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Chair

Mr. James Bezan

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● (0845)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): I call this meeting to order. Pursuant to Standing Order 108(2), we're going to start our study on the care of our ill and injured Canadian Forces members.

Joining us today from the Department of National Defence is Rear-Admiral Andrew Smith, who is chief of military personnel. Accompanying Admiral Smith is Brigadier-General Fred Bigelow, who's the director general of personnel and family support services; and Colonel Jean-Robert Bernier, who's the deputy surgeon general.

Welcome, gentlemen.

Admiral Smith, I'll open the floor to you for your opening comments.

[*Translation*]

Rear-Admiral Andrew Smith (Chief Military Personnel, Department of National Defence): Thank you, Mr. Chair.

[*English*]

and members of Parliament.

It is a pleasure to appear before you today to discuss how we care for the men and women of the Canadian Forces and their families if they are injured or become ill while serving. As you are aware, we've always had programs and services to address the health and well-being of Canadian Forces personnel; however, our operations over the last 10 years in Afghanistan have provided a catalyst for many changes and improvements. I will highlight some of these changes during my opening remarks. I will purposely keep these remarks brief, and will be happy to elaborate on details afterwards.

[*Translation*]

The Canadian Forces personnel function embraces dozens of lines of operation and hundreds of enabling policies, programs and activities.

As chief, military personnel, I am responsible for two strategic functions: personnel generation and personal support.

Personnel support includes providing responsive welfare, care and support programs for members, casualties, and their families. When this support is not provided properly, then personal generation and ultimately operational effectiveness are affected.

[*English*]

This is why mental health and the care of the fallen and injured and their families are my top priorities. When Canadian Forces members are injured or become ill, they must have confidence that they will receive the treatment and rehabilitation services necessary to restore them to health and that the needs of their families will be met. If they cannot resume military service, they must know that the Government of Canada will support them as they make new lives for themselves.

In this regard, Veterans Affairs Canada shares the Canadian Forces' commitment to provide Canadian Forces personnel and their families with comprehensive care and services. The two departments have a strong partnership and collaborate closely to integrate services and provide continuity of support. I'll be happy to expand on this collaboration during the question period, should you so desire.

We have just completed the document, placed in front of you, entitled “Caring for our Own”. It describes our comprehensive framework for the care of Canada's ill and injured men and women in uniform. This framework is based on five pillars: a whole-of-government approach to care and support, which really means the Canadian Forces and Veterans Affairs Canada working in tandem; an integrated multidisciplinary and multi-agency delivery system; access to consistent care and casualty management wherever Canadian Forces members serve; very importantly, a focus on continuous improvement to evaluate the effectiveness of policies, programs, and services in support of identified deficiencies; and communication—and that's both internal and external—regarding how we care for and support ill and injured CF members and their families.

● (0850)

[*Translation*]

Our concept of care envisages integrated and consistent delivery and administration of benefits and services as members navigate the three stages following injury or illness: recovery, rehabilitation, and reintegration into either military service or civilian life.

Recovery is the period of treatment and convalescence during which patients transition from the initial onset of illness or injury to the point where they are stable and ready to receive longer-term medical care and increase their ability to engage in all aspects of life including the vocational, social and physical.

[*English*]

Rehabilitation, which involves physical, mental, and vocational components, is the active process of regaining maximum self-sufficiency following illness or injury.

Reintegration is the transition to either returning the ill or injured CF member to a normal work schedule and workload in their regular force or the primary reserves, transition to the cadet organizations or to the rangers, or preparing for a civilian career and life after the forces.

There can be significant overlap between the three phases, as the ill or injured members move from acute recovery to long-term clinical, physical, mental, and vocational rehabilitative supports, and often simultaneously prepare to reintegrate into a work milieu.

The three Rs of recovery, rehabilitation, and reintegration are anchored in the principle of universality of service. The minimum operational standards associated with this principle include the requirements to be physically fit, employable without significant limitations, and deployable for operational duties. The universality of service is a necessary and equitable approach to preserving the Canadian Forces' trained effective strength and operational capacity.

[*Translation*]

While physical injuries and illness receive a great deal of attention, especially in light of battle casualties sustained in Afghanistan, I am equally committed to providing mental health care.

Indeed, my message is that we simply do not differentiate between the two, and commanders at all levels are acutely aware that they are expected to transmit that message to all our members, to ensure our people get the treatment they need, in part by removing the stigma associated with mental illness.

[*English*]

Because of the requirement to be fit for employment and deployment, we have an incredibly comprehensive and dedicated health care system. It is my firm contention that the Canadian Forces personnel have access to one of the best, if not the best, health care systems in Canada.

Above and beyond the delivery of world-class medical care, and to ensure consistent and equitable administration of military casualties, the Canadian Forces have established regional joint personnel support units with component integrated personnel support centres across the country to provide a comprehensive, decentralized, and integrated network of casualty support.

The joint personnel support unit delivers a set of core capabilities in a one-stop service approach, ensuring comprehensive and consistent support for Canadian Forces personnel and their families. Support includes return-to-work program coordination; casualty tracking; support outreach administration; and services provided by Veterans Affairs Canada, the Service Income Security Insurance Plan, Canadian Forces personnel support programs, Health Canada, and a military family liaison officer.

● (0855)

[*Translation*]

Public awareness is equally important in order to reassure Canadians that their sons, daughters, brothers, sisters, husbands, wives, friends and neighbours who have been entrusted to the custody and care of the Canadian Forces are being well looked after.

This trust is the basis of public support for the Canadian Forces.

[*English*]

The health and well-being of Canadian Forces members is a shared responsibility of leaders, health care providers, and the member. It includes a whole-of-government approach to ensure that those who serve their country and are called upon at the pointy end of the Canada First defence strategy are provided with the care and support they and their families need in the unfortunate event that they become ill or injured.

[*Translation*]

I want to thank the members of this committee for their interest in this very important matter and for their strong support for the members and families of the Canadian Forces.

I would be pleased to answer your questions.

[*English*]

The Chair: Thank you.

We'll start with a question and answer period.

Mr. Kellway, you have the lead.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you very much, Mr. Chair.

And thank you, Rear-Admiral, for your opening remarks.

I was wondering if you could tell us a little more about our experience in Afghanistan and the kinds of injuries our troops have sustained that the forces have had to deal with under this program.

RAdm Andrew Smith: Certainly.

In our experience in Afghanistan, there have been just over 2,000 casualities in total. Six hundred and twenty of those have actually been wounded in action, and about 1,400 of those injuries are non-battle injuries. The preponderance of casualties wounded in action are associated with improvised explosive devices. There have been any number of physical and mental injuries to accompany those. Some of the biggest challenges we have had involve the rehabilitation of people following amputations. Those injuries tend to get a lot of publicity, but there have also been any number of non-battle-related physical, musculoskeletal, back, or knee injuries as well.

One thing I would point out is that, in theatre, we now have in place better personal protective equipment. I think that is responsible for a higher survival rate from blasts that previously would potentially have caused a lot more fatalities. People have lost limbs and have had terrible experiences in explosions but have ultimately survived those. I think that's a testament both to the personal protective equipment they are wearing and, unquestionably, to the trauma hospital in Kandahar. A Canadian Forces member commanded that hospital for a period of time, and now it's under the command of an American. In 97% of the cases, if an individual makes it to what we call the Role 3 trauma hospital in Kandahar airfield, the individual will survive. It's a multinational-staffed hospital. People come together and they do miracles there. I've been there on three occasions, and I've seen the miracles they produce.

So, yes, we've had lots of casualities, but I would submit there would be significantly more fatalities had we not had the personal protective equipment and the health care in place.

Mr. Matthew Kellway: With respect to the 600 injuries, the in-action casualities, you mentioned IEDs being the main cause of those and the physical and mental outcomes of those. Do you include in the "inaction" numbers any other mental health issues, or just those that flow directly from a physical injury?

● (0900)

RAdm Andrew Smith: If a mental health condition were to be service related as a result of trauma experienced in a battlefield incident and not accompanied by a physical injury, that would certainly count in a wounded-in-action scenario.

One of the priorities I have continued to strive for is to have a mental health injury looked on in the same way as a physical injury —a bad back, a shrapnel wound, a bad knee, or a turned ankle. I think the Canadian Forces have an opportunity, in my estimation, to lead this country in reducing the stigma associated with mental health. I think we've come a long way in that regard. I freely acknowledge that there is room to improve, but I think we have seen some real progress lately in reducing the stigma associated with mental health.

When we bring soldiers out of theatre, before we bring them home we send them to a third location to decompress for a period of five days. During that five-day decompression period, they get a series of lectures and consultations on the importance of mental health and what a potential degraded state of mental health might look like. Based on that, I have seen young males, who in my estimation typically have the hardest time admitting they might have a mental health condition, put their hand up and say they'd like to see somebody. I think even as little as five years ago that type of admission, certainly in public, would have been inconceivable, and I take that as a sign of how we are moving forward in educating people that it's all right to put your hand up if you have a mental health condition.

Now, in fairness, I know your question was related to wounded in action, but the preponderance of mental health issues that we deal with in the Canadian Forces are not PTSD related. There are a lot of other mental health conditions, but your question was specifically about the....

Mr. Matthew Kellway: Well, it's interesting. You take these troops back through this decompression stage, and I take it a lot of the mental health conditions related to their experience in Afghanistan will emerge over time. Coming back to kind of regular life is what triggers a lot of these things, or they emerge at that point in time. So for those who don't put their hands up during the decompression period, in your statistics here how do you account for those kinds of conditions that emerge when they return from their service? What are the forces doing to help folks back home?

RAdm Andrew Smith: We have a program we put in place in the last two and a half years. It's called "The Road to Mental Readiness", and that includes both a pre- and a post-deployment educational awareness strategizing piece for both the members and their families. Families play a key role in this regard. So both the family and the member get an awareness session before the member deploys. On completion, the member will get the third-location decompression briefings I spoke about.

The family also will have access to an online decompression awareness piece so that when the member comes home, both the family and the member have a heightened awareness of things they might experience.

Then there is a follow-up period downstream three to six months later, when the individual will have a final post-deployment screening check-up for mental health issues.

The Chair: Admiral, his time has expired.

We're going to move on to Madam Gallant. We have to be quite judicious with time—otherwise we won't get around—so members can ask their questions.

● (0905)

RAdm Andrew Smith: Fine.

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

Through you to Admiral Smith, how has the frequency of casualties been impacted since Canada received its own Chinook helicopters in theatre in Afghanistan, Kandahar?

RAdm Andrew Smith: I am not well positioned to speak specifically to the reduction of casualties in terms of either the Chinooks or the Griffins that were deployed in theatre. I could take the question on notice. It would really be something that the folks in CEFCOM would have tracking stats on.

I'm happy to come back to you with an answer in that regard.

Mrs. Cheryl Gallant: All right.

Now I'd like to move to the Shoulder to Shoulder report, and I must say that this is thoroughly impressive. It sounds like you really and truly had consultative talks with the people who were impacted in the very early years of participation in Afghanistan. A handful of widows were left to struggle for themselves, and they were the Shoulder to Shoulder people.

They almost acted as skip-tracers, trying to find the spouses of people who had fallen that they'd read about in the newspaper so they could offer their support. Through the years they developed a list of things that they thought would be helpful to have in place for other women, men, and parents who were experiencing this. One was the virtual web-based forum, and we've already implemented the visits to Afghanistan, which is something they needed for closure.

So we have this Shoulder to Shoulder program for the very first widows who have young children who may start to ask questions 10 or 12 years from now. Are you conducting outreach to them, so that when this time comes they know what is available to them?

RAdm Andrew Smith: Thanks for the question.

The question is very timely. Just last Friday evening, Minister MacKay formally launched a Shoulder to Shoulder bereavement support program with members of the program—widows, families, fathers, and spouses of fallen members.

One of the key attributes of the Shoulder to Shoulder program is that it is designed to be an enduring commitment, not just something that will cease when a member leaves the Canadian Forces or when a member is deceased. This is an ongoing, enduring commitment. It involves social workers and the web-based peer consultation you spoke of.

There's a network of peer counsellors that we call the HOPE program—helping our peers through empathy. It's very successful for people who have had to go through this terrible experience and come out the other side. There are seven steps to the whole grieving process. When they come out the other side, some of them put their hands up and say they'd really like to help people after what they've gone through, so there's a reach-back peer assistance piece.

For the specific case you mentioned, where a spouse and children downstream have a desire or need to have some type of bereavement support, that's totally open to them. I will just cite that this Shoulder to Shoulder program is for any death—operational or due to illness or injury. It's really for bereavement for Canadian Forces surviving entities.

Mrs. Cheryl Gallant: Were families of the deceased in on these consultations directly?

RAdm Andrew Smith: Absolutely.

The Shoulder to Shoulder program is a national initiative that was born out of a wonderful initiative that started in the Edmonton area. It started out as something called the memorial cross network, when Edmonton was particularly hard hit back in 2006. Family members got together in an informal peer support, social networking piece. It was so successful that we said, “Can we not do something to take this nationally?”

We worked with chaplains and the HOPE network we had in place. We put some structure around it through the web-based consultation and the joint personnel support units, as enablers and facilitators. We pulled together some component parts, put a banner on them called Shoulder to Shoulder, and launched it. Part of it is marketing to get the word out to make sure that people know we have something in place to help people who have gone through terrible experiences.

● (0910)

Mrs. Cheryl Gallant: Is there some sort of identifier or card that a widow, for example, is issued, so if she wants to go into a joint personnel support unit and access any of these services she doesn't have to tell her whole story—she can show somebody and they can take a look at the history and go from there?

RAdm Andrew Smith: I would say I think we'd do even better than that. Every widow or surviving spouse has an assisting officer assigned to her to help her through all the immediate after-fatality administration, but that assisting officer at some point will disengage and go back to his or her primary tasks. When this happens, and before they disengage, the surviving spouse will be introduced to people in the joint personnel support units. So there is a formal hand-off between the assisting officer and the joint personnel support unit network, who will then be up to speed on a spouse's concerns, issues, and general situation. The spouse or the surviving member has immediate access into bereavement support through the JPSU.

Mrs. Cheryl Gallant: That's fine if they stay in the same community for quite a length of time.

Now I'd like to switch to operational stress injuries. We've done a terrific job in the last 10 years or so, raising awareness for PTSD and other operational stress injuries and treating them and removing the stigma. We still have in our ranks a number of soldiers who have suffered injuries from previous conflicts, like Rwanda. These people have also been deployed successively to Afghanistan. All this seems to build up. Not quite done with their careers, they still want to be soldiers and be deployable, but as a consequence of not getting the treatment they needed when the injury happened, they are being released medically.

Is there anything we can do to go back and actively help our soldiers who were injured in previous conflicts, so that we can keep them on the forces as opposed to having to double our recruiting efforts and training?

The Chair: Ms. Gallant, your time has expired.

Admiral, please give us just a brief a response.

RAdm Andrew Smith: I'm happy to come back to that later.

The Minister of National Defence announced in March a new, complex transition period for people. Some of those people that you identified would have traditionally been released within about six months. Now we know that some of these people have what we call a complex transition—they have physical, mental, or psychosocial needs. We now have a formal policy where we can keep them for up to three years to make sure they get all the medical support they need from our medical system, the whole family support piece. They are still, I would say in French,

[*Translation*]

entourés, encadrés

[*English*]

in the military system to make sure their transition is as smooth as possible and they're looked after to the extent possible.

The Chair: Thank you.

Mr. McKay, you have the floor.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair.

I'm pleased to follow up on the suggestion that Rear-Admiral Smith come before us with his colleagues and talk about what the military is doing. I was privileged to attend the seminar you put on for the military about a month ago. I was very impressed. I was very impressed with the military, and I was very impressed with how much I believe you folks have stepped up your game over the past number of years. I was also impressed by the senior leadership that supported the initiative, including General Natynczyk.

In that context, I also wanted to ask some questions pertaining to suicide and the de-stigmatization of mental illness and things of that nature, which is problematic for our society as a whole but also for the military. I agree with your comment that the military could lead in this area. You have a discrete population that you're working with, and you have resources available to you that could be useful to the larger society. The rate of suicide in the military roughly parallelled that of the larger population up until about 2007, and then it doubled for some reason. There doesn't seem to be any concrete explanation for why the suicides would double in the military around 2007. I don't have statistics for later than that. I'd be interested in the way in which the stats are now kept. Is there something else that might be going on?

● (0915)

RAdm Andrew Smith: The question of suicide is one that we pay particular attention to. Every time there's a death in the Canadian Forces, the announcement comes across my desk, and I always pause, particularly when a suicide comes across. They tend to hit me harder than others. I often wonder how things could have gotten so bad that it was the only recourse somebody thought they had.

Traditionally—and I'll ask Colonel Bernier to follow up momentarily—the rate of suicides in the Canadian Forces has typically been well below that in the greater population in Stats Canada. I wouldn't look to debate your stats versus my stats, but we have traditionally had a lower rate of suicide than the Canadian public. For argument's sake, we have about 12 to 17 suicides per year in the Canadian Forces. Even if that number were to go up by 5, to 22, I would say it's regrettable, but it's still not indicative of a greater issue of suicide in the Canadian Forces per se. If, over time, that were to sustain itself, then I think we would have a greater issue.

But I will say the cause of suicides is a vexing issue. We look at all suicides in what we call a deep dive to see what factors could be associated with it. There is, historically, no direct link between deployments and suicides. The majority of people who die from suicide do not have a deployment history. There are other stressors in life at play, whether that be family, financial, performance, or social issues.

Hon. John McKay: Colonel Bernier, would you care to add to that?

Colonel Jean-Robert Bernier (Deputy Surgeon General, Department of National Defence): Suicide, even a single one, is a tragic event, and it affects all of us. Some of them are our own medics. We have all the mental health conditions as well. Our family is the armed forces. We're very tight. Any suicide is a great tragedy for all of us.

However, to be statistically meaningful, we have to collate them, as do all statisticians, in blocks of about five years, because the numbers of rare events need to be cumulative to have adequate power to have any kind of statistical significance and to be able to show that they're not due to chance. That gives us enough of a denominator and enough of a numerator, the number of suicides, to come up with meaningful comparisons.

Every five-year block since 1995 has shown no change in the statistical number of suicides. Our most recent one was from the 2005 to 2009 block at the height of the operations in Afghanistan. In fact, that rate per 100,000 is lower than it was in the two previous blocks—very slightly lower, not statistically significant enough. But, in essence, our suicide rate has not changed. We can't go by a single year, because in a single year there could be anomalies due to chance.

For example, looking at all the suicides from the start of operations in Afghanistan in 2002 until 2010, including all suicides we were able to capture, including females—which are extremely rare, and most years we don't have any—as well as reserves, although some reserves we may not capture because we don't have as close observation of them, there were a total of 108. Of those, 67 had never deployed anywhere. Of the 45 who had deployed, only 17 had deployed to Afghanistan. So the majority of our suicides, and the majority of our mental health burden—mental health illnesses—are caused by the same stresses that affect all Canadians.

● (0920)

Hon. John McKay: The article I was reading seemed to parallel —in effect augment—your argument, and then there seemed to be this jump. Your argument, then, is that you have to look at it in a five-year block. In truth, the article doesn't look at a five-year block. The last year they looked at was 2007.

When you're tracking suicides, do you track those who have been discharged from the military? If I had been discharged two years ago, and for whatever reason I committed suicide this year, then it's an interesting argument as to whether you put that into the military suicide or you keep it out of the military suicide. How do you account for that, or not, as the case may be?

Col Jean-Robert Bernier: For that reason, the Canadian Forces health services led, with Veterans Affairs Canada and Statistics Canada, a study called the Canadian Forces cancer and mortality study. It looked at 188,000 serving or former armed forces members—because we don't follow them after they have been released from the armed forces.

Hon. John McKay: You, meaning the military, or you, meaning Veterans Affairs don't follow them?

Col Jean-Robert Bernier: The military. The Canadian Forces only follows those currently serving in the armed forces.

Because a lot of the stresses that may lead to suicide are cumulative and can manifest in mental health conditions and subsequently suicidal behaviour years after release from the armed forces or years after the stresses have occurred, we would lose track of them. For that reason, we did this study with Veterans Affairs Canada, including, of that 188,000, 112,000 people who had released from the armed forces in the past.

It found that so far, the first part of it, looking at mortality, causes of death, for all causes of death armed forces members and veterans had a 35% lower rate of death from all causes than the general public.

However, there were two abnormalities. One was a 2.6% higher rate of death by aircraft accident, and that's accounted for probably by virtue of the fact that proportionately our population has a much higher number of aircrew, people flying. Also, suicide overall was the same as the civilian rate. But there was a 1.5 times increased rate among those who had been released who were in the 16 to 44 age group who had been released after serving less than 10 years and before 1986, so before all the mental health programs, education, screening, etc., programs that we now have in place existed.

Hon. John McKay: These would be largely young men, I would have thought?

Col Jean-Robert Bernier: Mostly non-commissioned members as well, and mostly those who had been medically released or involuntarily released.

Hon. John McKay: Thank you for that.

The Chair: Thank you. The time has expired.

Mr. Opitz, you're going to kick us off on the five-minute round.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Mr. Chair.

Gentlemen, first, thank you very much for being here today. We really appreciate it, and it's very informative.

As far as suicides go, I know as a former serving CF member and in the civilian world I've had colleagues, both serving and non-serving, who have committed suicide, and I know through my own experience I never saw it coming. You just never saw it coming. Sometimes statistics are very difficult to quantify that sort of thing.

Admiral, there are some tremendous programs we have now, such as Shoulder to Shoulder and the JPSU, and things like that.

You mentioned the word “marketing”. I would substitute that with the word “outreach”. Is there any kind of a road show proposed to get around to CF members and civilian stakeholders to be able to get people to understand what the consolidated view is of all of these programs?

RAdm Andrew Smith: Great question.

Since November of 2010 we have visited 22 bases across the country on exactly that, an outreach piece with Veterans Affairs, which I've ultimately hosted on each base with the senior personnel, my counterparts from Veterans Affairs, to do exactly that, get the word out to serving personnel, regular reserve. Veterans are invited; the Legion is invited to get it out.

My contention is that, regrettably, and maybe fortunately, when people join the Canadian Forces at the recruiting centre, they often look only at the positive side. It's a selective understanding piece. They love the training, the opportunities, the travel, the professional competencies they can get. There's a sense of adventure. But I would contend that not everybody pays close attention to what happens if, *au cas où*....

I have said to people as I've gone around the country, what you really need to do, ladies and gentlemen, is pay as much attention to what happens if things go bad, because we're in a dangerous game, let's admit that. You need to pay attention to how you and your family will be looked after if that happens to you, if you're one of the unfortunate ones.

After having gone to 22 bases, I can say with confidence that the word is out. And we continue an outreach program through the JPSUs, which are on each base. We continue to put out awareness material in the various publications we have. But in my view, there is no substitute for the leadership going out, giving a presentation, and then taking the questions and answers. In almost every instance—we've been across the country—there have been tough questions from people who have either been frustrated or had a bad experience, and that's what we're there for, to help them understand this.

I think we have come a long way in doing that outreach piece.

● (0925)

Mr. Ted Opitz: I would agree. I think taking that contingency planning approach when somebody joins is very important, because you have to paint the whole picture of what they're headed for. I think both my friend Corneliu and I remember what joining was like.

We have a lot of public and private people, such as Canada Company. You have Care, True Patriot Love, Wounded Warriors, and so forth, also contributing to this. Canada Company, as you recall, had the scholarships for the children of fallen soldiers.

Can you comment on how these organizations integrate and complement these programs?

RAdm Andrew Smith: That's a great question. I'm going to ask General Bigelow to comment in a moment, but I will say that there has been an outpouring in the last 10 years. And we could have a debate about that, but it's probably been since the start of the Afghanistan mission. In my view, Canadians have discovered, or rediscovered, their Canadian Forces, their military, and have rekindled a love affair, something that is frankly unprecedented in my 32 years in uniform. We see this through corporate Canada, through charitable organizations, through John Q. Public who stops any one of us in bus stations or airports or on the street just to thank us for what we're doing. That is unprecedented in this country, and we have been particularly fortunate with True Patriot Love, Canada Company, and any number of charitable organizations. Those are only two. Many companies and organizations have come forward looking at how they can help.

So those donations flow into a non-public fund. Some of that goes to the military families fund to help people when the public cannot cover costs.

I'll ask General Bigelow. That's his specialty. All of those offers of help, casualty support, and charitable donations flow into his organization.

Brigadier-General Fred Bigelow (Director General, Personnel and Family Support Services, Department of National Defence): The boss touched on the military families fund. That is but one fund under the “Support Our Troops” umbrella. The hospital comforts fund relates to the discussion today to provide for some extras for folks who are hospitalized. One hugely positive aspect is the Soldier On fund, which is the non-public fund component of the Soldier On program. That is an actual regular force program we run for both current members and their families. These private agencies or fundraiser organizations or other fundraising activities we do in the military, in which our members participate, provide the funding for, in this case, Soldier On, which is, quite honestly, a fantastic program that takes injured members and gets them back into active lifestyles. That's one of the coolest things I've seen first-hand: adaptive sports organizations, family members, and injured members participating in something and just having a good time doing it. It's really heartwarming to see people in that situation have such a hugely positive thing in their lives and their families' lives.

That's a public program overseen and managed by us thanks to those donations we receive from the big fundraising organizations and from small grassroots stuff.

● (0930)

The Chair: We will move on.

Mr. Chisholm, you have the floor.

Mr. Robert Chisholm (Dartmouth—Cole Harbour, NDP): Thank you very much, Mr. Chairman.

Thank you, gentlemen, Rear-Admiral.

My community is metro Dartmouth—Cole Harbour, and we have a great number of military forces members and families, as well as veterans. I'm very pleased to be here to listen to what you have to say and to maybe throw a couple of questions your way.

I want to ask you two things. You indicated, in response to a question earlier, that when people come back, they don't often put their hands up and say they have a problem. My question to you is, what happens when they put their hand up six or eight months down the road and say they have a problem?

RAdm Andrew Smith: Obviously they may not have put their hand up previously, but now they're increasingly inclined to put their hand up. The same thing applies six, eight, or thirty months downstream if they put their hand up and say they think they have a problem. They're given the same confidential, proactive, comprehensive support that anybody else is given.

One of the things we have done involves this road to mental readiness that I spoke of. The mental health clinicians and social workers have put together a wonderful little pocket pamphlet, which I'd be happy to provide afterwards to the committee. It shows what a green state of mental health looks like and what yellow, orange, or red states look like, in deteriorating states of mental health. So people can look at it and say, “Do I have increased gambling, or do I have increased alcohol use, or am I more cynical than I used to be?” And they can see that maybe they have slid from green to yellow or to orange and put their hand up.

So they have that with them; they put it in their wallet or on their fridge. And they put their hand up.

Mr. Robert Chisholm: Thank you. What's in place to assist commanding officers and peers in helping their staff and colleagues reintegrate into active duty?

RAdm Andrew Smith: I would submit that the greatest thing we have done in the last three years is to stand up the joint personnel support unit. Notwithstanding that all leaders in the Canadian Forces are trained from day one to look after their troops, the reality is that the business of force generation—similar to what you may have experienced in Wainwright recently—is the day-to day-business. They still care about their troops, but it may not be their primary concern or they may not have enough time to do it.

So it's putting the joint personnel support unit in place, a comprehensive integrated suite of programs and agencies that is focused on doing just that, and getting that word out to commanding officers to say potentially the best thing you can do for Johnny or Jill is to get them to the joint personnel support unit, where we have people trained, qualified, and focused on helping those people.

Mr. Robert Chisholm: Okay. That leads me to my next question. There appears to be an attempt to integrate these services that the military provides with provincial services, both in mental health care and social services and so on.

I have to tell you it's not working particularly well in some areas. I'm hearing from a lot of people being referred to provincial services who are in line-ups, who are on huge waiting lists.

I know the military hospital of Stadacona has been ratcheted down. As the military is referring more, depending more, on the provincial system, and the system is not there to help the men and women who have come back from battle, it's creating some real problems.

I wonder if you could perhaps address that.

● (0935)

RAdm Andrew Smith: I'll ask Colonel Bernier, who is the deputy surgeon general, to address the issue specifically with respect to reliance on provincial systems.

Col Jean-Robert Bernier: At the end of the Cold War, we closed our military hospital system generally, not just for economies or anything like that, but primarily because seeing fit and healthy patients all the time did not clinically prepare our clinicians to be competent when operations occurred. So we integrated them into civilian hospitals, mainly university trauma centres, where they maintain their top-level skills.

At the same time, particularly for services that are difficult to access, such as mental health, where there are national shortages in Canada, we essentially doubled the Canadian Forces capacity so that most of the mental health care can be provided in-house. We went from 228 clinician positions to 447. Now we're at 380 positions that are filled.

Mental health tends to be the issue that causes us the greatest difficulty with regard to access. However, right now, compared to objective wait times that are compiled by the national Wait Time Alliance, particularly for psychosocial and psychiatric care, the wait times for Canadian Forces members are dramatically less than they are for any other Canadian.

Mr. Robert Chisholm: Let me ask you, if I can, about my community. What do I do with about those wait lists in my community?

The Chair: I'm sorry, Mr. Chisholm, your time has expired and we have to move on.

Mr. Chisu, you have the floor.

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much, Admiral, for the excellent presentation.

I would like to commend the Canadian Forces for the tremendous progress they've made in the area of providing care for the injured soldiers and their families. I can tell you from my personal experience in Bosnia in 2004.... I was one of the pioneers of the assisting officers situation. When a Hungarian contingent working with the Canadians had an accident, with one dead and a severely injured person, I was the only one who spoke Hungarian. So I needed to provide all the services for the families, and also the liaison with the Hungarian forces, who were just coming into Bosnia, to retrieve the body and so on.

Of course, following this, after three days of not sleeping, I became ill, so of course the care I was given by the medical services after coming back from the theatre was excellent. However, I didn't have the assistance to go through the process of recovery, rehabilitation, and reintegration.

I was well enough to deploy in Afghanistan in 2007, and I built the Role 3 hospital in which we installed the 16-slice CT scanner in 2007, instead of having the 2-slice CT scanner, and that saved lives of Canadians and allied troops.

Between 2004 and 2007, in 15 years in Bosnia we had 23 casualties, and during my deployment in eight months in 2007 we had 24 casualties. It is a great difference.

Returning to this, the assisting officer position is a very important one, to deal with families, to deal with the casualties. Can you elaborate on how this assisting officer selection process is taking place and how the training is improved from the time I took this course in 2008? I retired from the forces in 2009. I'm asking this question because of the selection of the assisting officer. He must be very strong psychologically. If you are not doing the selection correctly, in the situation interacting with the victims' families, the assisting officers can be traumatized also.

After you elaborate on the assisting officer training improvements, I will have another question. How are the medical records kept in the CF? Is there room for improvement? If a CF member accesses civilian medical services, how does the CF track down and monitor this member's treatment and well-being?

I am asking this about records transfer because I am still serving the cadets; it's very interesting. There's no conflict of interest, but the fact is that the medical file is not very easily accessible if you or a civilian is requesting.

● (0940)

RAdm Andrew Smith: I'll take a quick run at the second question first and say that the Canadian Forces health information system, the electronic health records system that we have just put in place and are rolling out, I would submit, is a world-class electronic health records system, second to none that I have ever seen. Colonel Bernier can speak to that later.

With respect to the assisting officers, as the chief of military personnel, I don't have a direct role in the selection of assisting officers. Individual units in the army, navy, or air force would identify assisting officers. That's strictly with the chain of command. What I can say is that through the director of casualty support management, who works for General Bigelow, they are intimately involved through the JPSU construct with the assisting officer training curriculum to refine that on an ongoing basis to ensure that lessons learned are folded back into that assisting officer piece.

You're absolutely right, it's a critical piece. We have learned lots, and fortunately, but regrettably, I would say, we have learned lots about the importance of assisting officers. I've witnessed that personally, and those lessons learned get folded back into the training curriculum that's provided to every assisting officer.

The Chair: Your time has expired.

We'll move on.

[*Translation*]

Mr. Brahmi, you have the floor.

Mr. Tarik Brahmi (Saint-Jean, NDP): Thank you, Mr. Chair.

My thanks to the witnesses for appearing today.

I heard a term in English, but unfortunately I did not get the French translation. Rear-Admiral, I think you used the term ”casualties“: 2,000 casualties.

Is that dead and injured or just injured?

RAdm Andrew Smith: It refers to the ill and injured specifically.

Mr. Tarik Brahmi: So it does not include those who have been killed.

RAdm Andrew Smith: Not necessarily.

Mr. Tarik Brahmi: Not necessarily, or not at all?

RAdm Andrew Smith: My priorities are the ill, the injured and the missing. Support for missing members mainly involves the families.

Mr. Tarik Brahmi: My question was about the figures from Afghanistan. You mentioned 2,000 casualties. Does that mean 2,000 injured, or does it include the fallen?

RAdm Andrew Smith: It does not include fallen members.

Mr. Tarik Brahmi: Fine. I just wanted to make sure about that.

I would like to continue along the same lines as RAdm Smith. He touched on the question of keeping up medical skills. I am sure that the skills needed to treat those wounded in action are different from normal medical skills.

Could you tell me whether the physicians and nurses deployed in Afghanistan will get programs that will allow them work in war zones once again and will maintain or improve those specific skills? Or are they going to come back to Canada and do completely different work?

RAdm Andrew Smith: The best man to answer your question is Colonel Bernier.

Col Jean-Robert Bernier: After their civilian training, all our medical personnel receive specialized training. So all those employees receive normal training, whatever their area, as clinicians, for example, as paramedics, as medical technicians, as surgeons or medical specialists. At the same time, they are also placed in university trauma centres in each region; that is especially the case with clinical specialists. Even in peace time, here in Canada, they continue to be exposed to very complex trauma cases. Before every deployment, they get a great deal of additional training. At the same time, they have professional training programs, such as going to conferences specifically on combat medicine. There are two training centres for trauma injuries, one in Montreal and one in Vancouver. There, all our personnel work together as a team and get additional training on combat injuries. In basic training, which is held in the school at Borden, personnel are trained to deal with disaster victims, chemical and biological weapons, tropical medicine, and so on.

Our medical technicians receive very specialized training in tactical medicine. They learn to care for war injuries in realistic combat conditions, with smoke or explosions, in the cold or dark. In addition, all medical units receive training in teamwork so that their skills are at a high level from the moment they arrive in Afghanistan, or any other theatre of war, and from the first injury they have to treat.

● (0945)

Mr. Tarik Brahmi: Fine. Could we also talk about improvements to personal protective equipment, or PPE? Could you tell me about any specific recent cases where technological improvements have provided soldiers with additional protection?

Col Jean-Robert Bernier: We are working on a program with our three main allies, the United States, Great Britain and Australia. Canadian Forces Health Services and Defence Research and Development Canada are both involved.The program is called CASPEAN; it encompasses all our wounded and fallen in action. We carry out a precise assessment of their injuries, or causes of death, and the effects on their protective equipment or armoured vehicles. We conduct in-depth analysis, here in Canada and in cooperation with our allies, so that appropriate changes can be made to vehicle protection and personal equipment. As a result of that process, changes to armoured vehicles and personal equipment have been made.

Mr. Tarik Brahmi: Thank you, Mr. Chair.

[*English*]

The Chair: Mr. Strahl, you have the floor.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much for coming to speak to us today. I want to come back to the issue of mental health.

If a soldier has an injury, breaks a leg, you can fix that up. You can patch it up. Two months later, they're back at full service. Mental illness often is a lifelong process. It can be managed, but it's not like something you can snap someone out of sometimes. You can't treat it and it's gone. There's no timeframe, often, for mental illness.

Is there a process for soldiers so that they are able to manage it and get back into serving fully operationally again? When someone has a mental illness event or seeks that help, are you looking for a cure, or is it management of the situation?

RAdm Andrew Smith: I would say a couple of things in response. Colonel Bernier can expand subsequently. First, I would agree with you that there is not necessarily any set timeframe. We have had people who have been fully treated and have returned to work. I know personally of many people who have been identified with any number of mental health issues and conditions who have successfully gone through a combination of clinical and non-clinical mental health treatment and returned fully fit for employment and deployment. They have indeed gone back to the operational theatre and have successfully completed the mission.

I said publicly during the Caring for our Own symposium that I now realize, given all the research we've done and our ability to categorize, that personally, when I came back from the Persian Gulf in 2002, I slipped from a green state of mental health to a yellow state and then rebounded back some months later. That was in hindsight. Having read up on it, I think it was a totally normal reaction that happens to many people.

I would say that we're looking to treat as many people as possible to bring them back to a normal state, acknowledging that there are some people, especially when you're talking about severe mental health conditions, severe post-traumatic stress disorders, and severe operational stress injuries, who will never be able to recover or be treated successfully. That's a fact. But we have had great success in treating people and returning them to service.

When I was in Afghanistan in 2010, I spoke with a mental health nurse. She had a wonderful mandate to go out into the field, on an intervention piece, and reinforce some of the training and awareness for people in the field who had incidences of anxiety. She would be there to discuss it with them, to reinforce some of the training, and, on an intervention basis, to focus them and help them deal with their anxiety to enable them to return to full service without having to be patriated out of the operational theatre. Those are some of the advancements I think we are really moving ahead with.

● (0950)

Mr. Mark Strahl: How would you say mental health treatment or awareness in the Canadian Forces compares to that of our NATO allies? Are we taking best practices from our allies and implementing them here in Canada?

RAdm Andrew Smith: I'm going to ask Colonel Bernier to expand.

I would put our mental health program up against any one of our allies' programs. The Road to Mental Readiness program was used as a model. It is a system the United States developed. I would submit to you objectively that our system is significantly further ahead than the United States model now. We also have the “Be the Difference” campaign that General Natynczyk launched back in 2009. It was an awareness and de-stigmatization program that has gone a large measure towards saying to people that it's all right to put your hand up, as a question earlier alluded to. When the leadership says it's okay to put your hand up, boy, you can't get a much better endorsement than that.

We've had *témoignages* from people who have gone through some of those terrible events and have come out the other side. I think in this country we are significantly ahead of a lot of our allies. I think part of that is because, ultimately, I would submit, Canadian society, on balance, is a far more tolerant society than many others. And I think that's a reflection of people's acceptance of mental health injuries, just like physical injuries, as part of life.

Colonel Bernier, do you care to expand on that?

Col Jean-Robert Bernier: The NATO research committee looks to Canada for leadership in mental health to the point that I was asked, partly for that reason, to be the chair of the NATO medical and health research committee. One of our specialists is the chair of the mild traumatic brain injury research group, and another is the mentor of the military suicide research group. NATO tends to look to us for lots of reasons, but primarily because of the comprehensiveness and the extent of our programs.

A couple of years ago, the *Journal of the Royal Society of Medicine* did a study of stigma in the armed forces. It found that of the major allies—Britain, Canada, the U.S., the U.K., and New Zealand—Canada had the lowest rate of mental health stigma. And the commentary included comments about the comprehensiveness of our program and that it appears to be working in many respects.

● (0955)

The Chair: Thank you.

Mr. Christopherson, it's your turn.

Mr. David Christopherson (Hamilton Centre, NDP): Thank you, Chair.

I'll defer my time to Mr. Chisholm.

Mr. Robert Chisholm: Thank you.

I want to go back to Colonel Bernier. This is not a question of finding fault. In the best systems sometimes there are weakness or holes, and it's our responsibility to make sure we respond to those weaknesses. There are problems in my community with lack of access to mental health services. What do I do to help those people get the kinds of services they need?

Col Jean-Robert Bernier: We monitor. We have a performance measurement system to identify situations where there's an over-supply or under-supply of services and then redistribute accordingly.

In some places, because mental health professionals are a rare resource in Canada, we're competing with lots of other organizations. In some rural areas, it's particularly difficult to hire civilians. In those situations, we post in military mental health professionals. If we can't get enough civilians to fill some of those vacancies, we'll use other approaches, like telehealth, or we'll fly in or move in, temporarily, mental health professionals from other bases to support the gap. Sometimes, if necessary, we'll remove patients.

I could take that on notice and look up the situation in your area to find out the statistics for waiting times, specifically for the different types of services—psycho-social, mental health, psychiatric, etc.

Mr. Robert Chisholm: I'm just asking as an MP. Say someone calls me or comes to my office and says he needs help because he's getting bounced around. He qualifies as a Canadian Forces member, but he's not getting the services he needs and he's in trouble. What do I do? Who do I call?

Col Jean-Robert Bernier: The individual presumably has attempted, through his medical officer or base surgeon, to have those services and they've not been made available.

Mr. Robert Chisholm: Right. They're in a line-up.

Col Jean-Robert Bernier: We have to look at each case. If that case was brought to our attention, from the top down, we would look into it.

Mr. Robert Chisholm: What can I do? I have to do something, right? These people need somebody to step up to help them and their families. So I'm asking you, what can I do?

RAdm Andrew Smith: I would offer you two opportunities. One is to have the individual approach his chain of command. That's what the chain of command is there for—to lobby, advocate, champion on an individual's behalf. That's the first thing. The second thing I would invite the individual to do would be to go to the joint personnel support unit. There is one in Halifax, as there is on every base. Between those two avenues, I have full confidence that the individual's problem will be addressed. That's what they're there for.

Mr. Robert Chisholm: And if not, whom do I call? I'm telling you, these are real problems. I don't mean to find fault with the system, the chain or command, but these are people who are hurting.

Suicides too often happen because people are not being listened to. I'm trying to listen to these people, and I know you are too, but I need to find a place for them to go.

RAdm Andrew Smith: Mr. Chair, in the event that the chain of command and the IPSC were to be unsuccessful—which, frankly, I have a very hard time believing—you could invite any member of Parliament to call Rear-Admiral Andy Smith.

● (1000)

Mr. Robert Chisholm: Thank you very much, Admiral. I appreciate that.

Let me follow it up with one question. You have given yourself up as an example, in terms of role models, or people who have experienced trauma and have changed in that continuum you talked about in terms of mental illness. But in terms of role models, do we have them? I guess you would be one—someone who has suffered trauma, gone through the system of support, and rebounded—who we could point to and say, “See? There is somebody we've recognized and we've helped, and that person is an example of somebody who raised his or her hand, who we helped, and who's back in and doing a great job.”

RAdm Andrew Smith: When we launched the “Be the Difference” campaign in 2009, we had five people come forward, very courageous people who had suffered depression, schizophrenia, post-traumatic stress disorder, and operational stress injuries, and stand up in a public forum to say, “I was there. I was in my basement. I couldn't get out of my basement. I didn't want to have any contact with my family. I was having dark thoughts, got into treatment, and came out the other side.” They put their hands up publicly and said, “Hey, I've been there. I've come out the other side. I'm okay. And I'm fully functioning.” By and large, with few exceptions, I would submit that the rank and file never offered any indication how badly those people were suffering. And those people came forward. Some of them were privates; some were majors who come forward. They are really poster children for the ability to put your hand up, get treated, and move on with your career.

I've also had several people, senior officers, come and express things to me. These are extremely high-performing people who opened up to me to say, “I was in a dark place. I almost wanted to jump off the bridge, the MacKay Bridge or the Macdonald Bridge, I got help, and got what I needed. What can I do now, sir, to be able to go out and help people?” They volunteer to be peer counsellors or peer support to help people get the help they need.

Mr. Robert Chisholm: Good. Thank you.

The Chair: Thank you, Admiral.

Mr. Dykstra, it's your turn.

Mr. Rick Dykstra (St. Catharines, CPC): Thank you, Mr. Chair.

From my perspective, prior to becoming elected in 2006, I had not spent a whole lot of time seeing the difficulties or studying the difficulties or becoming aware of the difficulties we faced with respect to our soldiers. And in this particular area, I guess it's why I focus a little bit.... I'm much more aware of it now, but I think it has as much to do with my job as anything else.

The fifth pillar you have is about the communications, both internal and external. You talked a great deal about the internal communications, and that gives me some confidence that you've moved leaps and bounds over the last 20 years.

One of the difficulties I see is the external communications. Whether it be going through the Caring for our Own document or reading the brief on Shoulder to Shoulder and having a chance to even go through a little bit more of the material, part of the issue I see here is public awareness. I wondered if you could very briefly describe how in the past you've worked through making the public more aware of what your responsibilities are and how we serve those who are in the military.

RAdm Andrew Smith: Thanks for that question.

Strategic communications, specifically with respect to care and support for military members.... Success stories like these, in my estimation, frankly, don't make front pages of newspapers—regrettably. We have done so much in terms of medical care, non-clinical care, casualty support, casualty administration, and career administration.

When we had the Caring for our Own symposium nigh on about a month ago, we very purposely reached out to parliamentarians, media, advocacy groups, veteran support agencies, ombudsmen—both the veterans' ombudsman and the DND ombudsman—and selected people who were advocates in the area, specifically just to try to get that message out. Shoulder to Shoulder is all over our Canadian Forces website. All the initiatives that have been put in place are available on our website, whether it is the Be the Difference campaign, Soldier On, Shoulder to Shoulder, JPSU, or The Road to Mental Readiness. However, trying to get it out on a continual basis remains a challenge. I acknowledge that.

● (1005)

Mr. Rick Dykstra: Actually, this is sort of leading into my next question, with our completion of the mission in Afghanistan and withdrawal from Libya.

One of the strengths and the characters of an organization is how it transitions from what's happened, and understanding it and describing it, and then of course transitioning as to what's next and how you are going to approach the future with respect to this issue.

I guess that's what I'm asking. How are you planning over the next two, three or four years to transition from what I understand now is a very focused and concrete program that you are trying to make people aware of, whether it's internal or external? I wonder how you plan to work through that transition over the next number of years.

RAdm Andrew Smith: I would offer to you that more than any institution I've ever been associated with, the Canadian Forces is a learning institution. We have a very rigorous and robust lessons learned approach where we fold tactical lessons, communications lessons, back in from a lessons learned approach in a vein of continuous improvement.

The Canadian Forces remain flexible. That's one of the things...the general purpose, combat-capable nature of our forces means that you are ready, flexible, and agile to respond, and that includes the whole area of casualty support, casualty administration, medical support. I think we've proven that over the last ten years, and I'm not worried or concerned that we are unable to face the next conflict area in that regard.

Mr. Rick Dykstra: Thank you.

The Chair: Mr. Alexander.

Mr. Chris Alexander (Ajax—Pickering, CPC): Thank you, Chair.

I'd like to add my voice to those commending our briefers for this incredibly valuable session, and also to pay tribute to the initiatives of recent years. You've mentioned a panoply of them. I know there are others that we won't have time to get into, whether it is Be the Difference or the Soldier On fund, and then the Shoulder to Shoulder initiative, which was the proximate reason for us having this session now, because of the immediacy of that initiative, and now the broader framework of Caring for our Own.

We do see you leading and learning the lessons. In reply to your strong message on this point, Rear-Admiral Smith, I think Canadians do expect the Canadian Forces to lead on the issue of bereavement and how to deal with it, care for the ill and injured, and also mental health—in all of those areas.

We see it. Yes, there is a communications challenge. Yes, there are always going to be gaps and adjustments that have to be made, but we commend you for the leadership you've shown and we know will continue to show.

I want to address a couple of issues that may not have been covered so far. The first one is very simple. We know what the impact of the last decade has been on recruitment, particularly after the launch of the Canada First defence strategy. It's been broadly positive. But I want to ask, perhaps Colonel Bernier, about recruitment specifically to the medical field, including mental health, both for deployment and positions here. We know there are still some gaps in mental health positions despite Herculean efforts to try to access all the right people. Tell us a bit about recruitment of the medical professionals on which so much depends.

Col Jean-Robert Bernier: Thank you.

There are still some issues that we're addressing with respect to some of the health professions where we're still short. However, for the first time in history we're actually going to be slightly over strength for physicians, which historically has been our biggest recruiting challenge, to the point that in some years we have had less than 50% of the number of physicians we needed to have. As the quarterbacks of the medical team dealing with casualties, that's a tremendous success and a tremendous operational requirement to be able to provide that care, both in garrison and in deployed operations.

The patriotism that the conflict in Afghanistan has generated led to the recruitment of some of Canada's top clinical specialists. For example, one of the top transplant surgeons in Canada is now one of our medical officers. The director of Canada's number one trauma centre, Sunnybrook, the biggest premier trauma centre in Canada, is one of our surgeons.

So it has generated tremendous recruiting interest with very dedicated medical officers who are soldiers in mentality as well as being health care professionals, in fact to the point that with the reduction in operations in Afghanistan as the threat is reduced, it may have an adverse impact on our retention and recruiting. So we're doing very well.

● (1010)

Mr. Chris Alexander: Thank you.

Because of limited time, I'll bundle together some of these other questions. Medical records are always a difficult issue. We know the system inside the Canadian Forces is quite robust, but I'm wondering if you could comment a bit on the fidelity of transfers after members are released to the civilian system. We have all heard about challenges on this front, and it probably varies from province to province.

What is your sense of that issue, and how many ill and injured soldiers are released from the Canadian Forces every year, post-combat mission in Afghanistan? What gaps do you see between the system that you and Veterans Affairs are offering and the provincial systems? Are there still gaps, either on the federal side or the provincial side?

RAdm Andrew Smith: I'll jump on what I think was the second of your three questions. Historically, we have released a thousand people, give or take, medically per year. That has been consistent. It's been 950 to 1,100 per year for the last 10 years.

With respect to transfer of health records, there are always privacy issues in play there. We do have a project under way with Veterans Affairs Canada to facilitate the transfer of medical records to Veterans Affairs, and given that I often refer to Veterans Affairs as our cousins—they're inside the family—they ultimately need to have access to those medical records to help Canadian Forces members through the VAC claims process.

I'll ask Colonel Bernier to speak to the issue of fidelity of transfer to other agencies.

Col Jean-Robert Bernier: We can't comment on the provincial jurisdictions. However, with regard to the transfer of medical records, the records are available to the individuals themselves upon request, and they're proactively transferred any time a veteran applies to Veterans Affairs for any kind of support. We have a robust program of making sure those records are transferred well before the release period.

Ultimately, our Canadian Forces health information system—the electronic health record—will be fully up and running by early next year, and we're working on all the details required to do an electronic transfer of those medical records while being careful to protect their confidentiality.

Mr. Chris Alexander: Thank you.

The Chair: Your time has expired.

We have time for a third round. Every party gets five more minutes.

Mr. Christopherson.

Mr. David Christopherson: Thank you very much, Chair.

And thank you very much for an excellent briefing.

Just to push it a little further, I want to follow up on the question Mr. Chisholm asked in terms of identifiable individuals in the armed forces, who, to use the current language today, have “raised a hand”. They came back and said they had a problem and now everything's cool in terms of their career and their life.

I want to go a step beyond that. Are there individuals the rank and file would know had a problem, know they had the services that were offered, and then were promoted, particularly into senior ranks, to visually show it's not just words...? For instance, is that happening in a way that leaves the impression with the average young officer coming up that if they had this time-out period where they had to deal, particularly with a mental health medical issue...? Realistically, does the average person in the armed forces believe they could still become chief of the defence staff?

RAdm Andrew Smith: I would certainly hope so. As a case in point, I spoke earlier about the Be the Difference campaign launch. One of the individuals who came forward with a very touching testimonial of her own nightmarish mental health issues has since been promoted from major to light colonel. There's not much better testimony to transparency, openness, and objectivity than that.

I would say, though, with those who put their hand up and get treated, that's not necessarily a public piece. When I say “put their hand up”, that could mean they appreciate the need to get help and they seek help privately. Putting their hand up might not mean it's a public display.

Sometimes their natural progression through the rank structure may happen following successful treatment for a mental health issue, but it may not be fully open, nor should it be, to the rank and file. If I have a bad back and then recover and get promoted, that's not really anybody else's business.

● (1015)

Mr. David Christopherson: Okay.

One other question crossed my mind, and forgive me if it was asked. On the suicide rates, I was interested to note that the rates are at least on par with or less than those of the Canadian population.

I'd also be interested in the rates of comparable armed forces. Are ours very consistent with theirs? You don't have to name them, but are certain countries known to have an accelerated rate, or do others do an exceptionally good job and have a statistically identifiable lower number than our armed forces?

Col Jean-Robert Bernier: The most valid comparison we can make, because of all the cultural and societal factors that impact suicide, is the United States. There are other countries that would make reasonable comparisons, but they don't investigate each suicide to the depth we do, and they don't maintain statistics. They don't aggressively go after all deaths to determine whether or not they may be suicides.

The United States, because of many factors, has a much higher suicide rate than the Canadian Forces. In fact, recently it has exceeded the civilian population's suicide rate. Because of the stresses of the operation in Afghanistan, we expected a higher suicide rate, a higher mental health casualty rate. We haven't yet seen it, but we remain vigilant. We remain about 20% below the national average.

The United States has various factors that may account for their rate. They have longer deployment periods, a different process, less education, less leadership education. So different factors account for the way the armed forces in the United States are administered, organized, and deployed that may impact on why their suicide rate is so much higher than ours.

Mr. David Christopherson: Thank you, gentlemen.

Thank you, Chair.

The Chair: Mr. McKay.

Hon. John McKay: Thank you, Chair.

It's been an interesting morning. I thank you for it.

I just want to make a comment on the conflict between putting your hand up and your career aspirations. It certainly is a very courageous thing to publicly put your hand up in the company of your peers, particularly if you are warriors. I was especially impressed by the senior leadership at the Caring for our Own symposium, where there was a meaningful sharing from people who are senior warriors. I think if more of that went on it would be very helpful to the de-stigmatization.

On the secondary comment with respect to suicide, I'll have to show you an article and get your comment on it, because it is at variance with your testimony. But I'm not going to pursue that point.

The one question I do want to ask is with respect to that soldier who disagrees with his deployability or employability. You have an employment population of about 90,000 people, give or take. It would be absolutely astounding if every one of them were happy. At some point or another they're going to leave the armed forces, possibly not entirely of their own volition.

If a person is being discharged, or they're offered compensation that they think is inadequate, does the military have a relatively neutral fact-finding or adjudicatory process that allows for the settlement of that type of dispute?

● (1020)

RAdm Andrew Smith: Anybody who is going to be released medically goes through a very rigorous administrative review process, starting with the medical community, once that person becomes stabilized. That's an important piece to understand here. No decision is taken until the individual's medical condition is stabilized. Then an assessment is done on their ability to meet the conditions of universality of service.

If those conditions are not met, the individual goes through a fully transparent disclosure process so they have an opportunity to make their representation prior to any final decision being rendered. Notwithstanding that we have the medical file and the career administration file, they may have something else that may bear positively on a decision. They're given ample time to do that. Once a decision is rendered, if they're unhappy with it, there's always an opportunity for them to formally grieve that decision.

Hon. John McKay: Can you formally grieve it in the same sense that a union person can grieve a decision, or do you just simply go out, retain a lawyer, and sue for wrongful dismissal?

RAdm Andrew Smith: No, no, there's a formal grievance process. They're allowed to make representation. There is an initial and a final level of—

Hon. John McKay: But if I grieve it, do I therefore lose my right to sue for wrongful dismissal?

RAdm Andrew Smith: That's a legal question that I'll have to take on notice.

Hon. John McKay: I'm sure the process handles about 90% of the population that's being discharged, but there's always that 10% who have a legitimate—although not necessarily legitimate—disagreement with deployability or employability.

RAdm Andrew Smith: But we also have, in fairness, in the determination of an individual's ability to meet universality of service from certainly a physical fitness perspective, a threshold test. We all have to do that once a year to confirm our ability to be employable and deployable. If an individual is unable to meet that test, that's really a “go/no-go” gate. It's not a debatable point.

So there are some fairly black and white gates during that determination process.

Hon. John McKay: Thank you.

The Chair: Thank you.

Mr. Chisu.

Mr. Corneliu Chisu: Mr. Chair, I will split my time with my colleague Ted Opitz.

My question is a very brief one. If an ill or injured member is medically or generally released from the Canadian Forces, to what extent do the Canadian Forces help him or her to find gainful civilian employment?

CF members are not considered civil servants. When General Hillier was Chief of the Defence Staff, he allowed retired members to apply for civilian jobs in DND. However, this opportunity is not applied in other government sectors, in other ministries.

RAdm Andrew Smith: First, medically releasing personnel do have a priority referral status within the public service.

Second, the joint personnel support units—we have a colonel with us today who is in charge of all the joint personnel support units across the country—run something called TAP, the transition assistance program. They have a series of employers who have identified an interest in employing releasing Canadian Forces personnel.

Additionally, we are working closely with Mr. Blake Goldring and Canada Company as he looks to bring together corporate Canada, whether that be grocery chains, banks, or moving and cartage companies, to fill any number of positions that they are looking to fill. We are trying to match their need with our supply of people who are releasing medically to find a fit that enables them to transition.

Additionally, it bears mentioning that we work very closely with Veterans Affairs. They are an integral part of the joint personnel support unit. Every Canadian Forces member who is releasing, irrespective of reason for releasing, will have a transition interview with Veterans Affairs to identify needs and employment opportunities.

I guess the last thing I would say is that we also run, as you may recall, the second career assistance network, where we assist people with resumé writing, job skills, and interviewing skills. We also have the service income security insurance plan, which offers a vocational rehabilitation opportunity. People get to plug into that insurance program to vocationally retrain themselves.

All of that is just to give you a bit of the panoply of services that we have. We work very hard to assist people as they transition.

● (1025)

The Chair: Mr. Opitz, you have less than two minutes.

Mr. Ted Opitz: Okay.

Admiral, there have been reports in the House of former CF members becoming homeless or using food banks. Can you comment on how serious this issue may be and on how many former members this may apply to? Is this possibly a direct impact of mental health? And is there a mitigation strategy?

I can cover those again, if need be.

RAdm Andrew Smith: I work closely with my colleague, the senior assistant deputy minister at Veterans Affairs. Once they release from the forces, we lose tracking capability on people.

Veterans Affairs is very attuned to this issue. They have had a series of pilot programs in Montreal and Calgary looking to outreach to people who may have, for any number of reasons, become homeless. I would speculate that some of these situations could be due to mental health conditions. Your specific issue is of concern to us, but it's really a Veterans Affairs lead.

Mr. Ted Opitz: With regard to stigmatization within a unit, within a troop, I know as a former CO that I never had a problem with any of this. My troops would always be able to come to me or my colleagues, other COs of other units. They would always be able to speak to us—your troops are absolutely your most valuable asset. The health and well-being of all soldiers has always been top of mind throughout the chain of command. This is true of any commanding officer, and certainly up into the flag and general ranks. I know that for sure.

Colonel Bernier, with respect to the treatment of troops in the field, I was interested in how the staff go out and head off operational stress injuries, trauma injuries in the field. They can return a soldier to fighting form without even having to send him anywhere else. Can you comment on that a little more?

Col Jean-Robert Bernier: That's only part of the process. We start by screening and providing education right from enrolment. We do screenings at enrolment and perform periodic health assessments throughout the member's career. This extensive road to mental readiness is essential for pre-deployment resilience. Realistic training has a tremendous impact on enhancing resilience. In theatre, we provide a robust mental health staff, including a psychiatrist. Some of the mental health staff will go to the forward operating bases.

So between that, the education provided by the supervisor, and the chain of command and colleagues keeping an eye on one another, we can identify early on the individuals who need help. That help can often be provided in theatre, so we rarely get a repatriation for mental health reasons out of Afghanistan. Our repatriations are mainly for psychosocial or family issues. But for acute mental health illnesses, it rarely happens in Afghanistan. Most of the problems manifest themselves afterwards.

We don't discriminate. We treat mental illness the way we treat any other illness or injury. We do an assessment on an individual basis. If the individual, by the best clinical assessment, can be shown to be able to fulfill all of his duties under stress, then we don't preclude him from deploying or from going outside the wire in dangerous conditions. We've had a number of these cases. The priority is not the mission but the individual's health and safety. We have had individuals who've been able to stay in theatre or who, after illness in Canada, have been able to redeploy and return to full duty.

● (1030)

RAdm Andrew Smith: Part of this road to mental readiness is an appreciation that's given to members of the physiological reactions to stress—how to mitigate it with self-talk, visualization, and breathing techniques. My francophone colleagues often invite me to

[*Translation*]

respirer par le nez.

[*English*]

Well, that's helpful. The mental health nurse goes out in the field to reinforce some of those techniques that people have been taught but that may need a bit of reinforcement. This has proven to be very useful.

The Chair: I have a couple of questions myself. Mr. Chisu asked about the management of medical records and didn't have a chance to hear a response. How has the armed forces been making out in tracking the medical records? Especially when members are transferring between units, deploying, and then returning home, is there any need for improvement in how these records are moved around in the system?

Col Jean-Robert Bernier: Any organization that uses paper records has some difficulties in that regard, particularly with a mobile patient population that moves around all over the place, with delays in getting records delivered here and there or with having the complete medical record available, if, for example, a sailor is out at sea on a warship or on a deployed operation.

By June 2012 at the latest, we'll have the fully rolled out Canadian Forces electronic health records system in place that will permit any physician or any medical staff, anywhere in the world—on a warship, in Kandahar, in Afghanistan, or in Kabul—wherever there is a terminal, to be able to access the medical record of any CF member. So they could be in Victoria one day and in Kandahar the next, and the physician at each location will be able to see the complete medical record. So there won't be any issues anymore with that kind of transition.

We've made strides in the interim with various measures to try to enhance the reliability, the completeness of the medical record, and the speed of its transfer for deployments or for the people who are mobile across the country. In fact the health information system is being looked at as a model across Canada. It's the first one that'll be pan-Canadian, that'll provide that kind of real-time access to the complete medical record anywhere in Canada or the world where troops are deployed.

The Chair: And would that be available as well to provincial health care service providers, because we do depend on them for many in the armed forces?

Col Jean-Robert Bernier: The architecture is based on the Canada Health Infoway structure that's been accepted by all health jurisdictions in Canada as a basis. The problem is that we're further ahead than most jurisdictions, so most jurisdictions don't have the ability to tap into a medical record and to transfer information. So for various things like lab results or consultations from civilian facilities, we'll still have to rely on the transfer of paper records or an electronic version, like a PDF of paper records, and enter them manually into our electronic health record.

Eventually, however, when all of the provinces and all of the regional health authorities have become digital, using the Canada Health Infoway infrastructure, we'll be able to transfer information directly back and forth to any health jurisdiction.

The Chair: Thank you.

In one of your responses to either Mr. McKay or Mr. Chisholm, you were talking about the wait times for mental health care. You said that the armed forces have a dramatically shorter wait time, generally, in comparison to the rest of Canada. Can you quantify that? How much is “dramatically shorter”?

Col Jean-Robert Bernier: It varies from region to region. For example, in Petawawa, the average wait time for psychiatric care is about 6.5 weeks for all of Ontario, and it may be longer for Petawawa specifically. For the military personnel at the base, it's about 3.5 weeks or less.

● (1035)

The Chair: So it's half the time or thereabouts.

You also made mention that we're in the process of hiring more mental health specialists, that we're up to 380 in the technical field. You're going to be hiring more, though, because I think you said we're heading for 420.

Col Jean-Robert Bernier: It is about 380, and we are heading for 447.

The Chair: Okay, it is 447.

And in what timeframe are you going to fill the rest of those positions?

Col Jean-Robert Bernier: It will be as soon as we can. We've been trying for years to fill them all, but the process of finding people, in competition with the scarcity across the Canadian market for mental health professionals, is challenging. In the interim we have to augment services by using innovative methods like telehealth, teleconsultations, and movement of uniformed mental health professionals to where they're needed most.

The Chair: The last question I have is to Rear-Admiral Smith on this whole issue of reintegration. I'm following up on Mr. McKay about the return to work program, when those individuals who unfortunately have had a physical injury or a mental injury are not able to be classified as being employable or deployable within the armed services. Yet these are individuals who wanted to be career soldiers, with a career in our military, and they still want to work with the armed forces. Is there any way to transfer them to the civilian population and then rehire them, because we do use a lot of civilian staff with the Canadian armed forces? Is there an opportunity to use some of those people who may be amputees or suffer from other injuries and still fulfill their desire to be involved with the Canadian Forces?

RAdm Andrew Smith: Mr. Chair, I'll give you a two-pronged answer. First of all, for those people who are releasing and who want to stay associated with Defence, there is really a civilian tangent to the answer and a military tangent.

On the civilian side, I refer to the priority hiring that's available within the public service. The overriding criterion, though, has to be the ability to be competent in the job. So through the vocational rehabilitation services that we provide through the insurance program, if somebody wants to be a heavy equipment operator, they can go and follow that training with a view to becoming a heavy equipment operator in the public service, but they still have to be competent for the job. So we look to facilitate that.

The second one is if someone has a burning desire to remain and wear the uniform every day, we will offer them an opportunity to stay in either the cadet organization or as part of the administration of the Canadian Rangers, where the principles of universality of service do not apply. If they would elect to do so, we will transfer them, but that would mean they'd no longer be an infanteer or a bosun or a pilot, but they would still be able to be part of the uniformed family, if you would.

The Chair: Thank you very much.

I want to thank all three of you and your staff for the compassion and the leadership you are showing in caring for our ill and injured, for working with our military families, and for providing services that are so desperately needed.

This is a great way to kick off our study, and it is one into which we are going to put a lot of elbow grease over the next few weeks. So I do appreciate your taking the time to come here to present today.

I'm going to dismiss you.

We do have one other piece of business to deal with. As everyone knows, we are without a first vice-chair, and according to Standing Order 106(2), I will turn over the election of our vice-chair to our clerk.

Mrs. Isabelle Dumas (Procedural Clerk, Committees Directorate, House of Commons): I am now prepared to receive motions for the first vice-chair.

Ms. Gallant.

Mrs. Cheryl Gallant: I'd like to nominate David Christopherson for the position of first vice-chair.

Mrs. Isabelle Dumas: It has been moved by Ms. Gallant that Mr. Christopherson be elected as first vice-chair of the committee.

Are there any other motions?

Is it the pleasure of the committee to adopt the motion?

Some hon. members: Agreed.

Mrs. Isabelle Dumas: I declare the motion carried and Mr. Christopherson duly elected first vice-chair of the committee.

Some hon. members: Hear, hear!

The Chair: I join in this.

Mr. Kellway.

Mr. Matthew Kellway: Mr. Chair, is there an update to the committee calendar available?

The second part of that question is this. Can you, or through you to the clerk, provide an update on the efforts to bring General Leslie to the committee?

● (1040)

The Chair: I will deal with General Leslie first. He had declined our invitation to appear before the committee. At this point in time we are accepting that, otherwise we'd have to subpoena him if we wish to bring him here. I don't think we're at that point. We do have his report that we can reference, and he also testified before the Senate committee and we can look at that testimony in our consideration of business.

As to a work calendar, I'm going to suggest that sometime next week we do need to have a steering committee meeting to organize our work after the break week, so we'll get that organized in the next day or so.

With that, I'll entertain a motion to adjourn.

An hon. member: I so move.

The Chair: We're out of here. The meeting is adjourned.

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