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RCMI
The Journal of the Royal Canadian Military Institute
SITREP

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Military and First Responder Health
From the Editor

As expected, the tempo at the RCMI has increased significantly with the arrival of September and the fall period. By the time you receive this edition of SITREP, the Canadian federal election will likely have occurred and, based on recent polling, the outcome is too close to call. As is so often the case, the federal election campaigns have focused almost entirely on economic promises and plans, along with some forays into social policy differences, while nary a word is spoken on foreign policy, international affairs, the Canadian military or any number of ongoing and significant issues in the overall defence and security realm.

To name but three significant issues: ongoing frictions with China over our detention of the Huawei financial executive, and the ongoing detention of Canadian citizens in retaliation; the imminent arrival of Brexit in October, and the potential impact this may have on Canada-UK trade and European security structures; and the arrest of a very high-ranking member of the RCMP intelligence service who “obtained, stored, processed sensitive information we believe with the intent to communicate it to people that he shouldn’t be communicating it to.” At the same time, there are open concerns regarding the potential for foreign states to interfere in the upcoming Canadian election, as well as the US election in 2020.

With regards to this latter point, the Defence and Security Studies Program Committee have selected the topic of foreign interference in democratic elections as the focus for our next annual conference which will be held on April 24, 2020. Please hold that date, and watch for more details to appear in your in-box shortly. Wedged, as this conference will be, between the Canadian and US elections, the discussions ought to be extremely interesting indeed.

As for other future program notes, we have two excellent events planned for October and one for November. On October 1, Mr. Phil Gursky, a former member of CSIS, and an active security analyst, will address the question of “terrorism: how big is the threat to Canada, and how worried should we be?” On October 15, Dr. Greg MacCallion from the Australian National University will be present for the launch of his new book “National versus Human Security.” On November 5, Dr. Jon Lindsay will present his views on “Cross-Domain Deterrence: Politics by Many Means.” All of these presentations bring to the RCMI experts of the highest quality and I encourage you to attend as many events as you can. With respect to Professor Lindsay’s presentation, the subject of deterrence (yes, it’s back!) will be the focus of the November-December edition of SITREP; it will examine deterrence in the cross-domain sense, counter-terrorism, cyber and nuclear realms (other subjects, by the way also not discussed in the federal election...).

As for this current edition of SITREP, we focus on an extremely important subject, namely, military and first responder health issues. On September 10, the RCMI was very fortunate to host Dr. Peter Collins and Mr. Ryan Dermody who both spoke eloquently and passionately about the problem and agony of post trauma stress disorder, or PTSD. While this presentation was not video-taped, I have attempted to capture the salient points while respecting the privacy of the presenters to the greatest degree possible.

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On September 10 the Defence and Security Studies Program Committee hosted two distinguished guests to speak on the subject of living with PTSD.

Dr. Peter Collins is a well-known and highly respected forensic psychiatrist who provides consulting and education support to police services and military forces in Canada and the US. He is a former Canadian naval reserve Officer and served twice in Afghanistan, providing psychiatric and medical support at the Role 3 hospital in Kandahar and other locations. He is considered an expert on PTSD, and is frequently called upon as an expert witness in legal cases which involve this disorder.

Mr. Ryan Dermody served in the UK Royal Navy for over eleven years, and since returning to Canada has held senior roles in finance and management and currently lives with his family in Montreal. Ryan has been working with Dr. Collins at the University of Toronto on a study of how to best treat military members who have PTSD, and he was invited by Peter to participate in the presentation in order to share his observations.

Peter began his presentation by canvassing the very well populated audience regarding their own backgrounds. It was determined that members of the military, both serving and retired, along with members of various police services, physicians, allied health services, nursing and other emergency first responders were in attendance, so it was a very engaged and informed audience.

While his experiences working with the military and policing services has provided him with an extensive background in the subject of PTSD, Peter indicated that it was not going to be possible to address everything that is known about this disorder, as it is a complex and evolving field of study.

It is well-known that the condition currently referred to as PTSD has a long history throughout both ancient and modern conflicts, and has had many labels including “war nerves”, “combat stress”, “nostalgia”, “physical exhaustion”, and “shell shock”, amongst others. During the Crimean conflict it was believed that the problem was linked to a heart disorder. Peter recommended a recent book by Mark Osbourne Humphries entitled “Weary Road” as an excellent study of PTSD in Canadian soldiers in World War One.

In the post-Vietnam period, the American Psychiatric Association (AMA) had settled upon the PTSD nomenclature in the Diagnostic and Statistical Manual of Mental Disorders (DSM), used by clinicians and researchers to diagnose and classify mental disorders. Over time, the definition of what constituted PTSD began to widen, and there is an ongoing professional discourse regarding what constitutes PTSD as...
PTSD, also sometimes referred to as combat stress, is, at root, an extended activation of the built-in ‘fight or flight’ reaction when a human encounters a threat or real danger. This reaction triggers the nervous system to produce a biochemical or hormonal reaction – and this is entirely normal. In many cases, this response ceases when the stressors are gone i.e. the threat or danger ceases. In other cases, however, the reaction continues and may develop into PTSD – how and why this happens, and why it happens in some people and not in others, is not fully known.

In some cases, stresses may accumulate over time, either in response to a specific incident, or as a result of repeated exposure to threatening or dangerous situations (or other highly negative or unpleasant scenarios, such as witnessing dead bodies). Initially, people who are affected may respond normally but the cumulative stress may, over time, impair their ability to concentrate, their mood, or even their view of life. Some policing specialities are particularly prone to this type of problem, including those who work in child exploitation or child pornography, and crime scene and hit and run investigators. But as stated previously, there is no predictive means of determining which specific individual(s) will be susceptible to PTSD.

Research undertaken in the US following the Iraq war followed the health outcomes of military personnel with PTSD five years after their military duty ended, and found actual physical changes were also present. For example, some of those suffering from stress also presented cardiac problems and cancers. In many instances the PTSD symptoms included an inability to cope with their lives, a loss of personal control and poor memory. People with PTSD often perform poorly on the job and, in the case of policing, may be prone to making bad decisions which can lead to shooting at inappropriate targets. This is less common in officers who are trained for police tactical units, or in the case of the military, special forces operators. In some cases, these problems were exacerbated by poor choices in lifestyle, including poor eating habits leading to diabetes, or overuse of alcohol as a form of ‘self-medicating.’ Some research has shown that stress can actually alter the form of brain neurons themselves, and Dr. Collins illustrated this in a visual slide.

Dr. Collins highlighted the fact that human reactions to stressful situations is a normal condition. While some short-term symptoms may be similar to PTSD (such as nightmares, persistent thoughts about the incident, insomnia and so on), these will normally last for approximately two to seven days and, indeed, the goal in Afghanistan was to return such personnel to active duty within seven days. The key to success is to not identify them as ‘ill’ or stigmatize them in some way, rather, to acknowledge the temporary condition as just another form of injury.

As mentioned previously, the study of PTSD within the field of psychiatry is a complex one. While preparing to write this article I reviewed the AMA website and found 67 books and numerous articles on the subject of PTSD on offer; no doubt many more may be found in other sources. Much of the discourse centers on what Dr. Collins identified as inclusion and exclusion criteria, in other words, what symptoms should be classified as constituting PTSD or not.

The American DSM referred to earlier is considered a significant resource for practitioners and researchers, but is not in itself definitive. That said, it is clear that the definition of PTSD has ‘widened’ over time to include not only stress resulting from direct, that is personal threats or personally witnessing an encounter, but learning that an event has happened to someone else, or repeated exposure to stressful situations.

There are many symptoms which are common to people suffering from PTSD. These include recurring distressful memories, physiological reactions such increased heart and pulse rates, profuse sweating, an inability to express themselves and poor concentration. Often these reactions are caused by internal or external triggers, although disturbing thoughts may manifest without any apparent trigger present. Many people with PTSD will make efforts to avoid triggers that may remind them of the source of the stress. In spite of this, people with PTSD may have negative alterations in mood, a negative belief system, a belief that they will have a short lifespan, depression, a loss of interest in normal day to day activities and hyper vigilance that may cause them to avoid crowds or other situations, even family. Acting out in anger, or pursuing reckless behaviours is also a common product of PTSD. It is also clear that people may be more at risk to self-harm, panic attacks, and overuse of alcohol. Dr. Collins reiterated that it would not be possible to discuss all possible symptoms of PTSD simply because every case is different.

Fortunately, the medical profession is getting better at treating PTSD, and different approaches to therapy, such as exposure therapy combined with certain medications, are having positive results. One of the most impactful approaches over time is ‘talk therapy.’ Education is also a critical component. Soldiers need to be made aware of what PTSD is, how to detect it and where and how to find assistance. Awareness of normal post trauma stress indicators should be a routine part of any pre-deployment training. While clinical support for post trauma recovery may be necessary in some instances, the availability of peer support is also a key recovery tool. Education, resilience training and exposure to PTSD as a risk...
is all helpful ahead of time. While some employee assistance programs and military wellness programs are also valuable, there is, as he stated at the outset, no means of determining who will or will not be susceptible to PTSD, and no ‘cookie cutter’ solutions – every individual is different.

Ryan Dermody followed Peter Collins and his presentation focused on how services for veterans suffering with PTSD could and should be improved in Canada. The model cited for having a very good approach to supporting veterans is in the UK and is a charitable organization entitled Combat Stress. This community-based organization focuses on personalized treatment programs, both residential and non-residential, which are essentially veteran-led. It has been found that veterans who are suffering with PTSD are more inclined to engage with other veterans at the outset of treatment, rather than with physicians or psychiatrists. Residential programs can be three to six weeks in duration, and the program is designed to reinforce the kind of ‘regimental bonding’ that veterans would have been familiar with while in service.

While the program operates under the auspices of the National Health Service (NHS), this is not a disadvantage, as all medical services for veterans in the UK are under the NHS umbrella. This contrasts with the Canadian system which is bifurcated between the federal level i.e. Veterans Affairs Canada (VAC) and the provincial ministries of health. There is often a breakdown between these levels and agencies and veterans may end up waiting for months for appropriate treatment services. For some veterans who have strong support networks and solid financial footing, these gaps may be overcome for a period of time. Too often, however, this is not the case, and many veterans who are suffering with PTSD become homeless, addicted or commit suicide.

The U of T study referred to at the outset of the article focused on the advantages of a creating a similar organization to Combat Stress here in Canada, and that study is now complete. It was found that, unlike the UK, Canada has only one residential treatment centre (in Montreal), and maintains only ten residential beds for the entire country – clearly an unacceptable state of affairs. The study also found that peer support services for veterans suffering with PTSD is vital.

One interesting and important element regarding the study was the high level of support it received from corporate Canada. Corporations donated significant funds to support the study, and the donor list is indeed impressive. Ryan ended his presentation with a reminder to all that Canada has a moral obligation to support our veterans, and that the current system is inadequate to address the problem of PTSD. The next step is to engage the federal government in order to try and actualize the results of the study and establish an effective, coherent, responsive, national program to help veterans suffering from this devastating disorder.

Dr. Daniel Derek Eustace, CD is Director of the RCMI Defence and Security Studies Program.
mission for reserve forces. In general, post-mission mental health services for reservists are provided by their military, veteran's organizations, national medical systems or some combination of these organizations.

Interestingly, there are only a select handful of countries which engage the military, family and employer in addressing post-mission mental health issues. Estonia, for example, indicated that the Estonian Defence Force psychologists, in conjunction with the family and with the permission of the reservist, the employer will work collaboratively to alleviate psychological injuries. New Zealand also highlighted that the family is usually involved in post-deployment psychological debriefs, and while employers are not routinely involved, they can be if the need arises. However, it was noted that this collaborative effort is difficult to organize due to apprehension that the injured reservist will be perceived negatively by others. The Czech Republic acknowledged that the deployment cycle created significant stress on reservists and those close to them. In light of this, a model that takes into account the entirety of the deployment experience – from pre-mission, to deployment, to return – was created. This treatment framework is supervised by Department of Operational Psychology of the Military Health Agency, created in 2013. This department gives psychosocial help to members of the Czech Ministry of Defence and their family. This aid can be accessed in a variety of different ways, including via counselling centres, by telephone or email.

An idea that took root in the United States Army as a result of their operations in Afghanistan and Iraq was that of holistically preparing members for operations and training by increasing mental and physical readiness and resiliency to stress through better lifestyle. These concepts also gained credence in the Canadian Army. Approaches to achieve better sleep, physical activity, nutrition, and spirituality have been put together as a resiliency program. These skills are taught and reinforced at the individual and unit level, with introductory packages being given to entry-level combat arms officers and, in some locales, soldiers. At this time the program is not being consistently applied across Canadian Army training centres and schools. Despite that, the intent is to systemically integrate this approach into the formal training system and at the unit level for all active and reserve elements. By implementing this approach, it is hoped that physical and mental health issues that may occur during deployment will be reduced, with positive effects for both individuals and their units during the post-mission period. The Canadian Armed Forces is in the process operationalizing an equivalent to this Canadian Army initiative.

Also, Canada has created institutional mechanisms that can assist leaders in dealing with the stress of operational conditions. These arrangements may also bear fruit in the post-mission phase. A relatively new concept is that of the “command team”. This is a grouping of a commander with a corresponding non-commissioned officer. While the non-commissioned officer does not share the function of command, they support the commander in exercising it and provide a sounding board for discussion and experienced advice. In the Canadian Army this type of relationship between officers and their non-commissioned officers existed informally prior the articulation of the command team concept; however, it is now institutionalized.

By and large military support to reservists during the post-mission phase varied in terms of how nations deploy their reservists. If one tended to use reservists to augment active duty forces, a structured checklist approach seemed to be the most common manner of ensuring that all military aspects of post-mission reintegration were carried out. Many NATO countries process reservists and active duty personnel similarly for post-mission return. Another perspective is that of the United States, which deploys large numbers of individual reservists, reserve units and formations, and therefore has a holistic and layered series of activities addressing many aspects.
of military, family and employer reintegration. Less elaborate, programs exist in other countries.

The United Kingdom offers decompression services and they monitor reintegration with the family and employer in order to assist the reservist with a return to society. There is a baseline set of policies that have to do with such things as decompression time with family before returning to work, as well as information sharing with the family and the employer. Government veteran services provide reintegration support to help veterans re-establish themselves. Communicating all of that which is offered in the post-mission phase is key to ensuring that the reservist and their family is aware of what is available. Finally, there is always an obligation to deal with any health issues that may arise during the deployment.

The United States Department of Defense utilizes the nation-wide Yellow Ribbon Program. This program is intended to address the needs of American national guard and reserve forces. It connects the reservist and their families with resources that they require throughout the deployment cycle – from pre- to post-deployment. Similarly, Norway offers a 12-month post-mission program for all military, reserve and active, which includes: the provision of information from before through to after the deployment; a mandatory decompression program of three to six days after the mission; a medal ceremony; a medical screening three to six months after deployment; two to three mandatory post-mission interviews after 12 months; and, support to families up to 12 months after returning from the mission. Hungary provides a “regenerating rest” in the post-mission phase designed to assist with the strengthening of mental and physical health. They can do this alone or with their families. In Hungary there are no other formal reintegration mechanisms. In general, countries who continually use reserve forces have national oversight on all phases of the mission.

It was apparent that there are sometimes few mechanisms to track and monitor reservists after redeployment. In fact, Italy stated that when reservists, who for the most part deploy within active duty units, return they lose oversight and it is only through informal contact with their deployed unit or through military personnel staff that engagement is, at times, maintained. Whether tracking of this nature is required is a question that is yet to be answered. One suspects that it will depend on individual national situations in how reservists are employed during and after a mission. Those who deploy reservists as individuals and have little formal oversight post-mission may have more need for this type of post-deployment accountability mechanism than others.

Family

Access to medical and psychological resources, as well as decompression time, are not only important to the individual reservist but also to their family. The latter could include leave or vacation time. Also, recognition of the reservists service in a way that includes the family can be of great value in the post-mission phase. Denmark recognizes reservists in a manner which involves the family and community is seen as critical.

Of primary importance, however, is information and communication. Denmark provides literature, counselling and support to reservists prior to reunification with the families to assist with creating a positive homecoming. Another alliance nation, Germany, ensures the connections between positive military service and the family are maintained through a formal structure. This network provides links to other reserve families and specially trained military personnel who can provide many types of support. The philosophy underpinning this idea is that by creating confidence in the mission and providing national support, a positive family climate will be encouraged.

Australia gives a considerable degree of military support to all its personnel, both active and reserve, in the form of programs and professional advice. This service is also extended to families throughout all phases of a deployment and into the post-mission time. Like many countries, this assistance is the same for both active and reserve duty military members. A military member is psychologically screened prior to returning, and again three to six months after returning, and families can be involved in treatment or counselling if the military member agrees. Importantly, along with this help, there are a host of experts who assist families throughout military service.

Similarly, Belgium provides active and reserve families with the same services, information sessions about the deployment and pending return. In addition, the Ministry of Defence provides access to mental health advisors or other relevant services if needed. New Zealand offers systemic post-mission reserve family assistance only when reservists were deployed on a regular basis.

Employer Support

Many NATO countries rely on constant liaison and contact with employers to assure reservist availability for military service and assist with post-mission protection of employment. Denmark has had an employer support program that provides this type of help in place for two decades. However, it has been observed that this non-legislative program is still evolving to deal with the changes produced by the deployments of recent years. Their goal is to encourage Danish companies to develop a culture that can work with employees who are “twice the citizen.” Some, like Canadian Valerie Keyes, argue: “…that no legislation, compensation or other incentive can replace the goodwill that employers (and educational institutions) demonstrate towards their Reservist employees or student Reservists.” This perspective is reinforced by French researcher Guillaume Lasconjarias, who also argues for a wide range of programs to provide a multifaceted approach to obtaining employer support. Consequently, the reliance
on non-legal mechanisms, like financial compensation and dialogue, to ensure reservist re-employment, predominate.

In Canada, there is a good balance between job protection legislation and Compensation for Employers of Reservists Program (CERP) where employers are paid to release their reserve employee(s) for duty. The CERP program not only entices the employer to release that employee, it indirectly ties the employer to the success of the Reservist’s military career all the while making them part of the defence and security posture of the nation. Without supportive and willing employers, Canada would not be able to sustain the deployment of reservists. Sweden has in fact taken this to the next level with their ongoing project to integrate all relevant sectors of government and industry in the defence of the nation. For some nations, it is better to entice employer cooperation than force compliance through legislation.

Formal employment protection takes different forms in various countries and supports the employment of reservists. These legal policies normally have three general principles: (1) employers cannot treat a reserve force employee any different than an employee who is not a reservist, (2) employers cannot impede their employees from reserve service and may be obligated to provide them with time off to fulfill reserve duties, and, of importance for the post-mission period, (3) once the reservist returns to work they must be reinstated without loss of benefits or pay. The United States is a well-known example of a country that has a wide-ranging legal framework that provides for employment protection. Notably, among various legislation is the Uniformed Services Employment and Re-employment Rights Act (USERRA), which includes all these elements to safeguard reservists.

There are international and national groups that encourage employers to support reservists. The International Conference on Employer Support for the Reserves (ICESR), is an informal grouping of nations with aligned interests concerning the military and national potential of reserve forces. In a like fashion, there are national organizations that assist with interfacing between reserve force employees and their employers. The Netherlands provides an example of one such employer support program for that deals with regular operations and training, as well as deployments. It promotes the employment of reservists with existing employers by highlighting strengths they bring to the employer and providing potential employers with information that elaborates on the benefits of employing reservists. There are organized visits with reserve forces to view the service that they perform. In addition, there is financial compensation for employers during deployments of greater than three months, as well as annual awards for employers supportive of their reservists.

Conclusion

A successful deployment consists not only of transitioning the reservist to full-time service but also reintegrating the individual back to their reserve unit, family and employment. This post-mission area needs more study regarding how it affects NATO reserve forces. Further reinforcing that observation is that many countries studied treated active duty and reserve forces the same as regulars in terms of re-integration post-mission with no data to support that methodology. Also, similarly, there were no specific programs or data with regards to family and employer support, or factors affecting reserve retention after a deployment. It is evident from the lack of much formal scrutiny that this reserve topic has generally been neglected in terms of gaining understanding by most countries. The one notable exception to this lack of research into post-mission aspects of reserve service is the United States which has invested consider resources into investigating this subject. This can be explained as the need to understand how to prevent erosion of reserve capabilities in the context of reoccurring reserve force deployments. Along with this, it would be helpful, for future reference, if countries could enter specific lessons pertaining to reserve force deployments in their national lessons learned system, and share that data, along with any reserve force deployment studies.

Retaining reservists for future operations requires a holistic approach – it’s not simply about the pre- or post-mission periods or the deployment itself but all three, taking into account the discursive relationship between the military, family and employer in support of their reservists. The focus of all of this work is to prevent the degradation of NATO reserves by maintaining their force levels and their ability to support NATO operations. Accordingly, the emphasis is not solely upon enabling reservists to be available prior to a mission and supporting them during the deployment, but also successfully transitioning them during the post-mission phase. New Zealand succinctly articulated the desired objectives of that post-deployment period by stating that success or failure will be defined by the attainment of reintegration with family, employers and reserve units – reconnecting to normal family routine, demonstrating value to their employer and bringing new skills to their units. While the processes related to the attainment of these goals may look different for the various NATO nations the end result for all is that the reservist has received the necessary support, to allow them to re-engage with family, employer and military and is available to again deploy if the need arises.

The original submission of this paper has been edited for length and citations have been removed for ease of publication. The original version of the paper, along with all citations, are available from the Editor of SITREP upon request.

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High Command Responsibility for Canadian Armed Forces Members’ Health

by Brigadier-General Marc Bilodeau, CD

Introduction

The recent Canadian Armed Forces (CAF) refocus on people has highlighted the importance of human resources as the most crucial resource of a military organization. There are numerous opportunities to optimize this precious asset and health is an area where improvement is possible. More than a thousand Regular Force members are released from the military in any given year, many of them because of preventable illnesses or injuries.

CAF members’ health is a shared responsibility between the member, the Canadian Forces Health Services Group (CFH Svcs Gp) and the chain of command (CoC). This article will argue that the latter is the most critical part of this equation, and that the military organization is ideally structured to influence members’ health through its leadership, which starts at the highest level of the institution.

Health and Readiness

Health has many components all as important in what constitutes total health which closely influences readiness, a critical aspect of military organizations. Health is influenced by several factors, in addition to genetics and life habits, known as determinants of health, which interrelatedness makes health a complex notion. These determinants have been adopted by the Public Health Agency of Canada and include:

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Gender
11. Culture
12. Race / Racism

The concept of total health described as “a dynamic state of wellbeing characterized by a physical, mental and social potential,” has also emerged over the last decades. In the Canadian military context, health goes beyond the period of service and is approached from a lifelong perspective.

The concept of resilience has also gained traction lately in several contexts. Resilience is defined as “the capacity to recover quickly from difficulties.” It is closely linked to fitness, which is defined as “a state of adaptation in balance with the conditions at hand.” These two concepts are influenced by many domains such as: “medical, nutritional, environmental, physical, social, spiritual, behavioral, and psychological.”

Both resilience and fitness are interdependent with the notion of health. Finally, someone can be fit to achieve a task but still be unhealthy, which could impact his or her resilience negatively. As well, a disability for which an individual has been able to compensate does not mean that this person is unhealthy or even unfit as is the case of an amputee who is fully functional and likely highly resilient.

Readiness is defined as “the quality or state of being ready.” In a military setting, readiness means having “enough of the right types of skilled and adequately trained personnel, and [...] adequate stocks of equipment in good working order.” This definition does not, however, capture well the qualitative component of readiness. A more useful definition might be: “a combination of a soldier’s willingness and ability to do his job and cope in peacetime and during combat.”

Linking Health to Military Readiness

Based on the definitions of health, resilience and fitness proposed above, it is easy to draw parallels between these concepts and the one of military readiness. We can, therefore, argue that the social determinants of health as much as the resiliency and fitness domains are also factors of readiness.

There is also historical evidence that readiness is negatively impacted by non-optimal health. From several recent conflicts, we know that about 80% of hospital admissions are a consequence of diseases and non-battle injuries, many of them preventable. The conclusion is, therefore, that the better the total health of its serving members, the higher is its readiness as a military organization. In other words, the healthier the soldiers of a nation are, the more likely is its military to have superiority over its adversary.

The cost of poor health cannot be ignored, either. As an example, obesity, which has significant linkages with personal life habits, is a predisposing condition for many diseases, such as high blood pressure, diabetes, heart disease and osteoarthritis. Taking into consideration the costs associated with treating obesity in addition to the medical diseases resulting from this condition, they quickly add up and therefore result in a significant financial impact preventing the CAF from using these funds somewhere else, thus indirectly impacting readiness.
Responsibility for Health: Individual Member

As described in the Surgeon General Integrated Health Strategy, “CAF members and their families must be fully engaged as a partner in their health, preventing illness and injury and participating actively in their treatment and recovery when they are unwell, so that they can improve their quality of life, long-term wellbeing and resilience, as well as their operational readiness.”

Member engagement is critical in achieving better health, and this is independent of the health services offered by the CAF. The military code of conduct as described in Duty with Honour expects each CAF member “to be held accountable for his or her performance, always acting in compliance with the law and maintaining the highest standards with respect to all the professional attributes.” One of these attributes is physical fitness. This shift towards a higher level of engagement of members is also part of a new health care approach linked with better outcomes that the CF H Svcs Gp has adopted under its Patient-Partnered Care Framework.

Responsibility for Health: Health Services Group Responsibility

The Canada Health Act excludes CAF members from the provincial responsibility to provide health services to their citizens. This exclusion triggered the requirement for the CAF to create its own health care system. The Chief of the Defence Staff (CDS) has assigned to the Chief Military Personnel, the functional authority for health and dental services. The National Defence Act is silent regarding health care. Chapter 34 of the Queen Regulations and Orders (QR&O) states that “the senior medical officer at all levels of command is the responsible adviser to the senior officer exercising the function of command or executive authority on all matters pertaining to the health and physical efficiency of all personnel under his jurisdiction.”

By extension, the Surgeon General, the most senior CAF physician, is the health adviser to the CDS. In addition to being responsible for providing health advice, the CF H Svcs Gp is also mandated to provide health services, including deployable capabilities in support of CAF operations. Its mandate is, therefore, similar to the Canadian provinces and territories’ responsibility to provide care to their citizens. Based on the
Canadian Medical Association, the lack of access to health services, however, represents only 25% of what makes Canadians sick. This means that there are several other ways to improve health other than providing health care.

Instead of being a reactive system which provides care to ill and injured personnel, the CFH Svcs Gp has therefore favoured programs to prevent illnesses and injuries and promote healthy lifestyles. Strengthening the Forces (StF) is a voluntary health promotion program delivered on CAF bases and wings focusing on areas like addiction, injury prevention, inactivity and social wellness. The CAF, therefore, has, on behalf of the Government of Canada, a health promotion and prevention responsibility for its members, similar to the Public Health Agency of Canada for Canadians.

The QR&O also state that “a commanding officer is responsible for the whole of the organization and safety of the commanding officer’s base, unit or element.” The CFH Svcs Gp supports the CAF leadership in meeting these critical Force Health Protection functions, as a sub-component of Force Protection, a concept “essential to operations – and, therefore, a clear responsibility of command.”

Responsibility for Health: Command Responsibility

In his Guidance to Commanding Officers (CO) and their Leadership Teams, the CDS intent is expressed as: “The CAF must be fit to fight. COs and their leadership teams are responsible for the promotion of health and fitness within their units. They will vigorously promote physical activity, recreation, and sports, and actively support CAF injury prevention, addiction awareness and prevention, nutrition and social wellness programs, working closely with our medical professionals to develop and maintain the climate of trust and understanding required to support healthy lifestyles.”

The document also addresses the mental health aspect of the command responsibility in saying that “COs and their Leadership Teams contribute to mental health and resilience by knowing their personnel, ensuring that their people are mentally prepared for the tasks assigned to them and have the fitness, sleep, rest and recreation opportunities required to manage stress and maximize effectiveness.” It finally highlights the importance of creating a climate of trust and confidence in facilitating access to health services.

The leadership team’s obligation regarding members’ health is also mentioned in several other doctrinal documents. The QR&O give a specific role to the non-commissioned members in promoting “the welfare, efficiency and good discipline of all who are subordinate to the member.” Duty with Honour assigns to the profession of arms the responsibility to “ensure the care and well-being of subordinates.” The Conceptual Foundations of the Leadership in the Canadian Forces identifies member well-being and commitment as one of the three value dimensions critical to effectiveness and mission success. This notion is expanded further in Leading the Institution by calling for a transformation to a culture of understanding where “leaders emphasize proactive influence behaviours such as facilitation, support, participation and delegation” instead of a culture of rules-based compliance. The latter also links members’ quality of life with optimal performance.

CAF members also have a moral responsibility towards Canadians expressed as “honouring the social contract is essential to maintaining legitimacy in the eyes of the public.” This societal framework between Canadian people and military personnel is considered both as “the anchor of the personnel management framework and a fundamental change driver.” That unique relationship stems from the CAF members’ willingness to put the needs of Canada and Canadians before their own. The expectation of the members is that they will be given appropriate benefits and support for themselves and their family. “This social contract is an unbreakable common bond of identity, loyalty and responsibility which has sustained the military forces of Canada throughout their already significant involvements on the world stage.”

There is, however, a tension between the mission and the wellbeing of members. This friction, under the umbrella of the unlimited liability concept, will sometime force commanders to have their subordinates in harm’s way, therefore, putting their health at risk. This tension drives the constant requirement of military leaders to “balance mission accomplishment with member well-being in challenging operational contexts and in situations where there is incomplete information, rapidly changing circumstances, and no right answer.”

The obligation of operational effectiveness and accomplishment of the mission assigned by the Canadian government cannot be ignored and “is the fundamental criterion against which all personnel functions and supporting policies must be developed and evaluated.” It requires the delicate balancing of the individuals’ needs with the collective ones. “This balance makes the personnel management system extremely complex and challenging to manage.” Such tension was reaffirmed by the current CDS when he launched Operation Honour in 2015 and affirming, “People First, Mission Always.” This focus on people was also confirmed by making the first chapter of the Strong, Secure, Engaged (SSE), the one about people.

Improving Health to Manage Readiness

Despite all the conditions being in place to ensure a CAF optimal health and fitness level, the current health status of the CAF and its negative trends in the last few decades are not encouraging. The most recent Health and Lifestyle Information Survey revealed that the overall perceived health status, health-related activity limitations, chronic conditions, and rate of acute injuries from the surveyed members, have not
changed compared to previous surveys.

Members, however, still spend a significant amount of time away from work; 18.4% of Regular Force members had missed a minimum of a day of work as a result of illness or disability in the month before the questionnaire was answered. This number translates to about eight workdays per year, which is above the Canadian population average of 7.7 days.

Stigma related to mental health issues, while significantly reduced, still exists. Only 60% of personnel who contemplated suicide in the previous 12 months sought mental health support, and only 50.9% of those knew where to find help after hours. As well, a significant proportion of CAF members are still engaged in high risk or harmful drinking activities.

The survey has also shown an increase in repetitive strain injuries from 22.6% to about one third. Two thirds of members have engaged in unsafe physical training practices, of which 12.5% resulted in injury. Obesity and overweight rates (25% and 49% respectively) have also increased in the last ten years. The smoking rate is otherwise steadily decreasing, but 18.5% of the current smokers started smoking after joining the CAF, 57.1% during basic training.

There seems to be a better awareness of StF programs but mainly for the 40 to 60-year-old group. The 18 to 29-year-old group does not appear as responsive at adopting healthy lifestyle changes. The number of hours spent on sedentary activities increased by more than 3 hours since the previous survey, and 6 hours from the one before. Finally, only 28.7% of personnel consumed more than six servings of vegetables and fruits per day, and more than half of the members underestimated Canada’s Food Guide recommendations for this food group.

**A Proposed Way Forward**

Based on previous successes such as in reducing stigma related to mental health issues or improving smoking rates, evidence supports that changing behaviours is possible. We also know from former senior commanders’ attempts to improve health and wellness within their command, that top leadership involvement and buy-in are critical for success. A few examples are the Canadian Army Integrated Performance Strategy launched in 2015, and the Royal Canadian Navy Health and Wellness Strategy implemented around 2012, some of which has led to significant improvements.

Over the last few years, the stars seem to have aligned even further, starting with the release of a strategic initiating directive by the CDS and the deputy minister of National Defence on total health and wellness in January 2017. This direction was then reinforced in SSE in which $198.2 million was promised to “favour a more comprehensive approach to care – known as “Total Health and Wellness” – and will consider psychosocial well-being in the workplace, the physical environment, and the personal health of members.” It further adds that it will: “support health and resilience; promote a culture of healthy behaviour; and support military families.” A strategic framework is currently being developed, of which current draft addresses the crucial role of leadership in such an endeavour.

Finally, BALANCE, the CAF Physical Performance Strategy was just released and focuses on key elements such as “be trained and fit, properly fuelled, well-rested, and free from injury” that drive performance and operational readiness. Physical activity, nutrition, sleep and injury prevention constitute the Performance 4 (P4) behaviours as the foundation of this strategy. It also recognizes the importance of building a culture of fitness with appropriate policy, social and physical environment to support it. As well, it highlights the accountability shared between the institution, its leaders and the individuals for achieving the desired outcomes. Finally, it relies on a decentralized execution of this central commitment by allowing each Level 1 command to provide its directions on its implementation with the aimed of having a more targeted approach to each subgroup of CAF members.

**Conclusion**

The recent CAF refocus on people has led to the release of several strategic documents that align on a shared purpose for improving the health of the CAF population, thus operational readiness. This alignment creates the perfect conditions for coordinated actions. While health is a shared responsibility between the members, the CF H Svcs Gp and the CoC, the CAF leadership is the critical component of this equation.

Improving CAF health requires a robust measurement framework allowing for real-time monitoring of the health status. It also calls for a culture change towards health and wellness by opposition to disease and sickness and appropriate incentives to support such an approach. As well, a refresh of the military ethos to ensure its relevance for the younger generations is required.

Finally, and, perhaps, most importantly, a strong and sustained leadership commitment will be an essential component of success. The voices of senior commanders still need to be heard to maintain the momentum established by the strategic documents released lately. But, more importantly, it requires actions, offering powerful role models to subordinates. Only then, will CAF members behaviours be influenced in support of better health and improved readiness.

This paper was written in order to satisfy a course of instruction at the Canadian Forces College (CFC) and is printed here with the kind permission of the author and CFC. It has been edited for length and citations have been removed for ease of publication. The original version of the paper, along with all citations and the bibliography, are available from the Editor of SITREP upon request.

Brigadier-General Marc Bilodeau, CD is the Deputy Surgeon-General of the Canadian Armed Forces.

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The Canadian Institute for Military and Veteran Health Research (CIMVHR) was founded in 2010 with a vision of maximizing the health and well-being of Canadian military personnel, Veterans and their families through world-class research resulting in evidence-informed practices, policies and programs. Every day, CIMVHR strives to enable more of Canada’s military, Veteran and family health research requirements to be met; enhance the accessibility of this research; and engage with stakeholders to foster collaborations, which supports increased research and improves knowledge translation activities.

Enable more of Canada’s military, Veteran and family health research requirements to be met.

There is a need for Canadian research that addresses health protection and care across the life course of those who serve Canada in demanding environments, as well as research related specifically to the transition from military to civilian life. There is also an increased awareness of the need to provide relevant research related to families of those who serve and have served. Since its inception, CIMVHR has received over $19M in research funding to advance the field of military, Veteran and family health, leading to improved outcomes for this population.

Since 2010, CIMVHR has built a network of 43 Canadian universities who have agreed to work together to address the health research requirements of Canadian military personnel, Veterans and their families. The institute acts as a conduit between the academic community and research funding organizations. To date, CIMVHR has awarded 92 tasks to researchers in its network to fund projects aimed at advancing the health research requirements of this unique population.

CIMVHR’s role in advancing this field is well illustrated when it comes to military and Veteran family health research. A decade ago, there was only a small handful of family health research presentations at CIMVHR’s annual research Forum. Over the years, this number has grown to where there are full sessions dedicated to this population. In 2017, CIMVHR and King’s College London co-hosted an invitational roundtable on military family research. It was evident through discussions that there was a need to define the term “military family.” Responding to this need, a second roundtable was held later that same year to discuss the definition of “military family” and the content of the now published (2018) CIMVHR technical report, What does the term Military Family mean? A comparison across four countries.

CIMVHR plays an important role in growing the field of military, Veteran and family health research by facilitating sessions that bring thought leaders together to advance emerging research, such as suicide prevention for military personnel and Veterans. As an organization operating at arms-length from government, CIMVHR is ideally placed to assist in engaging the whole community in evidence-based suicide prevention for military personnel and Veterans. In May 2018, CIMVHR hosted the inaugural suicide prevention workshop to begin the process of bringing together academia, military personnel, Veterans, public safety personnel, their families, and public and private sector organizations. The objectives of the roundtable were to (1) start a discussion on suicide prevention in military personnel, Veterans, and public safety personnel; (2) share suicide prevention knowledge and practices; (3) start developing a “whole of community” approach that all stakeholders can take part in; and (4) explore next steps. A subsequent meeting in May 2019 allowed for a continuation of this vital work and placed an emphasis on leading by example. A CIMVHR technical report documenting the proceedings of the May 2018 workshop was published in December 2018. Outcomes of the May 2019 workshop are in the process of being consolidated into a report.

Over the last ten years, CIMVHR has been striving to enable more of Canada’s military, Veteran and family health research requirements to be met. CIMVHR's strength at harnessing the national capacity for research has led to the administration of numerous research contracts with various funding organizations as well as the advancement of emerging research through sessions that facilitate bringing thought leaders together. Through research, CIMVHR aims to maximize the health and well-being of Canadian military personnel, Veterans and their families leading to evidence-informed practices, policies and programs.

Enhance the accessibility of military, Veteran and family health research.

CIMVHR has a network of over 1,700 researchers whose research interests improve the health and well-being...
of military personnel, Veterans and their families. Translating the research outcomes of this network to policy-makers, practitioners, students, the global research community, and interested parties primarily happens through the Journal of Military, Veteran and Family Health (JMVFH); the annual CIMVHR Forum; and CIMVHR’s annual graduate course.

JMVFH, the official journal of CIMVHR, is an online, open access, peer-reviewed scholarly publication. Its aim is to maximize the health and social well-being of military personnel, Veterans, and their families by publishing world-class research for a broad international and multidisciplinary readership of researchers, health practitioners, administrators, and policy makers. The barrier-free, no fee model of this journal facilitates a concerted effort to provide the most relevant research to anyone who wishes to access it.

CIMVHR’s Annual Military and Veteran Health Research Forum is heading into a milestone year. This October, will mark the 10th year CIMVHR has hosted this international event. CIMVHR Forum is where delegates from around the world gather to hear about leading research in the field of military, Veteran and family health. Each year, CIMVHR Forum brings together academia, government, industry, philanthropy, clinicians, and decision-makers to improve the lives of our serving members, Veterans and their families. Forum also offers workshops designed to engage and develop emerging research fields. CIMVHR Forum is the premier event bringing the latest military, Veteran and family health research to those who develop practices, policies and programs.

Each year at CIMVHR Forum, emerging scholars in the field of military, Veteran and family health gather at the Annual Student and Post-Doctoral Engagement Committee (SPEC) Networking Event. SPEC is a peer-support network that empowers the next generation of researchers and promotes networking opportunities among graduate and post-doctoral students in military, Veteran and family health. CIMVHR established SPEC in 2016.

Leveraging the growth in the area of military and Veteran family health research, the formation of a new multi-disciplinary working group dedicated to military family health research was announced at CIMVHR Forum 2018, Innovation to Impact: Translating Military Family health research into practice. The working group, a collaboration between Calian Group Ltd., Military Family Services, The Vanier Institute of the Family and CIMVHR, is striving to make military family research more readily accessible and available to Canadian health care providers and military families.

In addition to all these knowledge translation activities, CIMVHR offers an annual graduate course in the fall semester through both the Royal Military College of Canada and Queen's University. Students from across CIMVHR’s network of member universities are encouraged to register for this online course where they will have the opportunity to hear from an expert guest lecturer each week. The course is an introduction to military, Veteran and family health research providing students with a foundation for health-related issues associated with experiences unique to military populations.

CIMVHR’s work to enhance the accessibility of military, Veteran and family health research is demonstrated through various knowledge translation and education activities, including CIMVHR’s open-access Journal, JMVFH; CIMVHR’s Annual Military and Veteran Health Research Forum; and CIMVHR’s graduate course.

Engage with stakeholders to foster collaborations, which enables increased research and improves knowledge translation activities.

Engaging with the individuals and organizations who can play a role in advancing the health of our military, Veterans and their families is at the core of the work we do. With a Canadian population of 60,600 military families, 71,500 primary force members, 30,000 reserve force members and 649,300 Veterans, there is an inherent need to advance health research for our nation’s heroes. CIMVHR is only able to begin to meet this need with the generous support of its funders from government, industry and philanthropic organizations. This support translates to research, scholarships, JMVFH, conferences, and day-to-day operations of the institute.

On July 10, 2019, the Minister of Veterans Affairs Canada, the Honourable Lawrence MacAulay announced the Government of Canada will provide funding to CIMVHR in the amount of $25M over 10-years. This funding recognizes the importance of research and the impact it has on Canada’s military personnel, Veterans, and their families. The announcement was held at Queen’s University and attended by local stakeholders, including Veterans’ organizations, CIMVHR staff, Royal Canadian Mounted Police, and Canadian Armed Forces representatives. This funding succeeds Health Canada’s $5M contribution to CIMVHR. At CIMVHR Forum 2014, Health Canada announced their 5-year contribution, which will end on March 31, 2020. The funding provided from the Government of Canada through both Health Canada and Veterans Affairs Canada has been instrumental in providing CIMVHR with a solid foundation to grow military, Veteran and family health research in Canada. The long term sustainable funding will afford CIMVHR the opportunity to continue its operations, supporting the health research for Canada’s military personnel, Veterans and their families.

In 2012, CIMVHR entered into an agreement with Public Services and Procurement Canada (PSPC) to support the recruitment of specialized research teams to conduct research, which fulfills requirements for Defence Research and Development Canada (DRDC), Canadian Forces Health Services Group (CFHS) and VAC. To date, CIMVHR has
administered more than 70 tasks through this agreement. It is through agreements such as this that CIMVHR is able to remain at arms-length while mobilizing its network of university members to fulfill the research needs for DRDC, CFHS and VAC.

Through the joint efforts of CIMVHR, IBM Canada Ltd. and Babcock Canada Inc., the Advanced Analytics Initiative was established in 2017 to fund cutting-edge research using ‘big data’ analytics, machine learning and other novel approaches to health solutions for Canadian military personnel, Veterans and their families. The goals of this initiative are to further the understanding and management of complex health issues that result from military service, enhance the development and consolidation of relevant research datasets and support broader collaboration between academia, industry and government focused on these important Canadian populations. This initiative will also support research that drives new skillsets and develops “Highly Qualified People” (i.e. post-doctoral fellows, doctoral and Master’s students) focused on researching military, Veterans and their families’ health. The initiative will support the creation of an advanced analytics platform for future research and innovation related to the health of Canadian military, Veterans and their families. This collaboration highlights how CIMVHR connects researchers to industry to achieve common goals, all while moving the field forward.

In 2014, True Patriot Love Foundation (TPL) announced a $5M funding commitment to CIMVHR contributing to advancements in research and technology. This funding supports relevant and innovative research and program evaluation with a goal of improving health and health outcomes for Canadian military personnel, Veterans and their families. By funding timely and relevant research, this partnership aims to strengthen the dissemination of actionable knowledge between CIMVHR’s network of university researchers, government partners and other stakeholders to ensure that research can be rapidly translated into practice, policymaking and program development and implementation. Research activities funded through this partnership will also encourage the development of new skillsets and expertise of post-doctoral or graduate students, in turn supporting the next generation of researchers in relevant fields. TPL and CIMVHR will be administering a number of research activities in the imminent future.

CIMVHR awards two graduate scholarships each year: The Royal Canadian Legion Masters Scholarship in Veteran Health Research and the Wounded Warriors Doctoral Scholarship in Military and Veteran Health Research. The Royal Canadian Legion Masters Scholarship in Veteran Health Research, valued at $30,000 ($15,000/year for 2 years), is awarded annually to a master’s level student specializing in research related to Veterans and their families. Whereas, the Wounded Warriors Doctoral Scholarship in Military and Veteran Health Research is valued at $36,000 ($18,000/year for 2 years) and is awarded to a Doctoral level student conducting research on issues relevant to military members, Veterans and families. CIMVHR’s relationship with both the Royal Canadian Legion and Wounded Warriors Canada demonstrates how CIMVHR and philanthropic organizations are coming together to build the next generation of researchers.

CIMVHR creates countless connections each year with individuals and organizations in Canada and around the world who are committed to improving the lives of those who serve and have served. On a global scale, CIMVHR collaborates with international research centres in a coordinated effort to advance health research for military personnel, Veterans and their families. To date, CIMVHR has developed a network of 10 global affiliations.

CIMVHR engages with stakeholders to foster collaborations, which enables increased research and improves knowledge translation activities. These collaborations are what has afforded CIMVHR the opportunity to continue its operations, administer research contracts to its national network of researchers, fund scholarships and awards supporting the next generation of researchers, and become a global leader in military, Veteran and family health research.

CIMVHR’s largest impact on the field of military, Veteran and family health is bringing people together to advance health research for our nation’s heroes and their families, leading to evidence-informed policies, practices and programs. The relationships that CIMVHR fosters with stakeholders are the driving force that leads to more research and ultimately have an impact on those who so selflessly serve our country. CIMVHR is proud to serve those who serve us.

Eustace: From the Editor—continued from page 1

In addition to that article, we have submissions from the Deputy Surgeon General of the Canadian Armed Forces, BGen Marc Bilodeau, on command responsibility for health in the military; Dr. Howard Coombs on reserve military health in the NATO context, and an article on the work undertaken by the Canadian Institute for Military and Veteran Health Research. We were also pleased to receive a letter from a senior member of the Royal Canadian Legion, CWO Erl Kish, who outlines the problems and challenges associated with maintaining long-term care beds for veterans in Canadian hospitals. I trust that you will find this important edition informative and interesting, and I look forward to seeing you at one of our upcoming Security After Hours events.

Maj Daniel D. Eustace, CD, PhD (Ret’d)
Director, Defence and Security Studies Programme
A Letter to the Editor

from Erl Kish

Dear Sir,

When I discovered that this edition of the RCMI SITREP was to be devoted to issues pertaining to Veteran’s health issues, I felt compelled to bring a matter of great concern to your attention. I am referring to the current state of affairs with respect to how hospital beds in Ontario (and other provinces across Canada) are allocated, or more precisely, misallocated, for military Veterans.

To better understand this problem, a brief history lesson is necessary. At the heart of the problem is how the federal government initially identified what constituted a Veteran. It was determined that only those Veterans who had served on active duty prior to July 27, 1953 would qualify to apply for a Priority Access Bed (now referred to as a “Contract Bed”) in a hospital, and receive the additional care that would be required. This designation therefore excluded personnel who served in the Canadian military prior to that date, but who did not deploy into a theatre of war, as well as those who served in Korea after the signing of the cease fire, and all those who served Canada during the Cold War, and many other NATO and UN missions including Cyprus, Egypt, Congo, Rwanda, Croatia, Bosnia, the Gulf War and Afghanistan.

The problem was further magnified when responsibility for Veteran’s health care was transferred from what were designated military hospitals, or specialty wings, to provincial jurisdiction. In fact, this process took approximately fifty years to complete, beginning with the Wascana Rehabilitation Centre (formerly the Regional General Hospital Veterans Pavilion) in Regina, Saskatchewan, in 1966, and ending with Ste. Anne’s Hospital in Quebec (formerly Ste. Anne de Bellevue) in 2016. This transition resulted in an erosion of specialty care for Veterans, and a lack of understanding for the needs of Veterans in terms of their unique mental and physical care requirements. Over time, as a province’s systems and priorities overtook the previous ones, the Veteran became just another patient.

The problems associated with these two policies still exist today. While Veteran’s Affairs Canada (VAC) provides the funding for Contract Beds, provincial ministries of health, and local health care delivery agencies, have most of the control over who is actually placed in those beds. For example, a recent survey undertaken by the Veterans Service/Seniors Homeless Veterans Committee (VSSHV) attempted to identify where Contract Beds were located across the province, and if they were occupied by a Veteran, a non-Veteran or were simply empty. The survey discovered that while there were many vacant Contract Beds, or Contract Beds occupied by non-Veterans, across the province, there were many Veterans waiting for access to long term care (LTC), but who do not qualify for a Contract Bed as a result of the “July 1953” rule.

Given his information, the VSSHV asked VAC how many Veterans (i.e. any Veteran who served before or after July 1953) were on a waiting list somewhere for LTC. In fact, VAC was unable to provide this data, and stated that the Ministry of Health is responsible for tracking this metric. VSSHV then followed up with a large Ontario-based Local Health Integration Network (or “LHIN”) and was advised that they do not keep separate data on Veterans, and that there is no tracking mechanism in place; clearly, an unsatisfactory outcome given that VAC is providing funding specifically for that purpose.

Recently, VAC has begun to address the Veteran LTC bed problem in large centers such as Toronto (Sunnybrook Health Sciences Centre), Ottawa (Perley Rideau Hospital), and London (St. Joseph’s Health Care Centre Parkwood) in these facilities, vacant Contract Beds are being re-designated as Preferred Access Beds in order to allow access to some previously denied Veterans. Unfortunately, this represents only a very partial solution given that many Ontario-based Veterans who require LTC do not reside in large centers, but in smaller communities where vacant Contract Beds now exist.

Clearly, given that VAC has the authority to re-commit beds to Preferred Access Beds in large centers, this can be achieved in smaller centers as well. The first step will be to establish a list of Veterans waiting for LTC, and ensure that Contract Beds are available for any qualified Veteran who requires LTC in the community of his or her choice. This would allow our Veterans to remain in areas they are familiar with, and alleviate travel hardships for Veteran’s families who otherwise may have to travel great distances to visit their loved ones.

This was acknowledged in a recent report by the VAC Ombudsman which stated, “Apart from eligibility, some Veterans living outside of urban or Veteran-population centres are experiencing continued difficulty finding long-term care within or close to the communities in which they reside. This difficulty is not experienced by Veterans in rural communities alone, but also by other Veterans, who can at times be placed on waiting lists for beds funded by the Department in their preferred facility due to the provinces’ determination of whom to provide priority access to.”

That said, there is also a need to change the existing Veterans Legislation to remove the criteria for Contract Beds, and make them available to any and all Veterans who have served Canada at any time. After all, A VETERAN IS A VETERAN IS A VETERAN.

CWO Erl Kish, CD (ret’d) is a former Ontario Command President, Royal Canadian Legion, and currently Vice-Chairman of the Veterans Service/Seniors Homeless Veterans Committee (VSSHV).

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