes. These glasses and the helmets worn by soldiers prevented many serious head injuries. According to Major Wiss, death from head and neck trauma constituted only about 5% if the patient was still able to breathe. If the windpipe was disrupted, however, the mortality rate would go up sevenfold.[46]

Protecting CAF personnel inside their armoured vehicles from IEDs is an ongoing challenge, and DRDC has developed unique facilities to continue studying the effects of these blasts on vehicles. As Major Wiss explained, the armour on these vehicles could work against CAF personnel when their vehicle is hit by a roadside bomb. If the force of the explosion breaches the armour but remains contained within the vehicle, this buildup of pressure can be lethal. If the armour of the vehicle is not breached but only buckles, "the

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43 Ibid.

44 Col Homer Tien, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 74, 27 March 2013.

45 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

46 Maj Ray Wiss, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 77, 29 April 2013.

floor of the armoured vehicle comes up into the crew compartment so fast; it's as if the soldier had jumped off a third- or fourth-storey balcony."[47]

Dr. Fortin informed us that when Canada's operations in Afghanistan first started and the IED threat became increasingly apparent, DRDC reallocated its workforce to focus on reducing the impact of IEDs on vehicles by improving the armour and also the interior components such as the harnesses, the seats, and the suspension of those seats.

**Care at the Role 3 Multinational Medical Unit**

With respect to ongoing in-theatre treatment, the Committee was briefed on the full range of trauma care provided to ill and injured CAF personnel in Afghanistan. While CAF members with physical injuries were evacuated out of the country for ongoing treatment, very few with OSIs were sent home before the end of their tours. The Committee was impressed by the achievements attained by medical staff at the Role 3 hospital. With respect to mental health, however, the Committee questioned the CAF's lack of a uniformed psychologist capacity, particularly for in-theatre care, and were concerned about the inability of Francophone CAF personnel to access mental health services in their preferred language while deployed to Afghanistan.

While the Committee learned about the important pre-hospital care CAF personnel receive when injured on the frontlines, they also heard of the crucial life and limb-saving treatment in-theatre which continues after a member is medically evacuated to the Role 3 Multinational Medical Unit in Kandahar. Col Tien took over the Unit in 2006 when it was a US combat hospital. At that time, it was merely a small plywood shack with one operating room. When Col Tien left after his final tour in December 2011, the hospital was a modern brick building with three operating rooms. Over that time, it acquired new equipment and, as a result, diagnostic capabilities improved. He stated "there was quite an evolution of capability in that time." Given that the care of injured CAF members was a significant priority, the hospital "had very quick access to resources."[48] Further, improvements to care were implemented as soon as trauma clinicians saw a problem. This ensured that trauma care was always at its most advanced throughout the conflict.

The Committee was informed that a Canadian Forces Health Services Group study determined that if an injured CAF member arrived at the Role 3 hospital with vital signs, he or she had a 97% chance of surviving — the highest survivability rate in the history of warfare, according to Cmdre Jung. A remarkable achievement given not only the difficult terrain, but also the fact that this was the "first time NATO ha[d] run a multinational hospital in a combat zone, with mass casualties coming in almost daily."[49] According to

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47 Ibid.

48 Col Homer Tien, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 74, 27 March 2013.

49 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

BGen Bernier, there were "obstacles to overcome" with respect to differences in national standards, credentials, and cultural differences regarding scopes of practice for different health occupations. As well, coordinating these medical practitioners from various countries into effective trauma and operating room teams was also a challenge. Working with allies who share common medical practices such as the British, the Americans, the Australians and the New Zealanders proved less problematic. Major Wiss informed us that during his time at the Role 3 in 2007 and 2009, working with all NATO personnel was relatively seamless.

Finally, the biggest challenge, according to BGen Bernier, was the evolving mandate for the Role 3 hospital. The Committee was told that the hospital's original mandate was to treat ISAF casualties. However, according to the same witness, 80% of the casualties it was treating were Afghans, and mostly Afghan civilians, including children. We were informed that war zone military hospitals, unlike military hospitals in humanitarian assistance missions, are meant to have a "minimal medical footprint on the ground and a very efficient medical evacuation" to take casualties to a "hospital with greater capabilities in a more secure zone."[50] The equipment, capabilities, and clinical skills required were based on this model. According to BGen Bernier, all of this evolved, however, when the senior leadership of NATO and other political drivers changed the rules as to who was eligible for care at the Role 3 NATO hospital. [51]

Injured CAF personnel would only stay at the Role 3 hospital for about 24 hours before being medically evacuated to a tertiary care facility for additional stabilization and detailed surgery. Injured CAF personnel were usually evacuated to Landstuhl Regional Medical Centre in Germany, a US Army and US Air Force hospital, for tertiary care. According to Cmdre Jung, Canada owes a considerable amount of gratitude to our American allies for access to care at Landstuhl as well as for their medical evacuation system. Once strategic medical evacuation was possible, a CAF medical specialist team would bring wounded personnel home to Canada to a quaternary care hospital, for additional care and rehabilitation "as close as possible" to where maximum social and clinical support for the members were located.[52]

The Committee was informed that the number of CAF health care providers deployed on operations depends on the size and the extent of any given mission. When Canada's combat role in Afghanistan ended in 2011, the number of CAF medical personnel in-theatre was reduced. During Operation Attention — Canada's follow-on mission to train and mentor the Afghan National Army at various locations in Afghanistan, which lasted until 2014 — CAF members were provided with "immediate acute care at the primary care level," meaning access to CAF physicians and medical technicians. For more severe injuries, CAF personnel were dependent on US and French military hospitals

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50 Ibid.

51 Ibid.

52 Ibid.

in-theatre.[53] Post-Afghanistan, CAF health services, particularly with respect to trauma care, will need to remain an agile and capable force, and require at least a skeleton capability in all areas in preparation for the next time they deploy.[54]

### In-Theatre Operational Stress

In-theatre care for operational stress is different than for physical injuries in that CAF personnel with a mental health issue as a result of combat are rarely repatriated home. Typical symptoms of operational stress included nervousness, anxiety, insomnia, and hypervigilance. Cmdre Jung, along with a number of other witnesses, highlighted the importance of treating operational stress as close to the frontlines as possible and returning CAF personnel to their battalion — a practice that was a lesson learned from the First World War and in practice since the Second World War. The Committee was given a number of reasons why CAF members are not sent home when faced with these mental challenges. Major Wiss explained that when a young person has been training for a significant part of his or her professional life to complete a job and is then faced with the difficulty of perhaps not being able to fulfill the mission, the loss of self-esteem as a result "is devastating." In addition, given that "the most important motivation a combat soldier has is his buddies and not letting them down," sending soldiers home while their buddies are still in combat is also "devastating to a psyche." Further, the longer that loss of self-esteem is felt, the harder it is for them to return to duty, and "the closer they are to depression and then to suicidal ideation."[55] According to Cmdre Jung, sending CAF personnel with operational stress home would have stigmatized mental health issues in the battlefield. Major Lisa Compton, Manager of the Maintenance of Clinical Readiness Program at DND, informed us that there were "heroes' hotels" located outside various Role 3 hospitals across theatre where military personnel affected by operational stress could take a break and were checked up on by the medical team until they were medically fit to return to duty.

Mental health teams consisting of a mental health nurse, a social worker and a psychiatrist were also deployed to Kandahar. Their first aim was to help CAF personnel complete their tours by providing mental health care on site; some of the mental health staff would also go to the forward operating bases. LCol Heber stated that one of the lessons the mental health team learned early on in Afghanistan, was the need to engage the chain of command on mental health issues and to train the leadership on how to support CAF personnel who needed on-site care. A component of the mental health team's role was to reinforce with all CAF personnel, including the chain of command, the training and awareness of mental health issues so that individuals who needed help were identified early.

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53 Ibid.

54 Ibid.

55 Maj Ray Wiss, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 77, 29 April 2013.

Given that mental health support is provided in-theatre, repatriations were rare and only conducted for psychosocial or family issues. According to BGen Bernier, acute mental illnesses rarely occurred in Afghanistan with most challenges manifesting themselves afterwards.[56] The Committee heard from Bombadier Geoffry Logue, who was one of those rare repatriations. He informed us that he was diagnosed with severe PTSD in Afghanistan and was repatriated home unaccompanied, on a civilian aircraft, without a period of decompression. We were shocked by his experience and without knowing the details of how this happened due to confidentiality constraints, we can only hope that the CAF has investigated this situation and improved its procedures since.

Committee members were also concerned that psychologists are not part of the deployed mental health teams, because the CAF has no clinical psychologists in uniform. We learned that CAF personnel who were in need of psychological care in-theatre were treated by American psychologists. Relying on our allies for mental health services could be problematic, particularly for linguistic reasons. CAF personnel benefit from the specialized role of clinical psychologists when in Canada, as they form part of the multidisciplinary medical teams at CAF bases across the country. However, these clinical psychologists are civilian and therefore cannot be deployed to conflict zones. Committee members learned that, over the last year, the CAF has conducted a study looking into whether or not it needs a uniformed clinical psychologist capability. So far, the CAF has deemed sufficient that the deployed mental health teams would only consist of a social worker, a mental health nurse and a psychiatrist, considering the long-term care provided by psychologists as not appropriate in deployed operations. BGen Bernier told us that he expects the results of this study at the end of April 2014.[57]

Finally, members of the Committee were concerned about complaints indicating that Francophone CAF personnel did not have access to in-theatre mental health services in French. BGen Bernier informed us that within these deployed mental health teams, the CAF endeavours to ensure that at least one of these individuals is bilingual. He also told us that the mental health team professionals are not the only practitioners on the ground who can assist with mental health care; all CAF doctors can provide mental health care.[58] Though this may be true, the Committee members maintain that mental health care should be provided by mental health care specialists in order to provide CAF personnel with the best possible care as early as possible. This includes the same level of care for both Anglophone and Francophone military members.

In addition to medical care and treatment, CAF personnel also have access to chaplains for in-theatre support. According to Colonel John Fletcher, Acting CAF Chaplain General, there are approximately 220 regular force and 120 reserve CAF chaplains who come from "over 20 different Christian denominations and represent the Jewish and

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56 Col Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 8, 25 October 2011.

57 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

58 Ibid.

Muslim faith groups, as well."[59] The majority of CAF chaplains work at the unit level or in deployed operations. Their role is to "provide comprehensive religious and spiritual support, advice, and care" to CAF personnel in both official languages in all military settings. We were told that the chaplaincy supports the mental health programs "aimed at preventing, identifying, and treating" mental injuries and illnesses that the military has expanded over the last decade.[60] CAF chaplains were not only deployed to Afghanistan, but were also employed at Landstuhl Regional Medical Center. As Col Fletcher explained, there are times when approaching the unit chaplain is an easier first step for military members suffering from stress or trauma-related mental issues rather than entering the mental health clinic. In these circumstances, much of the chaplain's role is to encourage military members to access the mental health resources available to them. This even includes accompanying them to the appropriate caregivers.

**Research and Innovation**

According to Dr. Alice Aiken, Director of the Canadian Institute for Military and Veteran Health Research (CIMVHR), one of the legacies of Canada's mission in Afghanistan will be the cutting-edge research that has been conducted and continues to be conducted with respect to trauma medicine and the rehabilitation afterwards. The Committee learned of research that was conducted while in-theatre with respect to trauma care. Much of this research continues at DRDC and in hospitals and universities across Canada in cooperation with our allies.

Both BGen Bernier and Major Compton informed us that the joint theatre trauma registry and system was a tremendous tool in improving in-theatre trauma care. The CAF had been part of the system since 2007. In Afghanistan, it allowed medical officers to concurrently collect and analyze data, which led to "almost real-time modification of clinical protocols and process that resulted in life-saving."[61] Major Compton stated similarly that one of the most valuable resources of the joint theatre trauma system was the clinical practice guidelines. These guidelines addressed how to improve care in a combat zone and also how to deal with injuries that are unique to the combat environment. We were told that Canadian Forces Health Services Group has published its research findings widely, including in the NATO Joint Analysis and Lessons Learned Centre, for the benefit of the whole Alliance.

Both Col Tien and Major Wiss spoke of the benefits of using in-theatre ultrasounds, particularly with respect to triage and medical evacuation. Knowing if a soldier is bleeding internally would allow medical personnel to rapidly prioritize the care of the wounded in a way that could save more lives. Given that internal bleeding is difficult to detect as there

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59 Col John Fletcher, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 74, 27 March 2013.

60 Ibid.

61 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

may not be any obvious external signs, having a diagnostic instrument such as an ultrasound could be a matter of life and death. Some Committee members had the opportunity to visit the DRDC facility in Downsview (Toronto) to see first-hand the ultrasound devices being developed. According to Dr. Fortin, DRDC is working to enhance the 3D ultrasound to make it "portable, rugged enough to be able to deploy, and reliable enough, of course, to deploy in theatre."[62] Col Tien informed us that as of March 2013, this research was still at the preclinical trials level. He thought that the added benefit of this new technology was that it was an automated diagnosis system. He noted that it can take years for a radiologist to learn how to interpret an ultrasound — years that combat medical technicians do not necessarily have. Having an automated diagnosis system would help in that respect. Major Wiss brought his own ultrasound device into theatre with him. Even though he knew of the ongoing work by DRDC, he noted that there are off-the-shelf ultrasounds on the market that are portable and able to detect internal bleeding or a collapsed lung in seconds. Having taught 8,000 Canadian physicians how to use an ultrasound, he was confident that he could teach a medic how to use one in 10 hours. He informed us that Canadian Special Operations Forces Command had purchased 16 or 17 ultrasound units and that he had trained all their medics on how to use them. The Committee does not know if these units are currently being used in deployed operations. According to Col Tien, the training burden and the possible risk of improper diagnosis were the reasons why the off-the-shelf ultrasounds were not deployed to all medics in Afghanistan.

As mentioned earlier, the leading cause of death on the battlefield remains exsanguination. Col Tien, who is the Major Sir Frederick Banting chair in military trauma research at Sunnybrook Hospital, is conducting several large trials with the US military on how best to transfuse patients who are bleeding to death. DRDC Downsview contributed to these efforts by formulating a new intravenous (IV) saline treatment and modifying the saline package to make it more portable. This was deployed in-theatre.[63]

Committee members were also informed that scientists at the DRDC facility in Suffield are conducting research with stem cells with an aim to improve the treatment of burn injuries. As well, as part of the blast injury program, they are examining crush injuries resulting from being trapped under a vehicle for a long period of time. According to LCol Roger Tremblay, Project Manager for Personnel Protection Research at DRDC, these incidents are occurring increasingly in-theatre. Canada, the United States, Great Britain and Australia are conducting research to improve the personal protection equipment worn by military personnel as well as vehicle protection. Canadian Forces Health Services Group and DRDC are both involved in the program entitled CASPEAN.[64] This research includes assessing the injuries of wounded personnel and the causes of

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62 Marc Fortin, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

63 Ibid.

64 LCol Roger Tremblay, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

death of the fallen, and the effects on their protective equipment or armoured vehicles. In-depth analysis is conducted here in Canada and in cooperation with our allies, "so that appropriate changes can be made to vehicle protection and personal equipment."[65] As outlined previously, certain improvements to personal protection equipment were made throughout the Afghanistan conflict.

According to Dr. Fortin, DRDC adapts its research programs to ensure that CAF personnel are equipped to deal with current and evolving threats. A concern that stemmed from the recent conflict in Syria was the possible future use of chemical and biological warfare agents against our armed forces. DRDC is training CAF personnel on how to deal with these toxins, and is developing vaccines and antidotes for chemical and bacteriological agents that are used in chemical weapons. We were informed that DRDC works with the intelligence services to "identify new threats and new weapons deployed in various parts of the world." With this information, DRDC can then develop solutions before CAF personnel deploy to a theatre of operations. Dr. Fortin stated that IEDs "remain one of the major threats to the deployment of personnel" and that "this threat will be around for many more years."[66]

**Supporting CAF Families**

Colonel Russell Mann, Director of Military Family Resources, informed us that today, 80% of military families live off military bases and are more reliant on their civilian communities than ever before. As a result, DND/CAF has had to adapt the way in which it assesses the needs of military families, adjusts its programming and reaches out to military families regarding the services that are available to them.

When CAF personnel deploy, their family members experience a number of stressors as a result of deployment separation. First and foremost, they worry day and night about their military loved one's safety and well-being. This is exacerbated by every news story of an injury or death in-theatre. Spouses take on more if not all of the household burden, children feel the effects of this disruption but may not understand the reasons behind it, and parents may feel isolated, particularly if they do not reside in the same city as their military son or daughter.

DRDC's Director General Military Personnel Research & Analysis conducted a survey and released a report entitled *Quality of Life among Military Families: Results from the 2008/2009 Survey of Canadian Forces Spouses*. Responses were received from 2,084 spouses, and gave an indication as to the stress experienced during their military spouses' deployment and accessibility of DND/CAF programming. Results included:

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65 Col Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 8, 25 October 2011.

66 Marc Fortin, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

- Almost half of the respondents reported using at least one DND/CAF service during deployment.
- During their spouses' deployment, 49.6% of the respondents were contacted by their MFRC during their partner's absence, while 27.3% were contacted by a CAF official.
- Almost half of the respondents reported that during a parent's deployment, their children became more clingy, while approximately one-third reported that their children exhibited behavioural changes such as young children sleeping with the parent, acting out, or anxiety.
- Approximately 5% of the respondents reported thoughts of taking their own life during the deployment of their partner, and 20% reported that they thought about ending their relationship with their partner during this time.[67]

Col Mann informed us of the various services and programs available to military families while their military loved one is on deployment. He further stated that during a mission, "a number of commanders and organizations" — such as MFRCs — get in touch with the families to connect them with the military community and the resources available to them.[68] Based on his comments and the statistics above, the Committee came to ascertain that this is not done consistently.

The Military Families Service Program (MFSP) website offers a number of information resources to help military families prepare for the stress associated with deployment. It also provides guidance on how to organize the families' health care, legal, and emotional needs before, during, and after the deployment. In addition, it connects family members to their local MFRC, of which there are 32 located at CAF bases across Canada, Europe and the US. We were also informed that as of 2014, the family information line was expanded to provide toll-free service 24 hours a day and 7 days a week. The family information line provides confidential, bilingual services by trained counsellors, who can assist with answering questions with respect to certain policies and procedures, resolving family crises, and connecting family members to local resources, including mental health care providers.

Another form of support may come from CAF chaplains. According to Col Fletcher, they are "the only military occupation that actually has a mandated role to provide services to family members." Chaplains also play an integral role in assisting the notification officer when informing a family about the death of their son, daughter, husband, or wife.

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67 Defence Research and Development Canada, "Quality of Life among Military Families: Results from the 2008/2009 Survey of Canadian Forces Spouses," August 2010.

68 Col Russell Mann, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 84, 5 June 2013.

He noted: "we know that our presence there can make a difference, and we seem to do that well."[69]

The Committee heard that parents of military personnel and family members of reservists are more difficult to reach. Col Mann acknowledged that parents may not live under the same roof as their military sons and daughters which make their needs more difficult to meet. He also told us that a number of reservists' families have indicated that they felt excluded. Parents and reservists who do not live near a military base could find themselves even more isolated from the military community and the services available to them. Col Mann informed us that over the last 12 months, he "changed the conditions and the description of the population served by MFRCs."[70] According to the MFSP's website, services of the MFSP have been extended for the periods before, during and three years after a deployment to include the following:

- Parents of full-time CAF personnel;
- Parents, spouse, children, step-children and dependent relative(s) of impacted Reserve Force personnel; and
- Parents, spouse, children, step-children and dependent relative(s) of Non-Public Fund (NPF) and Department of National Defence (DND) civilian employees deployed with the CAF on a mission outside of Canada.

He informed us that the CAF endeavours to have a clear and inclusive definition of "family" specifically for the family service program. However, DND/CAF does not have an overarching definition for the modern military family, as recommended by the DND/CAF Ombudsman in his November 2013 report on military families entitled *On the Homefront*. Col Mann told us that he has committed to lead the examination of the issue and respond to the Ombudsman within a year.

**Recommendation 5**

**The Committee recommends that the Government of Canada, through Canadian Forces Health Services Group, continue to actively support clinical research being conducted into how to prevent death by exsanguination.**

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69 Col John Fletcher, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 74, 27 March 2013.

70 Col Russell Mann, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 84, 5 June 2013.

**Recommendation 6**

**The Committee recommends that the Government of Canada support research into increasing survivability from blast injuries such as improvised explosive devices and mortar shells.**

**Recommendation 7**

**The Committee recommends that the Government of Canada, through Defence Research and Development Canada, or other bodies such as the Canadian Institute for Military and Veteran Health Research, continue to actively support research being conducted at the research centre in Downsview where ultrasound devices are being adapted to work in the theatre of operation, and to be able to enhance the 3D ultrasound diagnostic tools that are available to medics on site.**

**Recommendation 8**

**The Committee recommends that the Government of Canada actively train and promote CAF members to self-assess for mental health issues while being deployed.**

**Recommendation 9**

**The Committee recommends that the Government of Canada conduct periodic, rigorous mental health screenings for operational stress injuries and common comorbid conditions, during the deployment period of a Canadian Armed Forces member.**

### Stage 4: Recovery

> "… this time back, when she came down the escalator and I looked in her eyes, it looked like her—it was my daughter, it was the child I gave birth to, it was my soldier—but it wasn't her."
>
> Heather Allison, Mother of an Injured Soldier, 3 June 2013

The Committee heard from a number of witnesses, including ill and injured CAF personnel themselves, testifying that military members returning from deployment are still fighting the war in their minds, that a piece of them stayed behind in Afghanistan, long after they returned home to Canada. As mentioned previously, enhanced personal protective equipment and the Role 3 hospital's 97% survival rate saved numerous lives. However, those survivors have still experienced the trauma of combat and may be returning home with physical and mental wounds. According to DND, Canada sustained over 2,000 casualties in Afghanistan, of which 635 were wounded in action and another 1,436 were non-battle injuries. Wounded in action injuries include both physical and mental injuries "directly attributable to combat action" while non-battle related injuries

include accidental injuries not related to combat.[71] The Committee was interested in the prevention and diagnosis of mental injuries, the treatment and social support available to CAF personnel with physical and mental injuries, ongoing research and innovation on these issues, and support to CAF families who may be caring for ill and injured military loved ones.

### Prevention and Diagnosis

The Committee gained insight regarding the ongoing preventative measures that are in place to accurately detect and diagnose OSIs, and to encourage members to seek treatment early in order to prevent worsening symptoms, and to prevent suicide. A major challenge, however, remains overcoming the stigma of mental illness institutionally and individually.

#### a. Confronting Stigma

At the end of their tour and before returning home to Canada, most CAF personnel were sent to Third Location Decompression (TLD), a period of relaxation outside of the combat zone to have some space with their peers before returning to their families and to Canadian society. According to BGen Bernier, the decision to establish TLD was not based on any data, but on "a common-sense review" comparing past Canadian experiences following the Second World War and the Korean War, where troops had "a long time together before complete demobilization back in Canada,"[72] and the American experience following the Vietnam War, where troops did not have that kind of opportunity. Dr. Aiken noted it is helpful to have this time to rest, relax and receive information about reintegrating into family and civilian life. LCol Heber explained that she has heard anecdotally of the benefits of TLD. She noted that this decompression time is both social and educational. Mental health professionals are on hand to provide robust coaching, reminding CAF personnel of what they learned in their R2MR pre-deployment training on how to self-assess, cope with symptoms of stress or OSIs, and access the resources available to them. Those mental health professionals are also available 24/7 for those who may already need care. LCol Heber told us that there are times where she would receive referrals directly from TLD before CAF personnel return home.

A number of witnesses stressed the importance of treating CAF personnel with mental injuries or illnesses as soon as possible. This requires military members to present early with their symptoms. From the health care perspective, screening for these mental conditions, and subsequently making accurate diagnoses are also important requirements to getting CAF personnel into the appropriate care early. One of the most significant barriers to seeking mental health care in the CAF, but also in Canadian society, remains

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71 Department of National Defence, "CAF Casualty Statistics," 10 June 2013.

72 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

stigma. DND/CAF has done considerable work to reduce the stigma associated with mental injuries and illnesses. In fact, a number of witnesses acknowledged the CAF for being a world leader in de-stigmatizing mental health issues. Dr. Aiken noted that “other militaries look to Canada for how they would de-stigmatize.” She further noted that in her experience, other government agencies within Canada such as the RCMP and Correctional Services Canada, “wished” their institutions “could de-stigmatize mental health the same way the forces have.”[73]

DND/CAF initiatives to combat stigma have expanded over recent years. The *Be the Difference* campaign launched in 2009 and led by former Chief of Defence Staff General Walter Natynczyk extended the education of mental health injuries and illnesses across the CAF, encouraging personnel of all ranks to become personally engaged in building awareness and understanding through the JSB and the Operational Stress Injury Social Support (OSISS) program. Gen Natynczyk himself came forward and started speaking openly about the post-deployment mental stress he had experienced in the past. In addition, as mentioned previously, the R2MR training and resiliency package has a mental health awareness component that begins right at recruitment but continues through all stages of a member’s career cycle and specifically the deployment cycle. According to Col McLeod, “identifying post-traumatic stress disorder and illnesses … as injuries that occur as a result of combat has certainly improved in terms of the stigma as well.”[74]

Despite all of these initiatives, we still heard from a number of witnesses that CAF personnel suffering from OSI symptoms continue to be afraid to come forward. Numerous witnesses agreed that leadership is a significant factor when it comes to breaking down stigma barriers. However, this needs to occur at all levels of military leadership from sergeants to generals. Clinicians also have an important role to play. We were told that CAF personnel have a better chance of returning to duty if they seek treatment early. CAF leaders and clinicians have a responsibility of communicating this to all military members and reducing barriers to care.

As Col McLeod explained, military members “fear that if they present, they could be put on temporary categories or restricted service, restricted duties.”[75] We were also told that CAF personnel also fear that they will be medically released from the armed forces. In fact, Master Corporal Bill Nachuk informed us that he was threatened with medical release by two doctors at two separate military bases. For instance, he was told that if he ever had a relapse later on in his career, he would be placed on permanent category and released from the armed forces.[76] Given that PTSD is an ongoing struggle, he knew that if

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73 Alice Aiken, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 49, 4 October 2012.

74 Col Scott McLeod, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 54, 1 November 2012.

75 Ibid.

76 MCpl Bill Nachuk, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 60, 6 December 2012.

he ever did relapse, he could not ask for help again for fear of losing his job. Phil Upshall, National Executive Director of the Mood Disorders Society of Canada, noted that "mental health care is a stigmatized issue within the health care profession itself."[77] Louise Bradley, President and CEO of the Mental Health Commission of Canada, concurred, stating that "we have to focus on health care professionals when we hear they are one of the biggest barriers to people getting care."[78] This is particularly difficult when anyone suffering from a mental illness will likely go to their primary health care physician first. BGen Bernier informed us that "all of our doctors are expected to provide mental health services."[79]

Stigma can come from various sources. For instance, MCpl Nachuk told us that he felt that the military police were "keeping tabs" on him, and that he was scrutinized and targeted because he had mental health issues. As Cmdre Jung stated "stigma is both external and internal. You have to know where the stigma is actually coming from. Is it from their buddies? Is it from the unit leadership? Is it partially from themselves? It may be a combination of all of those, depending on the micro-culture that exists in various places."[80] The Committee was told that the military culture in itself is a barrier to care. As Master Corporal (retired) Paul Franklin stated: "I joined in 1994, back when if you were sick, you didn't tell anyone, and if you were hurt, you were a wussy. We might have encouraged that attitude a little bit back then."[81] We also heard that female CAF members in particular may be more reluctant to come forward, as it may imply that they cannot handle the military environment.[82]

According to LCol Grenier, the culture over recent years "has changed considerably." He noted that by 2011, "most military members — if not 80% of them — who were showing early signs of mental health issues 6 months after returning from Kandahar were already receiving clinical care. That was not the case during the Bosnian conflict."[83] He stated that at that time, military members would wait seven to eight years before seeking help. LCol Grenier cautioned, however, that the CAF needs to continue to treat physical and mental injuries as one and the same. He expressed concern that since he retired from the CAF he has noticed two separate streams, noting that going that route would be a "strategic mistake." He argued that the military would not be able to combat the stigma of mental injuries if, through its programming, it emphasizes or indirectly endorses

77 Phil Upshall, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

78 Louise Bradley, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

79 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

80 Cmdre (Retired) Hans Jung NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

81 MCpl (Retired) Paul Franklin, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

82 Bronwen Evans, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 72, 20 March 2013.

83 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013.

that “there are legitimate injuries and there are injuries of the mind that could be imagined.” He further argued: “It's one thing to say that an injured soldier is an injured soldier, but the military needs to behave like they truly believe that.”[84]

Cmdre Jung and Col Jetly both spoke of “self-stigma,” noting that often times, military members are willing to give their buddies a break, but are not willing to extend that same compassion to themselves. Ms. Bradley told us that in the Mental Health Commission’s research, they have found “that people would rather suffer than actually admit they are suffering from mental health problems. To admit is to be seen as incompetent or unstable.”[85] Dr. Don Richardson, Consultant Psychiatrist, Canadian Psychiatric Association, recommended that the CAF enhance its knowledge dissemination. He argued that military members “need to know that PTSD can be treated successfully with evidence-based treatments, including pharmacotherapy and/or psychotherapy.”[86] More CAF personnel may come forward earlier, if they knew that OSIs, including PTSD, were treatable conditions.

Reducing stigma is an ongoing battle. Although getting CAF personnel into care as soon as possible increases their chances of being able to return to duty, getting them to the appropriate care provider is just the first step. Dr. Aiken told us: “If you can make an accurate diagnosis and implement the appropriate treatment, then you have a greater chance of curing someone and allowing them to stay in.”[87]

**b. Diagnosing OSIs**

Witnesses informed us about the importance of enhanced and more frequent screening for OSIs, and of accurate diagnoses. According to Col McLeod, CAF personnel in TLD, “sign a declaration and identify any high-risk involvement they've had with any other traumas, combat, and so forth that would identify them as being in the higher risk population.”[88] Once back in Canada, those who have been identified as high risk are “immediately referred” to health care providers. Four to six months after CAF members return from deployment, they undergo an enhanced post-deployment screening comprised of an in-depth mental health questionnaire and a personal interview with a mental health care provider. In addition, CAF health care providers conduct routine periodic health examinations that include an “extensive screening for any type of mental illness.”[89] Dr. Richardson argued that “periodic screening for PTSD and common co-morbid conditions such as major depressive disorder, addictions, and suicide would enhance

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84 Ibid.

85 Louise Bradley, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

86 Don Richardson, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

87 Alice Aiken, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 49, 4 October 2012.

88 Col Scott McLeod, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

89 Ibid.

early detection and facilitate treatment."[90] We were told that health assessments in the CAF are done at recruitment and every 5 years until age 40. When a CAF member deploys, an assessment is conducted before every deployment, sometimes during the deployment, and a comprehensive assessment is conducted between three to six months post-deployment. Lastly, one final assessment is done before the CAF member is released from the armed forces.[91]

The Committee was informed that the accurate diagnosis of OSIs, including PTSD, is critical to the recovery of the individual. In the case of Mr. Woolvett's son, who served two tours in Afghanistan in 2007 and 2008, he was only treated for his alcoholism when he was finally diagnosed with catastrophic PTSD in 2010. Mr. Woolvett expressed his frustration as he explained to us the years he spent trying to convince CAF health care providers that his son's alcoholism was a product of PTSD. Dr. Richardson recommended that knowledge dissemination to clinicians regarding PTSD be enhanced. He argued that "clinicians need to be aware that PTSD rarely occurs in isolation, but often presents with co-morbidity. This co-morbidity needs to be treated aggressively in order to optimize treatment outcomes, especially if they are going to get involved in trauma-focused psychotherapy — that is, talking about the traumatic event in treatment."[92]

Reservists face particular challenges because they are more dependent on provincial/territorial health care providers. Unless they are screened, diagnosed, and receive treatment at a CAF base, they may not receive the appropriate care. Dr. Richardson recommended that the CAF work closely with the provinces and territories to ensure that primary care physicians and specialists ask patients if they or anyone close them has served in the CAF. This would ensure that patients who are reservists get screened for OSIs. He informed us that this initiative has been very successful in the US.

### c. Suicide and Suicide Prevention

An ongoing challenge is the issue of suicide and suicide prevention. LCol Grenier told us that if he could make one recommendation, it would be to invest in suicide prevention. Ms. Bradley informed us that the Mental Health Commission of Canada is also embarking on suicide prevention strategies.

A CAF Surgeon General report entitled *Suicide in the Canadian Forces 1995 to 2012*, concluded the following:

- From 1995 to 2012, there has been no statistically significant change in male CAF suicides.

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90 Don Richardson, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

91 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

92 Don Richardson, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

- The rate of suicide when standardized for age and sex is lower than that of the general Canadian population.

- History of deployment is not a risk factor for suicide in the CAF.[93]

Dr. Richardson informed us that although PTSD is associated with suicide, suicide attempts and suicidal ideation, PTSD often occurs with depression. He stated: "what we found was driving the suicidal ideation was actually the depression." In addition, Col Jetly told us that impulsivity is one of the biggest risk factors for suicide. Early findings from the *Army Study to Assess Risk and Resilience in Servicemembers* confirmed that "in general, major depressive disorder predicts ideation and not attempts, whereas impulse control disorders, such as intermittent explosive disorder, predict attempts among ideators."[94] We were told that suicide attempts are difficult to track, because CAF medical officers or the chain of command may never know of them. Therefore, the CAF can only capture the number of completed suicides among serving CAF personnel.[95] Suicides of veterans are not tracked by DND/CAF or Veterans Affairs Canada (VAC), though according to the 2011 Statistics Canada *Canadian Forces Cancer and Mortality Study: Causes of Death*, the percentage of deaths attributable to suicide is 45% higher for veterans than for the general population and currently serving members.[96] Dr. Zul Merali, President and CEO of the University of Ottawa Institute of Mental Health Research, informed us that the US Government does track veterans' suicides and its research has shown that the rate "keeps increasing with time."[97]

As BGen Bernier stated, "you can't divorce a suicide prevention program from the broader mental health system. Good mental health is what helps prevent suicide."[98] As a result of the 2009 Canadian Forces Expert Panel on Suicide Prevention, the CAF has changed its suicide prevention strategies. According to BGen Bernier, the Canadian Forces Health Services Group has "actioned" all of the recommendations from the Panel's report. The *CAF Surgeon General's Mental Health Strategy* outlines the way forward.

One of these recommendations was the need to conduct medical professional technical suicide reviews following each suicide. According to Major General David Millar, current CMP, and LCol Heber, these reviews have been in place since 2010. Within three days of a CAF suicide, a general duty medical officer and a uniformed psychiatrist from a different base conduct a review. They interview all parties, including all the clinicians who

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93 Department of National Defence, *Suicide in the Canadian Forces 1995 to 2012*, Directorate of Force Health Protection, March 2013.

94 Matthew J. Friedman, "Suicide Risk Among Soldiers: Early Findings from Army Study to Assess Risk and Resilience in Servicemembers," *Journal of the American Medical Association*, 5 March 2014.

95 Col Rakesh Jetly, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

96 Calculation based on data in Table 4, p. 9.

97 Zul Merali, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

98 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

treated the person, the family, and the police if the latter was involved. They then report back to the CAF Surgeon General within a month, identifying the circumstances and if there were any preventative measures that could have been taken. These reviews have allowed the CAF to gain a better understanding of what may trigger a CAF member to take his or her own life. We heard that based on the reviews conducted to date, approximately 60% of suicides included personnel who deployed; 40% had not. As well, the prevalent triggers are: 45% relationship-related, 21% disciplinary/career challenges, 16% financial and 10% legal.[99] We were also told that half of CAF personnel who committed suicide were in care at the time, and half were not. Finally, almost all had a mental health condition either treated or not treated.[100]

A Board of Inquiry (BOI) is also launched by DND following each suicide to determine the distribution of VAC benefits. There is currently a backlog of approximately 70 BOIs, which according to MGen Millar has not prevented the government from distributing the benefits to family members.[101] We were told that a "tiger team" has been established to complete these BOIs. As well, the CAF has reorganized BOIs, which now fall under one organization within the CAF instead of two.

BGen Bernier informed us that because half of CAF personnel who committed suicide were not in care, CAF health services "need continuous research to improve the treatments, better performance management to improve the treatments in individual cases for those who are in treatment, and continuous measures for reducing stigma and removing barriers to get people into care."[102]

### Access to Care and Treatment

With respect to treatment, the Canadian Forces Health Services Group is legally responsible for delivering health care to CAF personnel at home and abroad. If a particular health care service is not available through the military, CAF members are able to access provincial/territorial health care services, the costs of which are paid for by DND. Health Services Civilian-Military Cooperation (HS CIMIC) is mandated to establish partnerships with civilian health care organizations to facilitate this complementary care. Based on the testimony we heard, the care and treatment for physical injuries is fairly straightforward and the process is well established. Most of the concerns that were raised related to the treatment and support for those suffering from OSIs, particularly with respect to staffing shortages and providing services to reservists.

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99 MGen David Millar, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

100 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

101 MGen David Millar, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

102 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

Due to the closure of military hospitals, CAF health services "lack[s] a number of components, which makes it reliant on the civilian care network."[103] Huguette Gélinas, the Quebec Coordinator for HS CIMIC, told the Committee that HS CIMIC was established in 2003 and comprises of a national manager in Ottawa, and regional coordinators operating in various regions of the country. Since 2006, it has been mandated to secure treatment for ill and injured CAF members in Canadian health care environments, including acute or trauma care in Canadian civilian hospitals, rehabilitation services, mental health services and other specialised services such as home care. HS CIMIC is also responsible for securing the education, training, and the maintenance of clinical skills for CAF medical professionals at civilian hospitals and other health care settings. She told us that as of May 2013, 154 memorandums of understanding have been negotiated and formalized in that respect. Col Tien told us: "One reason why the level of CF trauma care is high is that many Canadian Forces clinicians are embedded within civilian hospitals."[104]

### a. Rehabilitation and Recovery for Physical and Mental Injuries

As mentioned previously, the preponderance of casualties wounded in action from the Afghanistan mission are associated with improvised explosive devices. As a result, the CAF was required to provide treatment for a considerable number of amputees. The CAF therefore "developed a system in conjunction with civilian rehab centres to ensure that they get the best health care possible."[105] According to MCpl Franklin, over the years, several rehabilitation hospitals and universities have made significant improvements in the treatment of CAF personnel. In doing so, this has also improved the way in which each province treats injured civilians. As he stated: "thousands of wounded have literally changed the entire Canadian medical system."[106] Cmdre Jung informed us that DND/CAF also purchased unique technology such as the Computer Assisted Rehabilitation Environment (CAREN) system to enhance the care of ill and injured military members, and all Canadians.

Helen Zipes, Clinical Director of the Rehabilitation Centre and Academic Family Health Team at the Ottawa Hospital Rehabilitation Centre, informed us that DND/CAF has purchased two CAREN units. One is located at the Ottawa Hospital Rehabilitation Centre and the other is located at the Glenrose Rehabilitation Hospital in Edmonton. The Ottawa rehab centre serves CAF personnel in central and eastern Canada, while Glenrose serves CAF personnel in western Canada. The virtual reality lab which houses the CAREN system began operations in March 2011. Before acquiring the CAREN system, physiotherapists and occupational therapists would work with amputees in the gym and

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103 Huguette Gélinas, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 78, 1 May 2013.

104 Col Homer Tien, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 74, 27 March 2013.

105 Cmdre (Retired) Hans Jung NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

106 MCpl (Retired) Paul Franklin, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

eventually take them outside on uneven ground. The process was lengthy, as it required considerable strength recovery to ensure the patient would not fall. The CAREN system is equipped with a dual-paced treadmill, a 180-degree screen that can be programmed to display any environment, and cameras surrounding the unit to measure balance, and gait depending on the goals of the treatment. Most importantly, there is a harness which keeps patients from falling. This harness allows health care providers to progress the treatment much faster as it gives patients the confidence to push themselves and reach further in a safe and controlled environment, making treatment challenging yet fun. The CAREN system has been used by physically injured military members who also have OSIs. Ms. Zipes informed us that Col Jetly has submitted a project with the rehab centre to work with military members with only OSIs, including PTSD.

Ken Brough, Doctor of Chiropractic and board member of the Canadian Chiropractic Association (CCA), informed us that the prevalence of lower back pain in the Canadian military is double that of the Canadian population, and that 53% of all medical releases result from musculoskeletal (MSK) conditions.[107] As well, half of the health claims of veterans are MSK-related. Although chiropractic services are already recognized by DND as part of a CAF member's extended health care benefits, military members often get referred too late, when other treatments have failed, and the patient is then considered chronic. His colleague, Eric Jackson, Doctor of Chiropractic, argued that early intervention in a team-based setting "can greatly improve outcomes and prompt return to duty."[108] In addition, studies have shown that this is also cost-effective. As part of its role in the recent DND expert panel on spinal health, the CCA was willing to put this to the test, and offered to fund a research project on five CAF bases with the aim of introducing chiropractors as part of the health care team. Finally, in light of the prevalence of MSK conditions in the CAF, the CCA recommended that the DND/CAF develop a broader and more systemic MSK strategy.

Physical and mental injuries often go hand in hand. Those who are physically injured may be traumatized by the incident that caused their injury; after all, "PTSD is a normal reaction to a very abnormal situation."[109] They may also have difficulty coping with the fact that their lives have changed dramatically. MCpl Franklin, who lost both legs in the same blast that killed diplomat Glyn Berry in 2006, told us, "It changes everything. It's going from black to white. It's going from young to old in an instant."[110] For many young and fit military personnel, this could have a devastating effect. As well, Elizabeth Steggles, Professional Affairs Executive at the Canadian Association of

107 Ken Brough, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 9, 10 December 2013.

108 Eric Jackson, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 9, 10 December 2013.

109 MCpl (Retired) Paul Franklin, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

110 Ibid.

Occupational Therapists, informed us that "90% of people who have mental health issues also have physical issues."[111]

While the Committee believes that the *CAF Surgeon General's Mental Health Strategy* is an important step in acknowledging that mental health within the CAF community is a top priority for the Canadian Forces Health Services Group, the next steps, of course, include implementation. As Col Jetly explained: "it's essential that when someone finds the courage to come forward and seek help, we stand ready to provide them with that support."[112]

National mental health organizations have weighed in on aspects of the *CAF Surgeon General's Mental Health Strategy*. For instance, Ms. Bradley told us that the R2MR training and resiliency package is highly regarded, particularly with respect to stigma reduction. As well, Mr. Ferdinand (CMHA), told us that his organization was "very encouraged" by the Strategy as it establishes an "evidence-based approach to addressing a person as a whole person." He called the approach multi-disciplinary, fairly comprehensive, and remarked that services are not only focussed on intervention, but also on "health promotion, prevention, and a number of different supports." Further, the CMHA was impressed that the Strategy also provides for ongoing research and evaluation.[113]

The Committee heard about the difficulty of treating PTSD. Dr. Richardson told us that although "evidence has shown that PTSD can be treated with evidence-based treatments, including pharmacotherapy and psychotherapy," treatment outcome research has "consistently shown that military-related PTSD does not respond to treatment as well as civilian PTSD."[114] The reason for this, he said, is unknown. However, it may be related to "the type of trauma or the higher rates of co-morbidity seen in military-related PTSD."[115] As mentioned previously, this means that military-related PTSD rarely occurs in isolation. A number of witnesses informed us that PTSD often occurs with other psychiatric illnesses including major depressive disorder, other anxiety disorders and addictions. Alcohol addiction is more prevalent in the CAF than drug abuse. LCol Heber informed us that in the CAF, a diagnosis of PTSD, alcohol dependence and major depression is a common triad that CAF mental health care providers encounter. This requires "a comprehensive treatment package" following diagnosis which would also include addiction treatment. Dr. Aiken informed us that "with PTSD that has been properly diagnosed, a third will be treated and get better and be fine, a third require ongoing treatment but can still serve, and about a third are not responsive to treatment."[116] Dr. Richardson recommended that

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111 Elizabeth Steggles, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 5, 21 November 2013.

112 Col Rakesh Jetly, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 60, 6 December 2012.

113 Mark Ferdinand, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 5, 21 November 2013.

114 Don Richardson, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

115 Ibid.

116 Alice Aiken, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 49, 4 October 2012.

"significant work is still needed to better understand the poor treatment response in the military and veteran population and how to match the various treatment modalities to the individual seeking treatment."[117]

LCol Heber manages the OTSSC in Ottawa — one of seven across the country. This is in addition to the 26 general mental health clinics across Canada that deal with the everyday stresses and illnesses that affect all Canadians. The Ottawa OTSSC was first stood up in 1999 to address the mental health needs of CAF personnel deployed to Rwanda, Somalia and Bosnia in the 1990s. Mental health care at the OTSSCs is OSI-focussed and provided by a multi-disciplinary team consisting of psychiatrists, psychologists, social workers, mental health nurses, a chaplain and a pharmacist. They also have access to addiction specialists, case managers and peer-support workers as required. The mental health team also has close access to the family doctors who are the primary care providers to CAF personnel. LCol Heber explained that two clinicians are dedicated to seeing patients with no appointment on a crisis basis. Between 2007 and 2009, the mental health team at the Ottawa OTSSC also cared for ill and injured CAF personnel from Garrison Petawawa before an OTSSC was stood up at that base.

The CAF mental health system, however, is still dependent on the civilian provincial/territorial health system in some ways. Although the OTSSC will assess, diagnose, and set up a treatment plan for CAF members, it "cannot provide the therapy for all those people" within the clinic.[118] LCol Heber told us that she would refer patients to psychologists in the community and after every 10 session, the CAF member would meet with one of her social workers to discuss how the treatment is progressing. We were told by BGen Bernier that although CAF members may be referred to outside sources, the general practice of continuity of care requires that CAF personnel be part of the military health system.

The CAF medical system is also dependent on civilian residential treatment facilities. LCol Grenier argued that "the criteria are so strict and stringent, that you're either too sick or too healthy to be in those programs."[119] While Ms. Allison was informed, prior to appearing before the Committee, that her daughter was going to be admitted to the civilian Homewood facility, she expressed the same concern as LCol Grenier, explaining that she was "fighting, kicking, and screaming to get it done."[120] BGen Bernier informed us that the decision is based on a clinical judgement "which is sometimes not an agreement" among clinicians, the family, and the individual.[121] Ms. Allison also told us that her daughter and

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117 Don Richardson, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

118 Alexandra Heber, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 78, 1 May 2013.

119 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013.

120 Heather Allison, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

121 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, 8 April 2014.

other soldiers were sent to psychiatric units for assessment with other patients with severe mental illnesses, which subjected them to terrifying experiences. LCol Grenier argued that it is important for the CAF to have its own in-treatment programs and create its own expertise in this area. In his opinion, sending ill and injured CAF members to civilian residential treatment programs is an abdication of responsibility. BGen Bernier informed us that the CAF has a series of in-patient addiction referral centres and one of its own residential referral centres in Halifax. The Bellwood facility in Toronto, where Mr. Woolvett's son is receiving treatment, now has a war-related PTSD program.

Mr. Woolvett, Ms. Allison, Cpl Kirkland and Bombadier Logue expressed concern that ill and injured CAF personnel were being overmedicated. BGen Bernier indicated that CAF health care professionals are "always trying to determine the best ways to treat patients, based on new research."[122] CAF health services also hold training sessions and push doctors to consult all new information. Although he couldn't comment on individual cases, Col McLeod informed us that in general, CAF medical professionals prefer to use a "multidisciplinary approach to care, which involves a balance between psychotherapy and pharmacotherapy," and that "the pharmacotherapy portion of that really should play a fairly minor role."[123] BGen Bernier stated that if there are any causes for alarm, he could initiate a clinical audit through the chief medical officers on all military bases and that he could also conduct a national assessment of specific cases.

#### b. Shortage of Mental Health Staff

According to the DND/CAF Ombudsman, and based on the testimony we heard, one of the ongoing challenges that affects the care provided to those suffering from OSIs is the national shortage of mental health care providers. All CAF witnesses acknowledged the shortage of mental health care professionals within DND/CAF and across Canada in general. Based on results from a Statistics Canada survey in 2002 coupled with data from the Rx 2000 program, the ideal number of mental health care providers was pegged at 447.[124] However, this number was identified prior to Canada's mission in Afghanistan. We were told by the DND/CAF Ombudsman that in 2005, DND/CAF agreed to increase the number of people in the mental health organization from 228 to 447, and the money was set aside to accomplish that.[125] According to Col. Jetly, as of 6 December 2012, DND/CAF had filled 379 of 447 mental health positions. The DND/CAF Ombudsman testified that, this number has remained relatively unchanged since 2010 (378).[126]

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122 Ibid.

123 Col Scott McLeod, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 54, 1 November 2012.

124 Pierre Daigle, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 72, 20 March 2013.

125 Ibid.

126 Ibid.

In addition to the scarcity of mental health professionals in Canada, Cmdre Jung confirmed that his challenge with respect to hiring civilian health care professionals when he was CAF Surgeon General was never an issue of funding. His inability to spend the money and hire staff was due to internal obstructions beyond his control such as hiring freezes, uncompetitive salaries and cumbersome bureaucratic hiring processes. He noted that it could take 10 months or longer to hire a civilian health care professional. As he stated: "The year-end comes, and I can't spend the money."[127] Jacqueline Rigg, Director General of Civilian Human Resources Management Operations at DND, informed us that another obstacle was the difficulty of hiring civilian health care professionals for rural and remote regions. Despite the freeze on public service staffing, BGen Bernier told us that the CAF was still able to hire civilian health care providers through Calian, a third-party contractor, and pay them at market rates.

In October 2013, the DND Deputy Minister lifted the civilian staffing freeze. Since then, we were told that the CAF established a "tiger team" to expedite the hiring process. MGen Millar informed us that the current goal is 452 mental health practitioners and support personnel. By 8 April 2014, Ms. Rigg informed the Committee that DND/CAF had only 17 positions left to fill compared to 54 since the first time she appeared before the Committee on 4 March 2014. DND/CAF engaged with the Treasury Board Secretariat (TBS) and the Public Service Commission (PSC) to "maximize the flexibility within the public service legislative construct to successfully attract and recruit mental health professionals."[128] For instance, with respect to hiring for isolated locations, TBS approved an increase from $5,000 to $40,000 valid until 31 March 2015 as a maximum reimbursement amount for candidates willing to relocate for the position. As well, the PSC agreed to refer priority persons to DND if they meet the needs and requirements of the position. These candidates would get priority clearance to reduce the time required to staff the position, and DND/CAF is offering the top of the pay scale in each clinical category in order to better compete with the private sector.

Given that clinical psychologist positions continue to be difficult to fill, particularly in isolated regions, an argument for uniformed clinical psychologists continued to be made. In fact, in his report *Fortitude Under Fatigue*, the DND/CAF Ombudsman stated that "the most difficult mental health specialty to fill at Petawawa, as well as several other geographically challenged locations, is psychology. A major reason for this is the absence of a military psychologist occupation. Creating uniformed psychologists would likely increase the number of these specialists able and willing to serve the Canadian Forces in isolated locations like Petawawa, as it does for psychiatrists."[129] As mentioned previously, DND/CAF is currently investigating this requirement. Cmdre Jung informed us that adding

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127 Cmdre (Retired) Hans Jung NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

128 Jacqueline Rigg, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

129 DND/CAF Ombudsman, *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve*, September 2012.

more uniformed health care providers is not as simple as it sounds. He stated that: "… if we increase the military health care providers in uniform, we have to decrease somebody else, because the total number the government has for the number of people in uniform has to stay fixed. Therefore, the requirement for who should be in uniform is dictated by how many people of what specific health care profession are needed for operations… For anything beyond that we go to civilians."[130]

Meanwhile, DND/CAF is enhancing the way in which it recruits mental health professionals. Col McLeod told us that the DND/CAF advertise vacant positions through publications and professional journals. The CAF Surgeon General and CAF senior psychiatrists also attend medical events to attract mental health professionals to the CAF. Ms Rigg also informed us that DND is developing communications products promoting DND as an employer of choice.

### c. Care and Treatment for Reservists

Ensuring that reservists are provided with timely and high-quality treatment can be particularly challenging. We were told that in the recent past, there was confusion among reservists and CAF medical professionals as to who was responsible for their care. As well, some reservists reside far from military communities, where the care and support structures are not available. With respect to physical injuries, the DND/CAF Ombudsman found that some reservists were only being compensated 40% of what other reservists and regular members were being compensated for the same injuries.[131]

Reservists augmented regular force troops by as much as 20% during the Afghanistan mission. When reservists are on operation and are employed under a Class C contract, they receive the same health care benefits as their regular force colleagues. When they return to Canada and are finished their duties, they return to their unit on Class A employment category. According to Padre Phil Ralph, Regimental Chaplain at 32 Combat Regiment and Program Director at Wounded Warriors Canada, there are two issues with respect to caring for ill and injured reservists: time and space. If injuries can be identified within the 30 days before a reservist's Class C contract expires, then the CAF can extend the contract to maintain the level of care available to regular force members. The reservist can then focus on recovery while still getting paid. However, given that symptoms of OSIs can present months or years post-deployment, it is difficult for reservists to access the appropriate care as civilians. It is the Committee's understanding that reservists who are ill and injured as a result of military service can access any CAF medical services. Reservists who live in isolated regions, however, would

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130 Cmdre (Retired) Hans Jung NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

131 Pierre Daigle, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 72, 20 March 2013.

still have difficulty accessing the appropriate care nearby. Meanwhile, these individuals are also trying to support their families and maintain their civilian jobs.[132]

While the DND/CAF Ombudsman was studying this issue, he discovered that some CAF doctors did not know what care they were entitled to provide to ill and injured reservists, and some reservists also did not know what care they were entitled to. In fact, there were instances where reservists who had approached CAF medical professionals on base were referred to provincial health care services. When the DND/CAF Ombudsman highlighted this issue, the CAF Surgeon General issued a temporary directive clarifying the care reservists are entitled to. However the DND/CAF Ombudsman told us that the CAF must go further and promulgate permanent policies and regulations that clearly identify reservists' entitlements in the *Queen's Regulations and Orders*. He also recommended that these entitlements be better communicated to reservists and CAF medical personnel.

Following a three-year pilot program which ran from 2008 to 2011, Field Ambulance Medical Link Teams (FAMLT) were stood up to facilitate medical follow ups with reservists. According to the *DND Report on Plans and Priorities 2013–2014*, the roles and responsibilities of the Reserve Casualty Support Initiative – Field Ambulance Medical Link Teams include:

- Provide coordination, support and unit liaison to facilitate medical follow-up process for all personnel returning from deployed operations — primarily dealing with Class A members. This entails contacting each deployed reservist three times.

- Conduct annual health care entitlement briefings to Primary Reserve units (Army, Navy, Air) within the Reserve Field Ambulance's area of responsibility.

According to BGen Bernier, the FAMLTs are mostly comprised of nurses whose responsibility is to monitor reservists who are ill and injured as a result of their military service. FAMLT staff are part of the reserve force and can be called up for military service for a minimum period of two weeks a year. These FAMLTs can also travel to reach reservists in isolated regions within their area of responsibility. Though reservists can access local health care providers, ideally they would seek treatment at a specialized military mental health centre — and the CAF is willing to transport them to one if necessary. Given that the Royal Canadian Legion has centres in most communities across Canada, the CAF has also partnered with the Legion to set them up as a "storefront" for all the available programs. The CAF is also developing advanced telemedicine as an option. BGen Bernier acknowledged that reservists are a "special vulnerability," and that "particular attention" needs to be paid with respect to their care.[133]

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132 Derrick Gleed and Phil Ralph, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 78, 1 May 2013.

133 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

The DND/CAF Ombudsman's study also noted the "enormous gulf" between what regular force members are offered and what reservists are offered if they lose a limb; this pertains to the Accidental Dismemberment Insurance Plan. The Ombudsman confirmed to the Committee that two weeks after the DND/CAF Ombudsman's report *Reserved Care* was released, the "Minister announced that reservists would be receiving the same compensation as regular soldiers for the loss of a limb. The Treasury Board of Canada has put that policy into effect. That has been solved."[134]

**Social Support Services**

While the Canadian Forces Health Services Group provides mental health services to ill and injured CAF members, the Integrated Personnel Support Centres (IPSC) across the country provide the social support and administrative services. There are 30 IPSCs and satellites that report to 8 regional command and control elements which in turn report to a Joint Personnel Support Unit (JPSU) located in Ottawa. Before 2009, these services were provided on an ad hoc basis where each base commander could use the resources they had available to them, and the actual services "were much more limited than they are today."[135] At that time, ill and injured members would be placed on the service personnel holding list (SPHL) until they were fit and able to return to their unit, or medically released. Master Corporal Jody Mitic told us that in the past, the SPHL was used as a threat and had a reputation of signalling the "kiss goodbye to your career." He further noted: while "SPHL was seen as a scrap heap … the JPSU is like a repair bay."[136]

The services made available through the JPSU include:

- Casualty tracking;
- Casualty administrative support and advocacy;
- CAF Case Management;
- Return to Work (RTW) Program coordination;
- Service Income Security Insurance Plan (SISIP) Financial Services;
- Liaison with MFRCs, local base support representatives and local unit Commanding Officers; and
- VAC client and transition services.[137]

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134 Pierre Daigle, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 72, 20 March 2013.

135 Col Gerry Blais, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 12, 25 February 2014.

136 MCpl Jody Mitic, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

137 DND/CAF Backgrounder, "Joint Personnel Support Unit," 28 May 2009.

The JPSU/IPSC network is meant to provide a "one-stop service." If CAF personnel are ill and injured to the extent where they cannot fulfill their duties for six months or longer, they are posted to the JPSU, and assigned to their local IPSC for care. Their primary focus while posted to the JPSU is to work on their recovery. The primary aim of the JPSU/IPSC network is to help bring ill and injured members "to optimal health so they can resume their career or be prepared for transition to civilian life."[138] As well, ill and injured members that require care but are able to continue working with some Medical Employment Limitations (MELs) can also access JPSU services. These MELs are issued by the base doctors and ensure the CAF member's confidentiality by disclosing what tasks the member is able to perform while not disclosing the member's medical condition. We were told that this confidentiality was key in helping ill and injured CAF personnel step forward and seek treatment. BGen Bernier stated: "if the troops understand and if our patients know that their health information will be well protected, that increases their confidence."[139] When we visited Garrison Petawawa, Colonel Gerry Blais, Director of Casualty Support Management and the Joint Personnel Support Unit, told us that 158 ill and injured members were posted to its IPSC, and almost twice that number access the services. He informed us that the current overall number of ill and injured members posted to the JPSU/IPSC network is just under 2,000, and an additional 3,500 are walk-in clients.[140]

However, MCpl Mitic told us that the JPSU/IPSC network may have retained some of the legacy of the SPHL as the "kiss of death" to a CAF member's career. He explained that when CAF personnel are posted to the JPSU, they lose touch with their unit, and are taken out of operations. We heard in Petawawa, that being taken out of the training cycle is also of concern to military members, as this could also impact their careers.

MCpl Mitic and Mr. Woolvett expressed concern with respect to the shortage of staff within the JPSU/IPSC network. Some staff are ill and injured themselves, approaching retirement, or are Class B reservists whose contracts eventually expire. As a result, "there is constant turnover of personnel in these units."[141] The DND/CAF Ombudsman has been following this issue closely. In October 2013, he released his preliminary assessment of the JPSU/IPCS network. He found that insufficient staffing relative to client demands was the primary issue raised by JPSU/IPSC staff across the board. A significant issue at that time was the loss of Class B reservists as a result of new rules regarding retired CAF personnel not being able to work as reservists while also collecting their regular force pension. As well, "numerous civilian positions had been left

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138 Pierre Daigle, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 72, 20 March 2013.

139 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

140 Col Gerry Blais, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 17, 1 April 2014.

141 MCpl Jody Mitic, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

vacant" during the period of public service staffing restrictions.[142] Since this preliminary assessment, the Ombudsman has confirmed that the DND Deputy Minister "provided exemptions to the hiring of Class B Reserve members (46 personnel) as well as approval to staff all civilian positions which had previously been left vacant during government-wide Public Service staffing restrictions."[143]

Another concern was the "need for better training to inspire staff confidence and resiliency while supporting and administering to ill and injured clients."[144] As a result, the Social Work Officer within Col Blais' purview has been tasked with developing a national training package that focuses on staff resiliency.

The ill and injured CAF members we heard from had varying experiences at their JPSU/IPSC. Some felt well served by the JPSU/IPSC network and some did not. It seemed to vary by location and also by type of service. For instance, both MCpl Frankkin and MCpl Mitic have been waiting years for the completion of their home modifications. They both stated that the bureaucracy and paperwork for accessing compensation and benefits from DND and VAC were overwhelming. Ms Steggles argued that occupational therapists (OT) could help CAF personnel navigate these challenges as they can fill the role as case managers, to oversee the whole recovery and rehabilitation of the individual. There is currently one OT on staff in Valcartier and one contracted OT in Edmonton. She told us that the OT in Valcartier works on return to work, driver rehabilitation, vehicle modifications, and home modifications. She informed us that in 2008, six occupational therapists were supposed to have been hired to assist military members with mental health conditions. To her knowledge, this has not been accomplished. Finally, she recommended that ideally, there would be one OT for mental health and one OT for physical health at each of the seven rehabilitation centres across the country.

MCpl Mitic argued that if the JPSU/IPSC network could have more success stories, then perhaps the perception of it would change. Cmdre Jung stated that a CAF member's satisfaction with the JPSU could also be attributed potentially to "the micro-culture of the units." Col Blais informed us that there are three separate reviews, (by the DND/CAF Ombudsman, the Chief of Review Services and the Program Review Board), currently underway to assess the effectiveness of the JPSU/IPSC network. In addition, he has a group that is specifically tasked to improve the programs continuously while taking into account suggestions from the ill and injured, the chain of command and families.

Peer support was considered by most of our witnesses to be a significant component of an ill and injured member's treatment and recovery. The OSISS program is the peer support program jointly managed by DND and VAC. It was established 13 years

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142 DND/CAF Ombudsman, "Preliminary Assessment – Joint Personnel Support Unit (JPSU)," 31 October 2013.

143 Ibid.

144 Ibid.

ago by LCol Grenier. Both Dr. Aiken and LCol Grenier explained that the benefit of peer support is that an ill and injured CAF member gains the confidence to seek help when hearing that others have been through similar experiences. As LCol Grenier explained: “There's nothing like asking the question and hearing an honest and genuine answer that comes from the heart. There's nothing like hearing someone explain how they overcame their problem, knowing they will be there for you and realizing you'll get through it together.”[145] Peer support offers that ongoing assistance. Peer support does not replace clinical care; it complements it. There is no diagnosis needed to join OSISS.

The majority of OSISS volunteers are housed in the IPSCs. There are currently 127 trained volunteers and 45 peer support coordinators at DND, and 10 at VAC. Peer support coordinators and volunteers are typically former CAF personnel living with an OSI. The services peer support coordinators provide include working with peers to encourage self-care, support peers in their efforts to better manage life events and transitions, work to break down barriers caused by stigma, and provide ongoing mentorship and guidance to peer volunteers. Peer support coordinators are public service employees and are therefore required to meet a language profile to ensure that peers are being served in their language of choice. These language profiles, however, cannot be enforced with respect to peer volunteers.

Col Blais informed us that there has been a 20% increase in the use of OSISS over the last year. OSISS coordinators and volunteers serve 2,000 clients in both individual and group settings. He indicated that the operational tempo of the program is being monitored to determine if more staff is required. During our visit to Garrison Petawawa, we were told by OSISS volunteers that they would like to see more volunteers join the program.

LCol Grenier observed that over the past two years, he has noticed a “laissez-faire attitude toward a few of the self-care policies” that were important to him.[146] Those policies are meant to ensure that people would have quick access to a psychologist when cases were difficult to handle. He was concerned that “monitoring ha[d] declined” and that peer support volunteers were being referred to “traditional programs for assisting federal government employees.”[147]

Another source of support is available from the CAF chaplains. Col Fletcher told us that a chaplain “needs to figure out a way to establish a relationship with the commander as well as with the lowest rank.”[148] The chaplain can become a barometer for how the unit is doing. He noted that the biggest risk is isolating oneself from the resources available. An ongoing role and challenge for chaplains is how to help foster community.

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145 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013.

146 Ibid.

147 Ibid.

148 Col John Fletcher, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 74, 27 March 2013.

Reserve chaplains have a unique role as they are often in smaller communities with limited health care and mental health care resources, and social support networks. They become the focal point. The CAF chaplaincy strives to give reserve chaplains the tools and the resources necessary to establish and nurture community.

Mr. Woolvett recommended that a community response to ill and injured CAF personnel who are in crisis would help improve care and prevent tragic consequences. He stated that the local police, children's aid services (if children are involved), probation officers (if the member is in trouble with the law), the chain of command, the military police and the medical team should coordinate their efforts when an ill and injured CAF member is in dire need.[149]

Finally, another source of support can come from charities such as True Patriot Love, Wounded Warriors Canada, and the Canadian Association for Disabled Skiing. A number of witnesses indicated that there is a role for the charitable sector in assisting with the care of ill and injured CAF members. LCol Grenier argued they are "instrumental … in making sure there's a safety net around our federal programs."[150] As well, Col Blais told us that government funds cannot pay for services that are not deemed "needs-based," while Col Jetly informed us that treatments that are not evidence-based cannot be funded either. Bronwen Evans, Managing Director of True Patriot Love, told the Committee that her organization raises money to distribute to other charities. It has raised $14 million in the last 4 years to support military families. For instance, it provided funding to all the MFRCs across the country, funding for children with special needs and mental health support for families. Derrick Gleed, Board Vice-Chair and Chief Financial Officer of Wounded Warriors Canada, informed us that the funds his organization has raised have gone to a canine therapy program and an equine therapy program. It also provided funds to the Veterans Transition Network to assist it with the delivery of its Veterans Transition Program in Ontario, and a 10-year doctoral scholarship in veteran mental health in partnership with Queens University and the CIMVHR. Padre Phil Ralph, also with Wounded Warriors Canada, told us that 60% of its funding is targeted toward mental health. He also noted that it was the one organization in Canada that has a particular focus on the primary reserves. Clay Dawdy, Director of the Canadian Association for Disabled Skiing, informed us of the winter sports clinics they offer for ill and injured CAF personnel and their spouses. He explained that allowing ill and injured CAF personnel to learn what they can do with their new bodies results in higher self-esteem. It also allows for the development of peer and mentor relationships, where individuals begin to share the personal and family impacts caused by their injuries. He recommended

149 Gregory Woolvett, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

150 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013.

that his organization become a DND-approved event so that ill and injured CAF personnel could attend his clinics while on duty. This would also maximize military participation.[151]

**Research and Innovation**

There are a number of innovative research initiatives being conducted in the public and academic sectors for both physical and mental injuries.

According to Dr. Aiken, there have been medical advances as a result of the number of amputees injured in Afghanistan. She told us that there are now limb transplant surgeons who can replace limbs. She and MCpl Franklin informed us that bionic limbs are being developed, particularly for upper limbs. These bionic limbs are wired to the brain such that the individual can move, and even feel with his or her artificial arm. Much of this work is being conducted by US military researchers.

With respect to OSIs, research is being conducted to assist with diagnosis and treatment outcomes. DRDC Suffield has a facility where scientists can replicate various blasts. They are currently "trying to understand the basic physiological effects of a blast wave on cells," and the origins of the trauma military members who have been exposed to blasts exhibit.[152] Col Tien confirmed that one of the top research priorities for the CAF and our allies is on Mild Traumatic Brain Injury (MTBI), including the rehabilitation and chronic pain issues that follow. Dr. Fortin further noted that DRDC is working with academic organizations to better understand the link between blast injuries and mental health issues, including PTSD. This research focuses on ways to improve early diagnosis which would hopefully lead to better treatment and the prevention of deeper symptoms from developing.

Cmdre Jung cautioned us regarding the medical community's "desperate" search to find a biological explanation for mental injuries. Cmdre Jung explained that the fundamental difference between a concussion in the civilian sector versus in the military is the intention behind the cause of impact. When an individual is hurt while playing sports for example, the opponent's intent was not to kill the player. Whereas in the military context, "the very incident that caused the concussion—a bomb or an IED—is in its very nature threatening the soldier's personal psyche and viability as a human being." Therefore, "the exact incident that could cause MTBI is also the exact precipitating cause that would trigger a PTSD." He was concerned that moving "too vociferously" in the direction that a mental injury resulting from a traumatic event could not possibly be caused by psychological factors, but rather is the result of a concussion, would inadvertently further stigmatize those suffering from OSIs.[153]

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151 Clay Dawdy, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 5, 21 November 2013.

152 Marc Fortin, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

153 Cmdre (Retired) Hans Jung NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 61, 11 December 2012.

On the other hand, Dr. Aiken argued that finding and understanding the distinguishing factors between MBTI and PTSD could prove extremely useful "because the symptoms people display are often very similar." She explained that this is particularly critical when it comes to diagnosis and subsequent treatment. She stated: "at the clinical level, if you make an incorrect diagnosis and you are treating for PTSD and the person has a MTBI, they are never going to get better." She informed us that current research is focussed on brain mapping to explore whether or not the chemicals in the brain are different when a person has an MBTI or PTSD. Finding these distinguishing factors could also help the military protect against MTBI and PTSD. She noted: "Mild traumatic brain injury could be an equipment issue. Post-traumatic stress disorder is not."[154]

With respect to treatment, the CIMVHR is working with several different research groups to create a mobile application (app) to help ill and injured CAF personnel with specific health care needs. For instance, for a military member with an OSI, the app could feed self-soothing techniques if he or she is encountering a stressful situation, or locate the nearest emergency services. Dr. Aiken believes that this would appeal to the younger generation of CAF personnel.

MCpl Nachuk and Bombardier Logue introduced us to the benefits of psychiatric service dogs. We were disappointed to hear that MCpl Nachuk faced resistance and was even ridiculed when he expressed his decision to use a service dog through the Manitoba Search and Rescue Dog Association. They both told us how their dogs assist in their treatment as their presence curbs the hypervigilance CAF personnel with PTSD often experience. Their dogs offer them a sense of protection, and when they go out in public, their dog receives attention and not them, which relieves their feelings of anxiety. MCpl Nachuk informed us that since acquiring his service dog, his medication and his appointments for depression were able to be reduced. Allison Vandergragt, Program Director at Hope Reins Equine Assisted Therapy Programs, and Ms. Hull, who has conducted equine therapy sessions as a social worker, introduced us to the benefits of equine therapy. Ms. Hull explained that horses are a valuable tool because they survive by reading non-verbal communication and by feeling emotional states. A military member has to be honest with his or her emotional state when seeking cooperation from the horse and to achieve success. Equine therapy can also be conducted as a family. We were told by CAF officials that there is insufficient evidence to support the inclusion of canine- or equine-assisted therapy in the spectrum of care offered to CAF personnel. Bombardier Logue stated that "the US and the UK both endorse and fund psychiatric service dogs for their soldiers, so the science is there."[155] With respect to equine-assisted therapy, Dr. Aiken told us that there is some "very significant solid research behind it."[156]

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154 Alice Aiken, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 49, 4 October 2012.

155 Bombadier Geoffry Logue, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 60, 6 December 2012.

156 Alice Aiken, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 49, 4 October 2012.

Unfortunately, this research has not been conducted with military populations yet. Ms. Vandergragt informed us that the UK and the US have initiated such research.

We were told that the Government of Canada provided $5.2 million for research into depression, depression-related suicide and PTSD through the Canadian Depression Research Intervention Network (CDRIN). The Government of Canada has also provided $200,000 for the Mood Disorders Society of Canada to develop, in collaboration with the Mental Health Commission of Canada, the CIMVHR, and the Canadian Medical Association, "a continuing medical education program directed at Canada's 76,000 family doctors, developing the theory of stigma but also advising them on how better to treat PTSD."[157]

Dr. Merali recommended that more attention be paid to sleep disturbances that are closely associated with PTSD. BGen Bernier told us that some CAF personnel have gone 10 years without sleep. We heard of interested research being conducted with respect to sleep issues by Dr. Moldofsky and Dr. Germain. Dr. Moldofsky told us that the key factor in our health is the operation of the brain – the sleeping and waking brain. Given that the brain does not stop functioning, awake or asleep, "if we don't sleep properly, we become ill."[158] Dr. Germain informed us of the evidence-based sleep treatments she and her colleagues have developed. She found that they not only improve sleep quality among military members, but they also improve daytime symptoms of OSIs, including PTSD. The University of Ottawa's Institute of Mental Health Research is also exploring sleep disorders, associated with PTSD. BGen Bernier informed us that DND/CAF is involved in sleep research, and has sponsored research involving drugs to enhance sleep and reduce nightmares. He noted that tackling sleep disturbances is part of CAF patient care protocols for OSIs, particularly PTSD, "because people cannot get better" until their sleep improves.[159]

Dr. Merali recommended that the "government consider establishing research chairs as a way to bridge the military and the armed uniform services with civilian research enterprises."[160] Col Tien continues to hold the Major Sir Frederick Banting chair in military trauma research. He told us that this allows him to facilitate, organize and conduct research of interest to the military, given that not all trauma research in general is directly relevant to the military. The chairmanship also allows him to do collaborative research with allies, and fund CAF medical officers who may be interested in conducted such research. BGen Bernier informed us that in 2013, he established a new military critical care research chair affiliated with Western University which is currently held by Navy Captain Ray Kao. He also told us that he is considering other military health research chairs.

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157 Phil Upshall, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

158 Harvey Moldofsky, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 8, 3 December 2013.

159 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 19, 8 April 2014.

160 Zul Merali, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

### Supporting CAF Families

Caring for the family members of ill and injured CAF personnel continues to be a challenge. As well, “the stresses inherent within the military lifestyle can in many cases weigh particularly heavily on military families.”[161] CAF medical professionals cannot provide health care, including mental health care, to family members and therefore they are reliant on provincial/territorial health authorities. The CAF is, however, able to provide social support through its Military Family Services directorate and Morale and Welfare Services. Col Mann stated that the DND/CAF is not “standing still” on providing support to families even though legislation does not allow for DND/CAF to provide health care for family members of CAF personnel.

A number of witnesses stated that the treatment for mental health issues is far better in the CAF than in the civilian sector. This means, though, that family members who are coping with an ill and injured member and are suffering from mental health issues themselves, do not have access to the same level of mental health care as the military member in their family. Military families can also encounter difficulties accessing mental health care services in civilian society. Constant relocations due to frequent postings to different military bases across the country require family members to find a new family physician in a new province or territory every few years. Col Mann informed us that DND/CAF was successful in having the provinces and territories waive the 90-day wait for provincial/territorial health insurance for military families.[162]

We were told that ill and injured CAF members would “suck it up” every day at work, and that it is mostly at home where “things fall apart.”[163] LCol Grenier argued that it is the family members who “stitch us back together when we come back from deployments and have a really hard time integrating.”[164] This can place considerable stress on family members. Parents, spouses, and children are all affected by a military loved one’s injuries, physical and mental, and they may struggle to obtain services in the community. As Mr. Woolvett and Ms. Allison both expressed, that they also suffer from battle fatigue. MCpl Franklin informed us that 90% of wounded soldiers are divorced. He also told us that it is the children who really suffer the most. Ms. Allison informed us that she found it very difficult to get information about her daughter’s condition from the military, and she felt that her local MFRC was not equipped to handle family of military members suffering from PTSD. She recommended that outreach to family members be enhanced to inform them of what services are available.

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161 Col Russell Mann, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 12, 25 February 2014.

162 Ibid.

163 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013.

164 Ibid.

Col Mann informed us that the feedback he received from military families focuses on the need for better access to health care, child care, and mental health care. There are 32 MFRCs across Canada, in Europe and in the US. The board of governance structure for every MFRC retains a 51% military spouse participation rate. The CAF provides $27 million a year for the programming it wants to remain consistent across the country, while MFRCs can receive additional funding from money raise by non-profit organizations to fund programs that are appropriate for their local conditions. Every three years, each MFRC conducts a community needs assessment. Since 2011, family liaison officers were introduced to the care offered to CAF family members. They are trained social workers, employed by the MFRCs but embedded into the IPSCs. These family liaison officers provide counselling and support to families. Also, in 2013, a program called InterCom was launched to provide couples' counselling. As well, Col Mann informed the Committee that a working group was launched to develop "unique family elements" of the R2MR program. With respect to outreach, which also includes reaching out to family members of reservists, Col Mann indicated that the CAF is taking a "multi-channel approach." Advertisements are placed in base newspapers and the *Canadian Military Family Magazine*, through local media and on social media to promote the range of services available. There are MFRCs in certain reserve communities, and some MFRCs are able to send personnel to a region to reach isolated reserve units and provide special programs for CAF members and their families there.

We heard positive feedback from Ms. Allison and through our meetings in Petawawa with respect to the family component of OSISS. One of the benefits of the peer support program is that those with similar challenges are helping each other. Dr. Aiken argues that families are not equipped to deal with their own mental health issues because they are dependent on a health care system that does not understand their unique needs. She told us that the CIMVHR is working on changing that. The Mental Health Commission of Canada has released national guidelines outlining the needs of family members who are caring for loved ones with a mental illness. Furthermore, Dr. Richardson recommended that "enhanced services to spouses and children and improved coordination with provincial community services are crucial to better meet the needs of the families, and by extension, military members and veterans."[165]

**Recommendation 10**

**The Committee recommends that the Government of Canada encourage the Canadian Armed Forces to implement a policy that strongly discourages military superiors from asking subordinates details of a medical issue, unless the immediate health and safety of the member or his unit members are at risk.**

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165 Don Richardson, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 76, 17 April 2013.

**Recommendation 11**

**The Committee recommends that the Government of Canada continue to recognize the importance of peer-to-peer support in recovering from operational stress injuries.**

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**The Committee recommends that the Government of Canada continue to recognize the important work done by non-governmental organizations such as Wounded Warriors Canada, Soldier On, True Patriot Love and the Canadian Association for Disabled Skiing in providing support for transitioning CAF members, and to foster relationships with new organizations.**

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**Recommendation 25**

**The Committee recommends that the Government of Canada continue to inform military members and veterans that PTSD can be treated successfully with evidence-based treatments, including pharmacotherapy and/or psychotherapy.**

### Stage 5: Transition

> "Now that I'm getting better, I want to have the opportunity to continue to serve in the military. I don't want to be abandoned. The military is all I've ever known; I joined when I was 18 year old."
>
> Bombadier Geoffrey Logue, 6 December 2012

Ill and injured CAF personnel posted to the JPSU will either return to work or transition to civilian life. If they return to work, they can either return to their original trade or re-muster into a different trade if there is a position available. If ill and injured CAF personnel do not meet the conditions of Universality of Service, which require them to be

"employable, deployable, and physically fit"[166] in accordance with CAF standards, then they are medically released. This transition to civilian life is a joint responsibility between DND and VAC. Most of the testimony we heard with respect to transition pertained to the Universality of Service principle, and the programs offered by DND/CAF to military members and their families during this process. Unfortunately, the Committee was not able to gain a detailed appreciation for VAC's roles and responsibilities with respect to the transition process, which limited our ability to study this important issue.

The DND/CAF Ombudsman testified that out of the 10 IPSCs his team visited, only 5% to 10% of military members were returned to their unit, which means that most of them were being released from the forces. Col Blais informed us that there are 1,000 medical releases every year. MGen Millar gave us an update stating that as of March 2014, the success rate of the return to work program was 23%.

Ill and injured CAF personnel could be posted to the JPSU from six months up to three years depending on how long they take to recover and either return to their units, or transition out of the military. Mrs. Steggles informed us that early intervention is beneficial with respect to return to work. She stated: "if somebody has been out of work for six months, then we know the chances of getting back to work after six months is pretty slim."[167] She also noted that the OT working on the return to work program in Valcartier had a success rate of return to employment twice as high as other CAF rehabilitation facilities across the country that do not have OTs on staff.

A number of witnesses disagreed with the Universality of Service principle, and asked for flexibility in its application. MCpl Franklin expressed the frustrations we frequently heard as follows: "we lost our limbs, we lose our jobs, and everything we have ever known is done and gone."[168] He explained that ill and injured CAF personnel could serve and deploy in another trade, behind a desk — in a "softer trade." Further, if CAF personnel believe that coming forward with their injuries will compromise their job, they are more likely to try coping on their own, or with their peers, and not seek professional treatment.[169] However, CAF officials maintained that the Universality of Service principle is important. Col Jetly explained that if an ill and injured CAF member is deemed unfit either physically or mentally to deploy, it could do "permanent damage" to this individual if sent on deployment.[170] According to MGen Millar, there are ill and injured CAF personnel who do meet the Universality of Service conditions and continue to serve in the military. Ill and injured CAF personnel who do not meet the Universality of Service conditions are offered

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166 MGen David Millar, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

167 Elizabeth Steggles, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 5, 21 November 2013.

168 MCpl (Retired) Paul Franklin, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 83, 3 June 2013.

169 Pierre Daigle, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 72, 20 March 2013.

170 Col Rakesh Jetly, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

to continue serving in the CAF through the Canadian Rangers and Cadet programs, which do not require meeting them.

When ill and injured CAF members are medically released from the armed forces, this transition period can be very challenging. A number of the ill and injured CAF members we met in Petawawa and those who testified before us stated that they felt a great deal of anxiety during this transition period. First and foremost, some ill and injured CAF members who are medically released believe that they should have been retained.[171] Following our visit to Petawawa, we realized that when joining the CAF, these young individuals did not expect their military careers to be cut short by injury or illness. Accepting this could be extremely difficult. Another source of anxiety comes from not knowing what medical coverage and benefits will be covered by VAC before being released from the armed forces. For instance, when LCol Grenier retired in 2011, DND and VAC still had two separate inventories of approved medicine for psychiatric conditions. As a result, when he was released, he was required to start paying for his medication himself. He stated: "… what if you are somebody with a low income who doesn't have a job and who has to find $180? What happens to these soldiers or veterans? Well, they go without, and when you stop medication, that's not a good thing."[172] He further noted that this issue was identified 12 years ago.

VAC officials are co-located at all the IPSCs. Col Blais told us that six months before an ill and injured member is released, he or she has a meeting with VAC where a transition interview is conducted, and a "transition plan is prepared to ensure that between the Canadian Forces case manager and the Veterans Affairs case manager everything is handed over so the full knowledge base is there." Yet, ill and injured CAF personnel continue to tell us that they do not know exactly what they were getting from VAC in terms of benefits and medical coverage. Michel Doiron, Assistant Deputy Minister for Service Delivery at VAC, did inform us however, that cooperation occurs at multiple levels between the two departments. For instance, the steering committee that he co-chairs with the CMP is a decision-making body that manages ongoing joint priorities that "generally fall under the effort to ensure a continuum of services, including in the areas of mental health and family support."[173] For instance, the departments are cooperating to educate and increase the awareness of mental health professionals in communities across Canada with respect to treating former military members.[174]

An additional challenge is the loss of identity that some CAF personnel experience when they transition out of the armed forces and the resulting emotional and mental toll this could take on them. Tim Laidler, Executive Director of the Veterans Transition

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171 Col Gerry Blais, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 12, 25 February 2014.

172 LCol (Retired) Stéphane Grenier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 73, 25 March 2013.

173 Michel D. Doiron, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

174 Col Rakesh Jetly, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 13, 4 March 2014.

Network, urged the government to invest in programs that assist CAF personnel during this transition process. He explained to us the challenge "when someone has to reinvent themselves" moving from a military career to civilian life, and also has to deal with symptoms of PTSD, depression and other mental health issues.[175] The Veterans Transition Network delivers a 10-day program over a period of 2 months. Veterans work with clinicians for four days in residence, then return to their families and communities for two to three weeks to continue working on their newly acquired reintegration skills. This cycle is repeated another time, with a final two days dedicated to checking in with the clinicians and finalizing the program. He noted that the Veterans Transition Network has identified a gap in the services that are available to ill and injured CAF members. He explained, they may "know cognitively what all the different occupations available to them are, yet there's this psychological transition, this identity transition, that seems to be missing."[176] Even CAF personnel who do not have a diagnosis may be "struggling with who they are going to be once they leave."[177] He also mentioned that the major problem facing veterans is underemployment. Having to restart a new career and start from the bottom, after being in charge of other people's lives, is "underwhelming."[178] Finally, he noted that the peer-to-peer recruitment model of the Veterans Transition Network is another key aspect of the program. He added that the peer support element helps overcome the stigma. Col Blais informed us that he is currently considering the program's application to become a DND-funded service provider.

Before an ill and injured CAF member is released, the JPSU provides a host of career counselling and military employment transition programs. These programs include vocational rehabilitation and priority hiring in the public service. A well, training is offered through the Service Income Security Insurance Plan which includes income support. DND/CAF has also partnered with the private sector through the Military Employment Transition Program. The program offers 10,000 jobs to those medically released from the CAF and a week-long university course for those interested in starting their own businesses. There are also opportunities to enhance education and attain the civilian equivalent to their military qualifications.

Col Mann indicated that during these periods of transition, a family income becomes increasingly important. There are also instances where the spouse may become the sole breadwinner if the military spouse is too ill or injured to continue working. MFRCs offer military spouses various forms of education and employment support, including academic upgrading and employment placement. He also informed us that DND and VAC are conducting joint research on the issue of spousal employment. They are

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175 Tim Laidler, NDDN *Evidence*, 41st Parliament, 2nd Session, Meeting No. 9, 10 December 2013.

176 Ibid.

177 Ibid.

178 Ibid.

currently conducting a gap analysis, so that DND can bolster its programming for spouses where current programs offered by either department falls short.

**Recommendation 26**

**The Committee recommends that the Government of Canada, through the Military Family Resource Centres, maintain support for the spouses of permanently ill or injured members through education and employment support.**

**Recommendation 27**

**The Committee recommends that the Government of Canada consider examining the Universality of Service requirement.**

**Recommendation 28**

**The Committee recommends that the Government of Canada continue to recognize that transition to civilian life for a CAF member equally requires emotional support as well as vocational opportunities in the civilian life.**

**Recommendation 29**

**The Committee recommends that the Government of Canada conduct rigorous mental health screenings during the transition period of a Canadian Armed Forces member, and encourage primary care physicians and specialists to do the same.**

**Recommendation 30**

**The Committee recommends that the Government of Canada ensure that CAF members are better prepared for the eventual transition to civilian life during their time of service.**

**Recommendation 31**

**The Committee recommends that the Government of Canada encourage the expansion and support for the Veterans Transition Network.**

**Recommendation 32**

**The Committee recommends that the Government of Canada develop a comprehensive, algorithmic, military skills translation software tool to facilitate CF members to obtain civilian employment upon release.**

## Final Thoughts

The Committee has learned a great deal with respect to the challenges facing ill and injured CAF personnel and their families, the programs and services available to them, and the ongoing challenges facing DND/CAF and VAC as they strive to meet these unique needs. Even as we continued our study over two years of hearings, these

programs and services were continually being evaluated and improved. We truly appreciated the effort by DND/CAF officials to make themselves available to us, and for updating us on all aspects of programs and services available to CAF members. We noted, however, a gap between what the CAF leadership told us, and what we heard on the ground. We heard about a number of distressing experiences where ill and injured CAF personnel felt abandoned, and had to fight the system that was supposed to be taking care of them. The Committee recognizes that given that CAF health services and programs are continually evolving and given the timing of some of the CAF personnel's experiences, it is possible that new services and programs were not yet available to many of the ill and injured CAF personnel and family members that we heard from at the time when they needed them most. We can only hope that these military members and their families are being appropriately cared for now, and that ill and injured CAF personnel coming forward for treatment today are getting the care they require.

It must be noted that we have a tremendous amount of admiration for the CAF medics, and all other health services personnel. As BGen Bernier stated, they "treated many horrifically injured casualties in Afghanistan, saw death often, suffered the highest number of casualties and killed-in-action after the combat arm, and suffer suicide and mental illness, like other elements of the armed forces."[179] The dedication of the Canadian Forces Health Services Group continues at home. We've heard of CAF doctors taking off their uniforms at the end of their work day and treating family members as civilian doctors in order to bridge that jurisdictional gap, and provide much-needed, consistent care for military families. We congratulate the Canadian medical service on the royal banner it received in October 2013 from Princess Anne in recognition of the valour, sacrifice, and clinical excellence of its members during the Afghanistan conflict. We would also like to recognize the work of JPSU/IPSC support personnel, peer support coordinators and volunteers, and CAF chaplains who are all responsible for providing important components within the spectrum of care. A question we consistently asked throughout our study was "Who helps the helpers?" We urge DND/CAF to have measures in place to also care for these helpers who often times help others before they help themselves. This includes ensuring that they receive appropriate tools and training to fulfill their responsibilities, and that there are enough staff to meet the demand and prevent caregiver burnout.

Given that the military environment is so unique, research pertaining to the care of CAF personnel and veterans must continue in a collaborative way. We are encouraged by the establishment of the Canadian Institute for Military and Veteran Health Research, and were impressed by how closely national mental health organizations are working together, and with DND/CAF. In relation to research, data collection is required to truly assess the ongoing needs of military members and their families. The results of the Statistics Canada mental health survey and the CAF health and lifestyle survey will be available in 2015 and will provide data to guide the CAF in how it shapes its health services over the next few

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179 BGen Jean-Robert Bernier, NDDN *Evidence*, 41st Parliament, 1st Session, Meeting No. 55, 6 November 2012.

years. We also hope that once the CFHIS is fully rolled out, it can also be used to inform the continual improvement of CAF health services.

One way that DND/CAF measures the effectiveness of its mental health services is by tracking wait times. BGen Bernier informed us that a clinical outcomes management tool will be established to evaluate responses to treatment. We believe that DND/CAF must have mechanisms in place to measure the success of their programs, particularly their mental health care services to ensure that they are effective. If ill and injured CAF personnel trust in the quality of CAF mental health services, this will encourage them to seek treatment early and complete their treatment plan. DND/CAF must also ensure that all military members, no matter where they are based, have access to consistent, high-quality care in their preferred language.

Furthermore, in keeping with the Canadian Forces Family Covenant, we encourage regular surveys of military spouses to be able to assess their needs, tailor support services, and engage with provincial/territorial authorities to facilitate care. Family members of CAF personnel also require and deserve consistent, high-quality care in their preferred language wherever the family is posted.

With the end of Canada’s mission in Afghanistan, we hope that hard lessons learned over the last decade will be remembered. Although much of the health services described in this report were derived from the Afghanistan experience, all physical and mental injuries as a result of former conflicts, everyday stress, as well as traumatic events at home are legitimate, and deserve the full attention and care of CAF health services. Many ill and injured military members have suffered in silence, and continue to suffer in silence. We truly believe that de-stigmatization is a leadership issue, and we encourage CAF leaders of all ranks to remain open-minded and supportive of ill and injured CAF personnel who come forward for treatment. In order to save lives, the military must continue to break this culture of silence.

Over the course of this study, the Committee has gained an understanding as to what preventative measures, treatment programs and social support services are available to ill and injured CAF personnel. We also learned about the ongoing research that is being conducted with respect to all these aspects, and the support that is offered to military families. Although there is no perfect system, improvements can always be made. It is our hope that the gaps identified in this report and the recommendations we made will help inform the Government of Canada on a way forward.

# LIST OF RECOMMENDATIONS


**Recommendation 1**

**The Committee recommends that the Government of Canada conduct rigorous mental health screenings during the recruitment period of a Canadian Armed Forces member. .................................................. 9**

**Recommendation 2**

**The Committee recommends that the Government of Canada, through Defence Research and Development Canada or other entities, expand its research into the pre-susceptibility of operational stress injuries. ..................................................................................... 9**

**Recommendation 3**

**The Committee recommends that the Government of Canada enhance education provided to military families for mental health issues prior to deployment of a CAF member through the *Road to Mental Readiness* program.......................................................................... 12**

**Recommendation 4**

**The Committee recommends that the Government of Canada enhance the preparation and training for potential operational stress injuries amongst CAF members before they deploy, and improve methods to train CAF members to self-assess for potential mental health issues.......................................................................................... 12**

**Recommendation 5**

**The Committee recommends that the Government of Canada, through Canadian Forces Health Services Group, continue to actively support clinical research being conducted into how to prevent death by exsanguination..................................................................... 23**

**Recommendation 6**

**The Committee recommends that the Government of Canada support research into increasing survivability from blast injuries such as improvised explosive devices and mortar shells. ......................................... 24**

**Recommendation 7**

**The Committee recommends that the Government of Canada, through Defence Research and Development Canada, or other bodies such as the Canadian Institute for Military and Veteran Health Research, continue to actively support research being conducted at the research centre in Downsview where ultrasound devices are being adapted to work in the theatre of operation, and to be able to enhance the 3D ultrasound diagnostic tools that are available to medics on site. ........ 24**

**Recommendation 8**

**The Committee recommends that the Government of Canada actively train and promote CAF members to self-assess for mental health issues while being deployed. ........ 24**

**Recommendation 9**

**The Committee recommends that the Government of Canada conduct periodic, rigorous mental health screenings for operational stress injuries and common comorbid conditions, during the deployment period of a Canadian Armed Forces member. ........ 24**

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# APPENDIX A
# LIST OF WITNESSES

### 41st Parliament – Second Session

| Organizations and Individuals | Date | Meeting |
|---|---|---|
| **Canadian Association for Disabled Skiing** | 2013/11/21 | 5 |
| Clay Dawdy, Director, Calabogie Adaptive Snowsports, National Capital Division | | |
| Bob Gilmour, Operations Director, Calabogie Adaptive Snowsports, National Capital Division | | |
| **Canadian Association of Occupational Therapists** | | |
| Nicolas McCarthy, Communications Officer | | |
| Elizabeth Steggles, Professional Affairs Executive | | |
| **Canadian Mental Health Association** | | |
| Mark Ferdinand, National Director, Public Policy | | |
| **As an individual** | 2013/11/26 | 6 |
| Anne Germain, Associate Professor of Psychiatry, University of Pittsburgh School of Medicine | | |
| **Ottawa Hospital Rehabilitation Centre** | | |
| Sean Gehring, Manager, Specialized Care Stream | | |
| Helen Zipes, Clinical Director, Rehabilitation Centre and Academic Family Health Team | | |
| **As an individual** | 2013/12/03 | 8 |
| Harvey Moldofsky, Professor Emeritus, Department of Psychiatry, Faculty of Medicine, Institute of Medical Science, University of Toronto | | |
| **Defence Research and Development Canada** | | |
| Sanela Dursun, Director, Research Personnel and Family Support | | |
| LCol Roger Tremblay, Project Manager, Personnel Protection Research | | |
| **Department of National Defence** | | |
| Marc Fortin, Assistant Deputy Minister, Science and Technology | | |
| **Canadian Chiropractic Association** | 2013/12/10 | 9 |
| Ken Brough, Doctor of Chiropractic, Board Member | | |
| Eric Jackson, Doctor of Chiropractic | | |
| **Veterans Transition Network** | | |
| Tim Laidler, Executive Director | | |

| Organizations and Individuals | Date | Meeting |
| --- | --- | --- |
| **Department of National Defence** | 2014/02/25 | 12 |
| Col Gerry Blais, Director, Casualty Support Management and Joint Personnel Support Unit | | |
| Col Russell Mann, Director, Military Family Services | | |
| **Department of National Defence** | 2014/03/04 | 13 |
| Col Rakesh Jetly, Mental Health Advisor, Directorate of Mental Health | | |
| Col Scott McLeod, Director of Mental Health, Canadian Forces Health Services | | |
| MGen David Millar, Chief of Military Personnel | | |
| Jacqueline Rigg, Director General, Civilian Human Resources Management Operations, Assistant Deputy Minister, Human Resources - Civilian | | |
| **Department of Veterans Affairs** | | |
| Michel D. Doiron, Assistant Deputy Minister, Service Delivery | | |
| Raymond Lalonde, Director, Operational Stress Injuries National Network | | |
| **Department of National Defence** | 2014/04/01 | 17 |
| Col Gerry Blais, Director, Casualty Support Management and Joint Personnel Support Unit | | |
| **Department of National Defence** | 2014/04/08 | 19 |
| BGen Jean-Robert Bernier, Surgeon General, Commander Canadian Forces Health Services Group | | |
| Jacqueline Rigg, Director General, Civilian Human Resources Management Operations, Assistant Deputy Minister, Human Resources - Civilian | | |

# APPENDIX B
# LIST OF WITNESSES

**41st Parliament – First Session**

| Organizations and Individuals | Date | Meeting |
|---|---|---|
| **Department of National Defence** | 2011/10/25 | 8 |
| BGen Jean-Robert Bernier, Deputy Surgeon General | | |
| BGen Fred Bigelow, Director General, Personnel and Family Support Services | | |
| RAdm Andrew Smith, Chief of Military Personnel | | |
| **Canadian Institute for Military and Veteran Health Research** | 2012/10/04 | 49 |
| Alice Aiken, Director | | |
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| Marie Josée Hull, Clinical Social Worker | | |
| **Department of National Defence** | | |
| Col Scott McLeod, Director of Mental Health, Canadian Forces Health Services | | |
| **Vanderbrook Farm** | | |
| Alison Vandergragt, Program Director, Hope Reins Equine Assisted Therapy Programs | | |
| **Department of National Defence** | 2012/11/06 | 55 |
| BGen Jean-Robert Bernier, Surgeon General, Commander Canadian Forces Health Services Group | | |
| LCol Alexandra Heber, Psychiatrist and Manager, Operational and Trauma Stress Support Centres | | |
| **Department of National Defence** | 2012/11/22 | 57 |
| Col Gerry Blais, Director, Casualty Support Management and Joint Personnel Support Unit | | |
| RAdm Andrew Smith, Chief of Military Personnel, Co-Chair of the DND/VAC Joint Steering Committee | | |
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| Geoffry Logue | | |
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| Rakesh Jetly, Mental Health Advisor, Directorate of Mental Health | | |
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| Cmdre Hans Jung (Retired), Former Surgeon General for the Canadian Forces | | |

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| Mary Kirby, Director,<br>Strategic Outreach, Planning and Research, Office of the Ombudsman | | |
| **True Patriot Love Foundation** | | |
| Bronwen Evans, Managing Director | | |
| Mariane M. St-Maurice, Manager,<br>Disbursements and Community Outreach | | |
| **As an individual** | 2013/03/25 | 73 |
| Stéphane Grenier (Retired) | | |
| **Department of National Defence** | 2013/03/27 | 74 |
| Col John Fletcher, Acting Chaplain General | | |
| Col Homer Tien, Canadian Military Trauma Surgeon and Military Trauma Research Chair at Sunnybrook Hospital | | |
| Maj Shaun Yaskiw, Reserve Chaplain,<br>Directorate of Chaplain Operations | | |
| **As an individual** | 2013/04/17 | 76 |
| Zul Merali, President and Chief Executive Officer,<br>University of Ottawa Institute of Mental Health Research | | |
| **Canadian Mental Health Commission** | | |
| Louise Bradley, President and Chief Executive Officer | | |
| **Canadian Psychiatric Association** | | |
| Don Richardson, Consultant psychiatrist | | |
| **Mood Disorders Society of Canada** | | |
| Phil Upshall, National Executive Director | | |
| **As an individual** | 2013/04/29 | 77 |
| Maj Ray Wiss<br>Canadian Forces Health Services | | |
| **Department of National Defence** | | |
| Maj Lisa Compton, Manager,<br>Maintenance of Clinical Readiness Program | | |
| Mark Zamorski, Head,<br>Deployment Health Section | | |
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| Huguette Gélinas, Quebec Coordinator,<br>Health Services Civilian-Military Cooperation, Canadian Forces | | |
| Alexandra Heber, Psychiatrist and Manager,<br>Operational and Trauma Stress Support Centres | | |

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| Glen Kirkland | | |
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| Col Russell Mann, Director, Military Family Services | | |

# APPENDIX C
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| Canadian Association of Occupational Therapists | | |
| Germain, Anne | | |
| Canadian Chiropractic Association | | |
| Department of National Defence | | |
| Department of Veterans Affairs | | |
| La Vie | | |
| Pizarro Andersen, Judith | | |

# APPENDIX D
# LIST OF BRIEFS

## 41st Parliament – First Session

## Organizations and Individuals

Allison, Heather

Association for Disabled Skiing of Canada

Mental Health Commission of Canada

Connell, Judith

Leonard, George

True Patriot Love Foundation

Wiss, Ray

# 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. 5, 6, 8, 9, 11, 12, 13, 17, 19, 26 and 29 from the 41st Parliament, Second Session and Meetings Nos. 8, 49, 54, 55, 57, 60, 61, 72, 73, 74, 75, 76, 77, 78, 83 et 84 from the 41st Parliament, First Session is tabled.

Respectfully submitted,

Rick Norlock

Chair

## Dissenting Opinion of the Official Opposition to the House of Commons Standing Committee on National Defence Report on Caring for Canada's Ill and Injured Military Personnel

> When I was in the hospital in Afghanistan, I spoke to my father on the phone. My dad said, "Don't worry, Canada will take care of you. You stepped up like we always have and you did your part, and Canada will do its part. It's only fair. Everything will work out." My dad was wrong. I am broken and can't be a productive, useful soldier. I wanted to be a cop someday, like my dad, but again, I'm too damaged and now I don't meet their standards. The bottom line is that we all stood up and offered to make the ultimate sacrifice for our country.
>
> Corporal Glen Kirkland, June 5, 2013

### Introduction

1. While we agree with many elements of the committee's majority report, we, the Official Opposition committee members, wish to express significant concern that several issues in the majority report have not been accorded appropriate seriousness given the gravity of the subject at hand. In addition, there are a number of issues that do not appear in the report, or are only briefly mentioned, that we believe should be given a higher priority and emphasis when considering the care of Canada's ill and injured military personnel. In general, we remain uncomfortable with the overly positive tone that runs throughout the text of the report. As illustrated in much of the testimony we heard during this study, the Department of National Defence (DND) has often been reactive to complaints rather than proactive in its treatment of Canada's ill and injured military personnel – particularly when it comes to services for those psychologically damaged, and their families - and we therefore feel consistent praise for their efforts is unwarranted. Moreover, several majority report recommendations are akin to those from the committee's 2009 report, "Doing Well and Doing Better: Health Services Provided to Canadian Forces Personnel with an Emphasis on Post-Traumatic Stress Disorder," suggesting that this report has not been given the necessary attention by the Government of Canada. Finally, we wish to express serious concern that the majority report was adopted in just one committee meeting lasting little more than an hour, an extraordinary decision that we find particularly worrying after a two-year-long study on this critical issue affecting thousands of Canadians. Our experience has been that rigurous committee discussion and debate has strengthened recommendations contained in reports from committees.

### Recruitment and Pre-Deployment

2. Throughout this two-year study, Operational Stress Injuries (OSI), including Post-Traumatic Stress Disorder (PTSD), were consistently raised in testimony as

some of the most serious health problems facing Canadian Armed Forces (CAF) personnel. Although statistics on this issue are sorely insufficient, one study reports that over an eight-year period following their first deployment in Afghanistan, approximately 20 percent of Canadian service personnel were diagnosed with a mental health disorder attributable to their service there.[1] This study was conducted both prior to and following the increased tempo of operations in Afghanistan, and therefore does not represent the full impact of the mission there, including increased psychological injuries due to the passage of time. With the end of our mission in Afghanistan, Canada must prioritize the treatment of PTSD within the military community. An important facet of future treatment begins with robust screening for mental resiliency in the recruitment and pre-deployment stages. Dr. Harvey Moldofsky, Professor Emeritus with the Department of Psychiatry, Faculty of Medicine at the University of Toronto, told the committee that he submitted a grant application to the Government of Canada to study predictors and symptoms of PTSD during the early stages of Canada's mission in Afghanistan. Unfortunately, Dr. Moldofsky never heard back from the Government.[2] Although anecdotal, Dr. Moldofsky's experience suggests that OSIs have not been accorded necessary attention and investigation. **We therefore recommend that Canada significantly augment its research efforts into PTSD and OSIs to ensure that mental health screenings at the recruitment stage are as rigorous as possible, and that treatment for those suffering are as effective as possible.**

### In-Theatre

3. The committee heard compelling positive testimony about the successes of tactical combat casualty care, and the Role 3 hospital, in saving lives on the battlefield in Afghanistan. We join in applauding these efforts, but are also concerned that there did not appear to be the same level of emphasis on in-theatre care for psychological injuries in Afghanistan. During that mission, deployed mental health teams consisted of a social worker, a mental health nurse and a psychiatrist. Brigadier-General Jean-Robert Bernier informed the committee that psychologists were not deployed because the CAF only employs civilian psychologists, and "only deploy military personnel abroad".[3] Military personnel needing psychological care in-theatre were treated by American psychologists. This reliance on our allies is problematic, particularly for cultural and language issues. Clearly, as the testimony from veterans and their families demonstrates, the consequences of psychological injures can be as serious and debilitating as physical ones. **This leads us to recommend that Canada expand its deployable mental health care teams, including psychologists in**

[1] David Boulos and Mark A. Zamorski, "Deployment-related mental disorders among Canadian Forces personnel deployed in support of the mission in Afghanistan, 2011-2008," *Canadian Medical Association Journal*, Vol. 185, No. 11, 6 August 2013.
[2] Dr. Harvey Moldofsky (University of Toronto), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 8, December 3, 2013.
[3] BGen Jean-Robert Bernier (Department of National Defence), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 19, April 8, 2014.

**uniform, to treat mental trauma in-theatre, and ensure that these mental health services are offered in both official languages. These teams should operate under status comparable to physical trauma teams.**

4. We were very concerned to hear the testimony of Bombardier Geoffry Logue, who was repatriated to Canada after being diagnosed with severe PTSD in Afghanistan. Bombardier Logue recounted his repatriation experience:

> I was repatriated to Canada on a civilian flight. I had no decompression time. My decompression was at the Boston Pizza in Portage la Prairie, Manitoba. I was presented a leave pass and told that I had the next two months off. I didn't have any support. I didn't have anyone to go to.[4]

Bombardier Logue's story is shocking. As several military officials pointed out to the committee, when and how psychologically injured military personnel return from deployment is critical to their future wellbeing. **We therefore strongly recommend that Canada investigate Bombardier Logue's repatriation experience, and implement the appropriate procedures to ensure that it is not repeated.**

### Diagnosis and Treatment

**5.** We are concerned by DND's difficulty in hiring and maintaining sufficient numbers of clinical psychologists, social workers, mental health nurses, and psychiatrists, especially for francophone CAF personnel. In 2013, then CAF/DND Ombudsman Pierre Daigle testified that DND had never reached its goal of hiring 447 mental health staff – a goal recommended in 2002 – but was instead 22 percent short.[5] This is particularly concerning given that this goal was recommended before the vast majority of the 40,000 Canadian service personnel that served in Afghanistan were deployed there, and before many of the mental health effects of the mission began to surface. Moreover, this staff shortage only began to be corrected in the spring of 2014. Although BGen Bernier stated that DND is "committed to hiring social workers, mental health nurses, and psychiatrists to the extent possible",[6] these efforts need to be successful in order to ensure that all serving members, both Anglophones and Francophones, have access to necessary mental health care. **We recommend that DND put in place the conditions needed to achieve the objective set in 2002 of hiring 447 mental health staff. We also recommend that DND immediately determine whether this objective needs to be increased in light of new needs following the return of 40,000 Canadian troops who served in Afghanistan.**

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[4] Bonbardier Geoffry Logue (As an Individual), NDDN, Evidence, 1st Session, 41st Parliament, Meeting NO. 60, December 6, 2012.

[5] Pierre Daigle (Department of National Defence/Canadian Forces Ombudsman), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 72, March 20, 2013.

[6] BGen Jean-Robert Bernier (Department of National Defence), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 19, April 8, 2014.

6. The committee heard worrisome testimony about misdiagnoses, especially of military personnel suffering from psychological injuries. Two instances in particular stand out for us in which military personnel suffering from PTSD were treated for alcoholism. Mr. Gregory Woolvett told the committee that his son, who served in Afghanistan, was diagnosed with catastrophic PTSD in 2010, but was initially treated for alcoholism. "When it comes to this specific injury—post-traumatic stress disorder—it's misdiagnosed and characterized as something different," he testified.[7] The treatment his son received was therefore highly unsuitable. The committee was also contacted by a veteran, Murray Wilkinson, who wrote of suffering a similar experience when he was enrolled in a 12-step alcoholism treatment program by the CAF, but was in fact suffering from PTSD. **We recommend that mental health professionals working within CAF/DND receive more robust training regarding the signs and symptoms of PTSD so that appropriate treatments are administered.**

7. Insufficient financial coverage for medications and prosthetics was also raised as a serious concern before the committee. For example, Cpl. Glen Kirkland sustained severe injuries while serving in Afghanistan when a rocket explosion hit the Light Armoured Vehicle he was traveling in, killing three fellow soldiers. As a result of the explosion, Cpl. Kirkland lost 75 percent of his hearing, and sustained a brain injury that caused his body to stop producing insulin. When he was prescribed insulin to keep him alive, coverage was denied due to the cost. Moreover, when Cpl. Kirkland was prescribed hearing aids with amplifiers, and as a result needed special eyewear to accommodate the aids, he recounted that the base medical officer said he had to choose: "I was told that when I leave my house I would have to make a decision about whether I would need to see more or hear more that day."[8] While this may not be the policy of the military, we find Cpl. Kirkland's treatment shocking. The committee was contacted by other military personnel who experienced, and are still experiencing, similar difficulties in obtaining appropriate medication and prosthetics for their injuries. **Based on this evidence, we recommend that Canada ensure that appropriate funding is allocated to cover the costs of prescription medications and prosthetics to treat injuries and illnesses sustained by military personnel.**

8. The committee heard from occupational therapists (OTs) about the various health care services – for both physical and mental health – that they could provide to military personnel and their families. In fact, this profession emerged during World War One in order to assist soldiers transitioning back to civilian life. Currently, there are only two OTs working with DND across Canada.[9] Elizabeth Steggles of the Canadian Association of Occupational Therapists (CAOT) informed the committee that these OTs have had significant success with, for

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[7] Gregory Woolvett (As an individual), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 83, June 3, 2013.
[8] Corporal Glen Kirkland (As an Individual), NDDN, Evidence, 1st Session, 41st Parliament, June 5, 2013.
[9] Elizabeth Steggles (Canadian Association of Occupational Therapists), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 5, November 21, 2013.

example, the return to work program. **In step with a recommendation from CAOT, we recommend that a total of eight OTs be hired by DND to assist military personnel and their families struggling with mental and physical injuries.**

9. Similarly, the Canadian Chiropractic Association presented useful evidence about chiropractic services offered to United States military personnel, and the effectiveness of such treatments in keeping people at work.[10] **We therefore recommend that consideration be given to the CCA's proposed musculoskeletal strategy.**

**10.** Colonel Gerry Blais assured the committee that all of the programs offered by the CAF's Joint Personnel Support Units (JPSU) "are for everyone".[11] However, Col. Blais's statement that "[w]e treat all our injured and sick members in the same way" [12] does not reflect the specific psychological and social aspects of women service members experiencing PTSD and other mental health issues, and particularly those who have suffered military sexual trauma. **Reintegration programs and mental health services should take into account the higher rates of sexual assault women service members suffer while deployed in Canada and abroad.[13]** Moreover, as Heather Allison, mother of a single-parent female medic, highlighted in her testimony, since women are often the primary caregiver in families**, DND should provide specific reintegration programs that help women service members with children during their post-deployment phase.**

11. We applaud the volunteer peer-to-peer support services provided at the JPSUs alongside that of public service employees. It is important and imperative, however, that all efforts be made to provide these services in both official languages, regardless of the location of the military base/installation. This needs to apply to both volunteers and employed service staff. The fact that the level of bilingualism of public servants (and one would assume volunteers as well), as Col Blais said, "…depends on the position and the region"[14] should not preclude CAF personnel from getting access to necessary services. CAF personnel of both official language communities serve across Canada and need to be able to access care in their preferred language.

[10] Eric Jackson (Canadian Chiropractic Association), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 9, December 10, 2014.
[11] Colonel Gerry Blais (Department of National Defence), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No.12, February 25, 2014.
[12] Ibid.
[13] Noémi Mercier and Alec Castonguay, "Our Military's Disgrace," in *Maclean's*, May 5, 2014, p. 20.
[14] Colonel Gerry Blais (Department of National Defence), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 17, April 1, 2014.

**Reservists**

12. We feel this study did not adequately explore the health care issues facing reservists. In Afghanistan, reservists augmented regular force troops significantly, often comprising 20 percent or more of a total deployment. **In light of the testimony we heard on this topic, particularly from Ombudsman Daigle, we recommend that access to health care services, including mental health services, for CAF reservists be expanded in terms of both geography (i.e. remote locations) and duration (post-deployment).** Not all reservists live near a military base or near a major urban centre, but this should not hinder their access to appropriate care and treatment. Deployed reservists should have access to health care services for an amount of time equal to that of regular force members. As Ombudsman Daigle stated, "…when they return to the unit to which they belong, after being on an operation, they are in a more isolated situation. They are no longer supported or overseen as they were in the unit where they were deployed. In those cases, there are many of them who do not have access to these services.''[15] **Moreover, based on the testimony of the Ombudsman, we recommend that Canada promulgate permanent policies and regulations that clearly identify reservists' medical entitlements, and that these entitlements be better communicated not only to reservists themselves, but also to medical personnel treating reservists, so as to prevent confusion**.

**Military Families**

13. The deployment of military personnel has tremendous effects not only on those serving, but also on their families. Gregory Woolvett, father of a medic deployed to Afghanistan, told the committee that "the soldier went to war, but the family went with him."[16] Family members of military personnel informed us of concerns about their lack of preparation, consultation and involvement when their loved one is ill or injured while serving. Heather Allison, whose daughter served in Afghanistan, recounted how her inquiries about PTSD were rebuffed by counsellors at a Military Family Resource Centre (MFRC), who told her: "We're not going to talk about that. We'll have that discussion a couple of weeks before your soldier comes home.'"[17] As the majority report acknowledges, it is clear that commanding officers and MFRCs are not consistent in reaching out to military families about the support and resources available to them. **We recommend that commanding officers and/or staff from MFRCs reach out to military families as soon as possible – each and every time their military loved ones deploy – to connect them with the military community and the resources available to them.**

[15] Pierre Daigle (Department of National Defence/Canadian Forces Ombudsman), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 72, March 20, 2013.
[16] Gregory Woolvett (As an individual), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 83, June 3, 2013.
[17] Heather Allison (As an individual), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 83, June 3, 2013.

14. Spouses of military members expressed concerns about the lack of consultation and involvement accorded to them during the treatment process of their loved ones in uniform. During the committee's visit to Canadian Forces Base Petawawa in December 2013, one military spouse recounted that it took her four years to receive counselling to assist her in dealing with her spouse's PTSD. Another military spouse contacted the committee to express concerns that:

> Spouses worry about their partner's return from missions. They want to support them. But they may have no idea what to look for or how to assist. Generalized and vague answers in reintegration seminars create more confusion, not less…The spouses provide care daily, and deserve to be provided with the tools to enhance, rather than hinder, that treatment.[18]

**The conclusion we reach is that there is an express need for the spouses of military members to be intimately involved in the treatment process, with education, training and counseling offered to them by CAF/DND, all with the aim of caring for the military member. Canada should undertake this training and support for spouses immediately.** This will also strengthen the wellbeing of the family unit, a particular concern given that a recent survey by the Defence Research and Development Canada (DRDC) found that one-fifth of military spouses reported that they thought about ending their relationship with their partner during their partner's deployment.[19]

15. In its 2009 report "Doing Well and Doing Better," the committee recommended that the federal government work with provincial and territorial governments to enhance relationships between local community health services and CAF health services. With 80 percent of military members and their families now living off military bases, the increasing dependence on provincial/territorial health care services is a growing challenge. Based on evidence presented before the committee, it was not clear that this challenge is being appropriately addressed by DND/CAF. **We therefore recommend that Canada redouble its efforts to enhance relationships between CAF health services and local community health and social services in order to improve timely and appropriate access for CAF personnel, including reservists, and their families. We further recommend that Canada initiate cooperative programs to offer incentives to qualified professional health care workers to provide their services to CAF personnel, including reservists, and their families, in locations where there is a shortage of such services.**

[18] Paula Ramsay (As an individual), NDDN, Correspondence, 2nd Session, 41st Parliament, May 15, 2014.
[19] Defence Research and Development Canada, "Quality of Life among Military Families: Results from the 2008/2009 Survey of Canadian Forces Spouses," August 2010.

### Transition

**16.** While the committee was conducting this study, troubling reports surfaced of military personnel being medically discharged just before they reached 10 years of service, and would therefore not be entitled to a full military pension. Cpl. Kirkland was among those speaking out on this issue.[20] The committee heard mixed results regarding the return to work rates of ill and injured CAF personnel. For example, Major General David Millar stated that as of March 2014, the return to work program had a success rate of only 23 percent. **These troubling statistics lead us to strongly endorse Recommendation 1 from the House of Commons Standing Committee on Veterans Affairs June 2014 Report, "The New Veterans Charter: Moving Forward", which precludes medical release of CAF members unless all criteria set forth in Recommendation 1 are met, and includes the recommendation that a committee be struck to ensure uniformity of criteria, services and benefits for CAF members and veterans.**[21]

17. **In tandem with the previous recommendation, we urge Canada not only to *consider* examining the Universality of Service requirement, as outlined in Recommendation 27 of the majority report, but to undertake an examination of this principle in a modern context as soon as possible.** In his 2012 Report, *Fortitude Under Fatigue*, Ombudsman Daigle made the same recommendation. As he told the committee, the rigidity of this principle may be preventing military personnel from coming forward to seek care, particularly with psychological injuries. He argued that in today's context, there are likely ways of "doing it differently without affecting the operational effectiveness".[22]

18. We are concerned that Recommendation 31 of the majority report with respect to the responsibility of the Government of Canada to our ill and injured CAF personnel. While the efforts of third-party organizations and charities are of great assistance, these should not be relied upon to replace governmental efforts to provide support and services to CAF personnel. Non-governmental organizations that help with soldier-to-civilian transitions are beneficial to military personnel looking to make career transitions, but it remains the responsibility of DND/CAF to provide the proper support to all service members, and in both official languages.

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[20] For example, see Murray Brewster, "Injured Canadian Military Troops Booted Before Pension Qualification," *The Canadian Press*, October 29, 2013.

[21] See Standing Committee on Veterans Affairs, "The New Veterans Charter: Moving Forward," Ottawa: House of Commons, 2014, p. 3.

[22] Pierre Daigle (Department of National Defence/Canadian Forces Ombudsman), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 72, March 20, 2013.

## Sacrifice Medal

19. The Sacrifice Medal recognizes sacrifices made by CAF members and those who work with them who have been wounded or killed under honourable circumstances as a direct result of a hostile action or action intended for a hostile force. BGen Bernier told committee that “the fact that we award the Sacrifice Medal to people who wish to receive it, who have suffered an operationally related operational stress injury, send a very clear message”.[23]Unfortunately, the application of the criteria has, for example, excluded those suffering from PTSD as a result of treating or assisting soldiers severely injured in battle. **We recommend that Canada review the criteria and policies regarding the Sacrifice Medal so that deserving CAF personnel receive it.**

## Boards of Inquiry

20. For months, we have expressed concerns about the 70 outstanding military Boards of Inquiry (BOIs) into the suicides of military personnel – some of which have been outstanding for five years. We were dismayed by MGen Millar’s simplified characterization of BOIs as “an administrative process to assign attributability for the purposes of Veterans Affairs benefits”.[24] In fact, according to Defence Administrative Order and Directive (DAOD) 7002-1, a BOI is convened if, among other reasons, a CAF member is suspected to have wilfully caused their own death, and in order to investigate the circumstances and possibly make recommendations so that future incidents can be avoided.[25] Done in a timely manner, BOIs could possibly assist in preventing future soldier suicides by highlighting issues or triggers that might partly lead to such tragic events among current and former CAF members. **We therefore recommend that Canada ensure that all outstanding BOIs into military suicides be completed as soon as possible.**

21. We are equally concerned by the tracking of suicides of current and recently released military personnel. MGen Millar told the committee that while regular male force, women and reserve force suicides are all tracked, only regular male force statistics are publicly reported.[26] Moreover, veteran suicides are not tracked, despite the fact that the percentage of deaths attributable to suicides is 45 percent higher among veterans than among current CAF personnel. **In order to better comprehend and prevent future suicides among current and recently released CAF personnel, we recommend that each of these groups be tracked by the CAF, and that these statistics be publicly released on an annual basis.**

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[23] Brigadier General Jean-Robert Bernier(Department of National Defence), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 55, November 6, 2012.
[24] Major-General David Millar (Department of National Defence), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 13, Marcy 4, 2014.
[25] http://www.admfincs.forces.gc.ca/dao-doa/7000/7002-1-eng.asp
[26] Major-General David Millar (Department of National Defence), NDDN, Evidence, 2nd Session, 41st Parliament, Meeting No. 13, Marcy 4, 2014.

## Research and Innovation

22. In order to measure the extent of physical and psychological injuries currently affecting members of the CAF, it is imperative that Canadians have access to reliable, up-to-date data. Unfortunately, for OSIs, committee members had to rely heavily on data from a 2002 Statistics Canada survey, before Canada's significant engagement in the Afghanistan conflict. A more recent Statistics Canada study has yet to be released.[27] We find this extremely disappointing. Ombudsman Daigle told the committee: "Without reliable data, it is very difficult to understand the extent and seriousness of the problem, and design and implement effective national programs to help those suffering from an operational stress injury."[28] **We recommend that Canada undertake the recommendation of former Ombudsman Daigle to create a national database that would accurately reflect the number of Canadian Forces personnel, including reservists, who are affected by operational stress injuries.** This was Mr. Daigle's first recommendation as Ombudsman, and should finally be implemented.

23. Arm's length research in military and veteran health is taking place at universities across Canada. Such research serves an important role in filling current gaps in knowledge about this pressing issue. Dr. Alice Aiken is Director of the Canadian Institute for Military and Veteran Health Research (CIMVHR), an independent institute made up of 25 Canadian universities that undertake research into the needs of Canadian military personnel, veterans, and military families. According to Dr. Aiken, "In terms of funding and sustainability, the short answer is that we're not."[29] We understand that CAF/DND does contract research through CIMVHR. **However, we recommend that Canada contribute to a significant and independent research fund that would allow the CIMVHR, through its partner institutions, to undertake self-directed research into the health issues affecting CAF personnel, veterans, and their families.**

[27] http://www.forces.gc.ca/en/about-reports-pubs-health/caf-mental-health-survey.page#question-04
[28] Pierre Daigle (Department of National Defence/Canadian Forces Ombudsman), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 72, March 20, 2013.
[29] Dr. Alice Aiken (Director of the Canadian Institute for Military and Veteran Health Research), NDDN, Evidence, 1st Session, 41st Parliament, Meeting No. 49, October 4, 2014.

## CARING FOR CANADA'S ILL AND INJURED MILITARY PERSONNEL
## DISSENTING REPORT, JOYCE MURRAY, M.P.

Ill and injured soldiers must be a higher priority for government

Liberals believe that full support of ill and injured Canadian Armed Forced (CAF) members and their families is a sacred obligation earned by their service to the country. We wish to express appreciation to the witnesses who shared their views and ideas, to procedural services who ensured smooth operation of the committee throughout our deliberations, and particularly to our Library of Parliament analysts for their hard work and dedication to the Standing Committee on National Defence's study on Caring For Canada's Ill and Injured Military Personnel.

Much of the text is a thoughtful exploration of the testimony heard by this committee; unfortunately, the recommendations of the report are not reflective of the urgency and very real concerns expressed by many witnesses who appeared before committee. While we appreciate the attention paid to issues such as the stigma of mental health issues and the need for transition support, the prevailing theme of "continue to support" or "continue to recognize" implies action on the part of the government that simply has not occurred. We are deeply concerned that the criticism levelled by many witnesses and the concerns expressed are not given more weight in the recommendations.

Furthermore, the minimal consideration given to this report in committee does a disservice to the over two years of meetings and deliberations. It is a disservice to the many witnesses who appeared and submitted input over the more than two years this study was undertaken, to the advocates who attended committee day after day, and to the men and women of the Canadian Armed Forces who look to Parliament to ensure their needs are met. Particularly given the length and scope of testimony, the time provided to deliberate on this report was completely unacceptable.

Lack of Concrete Recommendations

An overarching issue running throughout the report's recommendations is a lack of specificity. Conceptually the Liberal Party supports the ideas behind many of these recommendations, but we have concerns that the level of direction being provided to the government is inadequate when concrete actions and benchmarks are not identified.

By our count, 12 recommendations are built on the same "continue to…" or "maintain…." model. If the testimony heard at committee and elsewhere from ill and

injured CAF members and their families are any indication, the government is not doing nearly enough. To merely encourage the government to continue along this path of inaction is an insult to those raising concerns about the quality of care they receive, and yet another example of the government turning a blind eye to those in need of care and compassion.

Similarly, there are several recommendations that merely "encourage" the Government of Canada or DND and the CAF to take action. To take just a few examples: Recommendation 16 states that "The Committee recommends the Government of Canada encourage the completion of all outstanding boards of inquiry into military suicides." Recommendation 10 asks the Government of Canada to "encourage the Canadian Armed Forces to implement a policy that strongly discourages military superiors from asking subordinates details of a medical issue, unless the immediate health and safety of the member or his unit members are at risk." In cases such as these, the Committee needs to do more than encourage, it needs to demand action.

In addition to these overarching concerns, we have specific concerns about the tenor - or absence - of recommendations, some of which are enumerated below.

<u>Mental Health Services inadequate for post-Afghanistan casualties</u>

The Liberal Party has deep concerns about the mental health services available to CAF members. According to the government's response to an order paper question in December 2013, over half of all CAF bases did not have a single psychiatrist on staff, and a full forty percent had neither a psychiatrist nor psychologist on staff. This fact alone should raise serious questions about the level of mental health care available to CAF personnel based in Canada.

Despite persistent questioning, we found it difficult to ascertain exactly where these gaps were being filled when provided with aggregate figures. Furthermore, even the department's own officials were unable to identify specific remaining gaps to be filled. When we asked the Assistant Deputy Minister, Human Resources - Civilian at the Department of National Defence how many of the recent hires made were psychologists and psychiatrists, and how many of the remaining gap are psychologists and psychiatrists, she responded that she "[didn't] have a number for psychiatrists."

Even under direct questioning in a parliamentary committee, we were unable to get the most basic information about staffing levels in crucial mental health professions. In our view, this issue calls for greater transparency. To that end, we recommend the following:

**That the Department of National Defence and the Canadian Armed Forces make publicly available quarterly reports about the number of psychiatrists, psychologists, medical doctors and nurse practitioners available at each CAF base/location, as well as the ratio of patients to provider for each.**

While deployed overseas, we have similar concerns about the care available to CAF members. A particular area of concern is the lack of uniformed clinical psychologists in the CAF. While CAF members can access psychologists in Canada - at least on bases where they are available - those psychologists are civilians and cannot be deployed overseas. Instead, we are forced to rely on our allies for psychological services in theatre. This presents challenges not only on a cultural level, but on a linguistic level as well, with the burden falling disproportionately on francophone CAF members. The potential for disparities in care to emerge based on language is troubling, and deserves further investigation.

The need for uniformed clinical psychologists was not an area of concern that the CAF was forthcoming about in committee; it took an Access to Information request to discover this was an issue that the CAF itself was concerned about. When asked, directly, BGen Jean-Robert Bernier stated that "until now, we haven't found a need for it because the only reason we would have them in uniform is for deployed operations" while a briefing note from the CAF's own Director of Mental Health stated that "...there is strong indication that the addition of a uniformed clinical psychology capability would greatly enhance the mental health care of CAF members…" BGen Bernier later stated that an evaluation of the need for uniformed clinical psychologists would be "out by the end of April." To our knowledge, this report has not yet been made available to members of the committee, or to the Canadian public as of June 2014.

"Universality of Service" increases severity of PTSD

The Liberal Party of Canada believes that the universality of service must be re-examined and either amended or scrapped. Universality of service is the principle that that every CAF member must be fit for deployment. If not, he or she may not remain in the CAF but must be transitioned out of the military.

Furthermore, the fear of being forced to leave the CAF is cited as a key reason many injured members fail to request help.

The existing application of universality of service regulations pushes people out of uniform before they are ready - ignoring their continued desire and ability to serve - and should thus be re-examined and improved.

While we are heartened to see the issue of universality of service raised in the report's recommendations, recommendation 27 does not go nearly far enough.

In 2009, the Committee issued the following recommendation, "encourag[ing] 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 recommended continued employment of recovering soldiers. Clearly, encouragement from the Committee is not enough.

<u>Sexual assault in the Canadian Armed Forces cannot be tolerated</u>

The Liberal Party is dismayed by the absence of transparency and apparent lack of commitment to reducing sexual assault in the military.

The report does not contain a single reference to sexual assault. In the opinion of the Liberal Party of Canada this is a glaring omission. The link between sexual assault either in the theatre or at home and PTSD is well established, particularly for female service members.

In our view, it is necessary to address prevention and treatment not only of combat-based PTSD in the CAF, but to address other causes of service-related PTSD such as sexual assault. To that end, the Liberal Party of Canada recommends the following:

> **That the Department of National Defence and the Canadian Armed Forces conduct a formal evaluation of sexual assault prevention programs with a view preventing sexual assault and the resulting to adverse mental health effects.**

The Liberal Party of Canada recommends:

> **That the Department of National Defence and the Canadian Armed Forces conduct a formal evaluation of the response process and support services available to CAF members affected by sexual assault and ensure that these support services are integrated within the existing mental health care framework with an emphasis on PTSD.**

The Liberal Party of Canada additionally recommends:

> **That National Defence and CAF annually post a public report of incidences of sexual assault and measures implemented to reduce and/or eliminate this abhorrent problem.**

Inadequate Support for the Caregivers

The Liberal Party believes that added resources  and support must provide for families, and especially spouses, who shoulder the lion's share of the burden of caring for ill and injured service members. In the words of MGen David Millar: "families are the lifeline for our members. Our spouses are the lifeline. They are here today."

By our count, only three out of 32 recommendations even make reference to military families, and none of them make reference to the need to address the concerns of military families

Testifying before committee on June 3rd, 2013, Ms. Heather Allison - the mother of a service member suffering as a result of her service in Afghanistan - said the following:

> "*I am just new at this; my daughter has just returned. She's been back a year. In that short time, we've dealt with two ODs. The most recent was in March. We got a call. Actually a friend, another army buddy, called. The base didn't even call me, which I find really strange, since I am the next of kin. She's a single parent. But yet I don't get a call.*
>
> *This is a problem I'm having. As parents, it doesn't appear we have any rights. I know they're older, but they're still our children. I'm sure your mom's all want to know where you are, if you're driving on the highway, if you're safe. Well, we're no different as soldiers' parents."*

Even as next of kin, she was notified by a friend, rather than the CAF, of her daughter's overdose. A greater effort needs to be made to incorporate family members - with the consent of the CAF member - into the treatment of ill and injured CAF personnel. This needs to occur not only when the CAF member is in distress, but throughout the CAF member's treatment.

In our view, the recommendations of the report do not reflect the importance of family member support in the treatment process, nor do they provide the necessary recommendations to support family members.

Dedicated transparent government action required

Liberals believe that improvement in conditions for ill and injured members is a high priority for all Canadians. Throughout the Committee process, Liberals raised concerns about the absence of action by this government on many of the 36 recommendations

the Standing Committee on National Defence's 2009 report on ill and injured soldiers, especially those suffering with PTSD.

In many cases, the recommendations provided in that report were far more concrete, measurable, and indeed more actively addressed the practical concerns of ill and injured CAF members and their families, than the recommendations contained in the 2014 report. For example, the following is recommendation 23 from the 2009 report[1]:

> "*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."*

This is a clear, tangible recommendation that would have a very real impact on quality of life for injured service members and their families, and yet to our knowledge it has not been implemented across the country.

Indeed, in his testimony before the Committee, Cpl Glen Kirkland expressed his frustration at the both the distance from his base (CFB Shilo) and the burden the commute placed on him, saying:

> "*It was Deer Lodge in Winnipeg, which sounds like it's great, but it's a two-and-a-half-hour drive, and the whole way, driving there and back… I don't really understand why the main mental health clinic is two and a half hours away from the closest combat arms base.*"

The Committee heard this testimony on June 5th, 2013. Had the earlier recommendations from this committee been monitored and implemented, this might have been one less obstacle to care facing CAF members like Cpl Kirkland.

This is but one example of a larger pattern. We have seen no evidence that the government has made any effort to follow up by analysing and reporting on the progress or non-progress on the Committee's 2009 recommendations. To that end we recommend the following:

> **That the Standing Committee on National Defence request annual progress reports based on these recommendations and from those of the committee's previous report on PTSD from Department of National Defence and the Canadian Armed Forces, and that they be**

[1] "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. June 2009.

**submitted to the committee for review.**

In our view this would provide at least a minimum level of accountability for following through on committee recommendations, and would help prevent yet another report on this important topic from gathering dust on the shelves of DND Headquarters.

<u>Canadians expect better</u>

Canadians and the Liberal Party believe that Canada can and must improve prevention, care, and support for ill and injured soldiers.

In our view, this report -- like the system designed to support ill and injured CAF personnel more broadly reflects the ideas and dedication of many people who aim to contribute to improvement and solutions. However, it falls short of its potential and is plagued by a lack of transparency, and a lack of accountability. If the CAF and DND are not forthcoming with the number of mental health professionals available to CAF members, how can access be ensured? Without external monitoring and follow-up, what assurances do we have that these recommendations will be implemented? The existing report framework - and the existing CAF health care system - gives few assurances.

This is an important study, but fundamentally an unfinished one rushed to conclusion at the expense of discussion and a thoughtful process and improving the Committee's Report. Many of the recommendations found in the preceding pages of the main report tackle important issues; unfortunately, too many are a call to complacency and not a call to action.

The Liberals are strongly of the view that the men and women who willingly put their lives on the line for Canada deserve better.

Respectfully submitted,
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