



Current Issues in Mental Health in Canada: Mental Health in the Canadian Forces and Among Veterans

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Mental Health in the Canadian Forces and Among Veterans

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CURRENT ISSUES IN MENTAL HEALTH IN CANADA: MENTAL HEALTH IN THE CANADIAN FORCES AND AMONG VETERANS

1 THE HUMAN COST OF MILITARY OPERATIONS

On 7 July 2011, after nine and a half years in Afghanistan, Canada officially terminated its military combat operations in that country. Approximately 1,000 members of the Canadian Forces (CF) will nevertheless remain there until 2014 to provide training support for Afghan security forces.

A total of approximately 30,000 Canadian service personnel were deployed to Afghanistan, which in terms of strength exceeds Canadian participation in the Korean War between 1950 and 1953, thereby making the deployment in Afghanistan the largest Canadian military operation since the Second World War. One hundred and fifty-eight soldiers and four civilians died in Afghanistan.¹

The potential psychological after-effects of involvement in military operations are usually described by the medical term "post-traumatic stress disorder" (PTSD), or the military and police term "operational stress injury." These after-effects are more difficult to anticipate than physical injuries because they are less visible, reluctantly reported by those who suffer from them, and because the symptoms may only appear years after the traumatic event. Our understanding of the condition is therefore imperfect, and there are no certainties, except for the distress of those affected.

2 POST-TRAUMATIC STRESS DISORDER AND OPERATIONAL STRESS INJURIES

The diagnosis of PTSD is becoming well established in the psychiatric community, leading to the standardization of diagnostic criteria.

In North America today, a diagnosis of PTSD is normally based on the criteria established by the American Psychiatric Association (APA) in its *Diagnostic and Statistical Manual of Mental Disorders* (DSM):²

The diagnostic criteria for the manual's next edition identify the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.³

Use of the term "disorder" was hotly debated in the lead-up to the release of the current version of the DSM (the fifth edition, or DSM-5). The APA flatly rejected the arguments of military officials, who wished to see the term "disorder" replaced by "injury."⁴

In the Canadian context, the term "operational stress injury" was coined in 2001 by Lieutenant Colonel (retired) Stéphane Grenier, who started the operational stress injury peer-support program in the CF, known as the Operational Stress Injury Social Support Program. The objective was to give the treatment of "mental injuries" the same legitimacy as physical injuries. ⁵ It was also thought that this approach would be a way to de-stigmatize mental health problems within the organization.

The medical term "post-traumatic stress disorder" will be used in this paper, because this document focuses on the epidemiological dimensions of the issue.

3 OVERVIEW OF STUDIES ON CANADIAN MILITARY PERSONNEL

A study published in 2012 of Canadian military personnel deployed to Kandahar province, Afghanistan, in 2010 revealed that 8.5% of respondents "exceeded civilian criteria for symptoms of acute traumatic stress, major depression, or generalized anxiety." Using stricter criteria lowers this figure to 5.5%. As a comparison, the same strict criteria yielded a much higher current prevalence of 21% in U.S. military personnel deployed to Afghanistan:

The difference could be accounted for by the United States' much longer deployment duration; shorter dwell time (time between deployments); and higher combat exposure, all of which have an association with mental health disorders during deployments.⁷

Another study, released in 2013, focussed on the 30,000 Canadian service personnel deployed to Afghanistan between 2001 and 2008. It reports that, over an eight-year period following their first deployment, about 20% were diagnosed with a mental health disorder attributable to their service in Afghanistan. Since the rate tends to stabilize six years following the first deployment, it provides a good approximation of lifetime prevalence. Specifically for military personnel deployed to Kandahar, where risks were higher, prevalence over eight years rises to 28%.

Military personnel are recruited on the basis of physical and mental health criteria that make this population one that is at a lower risk than the general population. On the other hand, military personnel are exposed to many more trauma risks than the general population. These two factors cancel each other out and the end result is that the prevalence of psychiatric disorders among military personnel tends to be comparable to that of the general population.

The rates increase if only those military personnel who have taken part in combat operations or witnessed atrocities are included. The 2.3% prevalence of PTSD doubles for the former group, and quadruples for the latter to almost 10%. For major depression, prevalence increases to 9.7% for people involved in combat operations, and to 12.5% for those who witnessed atrocities.¹⁰

The study also shows that almost 20% of Canadian military personnel who were in service in 2001 and involved in combat operations during their careers experienced mental disorders and their related consequences in the year the study was conducted.

As lifetime prevalence tends to be two to four times higher than current prevalence, these data would indicate that at least 30% of military personnel involved in combat operations risk suffering from PTSD or major depression during their lifetime.

It is now generally accepted that exposure to combat is the key risk factor for military personnel and veterans developing a mental health disorder.

Though a number of clinical treatments, including access to civilian mental health practitioners, and non-clinical programs, such as peer support programs, are available to CF members through the Canadian Forces Health Services Group, barriers to care, particularly the stigma faced by those with mental health problems, still exist within the organization. Efforts have been made to de-stigmatize mental health disorders and encourage members to come forward and seek help early. The recent, decade-long, modernization of the continuum of care provided to CF members is also continually examined internally – as well as externally by the Office of the Ombudsman for the Department of National Defence and the Canadian Forces – so that necessary improvements can be identified and implemented.¹¹

In October 2013, the Surgeon General's Mental Health Strategy for Canadian Forces Health Services Group was released. It summarized the state of mental health in the CF and provided guidance for the delivery of services and the prioritization of resources and research over the next five years.¹²

4 OVERVIEW OF STUDIES ON CANADIAN VETERANS

When a member is released from the CF, that member becomes a "veteran," and responsibility for health care to address service-related injuries or illnesses shifts to Veterans Affairs Canada (VAC), as do any related financial benefits. If Second World War and Korean War veterans are excluded, it is estimated that 592,000 veterans were still alive in June 2010. Of these, 313,000 were former members of the Regular Force, and 279,000 were former members of the Reserve Force; 91% of these veterans were not receiving any services from VAC.

In January 2011, VAC and the Department of National Defence published a major report on the physical and mental health and living conditions of Regular Force veterans released between 1 January 1998 and 31 December 2007. For the chronic symptoms of PTSD diagnosed by a health professional, the figures for current prevalence are as follows:

- for all veterans of the Regular Force released between 1998 and 2007: 11%;
- for veterans receiving disability benefits whose application was approved before 2006 (Pension Act): 24.5%; and
- for veterans receiving disability benefits whose application was approved after 2006 (New Veterans Charter): 42.5%.

If the most prevalent mental health disorders that the Government of Canada includes under the term "operational stress injuries" (PTSD, depression, anxiety, mania, dysthymia and bipolar disorder) are taken into account, the figures for current prevalence are the following:

- for all veterans of the Regular Force released between 1998 and 2007: 23.6%;
- for veterans receiving disability benefits whose application was approved before 2006 (Pension Act): 40.2%; and
- for veterans receiving disability benefits whose application was approved after 2006 (New Veterans Charter): 59.9%.

These rates are well above those found not only in studies of active military personnel but also in studies of the general population. They indicate that veterans are at much greater risk than active military personnel. They also highlight a higher prevalence among veterans receiving VAC benefits or services than among veterans in general.

5 THE RISKS ASSOCIATED WITH OPERATIONAL STRESS INJURIES: FROM ABSENTEEISM TO SUICIDE

When the impacts of an operational stress injury are treated in a timely and appropriate manner, full remission may result in 30% to 50% of cases. An accurate diagnosis and the subsequent implementation of an appropriate treatment plan are crucial in giving a CF member a greater chance of staying within the CF. When the symptoms become chronic, there is a significant increase in the risks: absenteeism, unemployment, interpersonal and family problems, alcoholism and drug addiction, trouble with the law, homelessness and suicide. A recent study provides more information about the reasons why veterans become homeless. The scope of the problem is still difficult to determine because there are no procedures in place to monitor military personnel released from the CF, except for VAC clients.

The risk of suicide remains a major concern with respect to mental illness. A recent study on the causes of death for former CF members provided initial estimates of numbers:¹⁸

- men (total of 96,786): 2,620 had died, 696 (26.6%) by suicide; and
- women (a total of 15,439): 204 had died, 29 (14%) by suicide.

With respect to veterans, the percentage of deaths attributable to suicide is 45% higher than for the general population and currently serving members. 19

6 FROM SOLDIER TO VETERAN: THE DIVISION OF RESPONSIBILITIES

When a military member has an illness, whether physical or mental, or is injured in service and this leads to permanent disability, VAC pays a disability award in one or more instalments, the amount of which varies with the severity of the disability. The award may be paid to a member who is still in service or to a veteran. In most cases, the disability does not prevent the person from continuing a career within the CF.

If the disability is serious, the person must leave the CF on medical grounds. A decision concerning the necessity of a release is made only once the injury can be described as having "stabilized." As long as the person is a member of the military, the CF is responsible for health care and rehabilitation. Once the decision has been made to release the member for medical reasons, two or three years usually go by before the person is permanently no longer a member of the CF. Once this time period has elapsed, and not before, VAC may begin to provide rehabilitation programs and medical services.

According to numerous witnesses who provided evidence at House of Commons Standing Committee on Veterans Affairs hearings, most members who are released from the CF for medical reasons are released against their will. ²⁰ They would have preferred to continue their career in the CF. The transition to civilian life is therefore a painful step for many. The upheavals connected with the transition, and the loss of a structured occupational and social environment, constitute an additional risk from the mental health standpoint.

As long as they remain within the CF, persons at risk receive medical monitoring. Once they become veterans, only those who decide to request VAC assistance are able to benefit from the services to which they are entitled. In addition, current rules do not permit the families of military members or veterans to access the services offered by the CF and VAC.

7 LOOKING TO THE FUTURE

With the end of the combat mission in Afghanistan, the first challenge to be met regarding the mental health of military personnel and veterans will be an assessment of the scope of the problem to ensure that appropriate services are put in place.

VAC expects that more than 34,000 military members or veterans will receive a disability award between 2011 and 2016.²¹ Many of these beneficiaries will not have a serious disability and will continue their careers within the CF. As mentioned earlier, it is also expected that between 25,000 and 35,000 members will be released from the CF during the same period, and that between 6,000 and 10,000 of these members will be released for medical reasons.

If we apply the lowest rates from recent Canadian studies on current prevalence, ²² in the year following their release, at least 5,900 (23.6%) of these new veterans will suffer from a mental health disorder and at least 2,750 (11%) will suffer from a

severe form of PTSD. The rates for those who will suffer from these symptoms at some point in their life will be higher.

At the moment, almost three quarters of the veterans taking part in VAC rehabilitation programs following their medical release from the military are suffering from a mental health disorder.²³ Despite the considerable efforts made over the past 10 years – in particular the establishment of a network of specialized external clinics, as well as a group of affiliated professionals to whom veterans can be referred as required – the government is having trouble meeting the demand.²⁴

Under the most optimistic scenarios, these needs will double over the next five years. Furthermore, because health services are involved, coordination with provincial resources will be crucial to prepare health professionals to deal with this specific problem. VAC's capacity to meet the growing demand for services over the coming years will be a major challenge for the Government of Canada.

NOTES

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- 5. House of Commons, Standing Committee on National Defence, *Evidence*, 1st Session, 41st Parliament, 25 March 2013, 1540 (Stéphane Grenier, as an individual).
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- 7. Ibid., p. 741.
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- Statistics Canada, <u>Canadian Forces Cancer and Mortality Study: Causes of Death</u>, Catalogue no. 82-584-XWE, 31 May 2011. According to the description on the Statistics Canada website, this report:

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- 19. Ibid. Calculation based on data in Table 4, p. 9.
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- 21. Veterans Affairs Canada, "Regulatory Impact Analysis Statement," Regulations Amending the Canadian Forces Members and Veterans Re-establishment and Compensation Regulations, 9 July 2011.
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- 23. Veterans Affairs Canada, "Presentation to the Standing Committee on Veterans Affairs (ACVA) on the New Veterans Charter," 13 May 2010.
- 24. National Defence and Canadian Forces Ombudsman (2012).