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GETTING PAST THE BARRIERS OF MENTAL HEALTH IN THE CANADIAN FORCES

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INTRODUCTION

Most military members enter a career in the Canadian Armed Forces (CAF) with a sense of excitement and curiosity for what the years ahead may hold. What these service members do not foresee are the risks, both physical and mental, associated with uniformed service as a member of the profession of arms. The concept of expeditionary service has deep historical roots in Canada where this is an expectation of conflict; however, the reality of serving in an operational area and later suffering from a form of mental illness may be challenging to openly confront. The images of soldiers being killed or injured on operations is portrayed in the media as flag draped coffins or amputees being recognized with a newly created Canadian honour; the Sacrifice Medal. There are no pictures of soldiers suffering from mental illnesses as a result from their deployment. These images are not seen, as mental health illnesses are invisible and they are often kept hidden for months, years, or until the member faces the reality that they are in need of help.

The after-effects of a traumatic event with regards to mental health are difficult to anticipate as the symptoms are less visible and are reluctantly reported from those affected.[1] This paper will examine the barriers that deter CAF members from seeking treatment for their mental health illnesses. The focus will be on two specific barriers commonly referred to as 'stigmas;' the self-imposed stigma and the stigma on career implications.

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[1] Jean-Rodrigue Paré, *Post-Traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans [Revised 3 September 2013]* Parliamentary Information and Research Service, 2013)., 1.

In order to understand the emphasis that stigmas have on an individual, it is important to understand the meaning of the terms. Stigma is defined as a 'brand' or 'mark of infamy' which is tied to a specific group or identity.[2] Stigmas are mostly negative leaving those impacted as feeling targeted and inferior to those around them. A mental health stigma is further defined as "a dynamic process by which a service member perceives or internalizes this brand or marked identity about himself or herself or persons with mental health disorders."[3] The biggest challenge with stigma remains it cannot be discounted as those effected truly believe that feelings of inadequacy are valid and that the member does deserve the perceived treatment. Dr. Micheal Boivin, a psychologist from the Royal Ottawa clinic who has specialized in operational stress injuries (OSI), believes the underreporting of post-traumatic stress disorder (PTSD) is directly linked to the attitudes within both the military and the general population.[4] Some Canadians could get the impression that PTSD is a disorder suffered by all service members returning from operations given the extensive media coverage however, non-combat mental health concerns are common as well with military personnel.

Although the recruitment process involves an assessment of general health under medical policies set forth in Department of National Defence (DND) guidelines, some members may be enrolled with an existing mental health concern. While CAF recruitment is predicated "on the basis of physical and mental health criteria that make this population [recruitment pool] one that is at a lower risk than the general

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[2] Joie D. Acosta, *Mental Health Stigma in the Military* (Santa Monica, CA: Rand, 2014)., 8.
[3] Ibid., 8.
[4] Becky, Rynor. "Veterans Stepping Forward for Treatment of Operational Stress Injuries." *CMAJ : Canadian Medical Association Journal* 182, no. 7 (2010), E281.

population,"[5] it is a reasonable expectation that not all pre-existing health concerns are identified. In other words, the implication is that this process is not absolute and some CAF members may enter the military with a mental health illness. Furthermore, these new service members are often silent as they do not want to risk their careers by seeking treatment or admitting that they have previous mental health concerns not relating to military service. The commonality of this phenomenon has not been researched in great depth; however, statistics show that one in five Canadians will suffer from some type of a mental health concern in their lives.[6] This illustrates the expectancy of mental health diagnoses, yet a dichotomy exists as pockets of society remain uncomfortable openly confronting the reality of its presence in everyday life. The reality of mental health concerns in the CAF was shown in the 2002 CAF Mental Health Survey which illustrated that "15 percent of all CAF personnel experienced symptoms of one of five common mental disorders in the previous 12 months (major depression, social phobia, post-traumatic stress disorder (PTSD), panic disorder, and generalized anxiety disorder)."[7] Unfortunately, this statistic is not widely known, sharing these results with military personnel would help illustrate how common mental health concerns are and would enable more personnel to accept their illnesses.

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[5] Jean-Rodrigue Paré and Melissa Radford, *Current Issues in Mental Health in Canada: Mental Health in the Canadian Forces and among Veterans*Parliamentary Information and Research Service, 2013)., 2.

[6] Maxime Bernier, *Doing Well and Doing Better: Health Services Provided to Canadian Forces Personnel with an Emphasis on Posttraumatic Stress Disorder*Canada. Parliament. House of Commons, 2009).., 25.

[7] National Defence and Canadian Armed Forces, "The State and Impact of Mental Illness in the CAF and Canadian Society," http://www.forces.gc.ca/en/about-reports-pubs-health/surg-gen-mental-health-strategy-ch-2.page; Internet: accessed, 13 April 2018.

BARRIERS TO TREATMENT

As a member of a profession that is concentrated on uniformity, physical fitness, and group cohesion it is difficult to accept when an individual is unable to meet expected standards where there is no visible medical obstacle. The National Defence and Canadian Armed Forces Ombudsman (Ombudsman) has taken a special interest in the delivery of mental health care to service members and published three reports (2002, 2008, and 2012) which identifies systemic problems while simultaneously providing corresponding recommendations. The 2012 report entitled *Fortitude Under Fatigue: Assessing the delivery of care for operational stress injuries that Canadian Forces Members need and deserve,* concluded that there are three main concerns regarding the care of those diagnosed with PTSD.[8] The first concern is that stigma associated with mental health disorders remains widespread amongst service members and the CAF community.[9] The second concern is there is a vast difference in what is being stated at the strategic level on how mental health service will be delivered and addressed, and what is actually occurring across the many different military installations where treatment is being delivered.[10] The final concern reported is the number of mental health professionals available to treat service members; this impacts both the diagnosis phase as well as long term treatment.[11] Although all three concerns are valid, these issues are not specific to the CAF; they are the same problems which remain relevant to the treatment of mental health patients anywhere in Canada. The requirement for specialty care in the

[8] Pierre Daigle, *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve*. Office of the Ombudsman, National Defence and Canadian Forces, 2012), 6.

[9] Ibid., 6.

[10] Ibid., 6.

[11] Ibid., 6

military is increasing, leaving CAF health care professionals facing a battle in how to apportion the finite amount of treatment resources available.

Accompanying the limited mental health resources brings forward another problem; receiving care in the patient's primary language. The ability to communicate in the service member's first official language is imperative as a method to verbalize the sensitivities of a mental health illness; it is an essential part of the diagnosis and treatment. With a physical injury, communication can happen through a variety of non-verbal cues or the use of x-rays, MRIs, charts or tests, however with the treatment of mental health disorders, the background information, detailed history, and emotions are vital for the professional to understand the complexity of care required. The military member must be able to control the narrative using language and expressions that can truly detail their experience. Confronting a mental health concern is a significant challenge for service members, but attempting to do this in a second language is less than optimal. With limited resources accessing treatment in a region where both official languages are not readily available is a significant barrier for one to face.[12]

In addition to the act of accessing mental health care, which is a major hurtle for service members in need, is the individual need for privacy and confidentiality. Many CAF installations across Canada have invested in the infrastructure solely dedicated to mental health care needs; these spaces are physically separate from outpatient Canadian Forces Health Services centers (CF H Svcs C). These locations include Operational Trauma Stress Support Centres, Mental Health Clinics, and various peer-support group meeting sites. The proximity of these spaces to generalized care can make it a barrier for

[12] Ibid., 60.

a service member to access services.[13] It is often felt that there is no sense of anonymity as those getting treatment feel that they are being judged as they enter these centres, often in an alternate form of dress. A parliamentary report for the Standing Committee on National Defence entitled *Doing Well and Doing Better: Health Service Provided to Canadian Forces Personnel With An Emphasis on Post-Traumatic Stress Disorder* details this obstacle by stating that "if psychological injuries are to be treated the same as physical injuries, perhaps Operational Trauma Stress Support Centres should be co-located with other medical services on the base to encourage the equivalency."[14] This makes sense as a service member obtaining medical services would go to reception to report for an appointment like anyone else and it should be seamless regardless of their health needs. It would be irrational to ask those seeking treatment for sexually transmitted diseases to enter the CF H Svcs C from another door, but somehow we think this benefits those with mental health concerns. Segregation based on health concerns only strengthens the perceived stigmas.

As compared to civilian practitioners, CAF medical professionals have a duty to outline medical employment limitations (MEL) to the service member's chain of command that, in turn, ensures the operational readiness of the institution. These MELs provide clear instructions on how a service member can be employed while simultaneously protecting the member's confidentiality. No mention of the specific diagnosis is presented. For physical injuries, the employment restrictions are well-defined providing understandable guidelines for supervisors of all ranks in the chain of

[13] Bernier, *Doing Well and Doing Better: Health Services Provided to Canadian Forces Personnel with an Emphasis on Posttraumatic Stress Disorder*, 38.
[14] Ibid., 39.

command. Conversely, a medical employment limitation for a mental health injury can erode the privacy and confidentiality of the member. Often, these limitations may restrict the member's ability to use weapons, machinery, and not being present for specific military training.[15] The immediate difference in the issuance of a MEL for a psychological as compared to a physical injury is the manner of employment. As an example one service member suffering from a visible injury may still partake in weapon ranges as a sentry or radio operator whereas their colleague with a mental illness may have to stay behind in unit lines. This disparity may trigger unwelcomed questioning and result in further alienation. Although the MEL does not detail the diagnosis, with the absence of physical injury and the specified limitations it may be clear what health issue the uniformed member is experiencing.

The origin of the term post-traumatic stress disorder began to be used in 1980 in the American Psychiatric Association (APA) which set out the criteria for the disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[16] Changes continued to be made to the DSM as medical professionals got a better understanding of the diagnosis of PTSD and other associated factors. Today, it is understood that PTSD is not associated with first responders or military members and that there is a high likelihood of over 80% of those diagnosed with PTSD may also have other mental disorders such as depression, anxiety, alcohol and drug addictions, or suicidal thoughts.[17] There is a belief that, due to the term "disorder" being used with post-traumatic stress, that this, in turn, serves as a barrier to service members getting help. Recently military leaders have

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[15] Ibid., 20.

[16] Paré, *Post-Traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans [Revised 3 September 2013]*, 2.

[17] Ibid., 5.

requested that 'disorder' be removed and the word 'injury' to take its place.[18] It was felt that the meaning behind disorder insinuated a permanent impairment, whereas the use 'injury' would provide a better outlook to the service member and their recovery. This request has not been upheld by the APA, and PTSD continues to be used today.[19] The consistent use of PTSD in the military environment can create a belief that this it is the sole mental health concern effecting uniformed personnel. Although PTSD can be more prevalent with military members, there are plenty of other mental health concerns impacting its members who may feel that all the attention is solely focused on those with a formal diagnosis of PTSD or combat related injury. In the Canadian military, the term 'operational stress injury' was introduced in the late 1990s to describe psychological injuries which occurred while participating in operations.[20] This term continues to be used today, as it is all encompassing and less intimidating than the medical terminology involving disorder.[21]

SELF-APPLIED STIGMA

As mental health concerns may not immediately present after an incident or occurrence in one's life, the side effects of a mental health illness can appear slowly or become apparent after a certain trigger. The magnitude of significance may dictate how and when an individual may seek help. Some individuals may self-medicate or independently deal with their problems on their own and never need professional help,

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[18] Ibid., 5.
[19] Ibid., 5.
[20] The Standing Senate Committee on National Security and Defence, "Occupational Stress Injuries: The Need for Understanding," http://publications.gc.ca/collections/collection_2011/sen/yc33-1-0/YC33-1-0-372-14-eng.pdf; Internet; accessed 13 April 2018., 7.
[21] Ibid., 7.

while others are not able to cope and realize professional assistance is warranted but do not know how to access the care they require. In the instance of Lieutenant-Colonel Stephane Grenier, who is now an advisor on operational stress injuries and director of the operational stress injury social support project (OSISS) stated that when he returned from his 10-month peacekeeping mission in Rwanda he was injured and was not aware of the depths of his mental illness.[22] Grenier was reluctant to get help as he did not know how to describe what was going on in his head. This resulted in him sitting in his car in front of the medical clinic for 45 minutes trying to figure out what to do.[23] This is often the case, the member knows that there is something wrong, but they do not have the ability to put a label on it or describe their illness.

Another issue for those suffering from a mental health illness is the perception of telling a service member's peer or chain of command. This is supported in the 2012 Ombudsman report, *The Fortitude under Fatigue*, which stated that "within the military environment there will always be an element of the membership that simply cannot reconcile being a warrior with succumbing to an injury of the mind."[24] The notion that having a mental health concern is linked to weakness is an area that is continuously being addressed by leadership; they, in turn, message that addressing mental health is part of the desired morale strength of soldiers and ignoring indicators is not consistent with the expectations of service. The original Ombudsman report in 2002 found evidence that those diagnosed with PTSD were stigmatized as being "fakers, malingerers, or as being

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[22] Roger Collier, "Where "Stigma Leaves the Room"," *CMAJ : Canadian Medical Association Journal = Journal De L'Association Medicale Canadienne* 182, no. 6 (2010), 546., 546.

[23] Paré, *Post-Traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans [Revised 3 September 2013]*, 5.

[24] Daigle, *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve*, 59.

weak or incapable."[25] In the subsequent follow up report in 2008, the same attitude still existed and more guidance from senior military leadership was required as it appeared service members were not accessing resources. The evidence suggests this avoidance was a result of being negatively labelled by peers. This was clear in the report where it was stated that "mental health providers from virtually every military establishment across the country informed investigators that there is still a stigma with coming forward for assistance."[26] This report was written six years after the initial investigation from the Ombudsman and a heavy presence into combat operations in Afghanistan where it was well recognized that service members had been exposed to a litany of traumatic events.

CAF members undergoing mental health treatment can often feel a sense of abandonment by their unit and co-workers as their medical limitations often impact on the ability to work as a cohesive team. The CAF has made significant progress by standing-up multiple Joint Personnel Support Units (JPSU) across Canada which allows service members to leave their units, get treatment, focus on rehabilitation, and rejoin their unit when their prognosis dictates. Although JPSUs have taken a lot of pressure off the unit from administering the care of service members, those undergoing treatment feel abandoned and left to navigate both their illness and their new reporting structure where normalcy is completely stripped away and there is no familiarity of their previous routine left.[27]

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[25] Mary McFadyen, *A Long Road to Recovery: Battling Operational Stress Injuries: Second Review of the Department of National Defence and Canadian Forces' Action on Operational Stress Injuries*Office of the Ombudsman, National Defence and Canadian Forces, 2008)., 16.

[26] Ibid., 16.

[27] Bernier, *Doing Well and Doing Better: Health Services Provided to Canadian Forces Personnel with an Emphasis on Posttraumatic Stress Disorder*, 33.

The overwhelming feeling of guilt is another factor that can play a significant role in the life of a service member seeking treatment. Military members may have regret from a traumatic situation where they feel responsible or feel blamed by others.[28] This internal battle can hamper one's own self-worth and keep them from seeking care as they may mistake their mental health condition as a deserving sense of guilt in which they must carry. As stated previously, the side effect of serious mental health illnesses usually coincides with other conditions such as depression, anxiety, and suicidal thoughts. As these thoughts are internal and self-deprecating, the ability to acknowledge that military members are in need of help may not occur as they do not see themselves as deserving of professional care.

CAREER IMPLICATION STIGMAS

Due to the limitations placed upon CAF service members with the policy on *Universality of Service* the guarantee of a lifetime employment does not exist.[29] This policy is predicated on a soldier's first principal which requires that all members of the Canadian Armed Forces "must at all times and under any circumstances perform any functions that they may be required to perform."[30] Members are also expected to be mentally and physically fit, employable and able to deploy in operational theatres.[31] For someone that has been fighting an internal battle and is in need of mental health care, this could be one of the biggest deterrents. As stated in the 2012 Ombudsman report "a major barrier to care remains the fear that coming forward with a mental health injury

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[28] Cheryl Lawhorne Scott and Don Philpott, *Military Mental Health Care: A Guide for Service Members, Veterans, Families, and Community* (Lanham, Md.: Rowman & Littlefield Publishers, 2013), 229., 117.

[29] Department of National Defence, Departmental Administrative Order and Directive 5023-0.

[30] Canadian Human Rights Act, Section 15 (9).

[31] Bernier, *Doing Well and Doing Better: Health Services Provided to Canadian Forces Personnel with an Emphasis on Posttraumatic Stress Disorder*, 42.

will adversely affect, or even end, one's military career."[32] This could also explain the length of time it takes for someone to identify they have a problem as the consequences of coming forward could have a major impact on their lives. For many, being a military member is their identity, and the thought of them no longer being a uniformed member is not an outcome they wish to consider.[33] The struggle between being pushed to the edge with mental health concerns and wrestling with the consequences of career implication is a real concern for those combatting stigmas.

Another concern is the perception that those with physical injuries are able to recuperate and those around them see that they are physically getting better, whereas with mental health illnesses there is no visible progression of healing or an associated and predictable timeline. Throughout military training, the mantra of "service, mission, self" is embedded in the mind of service members, where the expectation is that one's needs are subordinate to those of the nation and assigned mission. There is little guidance on when you need to put yourself first. Many members interpret seeking professional help as letting their peers down as they are no longer strong enough for the warrior like mentality.[34] Being in an environment where tasks are delegated and a large percentage of the work is completed in small section size groups of 8-10 individuals, when a member seeks professional medical assistance they recognize there is something different going on with them which erodes group cohesion and a sense of belonging.

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[32] Daigle, *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve*, 60.

[33] Ibid., 22.

[34] Susanne W. Gibbons et al., "Military Mental Health Stigma Challenges: Policy and Practice Considerations," *The Journal for Nurse Practitioners* 10, no. 6 (2014), 365-372., 369.

Often due to the stigma involved with acknowledging that a mental health issue is ongoing, military members are not seeking treatment resulting in a time lag which affects the member's ability to seek effective treatment and return to duty with no limitations. However, those who do seek timely treatment have a 30-50% chance of full remission.[35] A study on the prevalence of mental health stigma in the United States (U.S.) military found the most common reasons for service members not seeking help for their mental health concerns were; (a)it would harm their career, (b)members of their unit would have less confidence in them, (c)their leadership may treat them differently,(d) impact security clearance, and (e)the issue of confidentiality. [36] Although the study took place in the U.S., these statements are also valid in the Canadian military as referred to in the Ombudsmen reports.

Withholding a mental illness places the military member in a precarious position, as they are considered fit and could be sent out on operations whether it be on a field exercise away from medical facilities or deployed to an overseas operation. In fact, CAF policy governs the withholding medical employment limitations and service members are subject to policies as articulated in Defence Administrative Orders and Directives (DAOD), specifically, *DAOD-5009-0, Personnel Readiness.*[37] Further, for a commanding officer, it is their responsibility to know the readiness state of their uniformed personnel. In a 2003 report to the subcommittee on *Veteran Affairs of the Standing Senate Committee on National Security and Defence*, then Brigadier General (BGen) Ivan

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[35] Paré, *Post-Traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans [Revised 3 September 2013]*, 10.

[36] Acosta, *Mental Health Stigma in the Military*, 24.

[37] Government of Canada. Department of National Defence. (2017). *DAOD 5009-0, Personnel Readiness***.** Retrieved from http://www.forces.gc.ca/en/about-policies- standards-defence-admin-orders-directives-5000/5009-0.page; Internet; Accessed on 13 April, 2018.

Fenton expressed his concern regarding his responsibility to look after the well-being of his soldiers while they are afraid to come forward and admit they have a problem.[38] In rather direct language, BGen Fenton stated that "my commander's responsibility to the army and the nation to generate soldiers for new operations. I believe I have hundreds of wounded soldiers who on surface seem okay to deploy, but they are really not".[39] This sentiment is now a reality for the current leadership of the Canadian military, training and deploying soldiers who are deemed fit to deploy on paper, but even the Commanders see that there is a problem.

Although the CAF has made significant improvements to the medical system in providing numerous resources for those suffering with mental health illnesses, there is concern with those who deliver the care to the service members. The 2012 Ombudsmen report laid out evidence that there lacks a cooperative relationship between the main stakeholders responsible for getting military members the required health care.[40] The primary health provider, mental health caregivers, military chain of command did not report effective means of communication, therefore affecting the support structure of the member receiving care. There has also been evidence that the medical professionals who are providing the treatment and care to the service members suffer from burnout created

[38] The Standing Senate Committee on National Security and Defence, "Occupational Stress Injuries: The Need for Understanding," http://publications.gc.ca/collections/collection_2011/sen/yc33-1-0/YC33-1-0-372-14-eng.pdf; Internet; accessed 13 April 2018., 20.

[39] Ibid., 20.

[40] Daigle, Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve, 6.

by the lack of resources and the depth of the mental health care required.[41] The findings are an indication of the scope of the overall medical health approach in the CAF.

Members who have serious health concerns are routinely assigned a case manager who works within the CF H Svcs group, however, there can sometimes be a disconnect with the terminology which could cause concern to a military member already dealing with a multitude of issues. It is important that the case managers and both mental health and general physicians agree on the care for the effected member. Using transition language early in the member's treatment can cause them to withdraw from care all together or add increased pressure to their illness. One of the repeated concerns presented in the various research used for this paper was the notion that a soldier may need to "return to civilian life" this implies that the member's career has ended and that they had already experienced "civilian life" previously.[42] A military member generally does not consider themselves part of the civilian population as they may have joined the military right after high school or university. Not only is the member concerned with their new identity but, depending on their medical limitations, their ability to function outside of the military may be limited as well. The stigma of ending ones career and not knowing what options lay ahead may be great enough for a service member to not seek treatment of any kind.

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[41] McFadyen, *A Long Road to Recovery: Battling Operational Stress Injuries: Second Review of the Department of National Defence and Canadian Forces' Action on Operational Stress Injuries*, 21.

[42] Daigle, *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve*, 22.

IMPROVEMENTS AND THE WAY AHEAD

Unfortunately, there is no known solution to eradicating mental health illnesses from the CAF; however, there has been a substantial increase in the attention, resources and training made available to make it easier for service members to access care, and to educate the force as a whole in regards to the prevalence of mental health illnesses. Mental health education has been implemented into the basic training for all service members regardless of element or occupation. In 2012 an initiative called the Road to Mental Readiness (R2MR) was introduced; this training continues throughout a member's career progression and during both deployment and redeployment timelines.[43] Training such as R2MR ensures that military personnel recognize the mental health continuum and are able to pinpoint both their mental state and recognize some key indicators in others. The continuity of the training throughout a member's career encompasses different objectives as leader's progress through the various CAF individual training and education development stages. In turn, a comprehensive approach is presented to CAF members.

In 2014, Military Family Services (MFS) released a publication entitled "You Are Not Alone" which is a 68 page document detailing the various mental health resources available for military families that are located on military bases and wings, in the community or accessible online or through a toll free number.[44] The growing recognition of the caregivers for personnel undergoing mental health treatment is important as they

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[43] National Defence and Canadian Armed Forces, "CAF Mental Health Programs and Services - Understand, Educate, Care" http://www.forces.gc.ca/en/about-reports-pubs-health/surg-gen-mental-health-strategy-ch-3.page; Internet: accessed, 13 April 2018.

[44] Canada. Military Family Services, You're Note Alone: Connecting Military Families to Mental Health and Social Wellness Programs" https://www.cafconnection.ca/getmedia/2e130364-e845-4783-9cf6-8053c55daa5f/You-re-not-Alone-Web-Guide-Oct-2014-E.aspx?ext=.pdf; Internet Access, 13 April, 2018.

are impacted by their loved ones illness as well. The resources offered through the Military Family Resource Centres (MFRC) include social workers, support groups and access to the 24/7 Family Information Line which is managed by trained counsellors.[45] Military practitioners have also recognized the strength behind families supporting the service member through their treatment, and try to involve them in the soldier's recovery whenever beneficial.

The latest initiative that is currently being implemented is a new outlook on a military member's career options; this initiative is called the Journey. Although still being developed, the Journey is looking to offer different options to serve in uniform. This could see service members having the option to elect to stay in one geographic location, which could be beneficial to members who are undergoing treatment with specialists where a move could upset their prognosis. Although this may mean electing to withdraw from the normal stream of military service, a member will still maintain their identity as a military member, which has been previously discussed as a concern for those seeking treatment. As this policy begins to clarify what options military members will have as a result of this initiative, there will be implications to the Universality of Service policy, meaning this could be beneficial to those with MELs who cannot deploy. Until this happens, another option for medically releasing or released service members to consider is the public service priority employment opportunities now offered through the Veterans Act (Bill C-27). Depending on the veterans MELs, they may still be able to work as a civilian in the public service and have priority hire over other applicants. This

[45] National Defence and Canadian Armed Forces, "CAF Mental Health Programs and Services - Understand, Educate, Care" http://www.forces.gc.ca/en/about-reports-pubs-health/surg-gen-mental-health-strategy-ch-3.page; accessed, 13 April 2018.

measure was introduced in 2015 and has had positive results in getting released military members employed within their capabilities; some have even remained working as part of the Defence Team.

The new defence policy released in 2017, *Strong Secure Engaged: Canada's Defence Policy* demonstrated the government's commitment to the well-being of its military members by singling out mental health illnesses. The policy indicates three main objectives for the CAF which will benefit those who have mental health concerns. The first objective is to establish a joint National Defence and Veteran Affairs Suicide Prevention Strategy.[46] This demonstrates that a member's mental health concerns do not diminish when they transition to civilian life; in fact, in some cases as mentioned earlier, the transition change can actually cause more stress and trauma to someone already in a precarious state. The second objective focuses on removing barriers to mental health care.[47] This is a sizeable objective to achieve, one that requires attention but where few solutions are found. The last goal outlined for mental health is the creation of more positions to address the call for resources. The resultant combination of these initiatives will assist in the previously discussed allocation of resources and provided the critical specialized care to those in great need.

A factor that should be considered by military leadership is to increase the mental health screenings that are currently mandatory only for some members. At present, the only times that military members are ordered to see a mental health practitioner are prior to a combat deployment and on redeployment, and also for specific postings. Having an

[46] Canada. Dept. of National Defence and Canada. *Strong, Secure, Engaged: Canada's Defence Policy* (Ottawa, Ont.: National Defence,[2017])., 26.

[47] Ibid., 26.

annual mental health checkup, or changing the requirement of a screening to all postings regardless of location would provide members with opportunities to openly discuss their concerns without facing the barrier of making an appointment for themselves. This may be seen as being overly cautious; however preventative measures can be beneficial in avoiding a tragic situation later in someone's career. Providing service members with opportunities to visit mental health for regular appointments also normalizes the mental health department like any other department in the medial facility.

CONCLUSION

The Canadian Armed Forces continues to help its members fight the stigmas associated with mental health concerns. Whether it be senior leadership coming forward and setting the example by sharing their personal accounts of receiving care, or the chain of command declaring that mental health will be looked at the same as any physical injury, this will help create an environment for members to access mental health resources. Continued support needs to be transparent to soldiers, airmen and sailors so that those suffering see that the military is taking steps to remove the perceived stigmas and barriers in order for its members to get the professional care available to them.

Whether it is self-imposed stigma or career implicated stigmas, the new initiatives such as R2MR, support groups, new research initiatives and awareness campaigns to outline the prevalence of mental health illnesses effecting military personnel will help normalize the procedure for identifying mental health concerns. The spectrum of mental health continuum not only gives a tool for individuals to self-identify when they should access professional care, but it assists leaders and peers to recognize signs in others.

Through the persistence of the various Ombudsmen reports, Parliamentary research, Veteran Affairs advocates and not-for-profit organizations, the government is now committed to contributing to the welfare of the military personnel through the various mental health objectives laid out in the newly release *Strong, Secure, Engaged: Defence Policy*. This in itself sends a strong message to service members that the government recognizes their sacrifices and is committed to providing them with the needed resources to getting back to a healthy state of mind.

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