HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on National Defence

NDDN • NUMBER 057 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, November 22, 2012

Chair

Mr. James Bezan

Standing Committee on National Defence

Thursday, November 22, 2012

● (1615)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone. Sorry for the delay. We had votes in the House, and there's a potential for more votes.

I want to move right into—

Mr. Jack Harris (St. John's East, NDP): Mr. Chairman, I have a point of order.

We have discussed this privately, but I would like to indicate, on the record, that I've received a complaint from Mr. Sylvain Chartrand, a decorated veteran. He wanted to come to this committee but was unable to get access to this room because he was denied entry at security downstairs. He subsequently went to the House of Commons, where he talked to one of our members, Peter Stoffer. Mr. Stoffer says that this person has been here very often, including at the last veterans affairs committee meeting, and had been welcomed there on many occasions.

I'm a little concerned that a decorated veteran who wanted to come to this committee to hear what our witnesses had to say and to follow the proceedings was unable to obtain entry to this building.

That's my point of order.

The Chair: I'll take that under advisement. I will be talking to Senate security and House of Commons security about this particular person to find out what the exact background is and to determine the best way forward.

With that, I want to move on. We are continuing our study on the care of our ill and injured Canadian Forces members.

We're glad to have with us today, from the Department of National Defence, Rear-Admiral Andrew Smith, chief of military personnel and co-chair of the DND and veterans affairs joint steering committee. Accompanying him is Colonel Gerry Blais, director of the casualty support management and joint personnel support unit. Welcome, gentlemen.

Admiral, you have the floor. If you could keep your comments to under 10 minutes, we'd appreciate it.

Rear-Admiral Andrew Smith (Chief of Military Personnel, Co-Chair of the DND/VAC Joint Steering Committee, Department of National Defence): Thank you, Mr. Chair and members of the committee.

It's a pleasure for me to appear before this committee again to discuss how we in the Canadian Forces care for the men and women of the Canadian Forces and provide support to them and their families if they are injured or become ill while serving.

Since assuming my present position in 2010, my top two priorities have been the care of the ill and the injured, and mental health. My ultimate goal is a health care system and a personnel administration support system that provide the best possible care to all members of the Canadian Forces, both regular and reserve.

In this regard, both the rollout of our health system renewal through the Rx2000 project and the lessons we have learned in support of operations in Afghanistan have led to significant advances and improvements in the care of our ill and injured. This significant improvement is facilitated by a comprehensive, interdisciplinary approach that requires the integration and coordination of services available through the military health care system, the military administrative and social support system, and the transition and veteran support system.

In this latter regard, I work very closely with Veterans Affairs. This approach has been communicated to Canadian Forces personnel and their families, as well as other stakeholders in our recent publication entitled, “ Caring for Our Own”.

Our model of care for the ill and injured is based on three phases. The first phase, acute recovery, includes physical, mental, and spiritual care. The second phase involves a longer term clinical, physical, mental, vocational, and non-clinical rehabilitative support for the patient and his or her family, while ultimately preparing for the third phase, namely, reintegration.

There can be significant overlap between the three phases as ill or injured members move from acute recovery to rehabilitative support, and often simultaneously prepare for reintegration.

Our ultimate goal is to reintegrate personnel to duty in their current military occupation when and where possible. The reintegration plan is dependent upon a reliable prognosis or functional capacity assessment. If it is not possible to reintegrate the member in his or her current military occupation, then transition to an alternate occupation consistent with his or her abilities and interests is considered.

When the illness or injury leads to permanent medical employment limitations that do not meet the conditions of universality of service, our focus then, rightly, needs to be on reintegration into civilian life or consideration for employment with Cadet Organizations Administrative and Training Service, or the Canadian Rangers for those who wish to stay within the Canadian Forces.

Some ill or injured Canadian Forces members who are employable on a full-time basis within their medical employment limitations may be retained in the regular force or primary reserve for up to three years prior to reintegration into civilian life. The reintegration into civilian life of severely ill or injured who are not employable in the CF may also result in up to three years of transition support by the Canadian Forces.

This support is provided in coordination with Veterans Affairs Canada in preparation for them to assume responsibility for their further reintegration and coordination with the provinces for the health care needs of the veterans and their families.

I often say that Veterans Affairs and the Canadian Forces look after the same people; we just have to look after them at different points in their career and their lives.

[*Translation*]

Our framework of care is supported by five pillars that define how the integrated, equitable, responsive and well-communicated delivery of health care and support services meets the unique needs of ill and injured Canadian Forces personnel, veterans and their families through the phases of recovery, rehabilitation and reintegration.

The first pillar is governance, which consists of a whole-of-government approach to care and support.

The second pillar is an integrated multi-disciplinary and multi-agency delivery system.

The third pillar is consistency. We are talking about access to consistent care and case management, wherever the Canadian Forces members may serve.

The fourth pillar is continuous improvement. Focus is placed on continuous improvement to evaluate the effectiveness of policies, programs and services in support of identified deficiencies.

The fifth pillar is communication—both internal and external—of how we care for and support ill and injured Canadian Forces members and their families.

In addition to the five pillars, it is imperative that our three phases —recovery, rehabilitation and reintegration—remain anchored to the principle of universality of service. All Canadian Forces personnel must be ready to perform general military duties and common defence and security duties, not only those of their military occupation or occupational specialty.

The minimum operational standards associated with this principle include the requirements to be physically fit, employable without significant limitations, and deployable for operational duties. Universality of service is an essential and equitable approach for preserving the Canadian Forces trained effective strength and the capacity to meet its operational requirements.

[*English*]

Within the Canadian Forces we continue to work diligently to reduce the stigma associated with mental illness and operational stress injuries, as evidenced by the participation and support of the Minister of National Defence, the Minister of Veterans Affairs, the chief of the defence staff, both former and current, and senior leadership of the Canadian Forces at my recent symposium on mental health on October 22. It is essential that we continue to maintain a focus on mental health as an essential component of our care for the ill and injured and ensure that Canadian Forces personnel are able to readily access the mental health system available to them. We continue to work with commanders, supervisors, and Canadian Forces members through our mental health education and training program, including but not limited to programs such as the road to mental readiness, the joint speakers bureau and the be the difference campaign, to ensure our people are aware of and get the treatment they need. The Minister of National Defence has also recently committed an additional $11.4 million to further enhance the mental health care services available to Canadian Forces personnel.

[*Translation*]

Canadian Forces personnel have access to one of the best mental health care systems in Canada, which incorporates a comprehensive multi-disciplinary primary care model other Canadian health jurisdictions are striving to achieve. It also integrates a mental health care system recognized by organizations such as the Canadian Psychiatric Association. This system extends from in-garrison care to the exceptional health care provided during operations such as Operation Athena. Thanks to the exceptional care provided by our highly skilled medical technicians at the point of wounding, and the medical evacuation chain of the Canadian-led Role 3 Multinational Medical Unit in Kandahar, our health care system has earned the recognition of the NATO Baron Larrey Award of Excellence.

[*English*]

Integrated with the exceptional health care is our comprehensive military administrative and social support system overseen and coordinated by Colonel Blais, the director of casualty support management. This system is centred on the regional joint personnel support units with component integrated personnel support centres established across the country to provide a comprehensive, decentralized and integrated network of casualty support, which ensures equitable and consistent support for our ill and injured and their families. Support includes return to work program coordination, casualty tracking, support outreach and administration and coordination of services provided by organizations such as Veterans Affairs Canada, the service income insurance plan and personal support programs.

[*Translation*]

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. It is essential that Canadian Forces members have the confidence that, should they become ill or injured, they will receive the treatment and rehabilitation services necessary to restore them to health and normal functioning, and that their families' needs will be met. If they cannot resume military service, they know that the Government of Canada will support them as they make new lives for themselves. Veterans Affairs Canada and the Canadian Forces are committed to providing Canadian Forces personnel and their families with the comprehensive care and services they require. The two departments have a strong partnership and collaborate closely to integrate their services and provide continuity of support to our ill and injured in order to ensure the best possible care and, where necessary, a smooth transition to civilian life.

[*English*]

Members of the committee, I thank you for your continued interest in the care of the Canadian Forces ill and injured and for your strong support of members and families of Canadian Forces.

With that, Mr. Chair, I would be pleased to answer any questions you might have.

● (1630)

The Chair: Thank you, Admiral Smith. I appreciate your keeping your opening comments under 10 minutes. With that, we're going to do five-minute rounds so we can get everybody on the record in the hour that we have left.

Mr. Harris can kick it off.

Mr. Jack Harris: Thank you, Rear-Admiral Smith and Colonel Blais, for coming today.

I appreciate your opening comments and your statement that your top two priorities as chief of military personnel are the care of injured and wounded soldiers and the mental health of soldiers. Similar remarks were made by the minister, that that is his top priority. I appreciate that this is obviously of great importance to you.

It bothers me when I see reports like that issued yesterday by the military ombudsman, when specific things were identified in 2008, agreed to by the department, through the minister, and four years later.... I congratulate you and your predecessor—you weren't there for all that period—for meeting some of the objectives, four out of twelve of them. Others were partially implemented and two of them weren't at all.

One of them was particularly egregious. It seems to be more an administrative problem as opposed to a major effort being required, and that is making sure that reservists, for example, are entitled to the same accidental dismemberment benefits as regular soldiers.

There's a 60% differential, I think. Members of this committee four years ago were rather astounded at that and very angry about it. I would have thought that something like that could be a quick fix. Here we are four years later with nothing done about that.

There is another thing that bothers me, particularly when we are talking about mental health. I guess we know more today than we did in even 2008 about the onset of PTSD as something that may happen later, after a person is back from a deployment. The lack of regular medical checkups and attention to reservists after deployment seems to be a major gap and could in fact avoid detection and diagnosis of PTSD or OSI and thereby avoid treatment.

Could you address those two issues in particular?

I guess the third one, which is closely associated with that, is there are reports that reservists have been turned away from military medical clinics due to ignorance on somebody's part that they are actually entitled to the services.

Those are three issues I hope you can address.

RAdm Andrew Smith: I do acknowledge the policy disparity related to the accidental dismemberment insurance program. I say with confidence that we have been aggressively pursuing changes to the program to correct that.

I will also say, in the next breath, that I do not have the authority to make those changes.

As is standard practice on compensation and benefit issues, my job is to recommend and staff advice forward. I note the strong support of the Minister of National Defence in that regard, which, for the record, was provided to me well in advance of the tabling of the ombudsman's report yesterday. That will cycle through the machinery of government on its way for consideration. That's with respect to the ADIP piece.

With respect to mental health, I'll take an opportunity to ensure that we are all aware that notwithstanding that operational stress injuries and PTSD itself tend to be what everybody associates with mental health, the overwhelming percentage of people who have mental health illnesses in the Canadian Forces are not related to OSIs. They are related to depression, anxiety disorders and others, acknowledging that there is a clear need to address those with PTSD as well. That's my first point.

With respect to the follow-up piece, all people who have been deployed to Afghanistan go through the road to mental readiness training, where they get a pre-deployment briefing, as do their families. They are given techniques to assist them in dealing with stressful situations in theatre. They all get a post-deployment follow-up some three to six months after they come back from deployment. Their families are also invited to have input into that post-deployment follow-up.

Although I do acknowledge that there can be an issue with reservists who deploy to a mission like Afghanistan, they would be on full-time service at that point. When they come home, and if they go back to part-time service, they are in far less of an obligatory service state, so making sure we maintain contact with them can sometimes be an issue.

With respect to your last question about turning reservists away from medical clinics, I acknowledge that has happened on occasion. We're not perfect. That shouldn't happen. The surgeon general and I have had a chat about this and he has provided clear direction that it is not to happen in the medical clinics across the country.

● (1635)

The Chair: Thank you, Admiral.

Ms. Gallant, you have the floor.

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

Through you to our witnesses, we've allocated over $11 million recently to mental health in the forces, and from there I understand there have been three psychiatrists assigned to Base Petawawa's JPSU, joint personnel support unit.

Can you tell me the number of person-days the psychiatrists provide to Base Petawawa?

RAdm Andrew Smith: Mr. Chair, I don't have the figure at hand. I would be happy to take that question on notice, the number of person-days available for Petawawa. I will take that away, if I might.

Mrs. Cheryl Gallant: Also, what are the wait times from the time a soldier is back from theatre and is diagnosed that he needs to see a psychiatrist to the time that he actually sees one? I am looking at the wait time.

RAdm Andrew Smith: First of all I am happy to say that the wait times for Canadian Forces members are far less than anything I know or the surgeon general has seen throughout the provincial health care systems in the country.

It bears mention that when people come home and they are assessed with a mental health illness or injury, in the first instance, much like any physical injury, there is a certain assessment and triage phase that goes on. Those who are in need of urgent care are seen right away. Those who are assessed as posing no risk to themselves or society are then placed in a prioritized system.

With respect to saying what the wait times are, frankly, the best answer I can give you is it depends, acknowledging that if anybody has an acute requirement, even if they were a lower priority, they could be seen right away.

Mrs. Cheryl Gallant: The veterans affairs committee paid a visit to Base Petawawa, and a soldier we met with said it was known that he needed to see one, and a year later, he still hadn't seen one. I'm hoping that wait time has decreased since then.

I want to move to the subject of the joint personnel support units. You made giant strides in a very short length of time. The speed with which it was deployed, anyone could be nothing but impressed with what you're doing in that regard. In a regular regiment, what is the usual ratio of leader to subordinates?

RAdm Andrew Smith: The ratio of leader to subordinates in a regiment?

Mrs. Cheryl Gallant: Section and section commanders; break it down that way.

RAdm Andrew Smith: That's strictly an infantry-related question. Note that I'm in the navy—

Voices: Oh, oh!

● (1640)

Mrs. Cheryl Gallant: Colonel Blais can answer that.

RAdm Andrew Smith: I would hazard a guess it was probably somewhere around 1:20 or 1:30. If you could help me understand the gist of your question, that might help me.

Mrs. Cheryl Gallant: I'm told that the usual ratio for section commander to subordinates is optimally 1:9, and usually in practice maybe 1:15. I'm told that at the JPSU in Petawawa, the ratio is about 1:45, and in some cases 1:70, and that an injured soldier takes about one and a half times the work of a healthy soldier. My question is, is there a staffing and infrastructure expansion plan in place to allow for the growth as required?

RAdm Andrew Smith: I'll give you a macro answer, and I'll invite Colonel Blais, because this is really his business, to amplify that.

The JPSU was stood up in 2009, and you're right, we have made giant strides. I frankly don't know where we would be without it, from an integrated support perspective with Veterans Affairs and all the various stakeholders.

The good news is that we have reduced the stigma associated with mental and physical injuries, which has invited people to come forward. Previously, I submit, they may have remained within the regimental lines and not come forward to seek help. The fact that we have more people coming forward I take as a good sign. There are places around the country, specifically at some of the mounting bases —Petawawa being one, and Valcartier, Gagetown, and Edmonton, being others—where there are some capacity issues that we track and address as things go by.

With that, I'd invite Colonel Blais to expand on that.

The Chair: I'll ask that you make a very brief comment, as we are getting towards the end of Cheryl's time.

Colonel Gerry Blais (Director, Casualty Support Management and Joint Personnel Support Unit, Department of National Defence): I will.

The other dynamic to be considered when we're looking at the numbers is there are a number of people posted to the JPSU in Petawawa, and there are a number who only receive services. If you distinguish between the two, there are approximately 600 people who are receiving services, but about 200 or so who are posted. Therefore, when you break down the ratios with simply those who are posted which are those for whom the military staff are responsible, those numbers go down quite a bit.

The other one is that in a unit, the NCMs are responsible for training and a number of other issues as well, whereas in the JPSU, they are strictly responsible for the personal administration of those, so the ratio can be a little higher and still be very workable.

The Chair: Thank you.

Mr. McKay, you have the floor.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair, and thank you to both of you.

I want to follow up on Mr. Harris's question on the accidental dismemberment insurance. You said that you don't have the authority. Who does?

RAdm Andrew Smith: Consistent with any compensation and benefit issue, that authority to expend public funds for that ultimately rests with the ministers of Treasury Board. That's consistent throughout government.

Hon. John McKay: We have you, as head of military personnel, saying that it should be changed, and we have the minister apparently saying that it should be changed. Therefore, the blockage appears to be at Treasury Board.

RAdm Andrew Smith: No, Mr. Chair, I did not say there's a blockage at Treasury Board. I said it will go forward for consideration with any number of other issues that will go before the Treasury Board.

Hon. John McKay: We've had four years to resolve this issue. What I don't understand is why this....

The Chair: I'll interject. As you know, pages 1068-69 in chapter 20 of O'Brien and Bosc state clearly that public servants and advisers to the minister aren't obligated nor should they feel compelled to share information they believe would jeopardize the relationship with the minister.

Hon. John McKay: Would you adopt the statement of the ombudsman who said:

> Notwithstanding the Minister's support for this recommendation in 2008 and the communication between the Chief of Military Personnel and Treasury Board Secretariat, the Department's efforts have yielded no changes to the Accidental Dismemberment Insurance Plan.

Is that correct?

● (1645)

RAdm Andrew Smith: Mr. Chair, an allusion was made earlier that this would be a fairly straightforward administrative change. A significant amount of work and analysis goes forward with staffing something of this nature, and that has been going on apace, consistent with my priorities related to the ill and the injured. We're trying to make the best progress we can on that.

Hon. John McKay: I'm not going to play junior lawyer here with you, but I think the ombudsman makes a pretty significant point. He says, “As such the office is of the opinion that this issue requires ministerial intervention in order to right this unacceptable unfairness”. I'll leave it there.

The second issue has to do with periodic health assessments. Apparently there's differential treatment between regulars and primary reservists. It's a little confusing as to why a reservist on deployment should receive differential treatment for immunization from the regular forces.

I'm sure you're familiar with the ombudsman's inquiry here. I'll be interested in your views.

RAdm Andrew Smith: Certainly. In the first instance, reservists who deploy on international expeditionary operations receive the same training, administration, and health care benefits as regular force people do prior to and during deployment.

When reservists come home from an international operation, and many of them do and then revert to part-time service, one has to remember those part-time reservists' health care needs are the primary responsibility of the provinces. Where there is a service-related need the Canadian Forces will provide those health care services.

In relation to the periodic health assessments, a trial was done in November 2010 in one location on what that would mean in order to provide periodic health assessments. A second trial is now ongoing in four locations to capture the total resource requirements for implementation for all primary reservists, some 30,000.

The office of the ombudsman was advised in 2009 that periodic health assessments would be provided to all members of the primary reserves in a phased approach, and that phased approach would be subject to approval at various stages in full view of the costs associated with it.

Hon. John McKay: That strikes me as saying we're doing this program of immunizing and vaccinating, yet when the reserves get back, it's really the province's problem.

I thought the issue here should be a similarity or equivalency of treatment for a deployed reservist. Again, the ombudsman says “the office senses a lack of willingness on the part of the department to fully implement these recommendations”.

I'm not quite sure of the basis for the reservation.

RAdm Andrew Smith: Maybe I'll come at it a different way.

The periodic health assessments are not required for deployed operations, and then it becomes a question of making sure reservists are ready. It becomes a readiness issue to deploy for operations as may be required in Canada.

The Canadian Forces fully acknowledge their responsibility to provide medical care for those reservists who come back from deployed operations who subsequently present with a mental or physical illness or injury that was related to their operational service, but the standard health care for reservists on a part-time basis rests with the provincial authorities.

The Chair: Thank you. Time has expired.

The bells are ringing. We have 20 minutes to get to the House.

My duty as chair is to suspend the meeting. I don't think we're going to get back before 5:30, by the time the votes are finished, so I'm going to ask for a motion to adjourn.

Before I do that, Admiral Smith and Colonel Blais, thank you for coming in. I apologize for not allowing a fulsome discussion on your presentation today. We want to thank you for your commitment to our ill and injured who serve. We want to make sure that we put together a great report and help provide direction to the government on how to move forward with the ill and injured of the Canadian Forces.

With that, the meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca