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## Tuesday, December 11, 2012

## Chair

**Mr. James Bezan**

# Standing Committee on National Defence

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● (1530)

[*English*]

**The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)):** Good afternoon, everyone. We are going to continue on with our study of the care of our ill and injured Canadian Forces members.

Joining us today is Commodore Hans Jung, who is the retired former surgeon general for the Canadian armed forces. He was born in Korea and assumed the office of Canada's surgeon general in 2009 and retired in July of this year, after serving 31 years in the Canadian Forces. During his tenure he was the primary mover for the physician assistants program as well as the Canadian Institute for Military and Veteran Health Research, which we are very familiar with, which is a network of university researchers focused on military and veterans issues.

Commodore, if you want to bring us your opening comments, we are interested in hearing what you have to say.

**Commodore (Retired) Hans Jung (Former Surgeon General, As an Individual):** First of all, since I'm now retired and I'm not representing any organization per se, I really don't have any opening comments. I thought I would give you more time to ask the questions you need to ask.

First, let me say that I want to thank this committee and the membership for keeping the care of the ill and injured on the radar because this issue is not going to go away. There is a lag-time effect and it will be with us for quite some time to come.

[*Translation*]

I am now ready to answer your questions.

[*English*]

**The Chair:** This is just for committee members. We have an hour and a half with the commodore.

Mr. Harris, you have the floor for the first seven minutes.

**Mr. Jack Harris (St. John's East, NDP):** Thank you, Chair.

Thank you, Commodore, for joining us. I guess now that you are retired maybe you can speak a bit more freely about some of the concerns you may have had during your tenure since 2009 as surgeon general.

We've looked at a number of studies, particularly about mental health. I'm going from the ombudsman's reports starting in 2002 to 2008, our own committee's report in 2009, and reports out of Petawawa in 2012 which were quite disturbing. There seems to be a pattern in that the problems are being identified in terms of the ability to deliver on programs for soldiers. I'm thinking particularly in this moment about mental health services. One of the problems identified is that although the desire may be there, the actual ability to deliver is not.

I note, and perhaps you can speak to this, that you raised some significant concerns in the spring of this year after the budget directives came down. You thought the mental health services being provided were being undermined by budget cuts. Did you have similar concerns about the failure to have resources available to deal with the recommendations that were made in terms of additional support services?

I'll follow up with another question, but did you have similar concerns as surgeon general from 2009 until your retirement in July?

**Cmdre Hans Jung:** Well, I think I've been on the record, while I was the surgeon general, as saying that the issue was never resources. In fact, each year we had to turn in some of the money we could not spend.

**Mr. Jack Harris:** As a department?

● (1535)

**Cmdre Hans Jung:** Obviously, as a department, but as the health services, there were a multitude of reasons for that. Number one, as you've heard many times, there is not a plethora out there of extra capacity of human resources for mental health services available in Canada that are free to be hired by some of the organizations. When you are looking for more services you are going to a market that is already fully engaged. The competition to move them into DND or the CF is not an easy one. There is not a whole lot of unemployed people looking for work.

Related to that, of course, is that as an agency of the government and as part of the public service—many of these are civilians we are looking at and we are not looking at CF members—there's not a pool of mental health care professionals in the public service who you could actually reassign or ask for through an internal competition. They are almost all external. You have to actually seek out these people from the civilian sector.

That leads you into a whole bunch of public service hiring practices, such as timelines involved and classifications. Therefore, there is a huge lag time from when you identify a person to when you can actually hire them. It's sometimes 10 months or longer. Of course, if any health care professionals out there are looking for work, they are not about to stick around for a few months, let alone 10 months to get an answer on whether or not you can offer them a job.

That part of the bureaucratic process that exists within the government was a hindrance.

**Mr. Jack Harris:** I have to interrupt, because we only have a short period of time.

We've heard that time and again, but when clinicians have spoken out. For example, in Petawawa in 2012, one of the things they said was that the salaries are not competitive with similar positions outside the military. That's why clinicians will not work there. There is little incentive to go to a military town to work. Staff retention is at risk. There is no flexibility in the use of part-time workers, full-time workers, flex-time work, or a compressed work week. There is a high turnover of staff.

If a psychiatrist diagnoses a mental illness and needs to refer the patient, the wait time is unreasonable and the clinician ends up using supportive therapy and there's a waste of valuable resources. There seem to be barriers. It's not just that they can't find the people. There seems to be a failure to organize the work or to appeal to the people who are ready to provide the work if the conditions are right. Was that identified by your organization?

**Cmdre Hans Jung:** Yes, it was. You have to separate some of the civilian hiring between the public service and the contractors. Our hands were completely tied with the public service, because public service pay schedules are not determined by DND.

You're absolutely right. There are only a handful of doctors in public service within CF or DND, because the public service fees were just not competitive. We'd often have to hire these people through Calian, the private contractor, so we could pay them a more competitive price.

**Mr. Jack Harris:** If money wasn't the problem, how is it that the minister all of a sudden comes up with $11.4 million right around the time you were making complaints? The response is that we now have four psychiatrists at Petawawa we never had before. How did that happen if money wasn't the problem?

**Cmdre Hans Jung:** The four psychiatrists we had were always there. However, psychiatrists are human beings too. They go on maternity leave, become ill, and so on. You can't always predict that there will be four full-time equivalents all the time.

I repeat, the issue has never been a lack of resources; rather, it was my inability to spend them because of the barriers beyond my control. There were the hiring practices. Every fiscal year, for example, there would be departmental directions announcing a hiring freeze because of the uncertain financial situation. There would be internal reviews. Those things all cause additional months of delay in offering positions to civilians who may be interested.

● (1540)

**Mr. Jack Harris:** Someone has to cut through all of this. What could we recommend to fix it?

**The Chair:** You can give a brief response, but the time has expired.

**Cmdre Hans Jung:** Well, there were 60-some positions that were approved to deal with the mental health resources. It was supposed to go up to around 440 people. With the last 60 to 80 people, we were never able to bridge the gap. There were internal obstructions even though the positions were approved and funded.

One of the things would be to simply give authority to fill those positions without having to go through the myriad levels of approval. Every single position has to be staffed and analyzed and has to be approved at various levels of the departmental hierarchy before it can be done. Right now, my understanding is there is still somewhat of a freeze on the hiring of public servants.

**The Chair:** Thank you.

Mr. Chisu, you have the floor.

**Mr. Corneliu Chisu (Pickering—Scarborough East, CPC):** Thank you, Mr. Chair, and my thanks to you, Commodore, for appearing before our committee.

First, thank you for your service. Thirty-one years is a long time in the military and I think you have seen a lot. From your experience, where would you like to see the Department of National Defence and the Canadian armed forces take health care programs in the future? What do you see for the future in health care programs? In an ideal world, what types of mental and physical rehabilitation programs would you like to see offered and integrated into the CF health care plan?

**Cmdre Hans Jung:** You have to understand that starting in 2000 the Rx2000 project, or prescription 2000 omnibus project, was started to rejuvenate the Canadian Forces health services. You have heard the comment about the decade of darkness. I have always talked about the decade of deep darkness within the health services. Rx2000 was designed to bring us back up to the standard where we needed to be. You also need to keep in mind that when Rx2000 was planned and approved, Afghanistan was not on anybody's mind. Everything we did before Afghanistan was based upon what we thought was more or less a peacetime requirement to provide health care. Subsequently, because of Afghanistan, we provided additional support. We beefed up the mental health aspect. We re-created the rehabilitation program which had disappeared in the 1990s. We rejuvenated much of the stuff.

In my mind right now, with the Rx2000 program ended and being where we are today, we have what I call an optimal health care system. I won't say it's a perfect system. No system is ever going to be perfect, obviously. This was well thought out and methodically executed. As you know, we have the only pan-Canadian electronic health record system in Canada. The Canadian Forces is a leading organization and model of care in a number of other ways.

My concern isn't so much about where we need to do more; rather my concern is that we spent literally a dozen years getting where we are today. I would be a bit concerned for obvious reasons—because of the fiscal condition of the country and a number of other stress sources with the cessation of conflict in Afghanistan—that over time, the focus on the care of the ill and injured may fade. The system we have worked so hard to develop today may start to recede. I know life is full of sinusoidal curves. Things go up and things go down, and there is a bit of a cycle. I would hate to see such an amazing system as the one we have today, which we have developed with so much hard work and with so many good people, be sacrificed slowly over time. That's why I think the work of your committee is very important to make sure we actually maintain what we have now.

In the last three years, I have said we don't need more money. We have a reasonable amount of resources. What we need is the flexibility to tailor our resources to where we need them in a rapid way, such that the ability to move in an agile manner will allow us to stay that way. For example, right now, the health care requirements, particularly in the land forces, fluctuate over time depending on their rotation patterns. As a public servant, if you hire too many people in one area and after a while that fades, it's almost impossible to shift them to a different area. It's the ability to move around and put resources where you need them to meet the surge in demand, to be really agile in that way, while keeping the overall envelope more or less the same.

If we can do that, we have a very, very good health care system. I know my NATO colleagues are very envious of the health care system we have in Canada.

● (1545)

**Mr. Corneliu Chisu:** How can we maintain military physicians in the forces? For example, when I was in Meaford and other bases, I saw civilian physicians who are on contract and so on. As you said, with military personnel you can take one from Petawawa and put one in Edmonton, and something like that. As professionals, they have a different approach to the people they are dealing with. They probably understand a little better the stress and the problems with serving in the military. How do you see it? I know it was an incentive for physicians to join the armed forces. It's not a question of money. It's a question of the personnel to join the army.

**Cmdre Hans Jung:** That's an excellent question. Again, this challenge is not unique to Canada; it's a challenge for all the NATO countries that have been involved in Afghanistan.

Physicians, nurses, pharmacists, health care professionals, join the military not just to provide day-to-day health care, because they can do that in the civilian sector and chances are they'd make more money and have better control over their lives. They do so because of the unique service they provide in the Canadian Forces, the operational exposure, the unique exposure they get. Afghanistan was, to be very blunt about it, a tremendous attraction tool. People looked to that and said, “You know what? I think I can serve Canada. I can do something unique. I can get some unique experience. This is a chance of a lifetime”. They feel they can make a difference above and beyond everyday practice.

The challenge is, and this is where General Devlin also has an issue with simply the army, how to train to excite. How do we maintain that unique excitement, that unique military culture of esprit, that sense of adventure, if you like? We have to be innovative about training our people, in the context of the future, in a much more interesting simulation to reflect what they may see in combat. As time goes along, we have to be much more interoperable with our allies to make sure that we train together to minimize costs and to increase synergy.

At the end of the day you have to excite. They're working side by side in an office, in a clinic in Canada, and the guy in uniform looks to the guy in the next office and says, “That guy's wearing civilian clothes and I'm wearing a uniform. He makes more than I do, doesn't have to do any duties, and there's no unlimited liability. What is it that makes my job so exciting that I want to be here?” That's what you have to consider. It means fostering the military esprit, the operational medicine, and giving them that opportunity to do so.

**The Chair:** Thank you. Time has expired.

Mr. McKay, you have the last of the seven minutes.

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

Thank you, Dr. Jung, for coming, and I, like my colleagues, thank you for your service.

We had a couple of fellows here last week who were pretty much on the edge, a couple of soldiers and several suicide attempts between them. It put a human face to what we're talking about. Most of the time around here we talk about money and what our plans are, all that kind of stuff. It's difficult to comprehend how badly injured some of these fellows really are.

The conversation until now, specifically with the people who have appeared here who have been injured, has to do with alternate therapies. The military's position is largely, “We have an alternate therapy on our desk each and every day. We can't sponsor everything, and besides, there's no empirical evidence to support some of their stuff.” The soldiers are saying, “Look, man, this stuff saves my life. This dog saved my life. This horse is great for me”, that sort of stuff.

You're now providing direct medical services to veterans. What's your view?

● (1550)

**Cmdre Hans Jung:** I think we have to be very careful, number one, to distinguish anecdotes from a systemic pattern. We also have to distinguish what people need versus what people want.

If your standard of success is to make everybody happy in terms of what they think they need and they're happy to get, then I don't think there's enough money in Canada to satisfy everybody's wants. At the end of the day, on the one hand we're talking about budget constraints right now and pressures to not only become more and more efficient but potentially even cut, and on the other hand you're saying to give people whatever they want based upon their personal desires.

One of the things that we have be very careful of is what makes you happy subjectively is not necessarily objectively what's going to take you there in the long term. For example, if someone said, “If you would fund my application to Bahamas every year, that would make me really happy because I feel depressed and everything”, is that legitimate? There's the care involving horses. That's why in the civilian sector we have all these organizations, such as the Heart and Stroke Foundation of Canada and the Canadian Cancer Society. These are volunteer organizations that can do some of that stuff in a relatively small population basis.

**Hon. John McKay:** His argument was that as a blind person needs a dog, his injury needs a dog as well. I was struck by the argument because I didn't think it was a warm, fuzzy, make-me-happy kind of argument. It spoke to an issue of the PTSD that this particular fellow suffers from. Is it beyond the realm of imagination that a physician like you could prescribe dog therapy?

**Cmdre Hans Jung:** I would never say I would prescribe it. What I would say as a private practitioner is if they can find a charitable organization that is willing to provide these services, by all means go ahead. I know OHIP is not paying for any of that. I'm pretty sure OHIP doesn't pay for dogs either. The CNIB or other organizations do that. There's a difference between what the public and the taxpayer should pay, because the problem is precedent, and where do you draw the line? If a horse is good for someone and maybe a lion is good for someone else and a trip is good for another person, you cannot run a policy—

**Hon. John McKay:** I buy the argument. I understand where you're going. I think your analogy that dogs are being provided by the CNIB is good. What disturbs me is a certain rigidity, and correct me if I'm wrong, with respect to seeking empirical evidence for these kinds of alternate therapies. I know practising physicians are probably some of the most conservative people you ever want to meet, and frequently they do things because that's what they were taught in medical school, and yet the world has moved on. I'll leave that.

The second thing I wanted to talk to you about in providing direct therapy to soldiers and veterans now, is the uniqueness of your position, particularly when at one level you understand the people who are walking through your door in a way that no civilian physician could understand them. What is it about the warrior mentality, if you will, that requires unique therapy or whatever, when the warrior is injured?

● (1555)

**Cmdre Hans Jung:** One of the things that was very obvious to me when I was in uniform was the difficulty the veterans were having in seeking family practice practitioners when they retired. They couldn't find anybody because there was a shortage, they felt. That was often the biggest one. I was frequently asked what I could do about the veterans and the families. I said that I couldn't do much because as long as I was in uniform as a surgeon general, my mandate was very limited.

As I was contemplating retirement, I asked myself what I should do in my second career. The obvious venue was to provide an opportunity for veterans to see a doctor who knows where they're coming from. I now have patients coming to me who already have a family doctor. Because they come to me, I ask them why they changed. It was because they couldn't communicate with that person, whereas I know the language. By looking at their rank, by looking at their trades, I know what they did. We share the same operational experience.

It's not that we speak different languages in terms of English or French, it's just that we share a certain culture. Having been in operations together, they feel comfortable. Often they don't have to explain; they just have to say a few words and I understand. I know exactly what they mean. It's my ability to understand their unspoken words, and then take the next step as to what we do about that.

It's something as simple as understanding how the VAC application system works, what it means, what a CF-98 is. No civilian is going to know that. It's things of that nature, the words you need to provide when you fill out the VAC form that VAC can understand. We must remember that most civilians hate to fill out forms. Often when you show up at the doctor's office saying you have your form, they just say they're not going to accept you as a patient.

I do all that, and I don't mind doing it, because this is my ongoing service to the veterans and Canada. It was a natural transition. It's simply because we share the same culture; I understand where they're coming from. When they talk about things, I intuitively understand what they mean, not necessarily just what they're saying.

**The Chair:** Your time has expired. We're now going to the five-minute round.

Ms. Gallant, you have the floor.

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

Since the beginning of our troops going to Afghanistan back in 2001 until now, we've seen a complete 180 in terms of how the military views operational stress injuries. Back then it was matter of sucking it up and ignoring it, to the complete opposite now when you're supposed to be recognizing in yourself when it's time to seek help. We introduced along the way the decompression phase because families were telling us that the troops were coming home too soon, that they need a little bit of time before they're brought back into the family and the community. There was still one further point to go and that was to have the observations of any potential problems in theatre and operations. Can you tell us what steps are taken when a platoon is on an operation and there's somebody who is impacted or showing signs of a potential OSI?

**Cmdre Hans Jung:** I'm not sure what we have done that's new. It's something that's implicit in part of the make-up of the platoon, the companies and battalions when they deploy, that there are medics, physician assistants, a battalion doctor. Of course the leadership and the soldiers themselves are now much more trained to understand and be aware of more social and psychological issues. If there is an issue that comes up, then we have a process whereby the medic or the physician assistant will determine whether or not it's something they can handle. There's a protocol for that kind of stuff. If not, there's a natural referral process.

Of course, as you know, we try not to, again, stigmatize mental health issues in the battlefield by sending them back to the rear echelon and punting them home right away. This is something that was well delineated during the First World War and the Second Word War. You have to treat them as close to the front as possible. If you bring them home, the chance of their going back to duty becomes dramatically less. The idea is to provide therapy as close to the front line as possible, and because of that, as you know, we deploy a mental health team, a social worker, a mental health nurse, and a psychiatrist in theatre so that if a high level of care is needed, it can be done on-site and then the soldiers can go back into their battalion and become combat capable. This is something that was in the SOP right from the beginning. We've continued to do that.

Of course, if somebody does have an issue, their file is flagged, and when they come back they're followed up. If you look at the statistics, the number of people repatriated in theatre because of that is extremely small.

• (1600)

**Mrs. Cheryl Gallant:** All right.

Another issue is turnover in the military. It was reported in the news not too long ago that from 2006 through to 2011, the number is over 98,000. Now that has not been verified in this committee, but it seems like a lot of attrition for that period. There's not an insignificant amount of money invested in these soldiers, and there's a lot of training. What percentage each year of the people who do release from the military would be releasing medically?

**Cmdre Hans Jung:** I don't have that number. It's been a while and I haven't kept track of this. Of all the releases that occurred in the last two or three years, I can't remember. I honestly don't know.

**Mrs. Cheryl Gallant:** All right.

Recently we had two soldiers here with the service dogs. They were expressing that they were due to be medically released. They weren't sure if it was 30 days, three months, or six months. They wanted to stay in the military and it was to their dismay that they were being medically released. They had the will to get well. At what point does the military say that they have to go? Is it a part of their having to cut down on personnel and they're at the bottom of the pack, or are there other criteria?

**Cmdre Hans Jung:** I think the answer to your question has two parts.

Part of it is that after a prolonged period of assessment, from a medical perspective, our job is to give them what's called a temporary category or a permanent category.

A temporary category means a person is still in flux, transition; they have not stabilized one way or the other. Once they've stabilized, meaning they're completely better or they've reached a plateau, a level at which we are confident they're not going to fundamentally change, we will give them a permanent category: they need regular specialty care, or a certain amount or type of sleep. There are, as you know, restrictions based on medical requirements.

That's what we do. Once we make a determination, that file goes to the director of military careers administration, the DMCA, who looks at it and determines whether that individual's rank, trade, and limitations are compatible with ongoing service in that trade or in another trade in the military that they could potentially remuster to. If they can, then they're retained, but if they cannot, then they violate universality of service, and the only option is release.

In that regard, that becomes more pressing and a very important issue the smaller the military is. The more and more people you have who are medically unfit, they hold military billets and other people can't be promoted into those positions, and neither can other people be recruited to fill them.

While you're carrying that person in terms of both pay and position, the rest of the Canadian Forces gets relatively smaller. Now you have a greater burden on the remaining people for both operational and personal tempo. That will drive up their fatigue, and it's more likely they'll get out also.

**The Chair:** Thank you. I'm going to have to cut it off there. We're way over the time.

[*Translation*]

Ms. Moore, the floor is yours.

**Ms. Christine Moore (Abitibi—Témiscamingue, NDP):** Thank you very much.

I would like to go back to the matter of medical release. The timeframe in cases like that are really not known; it varies from 30 days to three years. I have seen cases where people had only been in service for 10 weeks and had to wait for three years before being released.

During that time, you never know what is happening and when you will be released. That is a source of stress; you are not able to get your life under control. How can people like that stay motivated at work knowing that they are going to be released at some stage? I have seen cases of adjustment disorders and situational depressive disorders associated with the wait for release.

Have measures been taken to stabilize the cases of people waiting for release so that we do not get people who are asking for release for physical reasons ending up with psychological syndromes?

• (1605)

**Cmdre Hans Jung:** That really is a good question. If I may, I will give you the answer in English, so that I can communicate clearly and express the subtleties that are necessary.

[*English*]

There are two types of medical releases, if you like. One is a clear-cut physical one, for example, the individual is an infantry soldier who had a severe back injury, and he knows he cannot carry rocks and cannot march. He can no longer be an infantry soldier. That's very clear. Those things are quite obvious. You can see it on the X-ray. You can see it in the performance. Usually within six months to a year we know what their final condition is going to be, so we give them a permanent category. They know they can no longer be soldiers given their physical limitations, and psychologically they know they need to move on.

Those are the easier ones. It's the mental health ones that are much, much more difficult. First of all, often there is a delay in diagnosis, for a number of reasons. The person didn't know he was having problems and was just carrying on, but eventually when the diagnosis is made, you have to start treatment.

Again, mental health treatment is not like surgery. If someone breaks a leg, the treatment is very clear. You put the leg in a cast, or, depending upon the situation, there's surgery to fix it. You know that in six weeks to about three months it's going to heal. There will be six months of physio. The natural history of that situation is well delineated. We know what's going to happen, and the individual knows what is going to happen.

Mental health is not that simple. It's very complicated. The individual may get better for a while or may get worse. There are many factors that come into mental health. It may take up to three years to determine whether or not the person is going to get better and how well he is going to get. Is he going to get totally better, or partially? It takes many, many years.

At the same time, as you know, many of these people want to stay in the military. They really want that. In time it becomes known, for some, that they're not going to get back to a level at which they can continue. Eventually they're given a permanent category. This may take, as I said, three years.

With the new policy, once the diagnosis is given, and that may take three-plus years, the permanent category is given and they are called complex cases. The system gives them another three years to prepare psychologically, occupationally, vocationally to transfer to the civilian sector. It is a long drawn-out process. I know there are people who say “It's too long. Just let me out of here. I want to go”. Others want to stay as long as possible to retrain, or sometimes with the hope that they will eventually get better.

Unfortunately, there is no simple way to answer your question. Every individual is different. It is very, very complex. We have to look at each case individually.

At the end of the day, once they've stabilized, and we try to stabilize them as much as possible, we ask whether they have reached the level where they can become operational. If they have not, then the current policy is that they be either released, or I think they have a different avenue that they can follow to stay in uniform but not in the Canadian Forces per se.

[*Translation*]

**Ms. Christine Moore:** Someone with a serious knee injury clearly will no longer be able to work as a soldier, even if he has tasks that do not require him to be in combat. If that soldier gets the knee injury in the fourth week of basic training, say, and a year goes by before he can go back to being a civilian, do you think that is normal?

● (1610)

[*English*]

**The Chair:** The time has expired, so if you could make a very quick response, I'd appreciate that.

**Cmdre Hans Jung:** I'm not sure the issue is normal, but we do not want to send anybody to the civilian sector while in transition because of the complexity of the medical care on top of that. We try to get them to a level of equilibrium to then hand them over to the civilian health care sector. To hand somebody over, whether they have a physical condition or a mental health condition, during that transition makes the continuum of care very difficult.

**The Chair:** Thank you.

Mr. Opitz.

**Mr. Ted Opitz (Etobicoke Centre, CPC):** Commodore, thank you very much for your service. It was 31 dedicated years, and what you're doing now, post-CF, is very important for the troops. As you described, they know a kindred spirit. They can talk to you, and you intuitively know what they're telling you. That's sometimes very difficult to explain to a civilian doctor.

We did have a couple of soldiers here last week, and the young bombardier was saying.... Sir, you've just described the system and the process of three years and so forth very well, but could there sometimes be a failing in that? He described the situation and felt essentially that the sword of Damocles was hanging over his head because he didn't know if he was going to be released in three months or three years, that sort of thing.

Can the system be that uncertain at times?

**Cmdre Hans Jung:** If the system is played out right, that should not happen. Based upon the complexity of your condition, you will be told whether you're going to be in the three-year transition or the six-month transition.

**Mr. Ted Opitz:** Okay. We didn't have the specifics of his case at the time.

We talked about post-traumatic stress and brain injuries and mental trauma, but what about physical trauma? There are a lot of amputees who still return to duty. Can you tell us a little bit more about that program?

**Cmdre Hans Jung:** Just to be clear, I'm not aware of the return to duty, especially in the combat arms, of anyone who lost a leg above the knee. The ones who have returned are below-the-knee amputees. Although the amputees get, rightly, a lot of visibility, the numbers are not huge, relatively speaking. For the individual, though, it's devastating.

We have developed a system in conjunction with civilian rehab centres to ensure that they get the best health care possible. I think we've partnered with nine centres. They get the best health care possible in those jurisdictions, the best health care possible for a warrior. The requirements for a severe diabetic who's had a foot amputated are very much different from those for an amputation as a result of combat. The level of rehab that they've been exposed to, and that we've given them, is not available in the civilian health care sector. In fact, I think this has given the civilians new insight into some of the ways of providing rehabilitation to younger accident victims. We have also given them unique technology, as in the CAREN system. We try to ensure that our soldiers have the best and the latest technology to give them the greatest possible opportunities.

**Mr. Ted Opitz:** I know you're a believer in the education factor, not only for our troops, but also for people outside the CF. Do you still think that education is at the crux of mental health awareness, and the treatment of mental health issues, in the CF and perhaps outside?

**Cmdre Hans Jung:** Oh, absolutely. Ignorance breeds contempt, prejudice, and a number of other negative things. I believe education is the most important thing.

Some 30 years ago, when people mentioned the C word, you were a pariah. If you had cancer, people thought it was contagious and they stayed away from you. That was 20, 30, 40 years ago, but over time, with education, it is no longer the case. People are now very much interested in making sure they have screening tests done for cancer. I think it's similar for mental health. I believe the evidence shows, and I know my civilian colleagues will support me on this, that the Canadian Forces have blazed a path for the whole of Canada to get a handle on mental health, not as a stigma, not as something to be ashamed of, but rather as a disease that we can and should try to mitigate.

● (1615)

**Mr. Ted Opitz:** I believe I heard you mention that our allies see our system as something to model themselves after and have great admiration for it.

Staying with education a little bit, we have pre-deployment training, the execution of the mission, and then post-deployment training and decompression. When do you think is the best time to start applying treatment? I'm sure it varies from individual to individual, but once we start seeing the symptoms develop, when do we begin? Are we doing enough during pre-deployment, for example?

**The Chair:** I should mention that time has expired, so please be brief.

**Cmdre Hans Jung:** Treatment has to start at the earliest possible moment. Of course, often that depends on the individual coming forward. That's the issue. If you break a leg, it's impossible to hide it, but if you are suffering a mental problem, you can hide it. Unless you come to the table, there's nothing we can do for you.

**The Chair:** Thank you.

Mr. Kellway.

**Mr. Matthew Kellway (Beaches—East York, NDP):** Thank you, Mr. Chair, and thank you, Commodore, for coming today and providing your testimony.

Given your length of service and your role, have you been following along with the testimony at committee?

**Cmdre Hans Jung:** Well, no.

**Some hon. members:** Oh, oh!

**Mr. Matthew Kellway:** It wouldn't really be retirement, I suppose, if you did.

In any case, let me say that one of our early witnesses talked about the rate of mental illness and injury for those serving in Afghanistan and compared it with the rates for other countries also involved in that war, the U.K. and the U.S. If I recall the testimony properly, we sat in between them in terms of the rate, with about 40% of our soldiers returning with some kind of mental injury or illness. I think for about 20% it was PTSD, and for another 20%, depression was the diagnosis.

The other thing we've heard, and I think you've provided this testimony again today, is how unpredictable treatment and cure is, if I can put it in those terms, that these things can reoccur years later and that they're also very difficult to get over in the first place.

One other piece of testimony to which I want to get your reaction was from Rear-Admiral Andrew Smith. He talked and you've talked today about the universality of service, but he talked about the health and well-being of the Canadian Forces members. He talked in these terms:

> 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.

I have a really difficult time squaring that testimony and the Canadian Forces universality of service standard with this notion of care and treatment of our soldiers. Frankly, I'm angered and outraged by the application of that standard to the soldiers, who we ask to go into horrifying circumstances—terrifying circumstances—and who come home with injuries. We saw this last week with the two witnesses.

I'm wondering whether you have any response to that position. I think I've heard you try to square it today in financial terms, but this is not a social contract, from my perspective. If it is, it's an extremely one-sided social contract, when we talk about unlimited liability and the horrific experiences that these folks have had and the injuries that have been placed upon them.

**Cmdre Hans Jung:** That is a very complex question. I honestly don't believe that this is actually a.... To me, this is a question that goes to the root of what the purpose of the Canadian Forces is. Do Canadians want a Canadian Forces that is combat capable, or beyond that, is it also a social net for ex-members? In my mind, that's something for the military to answer.

If you want to keep these people, if that's the way the government and Canadians want it, then you have to change the whole construct of the Canadian Forces. There's a whole lot of legal issues, because we have the Charter of Rights and Freedoms, whereas often the other militaries are somewhat, and I don't want to say exempt, but they don't have the same constraints that the Charter of Rights and Freedoms imposes on the Canadian Forces.

To me, in the way I know the Canadian Forces, the mandate of the Canadian Forces is to be combat capable; therefore, universality applies, and Veterans Affairs Canada exists to look after the veterans who can no longer serve in the Canadian Forces.

That is the way I think it's supposed to work. That's the way they work it in the United States.

● (1620)

**Mr. Matthew Kellway:** I come at this from the private sector. One of my jobs for many years was dealing with accommodation issues for ill, disabled folks in workplaces. Of course, all employers have their own sense of what they're there to do; it's to provide efficient, productive service, etc., but that doesn't preclude their responsibility—and it's understood in this country outside of the military to be a human right—to accommodate people in their work when they have a disability or an injury of that nature.

I don't see it as an enormous stretch, in the context of the Canadian Forces. It doesn't make it a social net to say that when they return from combat and have suffered an injury or an illness, we will look after them and will have a place for them and their family for as long as they need it.

What is the problem with making a statement of that nature?

**The Chair:** Again, the time has expired, so—

**Cmdre Hans Jung:** Again, it comes down to whether or not there is enough room in the Canadian Forces to accommodate all of that, because every person who is not deployable and is accommodated then holds not only a position but a rank, which other people below them cannot ascend to. Even within the same rank, if that person is non-deployable, then the remaining people have to pick up that piece, so you put an additional burden on them.

Because the Canadian Forces is limited in absolute numbers, the greater the percentage you have—

**The Chair:** The time has expired.

Mr. Norlock, you have the floor.

**Mr. Rick Norlock (Northumberland—Quinte West, CPC):** Thank you very much, Mr. Chair.

Through you to the witness, thank you for being here.

Dr. Aiken spoke about research being done into the relationship between mild traumatic brain injuries or concussive injuries and post-traumatic stress symptoms. Has your experience or work found similar conditions, and what do you think are some of the main contributors to developing PTSD?

**Cmdre Hans Jung:** This is one of the big areas of research that is going to have to put some meat on the bone. Mild traumatic brain injury is another one of those cases in which the military has brought brain injury to the Canadian psyche. Until the military's MTBI. mild traumatic brain injury, issue, concussion in hockey players and football players was almost unheard of; nobody talked about it. We have actually brought this out, and they're learning from our experience also.

The fundamental difference between concussion in the civilian sector versus concussion in the military sector is that when a hockey player is hit, it is in the context of a game; the other person hopefully wasn't trying to kill the player. By contrast, in the military sector, the very incident that caused the concussion—a bomb or an IED—is in its very nature threatening the soldier's personal psyche and viability as a human being. The exact incident that could cause MTBI is also the exact precipitating cause that would trigger a PTSD. The question is which comes first, or do they both come at the same time?

Here, I would caution you a little bit. Even within the medical community I think stigma plays a part here. People are desperately trying to find a biological reason to explain why you might have PTSD. To me, there is an inherent potential stigma that the medical community itself applies, because the idea that somehow this huge, traumatic event, which is not normal for most people—somebody tries to kill you in a very horrific way—could not possibly be caused by psychological factors, but rather that you must have received some kind of unforeseen concussion, through some kind of traumatic, compressed air.... It may be, but I think we have to be very careful that if we go too vociferously in that one direction, we are not inadvertently further stigmatizing people.

● (1625)

**Mr. Rick Norlock:** What you're basically saying is that there are probably many causes for PTSD and that this may be just one of them.

**Cmdre Hans Jung:** It could be one, or the other, or a combination of both. I think a lot more research is required.

**Mr. Rick Norlock:** I come from a paramilitary background. Compared with when I did my 30-plus years, we now have a very stringent psychological component to the hiring process. The reason for that psychological component is of course to filter out people with the Wyatt Earp syndrome and to make sure that you're getting the average person out there.

Does the Canadian military have a psychological component? Does the military attempt, in the hiring process, through psychological questions, to see whether the person is prepared to take on the stressors of military life?

**Cmdre Hans Jung:** Are you talking about the recruiting stage?

**Mr. Rick Norlock:** Yes, I'm talking about the recruiting process. In other words, do you try to have a filter or a process whereby you tell people the things that could happen to them? When we watch television we often see the glamorous part, but we don't see the terrible part, seeing your buddies hurt or—

**Cmdre Hans Jung:** In the recruitment process, from a medical perspective we take a mental health history. If there is anything in the history that suggests there may be something, then we request additional information before the file is finalized. If the file is clean or the person never sought out anything and therefore doesn't know what he or she doesn't know, or is actually hiding it, that person will squeak through.

**Mr. Rick Norlock:** Thank you.

You spent 31 years in the Canadian military. Thank you for that service.

Think about when you first came into service and think about when you left service. In particular, think of the time when you were in charge. You were the surgeon general. Are you of the opinion that we have advanced as a country in the care of our ill and injured? Do you have a measure there? Can you compare it to our allies, similar in size, scope, and experience, as far as service around the world goes?

**Cmdre Hans Jung:** I think life in general, compared to what it was when I joined 31 years ago, and the whole health care system have become much more complex. Knowledge, technology, advancement, and research have become more complex. One of the things about medical knowledge is that they say that every five years 50% of the knowledge is obsolete and there are new advances. There have been advances, absolutely, particularly when it comes to mental health. There have been huge advances made in the last several years in particular.

There are a number of measurements out there, including a satisfaction survey. There's Accreditation Canada, which accredits the standard of care in a health organization. A lot of NATO countries are emulating what we're trying to do. Many of them can't emulate; they simply tell me they're envious.

**The Chair:** Thank you.

[*Translation*]

Mr. Brahmi, you have the floor.

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

I found what you said at the beginning interesting, that you did not have a problem with financial resources but with human resources. So we can deduce that there are not enough doctors and that it is difficult to hold onto them.

First of all, can you confirm to us that the Canadian Forces does not train its own doctors?

[*English*]

**Cmdre Hans Jung:** The military trains its own doctors. We train not just doctors. All the health care professionals in the military who we train and who are wearing a uniform are there because they have an operational role. If they're not there, then we don't have them in the military.

● (1630)

[*Translation*]

**Mr. Tarik Brahmi:** Let me rephrase the question more specifically. I was talking about the initial training. Do we recruit students after high school to give them the training they need to become doctors in the Canadian Forces or are they trained at civilian universities?

[*English*]

**Cmdre Hans Jung:** We recruit at various stages. We take medical students. We don't take high school students, obviously. We take anybody who is accepted into medical school, whether they're in first year or throughout their training, in various stages. If they're in medical school at whatever stage and they want to join, and they've passed the physical and so on, then we recruit them. Then we pay for the rest of their training. Some come to us already trained, and others come to us as students.

[*Translation*]

**Mr. Tarik Brahmi:** What do you think of the countries—because we have to compare ourselves to other countries as well—that have chosen to take care of the training of their doctors from the beginning and to make them sign a contract before they even register in school? Right when they pass the school's entrance exam, they sign a contract that requires them to stay in the armed forces for a certain number of years. In France, for example—and this is laziness on my part because it is easier for me to read in my language—military doctors in general practice have to stay in the armed forces for 12 years, and doctors with hospital specialties have to stay for 14 to 18 years, depending on the specialty.

What do you think about that kind of contract, one that would require not only doctors, but also students who want to become military doctors, to commit, before beginning their studies, to stay a certain number of years in the armed forces once they graduate? Could that be an approach to the problem you raised at the start?

[*English*]

**Cmdre Hans Jung:** I don't think we have a problem with having enough military doctors in uniform. We have all the uniformed doctors we need in the military right now. It's the civilian doctors at our clinics that we don't have enough of. We do exactly that. The training system and the process to get into medical school in Canada are fundamentally different from those in France. The French military is so huge the military has its own medical schools. We don't. Therefore, it's a bit of an apples and oranges comparison. We have no problem right now having enough uniformed health care providers.

[*Translation*]

**Mr. Tarik Brahmi:** You say that the number of military doctors is not a problem, but you do not have enough civilian doctors. If there were more military doctors, there would be less need for civilian subcontracting. Would that not be a way to solve the problem? This is the principle of communicating vessels. If there are enough military doctors, but you have to call on inadequate civilian resources, is the solution not to use military doctors in greater numbers?

[*English*]

**Cmdre Hans Jung:** That is an option, obviously. However, with the way the CF works and the number of military positions that are available, if we increase the military health care providers in uniform, we have to decrease somebody else, because the total number the government has for the number of people in uniform has to stay fixed. Therefore, the requirement for who should be in uniform is dictated by how many people of what specific health care profession are needed for operations. That's the number we have. For anything beyond that we go to civilians.

**The Chair:** Thank you. The time has expired.

Go ahead, Mr. Strahl.

**Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC):** Thank you, Mr. Chair.

At the end of this, I think we're going to want to come up with some recommendations for the government.

One of the things you mentioned is that flexibility is the key to meet surge demands. Maybe you could explain some of the choke points that are preventing that flexibility. What are your specific suggestions to ensure that the CF can respond quickly to the urgent medical care needs?

● (1635)

**Cmdre Hans Jung:** Well, obviously I can only talk about the health care requirement. I guess in DND and the CF all the expertise for health care management and leadership and organization is within the health services.

In my ideal world, it would be wonderful if the leadership said to me that this is the outcome they want, the level of service they expect health services to deliver to the Canadian Forces both in operations and at home, and they gave me the resources needed for that. Of course, there would have to be some discussion about that, but once it's decided, it is simple for them to tell me to execute that and then hold me, the surgeon general, accountable. Once that determination is made, it is up to me to hire for the position.

Let's go back to the case of mental health. There were some 440 positions that were approved and funded. Logically if they're approved and funded, then I should be able to hire people to fill those positions. However, even after they are approved and funded, each position has to have documentation submitted to the public service system, the CMP, chief of military personnel, system, to the DM, deputy minister, system. There are many levels of review where they say yes or no, and it takes time. It's somewhat illogical. Once the positions are approved and funded, why doesn't the system let me hire those people with minimum bureaucracy and then hold the system, vis-à-vis the surgeon general, accountable as to whether I have been able to deliver what I've been told to deliver?

The intent is clear. There has never been an issue about the intent from either the minister or the CDS. Their intent to me was clear: this is what we want you to do.

I went to the PMB, program management board, each year and said what the intent was, what I needed, and what we needed to do. Each time the PMB said, “Here are the resources you requested”. Then I turn around to the bureaucracy and the machinery and I try to hire those people, and it comes to a grinding halt. The year end comes, and I can't spend the money.

As I said and continue to say, I'm optimistic, but I'm somewhat cautious whether this additional money that has been given can actually be spent.

**Mr. Mark Strahl:** That's troubling. You also mentioned in response to another question that money was never the issue, etc., but the brief we received says you had expressed concerns over budget cuts to the vice-chief of the defence staff, Vice-Admiral Donaldson, saying “Before we take action as per direction, I want to be sure that you...fully understand the implications...”, etc..

Could you reconcile those two statements for me, that money wasn't an issue but you were very concerned about the proposed cuts to the budget? What ended up happening? Were the reductions as problematic as you worried they would be?

**Cmdre Hans Jung:** The resources that were given to me were sufficient prior to the potential cuts. The issue wasn't even the cuts themselves. It was the rapidity of the submissions we had to provide to make those cuts that by their very nature constrained my flexibility to search out what would have the least impact.

Because of the way the processes were driven, my hands were tied in a certain way that would have led to cuts that I felt were completely unacceptable. Because of the pace at which it was moving, I felt I had no choice, given my personal accountability to myself rather than anybody else, to make sure that the leadership was aware that the train was going down a track, and unless you switch over, if you're not careful, it was going to go down. Once it starts rolling it's very hard to stop. That's why I sought out the vice-chief, as you know, because again, his intent was clear to me. I went and as you know, the train was stopped. It didn't go down that route, so I'm happy about that. Now I think the process is rolling out a little more methodically to try to really prioritize various potential cuts. But let's be clear. When you make a cut, it doesn't mean it isn't going to have an impact. It just means where's the impact?

Here I have to be very concerned about the terms “too much head” and “too much tail”, those kinds of aspects, because health care doesn't quite fit in the head and it doesn't quite fit in the tail either. If you cut administration, that sounds simple, but most of that administration isn't necessarily there to provide doctors with care. It's to provide answers to Parliament. It's to provide answers to the newspapers and a number of other areas. If you cut those admin positions, somebody still has to do them. It's not like I can say, “If you cut that, don't come to me with any questions.” If you cut those positions, somebody else has to pick up that piece. That means eventually, some clinician is going to spend less time seeing patients, to find out how many patients were seen for this and that. Cuts will have an impact.

● (1640)

**The Chair:** Thank you.

Mr. Alexander.

**Mr. Chris Alexander (Ajax—Pickering, CPC):** Thank you very much, Commodore Jung.

Once again, thank you for your service and leadership, and congratulations on the award from NATO, which recently came to many of you who were helping to lead the Role 3 Hospital in Kandahar. I think it very much reflects on the quality of leadership we had when you were surgeon general.

Could I ask you the very basic question about how we have cared for the toughest cases? I'm talking here about visible injuries, casualties coming back from Afghanistan, the Panjwai. People try to kill our soldiers. Take us through an example. A platoon is on a patrol and one or more soldiers trip an anti-personnel mine or a booby-trap. Someone's lost a leg. Someone's in danger of losing their life, far from their vehicles. What happens? Take us through the movements, briefly.

What has Canada done particularly well in Afghanistan in these sorts of situations to earn the admiration of others? What could we be doing better? What should we be looking at improving before we ever embark on a combat mission again?

**Cmdre Hans Jung:** I think one of the biggest things we've done is to train our medics and soldiers well so that in the moment of injury, which is what we call—we hate to use these terms but it's very colourful—the platinum 10 minutes, the soldiers and medics can make sure the person does not bleed to death. The greatest cause of preventable death still is exsanguination in the battlefield.

With technology, with blood-clotting agents, special bandages, and special techniques we have trained our soldiers to do and the medics, we've been able to save lives right there.

Then we owe a huge amount of gratitude to the Americans for their medevac system, the way they can get the helicopter on the ground rapidly and then bring the person to our hospital.

There's the training we provided our surgeons, our nurses, everybody there, to provide the highest survival rate in the history of warfare. Coalition troops had a 97% survival at the Role 3 Hospital, the highest in all of Afghanistan and Iraq.

Then again with the Americans, there's the ability to move them to Landstuhl for them to be truly stabilized. Then there is the ability to partner with a civilian, usually teaching, tertiary care hospital.

That whole system chain has been phenomenally well done. When you're talking about 97%, I don't think we could have gotten any better.

One of the things you talk about in the military often is the so-called lessons learned. I actually don't talk about lessons learned because sometimes, regrettably, I think we learn very few lessons. We identify a lot of lessons.

To me, by definition, if you learned a lesson, you shouldn't make the same mistake again. We identify a lot of lessons, and then I think we sometimes put them on a shelf, and forget about them and re-identify them later on.

We've done phenomenally well at this campaign. Our challenge is, as the focus on Afghanistan potentially winds down and with the very budget and financial issues we have to deal with, whether we can make sure those lessons we've learned are cast in stone and we do not lose them.

● (1645)

**Mr. Chris Alexander:** This is the last question.

Tell us a bit more about stigma, because obviously a great deal has been done to address the issue for the Canadian Forces, but it's not even close to enough. There is the stigma of recognizing one is suffering, but then there is the question of getting those who need the care through the full cycle of care they need.

Tell us a bit about resilience. How much would more attention to building resilience help on the other end in reducing levels of PTSD and other OSIs?

**Cmdre Hans Jung:** As I said, I think the stigma has been reduced significantly. I know the military has taken a leadership role in trying to reduce stigma in general in Canadian society. A lot of that credit can be given to the senior leadership. General Hillier, General Natynczyk, and the commanders of the army, navy, and air force, and so on have done a tremendous job in that regard.

In terms of resilience, the answer is that nobody knows. No one knows whether you can actually instill resilience. We think intuitively that should be the case, but there is no research that says giving people resilience is going to actually help them in any way. Again, that's where the CIMVHR, the research, is really required to make sure we are in fact doing the right thing.

Let me again address one issue. I think in my mind that you as a committee may potentially aggravate that stigma. That is tragic, as people continue to suffer from severe consequences of PTSD. The fact they are continuing to suffer is not necessarily an indication that there's a failure in the system.

Even in the best hospitals in Canada there are people still dying of cancer and dying of heart disease. That does not mean those hospitals are incompetent. That is the best technology.

Regrettably, there will be people who will not get better from PTSD. Based upon our knowledge now, one-third of the people who are diagnosed with PTSD will never get better. No matter how good we provide the best technology, the best evidence, and the best resources we have today, they will not get fundamentally better. One-third will completely recover. The other third will have relapses, but they will be okay. They are not going to be perfect, but they will carry on. There's a third of the people who are diagnosed who are not going to get better. They can be here with tragic stories, and they are real, but that does not mean the system has failed them.

**The Chair:** We have time for our last round, but I want to keep it to three or four minutes per party.

Mr. Harris, you can kick us off.

**Mr. Jack Harris:** Thank you.

Commodore, I think I neglected to thank you for your service to the military. It's quite a remarkable period of time.

Just let me get to the question. No one expects miracles, obviously, and not everybody who is ill can be cured. What we're concerned about is making sure that those who can be cured, are cured.

One of the disturbing pieces of information we heard last Thursday was an individual, the bombardier, who said that he was diagnosed in the field in Afghanistan with PTSD. He was sent home on a civilian plane by himself, with no decompression and no accompaniment. That seems to be totally out of line with what everybody tells us happens to soldiers who come back from Afghanistan for any reason, even if they're perfectly healthy. They get decompressed. They come back as a soldier. They don't come back in a civilian aircraft by themselves with no support.

Does that sound even plausible to you? How could that happen?

**Cmdre Hans Jung:** Again, I think we have to be a bit careful with an experience that one individual has had. I'm sure that, from that person's experience, that's the way it was. I think you have to go a little deeper, and of course, given the confidentiality issues, you really can't do that. You have to really dig down for the real issues and the true diagnosis. What was the person's disability? What were tactical issues at the time that led to those decisions?

It would be somewhat irregular, and I don't mean to say that what the person said was not true, but to say that without knowing the full story behind it would be somewhat difficult. One thing I can say is—

● (1650)

**Mr. Jack Harris:** You discount the story.

**Cmdre Hans Jung:** Well, you need more of it.

**Mr. Jack Harris:** Well, is it possible that it could happen?

**Cmdre Hans Jung:** In the world, I suppose, if you want a yes or no, anything is possible. The decision to send somebody home unaccompanied would mean that there was a decision made in the theatre that they didn't have any concern that this person going home through civilian air would have any issue with that. If there were issues, they would have been accompanied.

**Mr. Jack Harris:** Let me ask another question.

We talked about relapse, and that was raised last Thursday as well. One of the witnesses said that they were told by commanding officers or superior officers that if they had a relapse, they were going to be medically discharged. It was presented in the context of this being a way of suppressing, or has the effect of suppressing, someone actually getting treatment because they're afraid to go to that. Would you comment on that?

Also, the ombudsman talks in one section of his report “Fortitude Under Fatigue” about people being posted to the joint personnel support unit viewing it as the kiss of death from a career perspective. He says that as long as this perception persists, it constitutes a barrier to care.

Could you comment on those two pieces of information that we were given in terms of how improvements need to be made or what improvements can be made?

**Cmdre Hans Jung:** On the whole issue about JPSU, I'm not sure if there's an answer to that one. There are people who went to JPSU and say that it was the best thing that happened to them and their whole lives changed. There are others who say that as soon as they went there, it was the kiss of death. A lot of it is their own perception and potentially the micro-culture of the units they come from.

Remember that I said we've made major progress in terms of stigma from a senior leadership perspective. I think we still have significant challenges at the more junior level.

Here I will make a point, and I've made this many times to senior leadership, about what I call the self-stigma. Often soldiers are willing to give somebody else a break, but they stigmatize themselves quite significantly because they can no longer function in a certain way. The stigma is both external and internal. You have to know where the stigma is actually coming from. Is it from their buddies? Is it from the unit leadership. Is it partially from themselves? It may be a combination of all of those, depending on the micro-culture that exists in various places.

As I say, some people love JPSU, and other people are not so keen on it. What I can tell you is that the JPSU does deliver what I call one-stop shopping.

**The Chair:** Mr. McKay, go ahead.

**Hon. John McKay:** Along the same line of questioning; we were also told that when someone went to see the shrink, it was posted on the board, “so and so is off to see the shrink”. That's a bit of an issue for some people. I was kind of surprised that the military would actually do that. Is there an explanation for that?

**Cmdre Hans Jung:** I really can't explain that. I recognize that the units have to understand where their people are. For supervisors to know that someone is going to the clinic would be fine, but to say that someone is going to see a mental health practitioner, or shrink, or something like that, would be inappropriate.

**Hon. John McKay:** Everybody in the unit knew that this guy was off for the next three hours to see the shrink. I can't see how that helps them reintegrate into the unit, and it doesn't help with the culture.

I was interested in Mr. Kellway's line of questioning because it is, if you will, almost a philosophical issue on what you want the Canadian military to be. You can get into what is accommodation.

It seems to me, at one level, that the level of accommodation for ill and injured soldiers needs to be higher than that for civilians. I say that because the expectation is that they are putting their lives on the line. They are unlimited liability. The corollary of that social contract of unlimited liability is that you have this guy for life, almost. I'm exaggerating but not terribly so. You've got this guy for life because you know darn well that if he goes into theatre, there's a high-percentage chance he is going to come out either ill or injured.

On the other hand, I understand you want a high-functioning military, and for every ill and injured soldier you're carrying, somehow or another, somebody else needs to pick up the burden.

I understand the argument, but I'm not sure I understand where you're coming down on the argument though. From listening to you over the last hour and a half, it seems to me that, in some respects, you anticipate there will be pressure on the physicians to move the ill and injured out and either into civilian life or into veterans care.

● (1655)

**Cmdre Hans Jung:** I don't know. I don't think there's any pressure on the health care system to do anything of that nature. I've been very clear: you make medical decisions based upon the medical natural history. They're very clear on that. We don't push people out; in fact, you will find people on both sides. Some people say, “You guys are taking too long. I want to get out”, and other people say, “You guys are making decisions too early. I want you to drag it out.” Because we get criticism from both sides, we're probably on the right path.

Again, I come down to the issue of social contract. This is a question you should be asking the JAG. It's part of the mandate of the Canadian Forces. Accommodation has been determined by the Supreme Court, I believe, on to what extent the CF should accommodate, and to what extent it's a burden that's unreasonable for the Canadian Forces, given its unique mandate. To me, that is more of a legal issue, and then it becomes a much higher political issue, as I say, almost a social issue, as what you want the Canadian Forces to be.

As a health care provider, if the patient is there, I am there.

**The Chair:** But you're not coming into that conversation.

Mr. Alexander, go ahead.

**Mr. Chris Alexander:** Thanks very much.

You mentioned the decade of deep darkness and the state of disrepair into which the military health system had fallen. Could you give us the two or three most important steps taken from 1999 to 2010 to bring the health care system back under Rx2000?

**Cmdre Hans Jung:** I think the biggest thing was Rx2000. That was the realization of the leadership, and remember that this project took almost 11 years. It was a long project.

During that time, we have had various chiefs of defence staff and governments. During that time, there has been steady support, all the way, to go ahead and finish this project, and we did. We did it on time, based upon the time set by Rx2000, and I think we came in under budget for that one. It was the continuous support through those many years by various governments, various chiefs of defence staff, various leadership, to say we need to bring it back up to the standard that we need it to be. Thank goodness we did so because otherwise, we would have been woefully behind when Afghanistan hit.

We, collectively, were prescient enough to go down this path early enough that we were ready and prepared to meet the needs of Afghanistan.

**Mr. Chris Alexander:** Given universality of service and what we ask of members of the Canadian Forces in missions like Afghanistan, there is a natural tension between a health care practitioner's duty to protect a diagnosis, to protect the information about a patient's condition, and the commanding officer's duty of care to the unit and to the person to not deploy the person if they have an operational stress injury or another invisible impediment to being deployed. Do you think that tension is being resolved successfully for the vast majority of CF personnel, or do we still have work to do?

**Cmdre Hans Jung:** I think for the vast majority, that what I call creative tension between the two opposing forces is handled well. This is one of the things we train our new doctors in the military in, including our civilians. We teach them a lot about those diametrically opposed forces and how to walk that fine path. The best way to do that is to look at the patient, look at the person's capabilities and limitations. If you follow that, everything will fall into place.

On the whole, I think we do. The vast majority I think are handled well. But again, as I keep saying, it does not mean the bar is set at 100% satisfaction in everything. Then we'll never meet it.

● (1700)

**Mr. Chris Alexander:** Give us your assessment of the road to mental readiness program for redeployment training. That's obviously something that's been highlighted by other witnesses. It's an important lesson learned and lesson implemented. How do you assess it?

**Cmdre Hans Jung:** I think that is only a part of it, you have to look at the bigger picture. Part of the mental health strategy, and it's already being implemented, is training the recruits about the aspects of mental health. At various levels of leadership training, both for the NCMs and officers, that's being incorporated into their training requirements. It's the general education and then the road to mental readiness, that five-phase thing, that's really around the deployment. If that's all you've focused on, it's too late, because you're not going to teach people, thoroughly change their thinking, based on that thing. They have to come to it from the recruitment stage to be inculcated into the new, enlightened way of looking at mental health right from the recruitment process, whether you're a private or an officer cadet.

**Mr. Chris Alexander:** Have you taken that mental health education far enough upstream in the training process?

**Cmdre Hans Jung:** Yes, we have. We're doing that now, immediately on recruitment. All the recruits get it, and they get it at the junior leadership course, the intermediate leadership course, and so on.

**The Chair:** Thank you.

Commodore, in the Canadian Forces we definitely have a great group of mental health professionals working on providing really good services to the members, often in very stressful and traumatic situations. Who's providing them their mental health care?

**Cmdre Hans Jung:** That's a very interesting question.

You've heard “physician heal thyself”. The mental health medical community is not that large, particularly in a base sense, unlike the civilian health care sector where there is no such thing as a supervisor. If you're a private doctor, you're on your own. Even if you practise in a group, it's up to you to seek care and the medical organizations have physician programs for their mental well-being also. But it's really up to the individual. No system gives them that supervision, except in the military.

In the military, if you go to a base, there's a base surgeon and then there's a senior nursing officer. We have a hierarchical system whereby each one of them is supposed to look at the other person. Of course, as you know, there's an annual process, the PER, personnel evaluation report, and a quarterly process, the PDR, personnel development review. We're supposed to interview people. Medical people are no different from any other people, except we have more knowledge in the medical area. We provide leadership. If we see that, the requirement is to take necessary action to provide them with the necessary help.

**The Chair:** Thank you.

Commodore, I want to thank you for coming in as a retired member of the CF, as a veteran now. Thank you for your 31 years of service and the great care that you've supervised and given personally to members of the Canadian Forces. Congratulations on your retirement. I hope you have a really enjoyable one. I know that you'll be very busy and your expertise will be called upon, just as we called upon it today. I want to wish you a very Merry Christmas and all the best in 2013.

Mr. Harris, I understand you have a point of order.

**Mr. Jack Harris:** Thank you, Mr. Chair.

I'd like to put on the record a correction, to paragraph 8 of the dissenting report of the official opposition on our committee's report, “The State of Readiness of the Canadian Forces”.

It's been pointed out by the Office of the Auditor General that the wrong report was referenced in quoting assistant auditor general Jerome Berthelette. In line 3 of paragraph 8 of our dissenting report, there was an inadvertent reference to the Auditor General's report on the F-35s. In fact, the reference should have been to the Auditor General's fall 2011 report. The quotation itself is actually correct, but the wrong report was referenced.

They've asked that we correct it, so I'm putting it on the record as a correction to that report.

Thank you.

**The Chair:** Thank you.

With that, we're going to suspend briefly. We have one item of committee business that we have to deal with.

I'm going to ask everyone to leave the room while we suspend.

The meeting is suspended.

[*Proceedings continue in camera*]

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