National Defence Défense nationale

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THE INEQUALITIES IN THE CANADIAN ARMED FORCES HEALTHCARE BENEFIT POLICIES FOR RESERVISTS

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JCSP 43 DL

Exercise *Solo Flight*

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CANADIAN FORCES COLLEGE – COLLÈGE DES FORCES CANADIENNES
JCSP 43 DL – PCEMI 43 AD
2017 – 2018

EXERCISE *SOLO FLIGHT* – EXERCICE *SOLO FLIGHT*

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Word Count: 4166

Compte de mots: 4166

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Introduction

History has shown that there have been inequalities in the Canadian Armed Forces (CAF) healthcare benefit policies for reservists. The CAF Ombudsman has written many reports the past decade identifying the inequities which have had a negative impact on the reserve force. During the 13 years Canada was involved in Afghanistan, 4,200 Reservists were deployed, many multiple times, and as such reservists are a critical piece of the CAF operational capability. Once a member puts a uniform on, they are in service to Canada. Both the Regular and Reserve Force personnel assume the same risk while deployed on expeditionary or domestic operations and exercises; therefore as such should receive very similar healthcare to treat the same physical and mental health occupational stress injuries which are attributable to the full-time service while deployed. In some cases, the Reserve Force assume greater risk because, as volunteers, they experience limited liability due to the inequity in the healthcare benefit policies. There needs to be an overall change in the culture. The CAF should look after all our uniformed force members in times of need, especially our reservists. This includes using every patient encounter to better educate our Reserve Force members (with respect to their entitlements to care) and ensuring the CAF, through the Canadian Forces Health Services Group (CF H Svcs Gp), partners with our civilian healthcare systems to better support our Reserve Force personnel throughout their careers.

The main purpose of this essay is to examine the inequalities in the reserve healthcare benefit policies within the CAF. The aim is to address the Reserve Force policy inequalities, as compared to their full-time counterparts who are guaranteed to have a general practitioner. I will argue that the CAF reserve healthcare benefit policies are not equal for all members who assume the same risk while serving their country. I will show that there are resource issues, a lack of clarity and knowledge in some of the CAF policies that confer entitlements to healthcare, access to Periodic Health Assessments (PHAs) is inconsistent, and eligibility for Reserve Force employment can be limited. The inequity in policies have had a detrimental effect on reservists especially those who are suffering from physical and mental health injuries. This is also compounded by the fact that the articulation of these policies have been inconsistent via the CAF medical system, which has led to inconsistent interpretations by medical practitioners and the reserve chain of command. I will conclude by summarizing the impact that the inequalities in the CAF reserve healthcare benefit policies have had on the recruiting and retention strategies of the CAF. The questions I am attempting to answer with this essay are as follows. Who are the members of the Primary Reserve and why are they different than Regular Force members as it pertains to the healthcare policy entitlements? What has been done to review the inequality in Reserve healthcare? At what stage does the CF H Svcs Gp relinquish the healthcare responsibility of reservists to the civilian healthcare system and is this appropriate? How has the inequity in policy affected the overall CAF recruiting and retention strategies?

Who are CAF reservists? CAF Reservists are both full-time and part-time soldiers. For the purposes of this essay, the inequity of healthcare policies will focus on the part-time soldiers who deploy as full-time soldiers, but upon return to Canada go back to being part-time soldiers. These part-time soldiers are further separated in to two groups based on their contract type. They

can be on a short term Class 'B' contract and working less than 180 consecutive days in a 365 day period with no roll over to a new contract. They can also be on a Class 'A' contract and work when they are on duty by signing a pay sheet. They typically work no more than 15 days in a calendar month and usually only work one evening a week and one weekend a month. Working more than 180 days consecutively is considered a full-time contract and these full-time reservists have comprehensive CAF healthcare similar to their Regular Force colleagues. The general healthcare policy for Class 'A' or Class 'B' less than 180 days is provided in CF H Svcs Gp Instruction 4090-02 - Interim Guidance for the Delivery of Health Care to Reserve Force Personnel. It reads as follows –

> If the injury or illness is related to duty or training, the care will be delivered by the CFHS until it can be safely transferred to the member's primary care physician. If the injury or illness is not related to service or is a chronic medical condition the member will be advised of this and told to follow-up with their civilian primary care physician.[1]

The overall policy states that the CAF is to look after the member until the member can be safely transitioned to the civilian healthcare system and this is where the inequity begins.

The country's Department of National Defence and CAF Ombudsman has found that "National Defence is reluctant to conduct regular health assessments on reservists because over one-third of them have no family doctor - and if they're sick it would be the department's responsibility to care for them."[2] For the CAF to take on that responsibility, the system would require many more resources especially the requirement for many more General Duty Medical Officers (GDMOs). At the current moment in time, the CAF is struggling to meet its strategic

[1] Canada. Department of National Defence. CF H Svcs Inst 4090-02, Interim Guidance for the Delivery of Health Care to Reserve Force Personnel. 2010.

[2] 2Brewster, Murray. Military health policy rapped; DND reluctant to monitor health of reservists. Chronicle Herald, Halifax, N.S., 29 Oct 2015: p. 1.

intake plan for GDMOs. The Medical Officer occupation has been identified as an understrength military occupation mainly because of retention which will be discussed later on.

Every Regular Force member has access to primary care. A good majority of Canadians do not. Current policy doesn't take in to consideration the fact that many reservists do not have a family physician. "Roughly 38 per cent of reserve soldiers report not having a family doctor."[3] The lack of a healthcare practitioner who can take over their healthcare needs means that many reservists are falling through the cracks. In contrast, even for those reservists who may have a civilian primary care physician and who can help transition the member, in many cases, the communication and records management are very poor. Since there are two different healthcare systems, the means to communicate electronically is not connected. Therefore there is a reliance on sending or transmitting by hard copy means instead of by an instantaneous electronic means. This leads to delays in care and in some cases medical files are easily lost or misplaced with no means to track whether the member has been followed up. In other cases, the civilian healthcare system is not always equipped to manage the combat related physical and especially the mental health related injuries because of the complexity of the cases. Additionally, these cases put an additional strain on the provincial and territorial civilian healthcare systems. The critical piece to this is that the federal and provincial healthcare systems are managed by two different levels of government. Federal transfer payments, which could be earmarked for healthcare, is not necessarily directed equally to each province or territory's Department of Health. Nor is the way healthcare is managed and delivered the same for each region. Priorities within provincial and territorial budgets dictate where the funding goes. For example, medication and services covered in one province or territory may not be covered in another. One might take this argument a step

[3] Brewster, Murray. Military health policy rapped; DND reluctant to monitor health of reservists. Chronicle Herald, Halifax, N.S., 29 Oct 2015: p. 2.

further and question how services are distributed to reservists coming from First Nations and Indigenous communities. Again, another system, adding more bureaucratic red tape, getting in the way of efficient communication for the best care. The lack of resources has led to the overburdening the civilian healthcare systems. This, in turn, directly correlates to the reserve force not receiving equitable healthcare for equal risk (as it has already been stated that once deployed the risk to the member is equal). As services vary from region to region, and issues in regards to communication get in the way of expediency and efficiency, the question of equity comes into play. Because care delivery is unequal, in relation to the level given to Regular Force members, inequities must be addressed in a relational way. When a Class 'A' reservist is hurt, information with regards to their condition and circumstance from the civilian system is extremely difficult to obtain and becoming more so. This provides a challenge to Commanding Officers seeking to support their class 'A" personnel due to lack of information.

At the heart of the issue is a lack of resources to help support the CAF clinics serve the part-time reservists especially in geographical areas with a large concentration of Reserve Force personnel compared to their Regular Force counterparts. The Rx2000 Initiative, the CF H Svcs Gp initiative created in the early 2000's, identified how the CAF Clinics were to be resourced in terms of personnel and funding. The program was based on the Regular Force personnel numbers rostered to each clinic. The formula has never been updated since and there has only been one additional increase in funding that came in 2014 when then Minister of National Defence, RHon Peter MacKay, allocated an additional $11 million to increase the CAF's Mental Health resources in terms of personnel.

To also address this issue in 2011, for example, the Director of Medical Policy (D Med Pol) did send out a communique identifying that "all reservists will be seen at a minimum and to

be triaged by a CAF practitioner."[4] Unfortunately, many of the smaller clinics with a larger reserve contingent have had to push back when asked to take on the follow-up care of reservists who had issues identified as part of their initial care plan. These clinics were never resourced with additional general practitioners. It was a well-intentioned policy, but a lack of any additional provision of resources to assist the smaller clinics to deal with the huge need among reservists only leads to a systemic failure to the reserve member and the clinic as a whole. One Ombudsman report explicitly stated that clinics such as Toronto, with relatively small Regular Force populations and large Reserve Force populations, would be overwhelmed. Ultimately, D Med Pol allowed them to continue the approach they had adopted as they recognized that they had no resources to offer that would assist with implementing their well-intentioned direction. This failed the reservists in these locations.

Unfortunately, this is not a high priority for the powers-that-be and until someone backs up the policy with resources, I don't foresee this changing. Reservists will still have their service related conditions cared for and treated by the CF H Svcs Gp, but anything else will fall to the province. This means many will not receive any primary care owing to a lack of family physicians. Of course, this also means that if a reservist does not have a family doctor in their province of residence, their only option to get one via the CAF is to join the Regular Force or take on a full-time contract. Indirectly, this can be construed as a recruiting strategy. That, of course, is a choice that an individual must make. Certainly the Regular Force member enjoys many benefits that the Reserve Force do not, but this comes with a cost in terms of geographical stability, deployment options, freedom for family members, etc. In many locations, at this point in time, it is not feasible for all reservists to have access to healthcare from the CAF. Since it's

[4] Canada. Department of National Defence. CF H Svcs Gp Directorate of Medical Policy Communique 2015-008 - Approval Process for Periodic Health Assessments (PHAs) and the Need for Better Transparency. 2015.

not a priority, there is no evidence that an analysis has been done to determine what the cost would be to grow the health services in terms of personnel and infrastructure in order to meet such a huge expansion of patient population. Similarly, the same type of issues are being experienced with retiring Regular Force members who have, over their careers, become accustomed to having access to primary care through their military clinic. Many get a rude awakening when they decide to retire in a region of the country with poor access to family physicians. That said, no one forces them to move to some of these areas so they can't say they were shocked to find out it is difficult to find a family physician. I don't think the military would fare well if they tried to institute a policy that gave them the power to deny retiring member's their retirement posting approval if they were choosing to move to an underserviced region in terms of healthcare. Fixing this will take resources and there is no indication that it will be forthcoming.

Also identified by the DND/CAF Ombudsman, there is "a lack of knowledge and awareness of the entitlements to care available to Reservists leading to gaps in the post-deployment follow-up activities and the general follow-up of Reservists."[5] The completion of post-deployment follow-up activities will help to identify members who may be in need of additional medical and chain of command administrative support. The CF H Svcs Gp has been tasked to provide post deployment follow up, however, if the member goes back to a part-time status, it is not mandatory for the member to follow up.

In addition, field ambulances have been tasked to provide awareness briefings to reserve units, however, in many cases, the leadership of the reserve units turn down the offer due to not having enough training days available, thus making it a lower priority than training.

[5] Canada. Department of National Defence. Ombudsman Report. Part-Time Soldiers with Full-Time Injuries: A Systemic review of Canada's Primary Reserve Force and Operational Stress Injuries. May 2016: p. 2.

> Reservists who deploy with Regular Forces are at a distinct disadvantage when they return home. Regular Force members return with their units where post-deployment medical assessments and many other services are available to them. Reservists return to their units and scatter to their homes, jobs, and families.[6]

The role of an engaged and informed chain of command is critical to having a healthy and productive organization. Our people are our best resource. The transition of care to the civilian health care system is important. If the transition is left in the hands of the member only, this becomes a problem especially for young people who don't know how to advocate for themselves.

Access to PHAs has been inconsistent for the part-time reservists. As noted in the October 2015 Ombudsman report '*The Feasibility of Providing Periodic Health Assessments to All Primary Reservists*' (a joint effort with the Surgeon General's Office), "some 26 percent or 6,883 of today's Reservists have no current medical assessment. We are, at times, putting boots on the ground to aid civilian authorities in natural disasters without a current medical assessment."[7] What if a Reservist, with no current PHA, is injured on duty? If Reserve Force member presents himself or herself at Veterans Affairs Canada to get compensation, "the onus is on the member to prove service attribution. Without that periodic health assessment, Veterans Affairs Canada will be hard placed to make the required assessment."[8] This is not fair to the member who may be suffering from an illness and who cannot articulate or advocate for their needs. "The level of care we deliver must be based on clinical need and may include diagnostic

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[6] Canada. Department of National Defence. Ombudsman Report. Our people, our security, our future. July 2016: p. 10.

[7] Canada. Department of National Defence. Ombudsman Report. The Feasibility of Providing Periodic Health Assessments to All Primary Reservists. October 2015.

[8] Canada. Department of National Defence. Ombudsman Report. Our people, our security, our future. July 2016.

workup and treatment if deemed necessary by the clinical staff."[9] For example, the CAF immunization policy is an area where there is inequality for the part-time reservist. The Director Force Health Protection Standard #CDCP/2007/02 (issued 30 Nov 2007), Annex C outlines entitlements for vaccines. For the reservists who are deploying, immunizations are considered "routine care" and as such, only Class B Reservist on a contract of 180+ days are entitled to vaccines and Class C Reservists. In some cases, this is a clinical patient safety concern, until the contract can be completed administratively. There is a timeframe to complete the immunization cycle prior to deploying and timelines are hampered if the contract cannot be completed in time. Healthcare waivers are sometimes needed to be staffed for approval. This is not in the best interest of the Reserve Force member. If someone is screening for deployment then we need to have the authority to start vaccines sooner than later, for example at the time the member is initially screened. Annex C, para 15 provides direction regarding Primary Reservist preparing for deployments.

The major restriction is noted in the final sentence: "Vaccinations must only be initiated if the Primary Reserve member has received official joining instructions, and is otherwise medically fit for deployment."[10] The issue is if an immunizer waits for the member to receive official joining instructions and has proof of being medical fit (approved medical/medial review) then it is next to impossible to provide North American standard and deployment specific vaccines due to the recommended intervals between vaccines with multiple doses.

In addition, reservists who go on course may be affected by the inequity of the immunization policy. Primary Reserve Class A, who commenced a primary series of

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[9] Canada. Department of National Defence. CF H Svcs Inst 4090-02, Interim Guidance for the Delivery of Health Care to Reserve Force Personnel. 2010.

[10] Canada. Department of National Defence. Director Force Health Protection Standard #CDCP/2007/02 issued 30 Nov 2007.

immunizations during Primary reserve training are to be strongly advised to complete any partial immunization series through their civilian health care provider. As a best practice, if we start them, we should finish them and not strongly advise them to complete them in their civilian healthcare system. Public Health in the provinces does not normally cover these vaccines in their programs and the cost would be borne by the member. As identified by the Ombudsman, "providing periodic health assessments to Reservists will positively impact operational readiness and safety as well as provide an opportunity to identify a Reservist who may be in need of support."[11]

The CAF does have a good disability compensation program for reserve personnel who have been injured. "Members of the Reserve Force on Class "A, B or C" Reserve service incapable of performing duty due to an injury, disease or illness attributable to that service are entitled to pay and allowances until the termination of that service."[12] If a Class "A" Reservist or Class "B" Reservist under 180 days sustains a duty related injury that results in their inability to report to their civilian jobs, under the Worker's Compensation Act Chapter 10, they are not entitled to Worker's Compensation benefits. They are; however, entitled to benefits under either The Department of Veterans Affairs Canada, or under the Government Employees Compensation Act (GECA). The member has a choice as to which Department they will seek compensation, but it must be one or the other. The negative impact and inequality issue is that the bureaucratic administration of these programs can be cumbersome and time consuming for many reservists and their families.

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[11] Canada. Department of National Defence. Ombudsman Report. Part-Time Soldiers with Full-Time Injuries: A Systemic review of Canada's Primary Reserve Force and Operational Stress Injuries. May 2016: p. 2.

[12] Canada. Department of National Defence. Director Casualty Support Management. The Guide to Benefits, Programs, and Services for Serving and Former Canadian Armed Forces Members and their Families. Caring for Our Own. October 19, 2015 Edition: p. 18.

How has the inequity in healthcare benefit policy affected the overall CAF recruiting and retention strategies for reservists? The best recruiting tool in the CAF is word of mouth. Friends tell friends and family members tell family members of experiences they enjoy. The many Ombudsman's reports the past decade has shed a light on the many inequities affecting reservists. The CAF leadership has reacted by creating new policies which affect both recruiting and retention of CAF reserve members or future CAF reserve members. The CAF have historically been under-represented by certain segments of society and have been working to become more attractive to these segments. "Gen Vance has since taken the unprecedented step of ordering the military to increase the percentage of female personnel to 25 per cent in the next decade, up from 15 per cent. Recruiters are now launching targeted advertising campaigns and reaching out to women who previously expressed an interest in a military career but didn't join."[13]

One such policy is expediting the enrollment process for reservists. As stated by Harjit S. Sajjan, Minister of National Defence, "Simplifying and streamlining recruitment for reservists is an important step forward as we improve our processes and standards, and enhancements like this will go a long way in improving reservists' experience in the CAF from day one."[14] Applicants for the Canadian Army Reserve are now able to enroll in just weeks rather than months. The intent of this initiative is to put in place an expedited process that will streamline enrollments. "Improving the recruiting process is just one of several initiatives in an

[13] The Star. The Canadian Armed Forces Aims to fix the Recruitment System to Foster Diversity. 27 June 2017.

[14] Department National Defence / Canadian Armed Forces News Release. Canadian Army implements an expedited enrollment process for its Primary Reserve Force. Ottawa. April 3, 2017.

ongoing effort to strengthen the Army Reserve, and to leverage its ability to deliver operational effect."[15]

Another positive move for reserve recruiting and retention is tasked as Initiative #81 in Canada's Defence Policy, *Strong, Secure, Engaged* (SSE), the CA will provide Full-time Summer Employment (FTSE) to all Army Reserve (ARes) members in their first four years of service who self-identify and volunteer to participate in this program. "FTSE not only will strengthen the ARes, but will also provide an assurance of a consistent salary throughout the summer employment period such that the ARes is envisioned as an employer-of-choice for serving members and potential recruits."[16]

Retention of reservists is important. "One of the key programs we're looking at doing right now is to facilitate the move between the regular and the reserve forces. It used to be a complex process to make the transition, but we now want to make it as simple as a transition of a matter of a week or two after showing intent."[17]

Conclusion

In conclusion, this essay has shed a light on the inequities of reserve healthcare benefit policies. The CAF reserve healthcare benefit policies are not equal for all members who assume the same risk while serving their country. In answering all questions, the analysis has enabled me to affirm my understanding of the dynamics and complexities of how policy development efforts

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[15] Ibid.

[16] Canada. Department of National Defence. Commander Canadian Army Implementation Directive – Full-time Summer Employment. 15 Jan 2018.

[17] Canada. Hon. Kevin Sorenson Chair. Report 5, Canadian Armed Forces Recruitment and retention – National Defence, of the Fall 2016 Reports of the Auditor General of Canada. Report of the Standing Committee on Public Accounts. June 2017. 42nd Parliament , First Session: p. 13.

are formulated. In many cases, the initiatives have had constraints imposed on them mainly because of lack of resources.

Unfortunately, the lack of resources, lack of clarity, lack of knowledge and lack of access to PHAs does exist. The inequity in policies have had a detrimental effect on reservists especially those who are suffering from physical and mental health injuries. The overall impact that the inequalities in the CAF reserve healthcare benefit policies have had on the organization's recruiting and retention strategies of the CAF will take time to fix, but certainly look promising with the initiatives being creating presently.

Once a member puts on a CAF uniform, they are in service to Canada. Both the Regular and Reserve Force personnel assume the same risk while deployed on expeditionary or domestic operations and exercises and as such should receive very similar healthcare to treat the same physical and mental health occupational stress injuries. There needs to be an overall culture of looking after all our uniformed force members in times of need. This includes using every patient encounter to better educate our Reserve Force members with respect to their entitlements to care and ensuring the CAF, through the CF H Svcs Gp, partners with our civilian health care systems to better support our Reserve Force personnel throughout their careers.

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