SPECIAL REPORT

TO THE MINISTER OF NATIONAL DEFENCE

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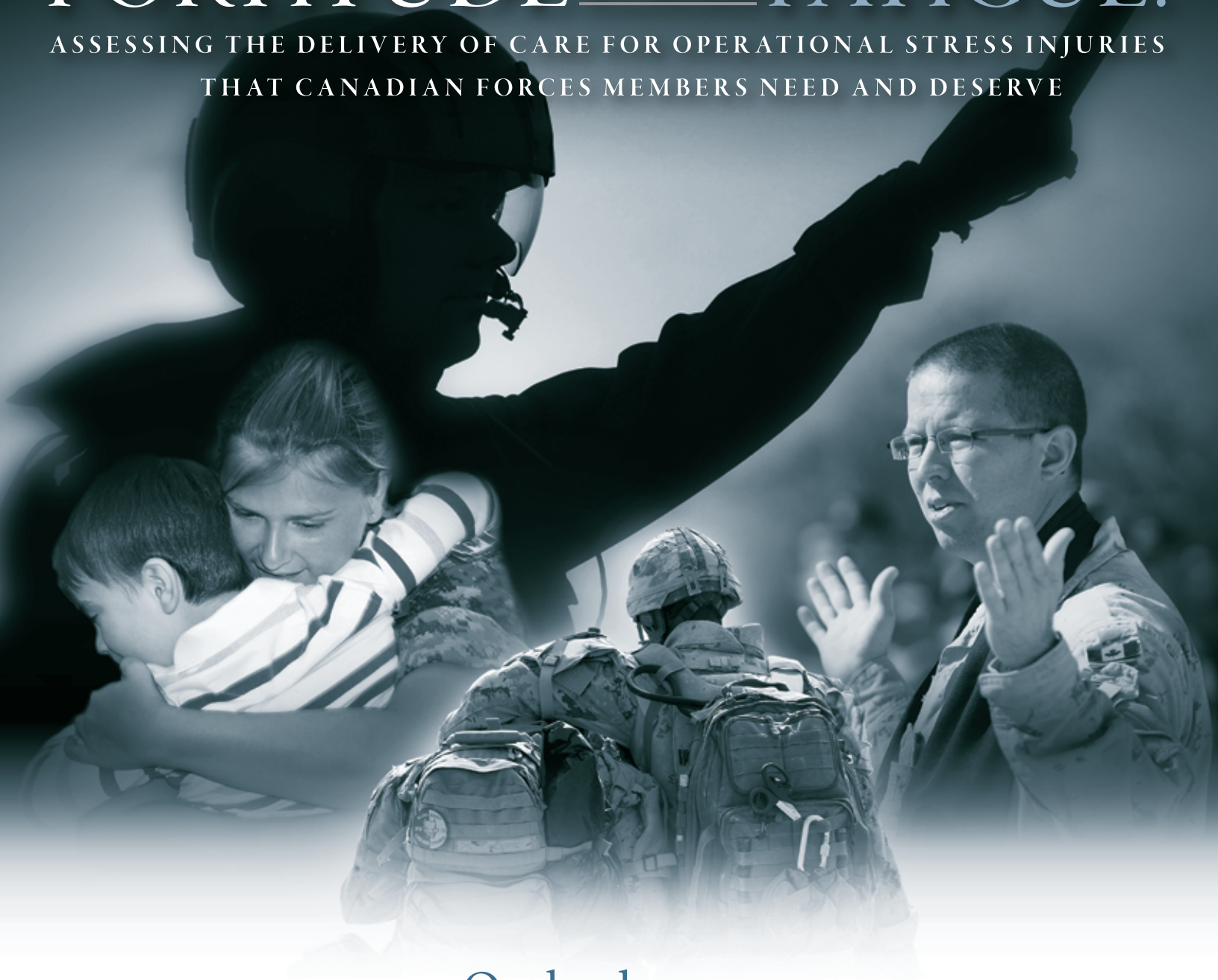
FORTITUDE UNDER FATIGUE:

ASSESSING THE DELIVERY OF CARE FOR OPERATIONAL STRESS INJURIES THAT CANADIAN FORCES MEMBERS NEED AND DESERVE



Ombudsman

National Defence and Canadian Forces

Défense nationale et Forces canadiennes

Canada

Fortitude Under Fatigue[1]

Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve

September 2012

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1 # Executive Summary

2 *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve* is the third follow-up by the Ombudsman for the Department of National Defence (DND) and the Canadian Forces (CF), evaluating the CF's ability to respond to the challenge of post-traumatic stress disorder (PTSD) and other operational stress injuries (OSIs). This report was based on the initial evaluation conducted in early 2002, and two follow-up reports in late 2002 and 2008. It also incorporated the Ombudsman's case study of the mental health situation in Petawawa carried out in 2008.

3 The study focused exclusively on Regular Force members of the CF and their families because a companion study specifically targeting the Reserve Force and OSIs will be conducted as a follow up to this investigation. It is expected to be completed by the end of 2013. While families were covered in this report, they will equally be the subject of a more focused analysis which is underway and will be completed in mid 2013.

4 A review of DND/CF action in response to the nine recommendations of the previous 2008 follow-up Ombudsman's report *A Long Road to Recovery* found that six of these were met, partially met or were being met, while two were considered inconclusive. One recommendation, the requirement for a national database accurately reflecting the magnitude of the CF's evolving OSI imperative, was not met. A summary of these recommendations is provided at annex A – *Progress Report Summary*.

5 Several observations and concerns were identified as part of this evaluation of the 2008 recommendations. The most significant is the considerable gap which remains between the *capability* to deliver the care CF members with OSIs need and deserve, and the actual *capacity* to deliver it. This gap is primarily the result of a chronic inability to achieve, or come close to achieving, the established manning level of the mental health function. The impact this has had on the frontline delivery of care, treatment and support to CF members with PTSD and other OSIs and their families has been profound.

6 Another concern is the extent to which enhanced support to military families coping with CF members with OSIs is coherent and effective in meeting their needs. The report also underscores the inability to assess the appropriateness of DND/CF funding allocated to the OSI imperative, along with the difficulty in evaluating whether the current mental health structure is sufficiently robust to meet the requirement. Finally, it highlights the reality that while operations in Afghanistan have wound down after more than a decade, the OSI burden remains at peak intensity, and will continue at this level for several years yet.

This is the result of the latent nature of the affliction, combined with the mounting cumulative burden resulting from 20 years of almost continuous CF operations.

7 *Fortitude Under Fatigue's* over-arching observation is that while the CF's capacity to meet the PTSD/OSI challenge is functioning, it is doing so largely due to the determination and commitment of the mental health providers who continue to deliver quality frontline care despite being severely overburdened and operating in difficult professional environments. The function is clearly strained.

8 Implementation of the recommendations made in the 2008 case study *Assessing the State of Mental Health Services in Petawawa* was also examined in detail. Of the seven recommendations in the case study, three were considered fully met and three partially met. One recommendation was no longer applicable. This assessment is also included in annex A.

9 Major observations and concerns regarding Petawawa include the dramatic increase in mental health provider manning, though a chronic shortfall persists. The continuing challenge of military families coping with members with operational stress injuries was observed despite important enhancements to family care and support. Overall, while Petawawa's mental health capacity has improved appreciably, it remains strained, reflective of the CF-wide situation.

10 In addition to the recommendations, *Fortitude Under Fatigue* flagged a number of key findings observed over the course of the study. These are captured at annex B – *Summary of Findings*. The favourable findings included: the progression from an ad hoc system into a comprehensive OSI care capability, though one that is still transitioning into a single coherent system; the commitment to the OSI issue of DND/CF strategic leadership, resulting in the inculcation of PTSD/OSIs across the CF as an accepted reality of modern military service; the professionalism, passion and dedication of DND/CF mental health providers, which has kept the capability functioning despite serious impediments; reduced barriers to care including an important reduction in the stigma surrounding OSIs, allowing CF members to come forward and seek the care they require more readily; and improved support to military families coping with CF members suffering from OSIs, predicated on the inextricable link between OSI-related care and stable family environments.

11 The less favourable findings include the previously mentioned chronic manning shortfall in spite of ongoing recruiting efforts and mitigation measures, representing a frontline caregiver deficit of 15-22% for the CF's steady state mental health requirement; extensive outsourcing of treatment for CF members suffering from OSIs with the limitations inherent in such

outsourcing; poor situational awareness of strategic and functional leadership of the magnitude of the OSI imperative as it evolves over time; and an ad hoc approach to systemic qualitative performance measurement which has hindered the CF's ability to assess the effectiveness of its OSI capability.

12 *Fortitude Under Fatigue* concludes with six specific recommendations, summarized at annex C – *Summary of Recommendations*. The first is that the CF must maintain the current institutional focus on the provision of appropriate care, treatment and support for CF members suffering from PTSD and other OSIs in spite of the natural deceleration resulting from the close of major operations in Afghanistan along with various corporate pressures, including renewed fiscal restraint.

13 The second recommendation is that the CF develop and implement a more assertive and innovative recruiting campaign aimed at reducing the persistent caregiver manning shortfall.

14 Recommendation three urges the CF to undertake systemic qualitative performance measurement aimed at assessing the effectiveness of its response to the PTSD/OSI imperative.

15 Recommendation four calls for a holistic evaluation of the CF's current mental health capacity a decade after it was first implemented.

16 The fifth recommendation encourages the CF's strategic leadership to examine the palpable and growing tensions between *commander and clinician* and *commander and administrator* relative to the medical care and administrative support for CF members suffering from OSIs.

17 Finally, recommendation six calls for the CF's strategic leadership to consider the viability of a more modern application of the principle of universality of service amidst concerns about the institution's continued moral commitment to its members.

Section 1: Background

> *"I believe we have one of the best military health-care systems amongst our allies and are leaders in health care in this country. But we are far from perfect."* [2]
>
> – Chief of the Defence Staff General Walter Natynczyk, May 2012

Initial PTSD Report. On February 5th, 2002 the Ombudsman for the Department of National Defence and the Canadian Forces (DND/CF) published a special report entitled *Systemic Treatment of CF Members with PTSD*.[3] It evaluated the CF's ability to respond effectively to the modern mental health challenge driven largely by post-traumatic stress disorder (PTSD).

The report rendered two major conclusions: (1) PTSD was a serious and growing problem for the CF and (2) the CF's approach to mental health injuries generally, and PTSD specifically, was inadequate.

These conclusions were reinforced by 31 specific recommendations designed to improve DND/CF's ability to diagnose, treat and care for members suffering from PTSD. These recommendations spanned the mental health care continuum, addressing institutional leadership and coordination; national tracking; awareness, education and training; standardized treatment; and caregiver stress and burnout.

First Follow-up Report. In December 2002, ten months after the initial report, the Ombudsman released an initial follow-up examining DND/CF action in response to the 31 recommendations.[4] This report determined that clear progress had been made despite the short interval, especially the heightened awareness of senior leadership of the importance of mental health injuries. The lack of progress in key areas such as organizational stigma, training, data collection, and national coordination was equally noted. The report concluded with a commitment by the Ombudsman to continue monitoring DND/CF progress in addressing the escalating PTSD challenge.

Second Follow-up Report. A second follow-up report on PTSD and other operational stress injuries (OSIs) entitled *A Long Road to Recovery* was released by the Ombudsman in December 2008 – six years after *Systemic Treatment of CF Members with PTSD*.[5] Its objective was to track the organization's progress during this decisive interval, dominated by operations in Afghanistan. In assessing the forward movement, the study posed the fundamental question: *Are CF members suffering from PTSD and other OSIs*

being diagnosed and getting the care and treatment they need to continue contributing to Canadian society, either as members of the CF or as civilians?

25 The report concluded that while there had been considerable progress across the care spectrum from 2002 to 2008 due to new OSI-specific policies, structural improvements and methodological adjustments, some members were still slipping through the cracks and not receiving the attention and care they needed.

26 The report also identified the prevailing organizational barriers to care: proximity to urban centers, the availability of mental health care professionals, and persistently negative attitudes of both superiors and peers towards those suffering from mental health injuries. In addition, the report lamented the absence of coordinated national support for the families of military members who were suffering from operational stress injuries. It found that accessing care and support was especially difficult for families living in isolated military locations. The lack of a national database allowing the CF to track the scope of the PTSD/OSI issue as it evolved was underlined as well.

27 Positive developments were also recognized. The report highlighted an improvement in identifying, preventing and treating mental health injuries; a more robust mental health capability at the local level; better pre- and post-deployment screening; and the addition of a post-deployment decompression phase to operational deployments. DND/CF's continued commitment to peer support through the Operational Stress Injury Social Support program was recognized as another positive step.

28 Finally, the announcement (coincidental to the release of *A Long Road to Recovery*) that the CF's mental health capacity would grow by 218 care providers and managers by end-March 2009 was praised. This increase would almost double the CF's existing mental health establishment. It was hoped that such a dramatic increase would alleviate the strain the Canadian Forces Health System was under in dealing with both the latent mental health care requirements of various CF missions of the 1990s in the Balkans, Africa, Southeast Asia and the Americas, and the new demand generated from ongoing operations in Afghanistan.

29 *A Long Road to Recovery* concluded with nine recommendations which required further DND/CF action, several of which were reprised from 2002's *Systemic Treatment of CF Members with PTSD* report. The Interim Ombudsman reaffirmed her commitment to tracking DND/CF's continued progress on this issue.

30 Canadian Forces Base Petawawa Case Study. Concurrent to *A Long Road to Recovery*, a companion case study was produced by the Office of the

Ombudsman in December 2008 examining the situation at Canadian Forces Base Petawawa.[6] The study, *Assessing the State of Mental Health Services in Petawawa*, was considered necessary due to a combination of factors: the exceptionally high operational tempo the base experienced from 2002 onward, the volatile nature of the operations its members were engaged in during that period, the base's geographic isolation, the considerable volume of complaints from Petawawa to the Office of the Ombudsman between 2002 and 2008, and a request from the Base Commander to the Ombudsman to look into the situation at Petawawa.

31 The case study yielded three conclusions. First, it determined that a critical lack of mental health care capability existed in Petawawa and the outlying area, often making it difficult and at times impossible for members suffering from PTSD or other OSIs to receive timely and appropriate care. The second was a palpable professional fatigue, and in numerous cases burnout, among Petawawa mental health providers as a result of excessive demand and insufficient resources. And the third was a negative, sometimes toxic, operating environment in which the relationships between primary health providers, mental health caregivers, and the chain of command were generally very poor, adversely impacting the care provided to those suffering from PTSD and other OSIs.

32 Seven recommendations deemed necessary to stabilize the PTSD/OSI situation at Canadian Forces Base Petawawa closed out the report. The recommendations addressed the deficit in mental health caregivers, the base's muddled health services governance structure, the deterioration of relationships between providers, the need for interim approaches pending long-term solutions, and the importance of helping the families of service members suffering from OSIs access available care and support.

33 Standing Committee Report. In June 2009, the Parliamentary Standing Committee on National Defence released *Doing Well and Doing Better; Health Services Provided to Canadian Forces Personnel with an Emphasis on Post Traumatic Stress Disorder*.[7] The study assessed the care provided to Canadian Forces members suffering from operational stress injuries from a whole-of-government perspective. It included testimony from the DND/CF Interim Ombudsman on the findings of *A Long Road to Recovery*.

34 The Standing Committee concluded that three over-arching issues were at the root of much of the challenge facing the CF in caring for members with PTSD. First, stigma towards those suffering from PTSD/OSIs remained prevalent. Second, a discrepancy between what was stated at the strategic level and what was happening at the unit and clinic level was detrimental. Third, the continued shortage of mental health professionals was impeding the delivery and sustainability of care.

35 *Doing Well and Doing Better* called for revitalized leadership involvement, as well as improved programming and services. It identified 36 recommendations on themes such as caregiver shortages, care for families, casualty tracking, and stigma reduction. Many of these were very similar to recommendations in *A Long Road to Recovery*.

36 Third Follow-up Report. This sequence of events is the prelude to *Fortitude under Fatigue; Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve*, the third follow-up report by the Ombudsman of the Department of National Defence and the Canadian Forces examining DND/CF's response to post-traumatic stress disorder and other operational stress injuries.

37 Format. This report consists of four distinct sections. This first section outlines the background leading to this report. The second section delivers a progress report on the nine recommendations from *A Long Road to Recovery* and the seven recommendations from *Assessing the State of Mental Health Services in Petawawa*. The third section contains the findings beyond these 16 specific recommendations, while the fourth identifies the key recommendations necessary for the CF to meet the OSI challenge moving forward.

38 Additionally, synopses of the progress report (section 2), findings (section 3) and recommendations (section 4) are presented in annexes A, B and C.

39 Limitations. This report is based upon extensive research. Over a ten-month period of study, eight bases were visited, 216 formal interviews were conducted and over 480 individuals interviewed or consulted, many more than once.[8] These included DND/CF strategic leaders, commanders and supervisors at all levels of the chain of command, senior staff officers and planners, medical professionals and managers, administrative support staff, researchers, external experts, and other stakeholders of note.

40 Military members themselves were interviewed as well, both those suffering from PTSD/OSIs and those not. Family members of CF service personnel suffering from PTSD or other OSIs were also consulted. The information obtained from all of these interactions, reinforced by over 650 references and documents, form the backbone of this report.[9] Almost without exception, those engaged were respectful, forthright and gracious, including those who were suffering. The Office of the Ombudsman extends its heartfelt appreciation to every individual who contributed to this endeavour.

41 As with its precursors, this report was developed with a single objective; to deliver an accurate and fair representation of DND/CF's ability to identify, prevent and treat post-traumatic stress disorder and other operational stress injuries. While the Office of the Ombudsman is confident that the portrait

presented in this report is precise and balanced, the challenges often involved in large, complex studies came to bear in this project. The sheer volume of information, combined with the number of players, perspectives and jurisdictions, resulted in contradictions and inconsistencies that were not always easily reconciled. Moreover, several key information gaps had to be contended with despite the mountain of evidence.

42 Each conclusion which follows is rooted in verifiable fact. Potential conclusions which could not be fully proven were discarded, no matter how compelling. Where conclusion cedes to observation or concern, the transition is explicitly indicated.

43 Time and space is an inevitable challenge in such a large analysis. The DND/CF mental health capability continues to evolve, as it should. Some information gleaned in the summer of 2011 had changed by spring 2012, and may well be different again in winter 2012 or summer 2013. As such, this report is a snapshot in time – it cannot be otherwise. However, the continuum of this series of reports, beginning with 2002's *Systemic Treatment of CF Members with PTSD* through to this concluding follow-up, presents a clear and revealing trajectory of the DND/CF mental health capability over time. As a result, the value of the findings and conclusions contained herein extend beyond the timeframe of publishing.

44 Terminology is important in an analysis as complex as this. In the interests of clarity, the term **capability** refers to the *intended ability to achieve a desired effect under specific standards and conditions*, while the subset term **capacity** refers to the *actual ability to achieve a desired effect under specific standards and conditions*.[10] More simply stated, the *capability* is that which is planned for, structured and intended, while the *capacity* is that which is tangibly in place and actually delivering results. This distinction is crucial to the analysis which follows.

45 This study focuses exclusively on Regular Force members with OSIs and their families. The omission of Reserve Force members is intentional – the scope of the Reserve care dimension of the OSI issue is sufficiently important to warrant its own examination. Consequently, care for Reservists suffering from OSIs is the sole focus of the forthcoming Office of the Ombudsman *Reserve OSI Report*, which will be completed by the end of 2013.

46 As this report will outline, there are few straight lines in assessing DND/CF's capability to meet the PTSD/OSI challenge. An issue as complex as operational stress injuries, tackled by an organization as diverse as the Canadian Forces, all but eliminates the possibility of simple, over-arching solutions. Recent history in this country and abroad has proven that there are few quick fixes related to OSIs.

47 While much improved, the CF's mental health capability is not perfect, as the institution's strategic leadership has admitted, and there is still important work to be done. There have been many hits and some misses since 2002, and forward progress has at times required some lateral movement.

48 The one unwavering straight line, though, has been the passion and commitment of those on the frontlines of this effort. The ceaseless devotion of the medical professionals, care providers, managers, clerical staff, and peers both enabling and delivering care has been the single constant throughout this analysis.

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Section 2: Progress Report

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Assessing the Recommendations of *A Long Road to Recovery* and Petawawa Case Study (2008)

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> *"In some cases, injured soldiers, sailors, airmen and airwomen who have served their country with courage and dedication are slipping through the cracks of an ad hoc system."*[11]
>
> – Excerpt from *A Long Road to Recovery*, December 2008.

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Recommendations – *A Long Road to Recovery*

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Recommendation 1: National Operational Stress Injury (OSI) coordinator

In December 2008 *A Long Road to Recovery* recommended:

A full-time position of National Operational Stress Injury Coordinator be created, reporting directly to the Chief of the Defence Staff and responsible for all issues related to operational stress injuries, including: the quality and consistency of care, diagnosis and treatment; and training and education across the Canadian Forces.

This follow-up review has determined that this recommendation has been met.

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Assessment

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As outlined in both the Minister of National Defence and Chief of the Defence Staff formal responses to *A Long Road to Recovery*, the Chief of Military Personnel was confirmed as the Canadian Forces' (CF) national lead on operational stress injuries, reporting directly to the Chief of the Defence Staff on all related matters.[12] ,[13] As the functional authority for health services, casualty support, and family support, among other portfolios, it was the position of both the Minister of National Defence and the Chief of the Defence Staff that creating an OSI entity or office independent of the Chief of Military Personnel structure would separate responsibility from accountability.

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To increase the Chief of Military Personnel's ability to focus directly on the OSI imperative amidst his spectrum of responsibilities, the position of OSI Special Advisor was established in May 2008.[14] A Lieutenant Colonel position, the OSI Special Advisor was mandated to oversee the management of non-clinical matters related to OSIs, including the creation of an education campaign to raise awareness of operational stress injuries. The OSI Special Advisor provided input on budget, business planning and hiring imperatives,

and contributed to the development and delivery of OSI awareness curriculum. He also supported and advocated for continued social and peer support.

57 In January 2009, the Directorate of Mental Health was created.[15] Its mission was to provide a single focus for mental health-related activities and programs within the CF. Such a focal point was considered essential due to the scale and intensity of the mental health function in its brisk evolution during the post-Rx2000 period of 2002 to 2008. Launched in January 2000, Rx2000 was the Canadian Forces Health Services' comprehensive reform project. It focused on the four pillars of continuity of care, accountability, health protection and sustainability of health services human resources.

58 The responsibilities of the new Director of Mental Health, a clinician at the rank of colonel reporting directly to the Deputy Surgeon General, included:

59 - ensuring adequacy of clinical resources to meet mental health treatment needs;

60 - ensuring coherence between clinical, occupational, peer support, educational, preventive, and family support aspects of mental health care;

61 - monitoring performance of CF initiatives pertaining to mental health including reporting on status, and benchmarking against our major allies;

62 - maintaining awareness of best practices and clinical research relevant to mental health problems of interest to the CF;

63 - ensuring ongoing coordination with Veterans Affairs Canada, select bodies such as the Canadian Mental Health Commission and other stakeholders; and

64 - acting as a preferred CF spokesman on matters related to mental health.

65 Additionally, the role of Mental Health and Psychiatry Advisor reporting to the Surgeon General was established in January 2010. Serving in tandem with the Director of Mental Health as the senior advisor on all mental health matters, the Mental Health and Psychiatry Advisor supports the mental health professional technical network, executes national mental health outreach activities, and serves as a senior spokesperson on mental health issues.

66 The stand-up of both the Director of Mental Health and the Mental Health and Psychiatry Advisor positions in rapid succession (2009-2010), twinned with the progress achieved in the period of the mid to late-2000s in institutionalizing the pertinence of the mental health imperative within the CF, led the Chief of Military Personnel to decide in 2011 that the OSI Special Advisor role was no longer required.[16] The levels of mental health inculcation and engagement at all levels of CF leadership were considered irreversible, and thus no longer dependent upon a single active champion – a function the OSI Special Advisor had ably performed since the position's inception. Moreover, the overlap in responsibilities between the OSI Special Advisor and Director of Mental Health/ Mental Health and Psychiatry Advisor was considered an opportunity to rationalize the structure without any drop-off in performance. Consequently, as of 2012's active posting season the position will no longer be filled.

67 It is clear that the senior OSI advisory function has been effective in supporting Department of National Defence (DND) and CF leadership, and bringing coherence and coordination to the mental health effort. While the route taken to achieve this was not that proposed in the recommendation from *A Long Road to Recovery*, the capacity sought has been achieved. The Chief of Military Personnel, supported by various permutations of OSI Special Advisor, Director of Mental Health and Mental Health and Psychiatry Advisor (directly and via the Surgeon General), has consistently provided the situational awareness, advice and guidance necessary for strategic leadership to exercise decisive direction on the OSI imperative. Moreover, the senior OSI advisory function has played a central role in enabling DND/CF's sustained institutional focus on operational stress injuries.[17,18] Accordingly, the recommendation is deemed met.

68 **Concerns**

69 The evolution of the senior OSI advisory role has brought forward one concern pertaining to the balance of perspectives. The interim construct in which the Chief of Military Personnel was advised by both the OSI Special Advisor and the Director of Mental Health/Mental Health Advisor ensured a combination of clinical and non-clinical perspectives to DND/CF strategic leadership.

70 While the pertinence of mental health has become firmly entrenched within DND/CF on an institutional scale over the period of the early 2000s to 2012, the role of OSI Special Advisor went beyond this promotional function. He was central to education, partnerships, and non-clinical approaches to treatment including social peer support. The decision not to renew the OSI Special Advisor could limit the extent of non-clinical 'operator' input the Chief of Military Personnel receives as both the Director of Mental Health

and Mental Health and Psychiatry Advisor view the OSI imperative through the clinician's prism.[19]

71 If the CF continues to adhere to the mixed approach of leveraging both clinical and non-clinical means in addressing the OSI imperative, as it has committed to since 2001 with the inception of the OSI Social Support program and reaffirmed repeatedly since then, reducing the senior advisory function to a single perspective may not be optimal. The inherent interplay between clinicians and non-clinicians has served the CF well in recent years in maintaining a balanced approach to addressing PTSD/OSIs based on both professional medical care *and* social peer-based support. The continued application of this mixed approach may become vulnerable with the removal of the OSI Special Advisor from the senior advisory equation.[20]

72 The Director Casualty Support Management has been designated to assume most of the OSI Special Advisor's duties, though it is not known whether he will be able to focus on the requirement to the extent his predecessor did due to the considerable breadth of his responsibilities. Moreover, much of the OSI Special Advisor role appears to have been formally and informally rolled into the functions of the Director of Mental Health and Mental Health Advisor, potentially limiting the Director Casualty Support Management's involvement. While the latter has provided, and will continue to provide, the Chief of Military Personnel with input and situational awareness obtained through his role as commanding officer of the Joint Personnel Support Unit, it is uncertain whether he will have the capacity to focus on the other aspects of the OSI Special Advisory function.

73 Recommendation 2: National OSI database

In December 2008 *A Long Road to Recovery* recommended:

The Canadian Forces develop a database that accurately reflects the number of Canadian Forces personnel, including members of both the Regular and Reserve Forces, who are affected by stress-related injuries.

This follow-up review has determined that this recommendation has not been met.

74 **Assessment**

75 The closest the CF has come to implementing a national PTSD/OSI database is the Canadian Forces Health Information System, a CF-wide electronic medical information database designed to manage health information efficiently in support of decision-making and enhanced operational effectiveness. It is intended to deliver integrated, automated health information for every serving member of the Regular and Reserve Force, based both in garrison and deployed around the globe. The Canadian Forces

Health Information System is a relatively new tool having only been completed in spring 2012, though it has been used for some time in its iterative form.

76 There are important limitations with the Canadian Forces Health Information System as a generator of a national OSI database. The first is its role. At present it can provide only basic reporting information on resource utilization, relating type of resource with location of patient, appointment type and availability. Obtaining a national portrait of any specific illness or injury, OSIs or otherwise, requires the extraction of large volumes of raw data based on specifically inputted parameters, followed by a detailed, labour-intensive interpretation of that data by the Canadian Forces Health Services epidemiological team. Without these steps the data is largely incoherent. A full week is generally necessary for this interpretation, subject to the availability of an epidemiologist. [21]

77 The second limitation is that the inclusion of mental health notes into the Canadian Forces Health Information System was not foreseen when the project was originally designed. As a result, notes from mental health caregivers cannot be inputted into the system as presently configured, and there is currently no firm direction regarding if or when this might change. Technically, the Canadian Forces Health Information System has the capacity to incorporate these mental health notes if the project parameters are adjusted, much as it has the potential to be used as a more responsive reporting tool if this is deemed a priority. However, such decisions have not yet been made. In the estimate of a senior CF medical authority intimately familiar with the Canadian Forces Health Information System, if the system was to be modified to regularly report on the OSI issue CF-wide (and there is as yet no indication that it will be) this would be unlikely before 2014-2015 at the earliest.[22]

78 Since 2000, the Canadian Forces has conducted considerable research on the impacts of mental health conditions, and continues to study this. The fall 2011 report entitled *Cumulative Incidence of PTSD and Other Mental Disorders in Canadian Forces Personnel Deployed in Support of the Mission in Afghanistan 2001-2008*, executed by the Deployment Health team within the Directorate of Mental Health, is one such research initiative.[23] Measuring the incidence rate of CF personnel deploying to Afghanistan between 2001 and 2008, the study provides detailed estimates of the fraction of deployed personnel diagnosed with an OSI over a prolonged period following their return. The report equips the CF with a strong indication of the scope of the OSI imperative specific to Afghanistan, and is especially valuable as a predictive tool for projecting future care requirements. It is consistent with the CF Health Services' research approach of informing the future rather than pinpointing the present or comparing with the past.

79 Though this research will assist the Canadian Forces to anticipate the impacts of OSIs in contemplating and planning future deployments, it does not consider the OSI incidence for missions other than Afghanistan, nor does it account for the cumulative aspect of operational stress injuries amongst CF members. As such, it is unable to provide institution-wide, single-stop tracking of the OSI issue at regular, specific intervals as it evolves over time.

80 The CF has placed considerable emphasis on the Enhanced Post-Deployment Screening process as a means of better assessing the health status of members upon their return from operational missions, including their mental health. By extension, this provides additional insight into the scope of the OSI issue.[24]The screening, undertaken as of 2007, is designed for all members deploying to an operational theatre for a minimum of 60 days, and is administered within three to six months following their return. Regrettably, the results of this enhanced screening are adversely affected by a response rate of only 76%.[25] A full quarter of those returning from deployment are not evaluated, offering the possibility of skewed results. Moreover, a number of recently deployed members indicated that the questionnaire was 'easy to beat' – that is they were convinced they could hide or withhold information pertaining to their mental health state they did not wish to share. This claim was corroborated by several senior medical professionals.[26]

81 The Canadian Forces Health and Lifestyle Survey, conducted every four years (despite a formal commitment by DND following the publication of *A Long Road to Recovery* to double the frequency to every two years as of 2008), examines the mental health status of a large sampling of CF members.[27] It provides another slice of the OSI imperative, but is unable to present a fully comprehensive mapping of the condition at any selected point in time.

82 Within both the Chief of Military Personnel organization generally, and the Directorate of Mental Health specifically, there is little inclination for developing a more complete tracking of OSIs. Exact case counts are not considered especially useful. The approach is that '*if you're sick, you're sick*' and all that matters is delivering the right care.[28] The precise prevalence of individual illnesses or injuries is not seen as particularly relevant.

83 Moreover, both the Canadian Forces medical and personnel communities claim to be experiencing what they had generally anticipated with regard to PTSD and other OSIs because operational stress injuries are not epidemic in nature and therefore follow a fairly predictable trajectory.[29]

84 In addition to the science of these various studies and surveys, the Canadian Forces Health Services also integrate a practical element in assessing the scope of the OSI requirement. Wait times required for patients to consult with mental health care providers are closely observed on a clinic-by-clinic basis

by the Director of Mental Health and the Mental Health and Psychiatry Advisor. This allows them to monitor not only the effectiveness of individual clinics, but through extrapolation the efficiency of the mental health system as a whole. Short wait times are generally indicative of sufficient capacity, while long wait times point towards demand outstripping capacity. Consistently long wait times can lead to detailed consultation with the concerned clinic, Staff Assistance Visits, the deployment of temporary augmented resources, or even an adjustment to the structure.

85 Once again, execution appears to have impeded effectiveness. Until only very recently the key metric that the Director of Mental Health and the Mental Health and Psychiatry Advisor monitored most closely was the wait time for the *first* available appointment to the mental health care provider: psychiatrist, psychologist, social worker, addictions counsellor or mental health nurse. It was acknowledged in 2012 that tracking this metric did not in fact accurately reflect patient access to care and often portrayed an overly positive representation.[30] As a result, in May 2012 mental health clinics were instructed by the Director of Mental Health to switch to the wait time for the *third* next available appointment, which the general health community considers a much more reliable standard for measuring patient access to care.[31]

86 Additionally, many mental health clinics have been unable to consistently generate the monthly statistics requested by the Director of Mental Health (which according to a number of mental health caregivers include several metrics of dubious value).[32] The effort required of clinics already facing excessive workloads to compile current accurate statistics has been onerous, especially since most clinics do not possess common information management or caseload tracking systems. This is largely a holdover from the pre-Rx2000 era when mental health clinics were very small, making caseload tracking and other data management requirements much simpler. As clinics ballooned to three to five times their pre-Rx2000 size in recent years, clinic managers and team leaders generally resorted to local, often improvised, information management solutions. The evidence indicates that these makeshift solutions have had varying degrees of success.

87 As an example, one clinic manager outlined that the only way to stay on top of his clinic's caseload was to cease all of his management and clinical activities for several days once every month, physically connect with every provider within the clinic, and put together a detailed compilation of all individual caseloads.[33] This appeared to be the practice for other clinics as well.

88 As a result of this difficulty in managing data and tracking key statistics at the clinic level, the monthly reports published by the Directorate of Mental Health have often featured outdated information. During much of 2011, as many as a

third of the mental health clinics did not report their current wait times and other statistics regularly. For the month of March 2012, the Director of Mental Health received only 7 statistical returns from the CF's 26 mental health clinics.[34]

89 When clinics have been unable to supply current statistics for a given month, the practice has been to plug in the last input received from that clinic, no matter how dated. In the 2010-2012 period, this *last known value* as it is termed was often as much as six-plus months out of date, distorting the overall precision of the national report.

90 In summary, while DND/CF possesses an array of research, informational and data inputs on PTSD and other OSIs, it is unable to generate a precise, punctual institution-wide portrait of the issue. The national representation generated by the Canadian Forces Health System is an amalgam of various inputs, which are all individually hindered by significant limitations. The Directorate of Mental Health CF-wide statistical report is based on patchy, often dated, inputs. The net result is institutional reporting on the scope of the OSI imperative that is neither sufficiently consistent nor adequately reliable to calibrate DND/CF priorities and resources effectively.

91 Recommendation 3: CF-wide mental health survey

In December 2008 *A Long Road to Recovery* recommended:

The Canadian Forces conduct an independent and confidential mental health survey, which should include current and former Canadian Forces members from both the Regular and Reserve Forces.

This follow-up review has determined that this recommendation is being met.

92 **Assessment**

93 The CF has partnered with Statistics Canada to execute a follow-up Canadian Forces Mental Health Supplement to the Canadian Community Health Survey in 2012, the results of which will be published in 2013. This will be the second such independent national CF mental health survey, bookending the 2002 Canadian Forces Mental Health Supplement to the Canadian Community Health Survey.[35]

94 This is a very important endeavour. The 2002 survey was the driver for much of the mental health structure's reconfiguration as part of the Rx2000 Mental Health Initiative. It was the major catalyst in establishing the CF's current mental health structure, establishment and footprint.

95 This 2012 follow-up will provide the opportunity to validate the CF's mental health capability. While a decade of sustained operations and other

contemporary factors have contributed to a number of punctual adjustments to the capability, the underpinnings of the Rx2000 2002 mental health construct remain largely intact. The pending survey is a crucial opportunity for the CF to validate its decade-old construct by measuring how effectively it is delivering the services and programs that CF members suffering from PTSD and other OSIs need and deserve.

96 As in 2002, this national survey will also allow the CF to compare its mental health capability with that delivered to the Canadian civilian population.

97 The CF demographic being surveyed will include a random representative sampling of all Regular and Reserve Force members serving as of mid-2012 (consistent with the recommendation). It will not include former CF members as this is beyond the purview of the DND/CF mandate and is the responsibility of Veterans Affairs Canada.

98 **Concern**

99 The 10-year interval between serials of this cornerstone national independent mental health survey is of concern, especially during a period of significant organizational strain punctuated by sustained operations in Afghanistan. The CF conducted considerable related research during this interval such as the Enhanced Post-Deployment Screenings, the cyclical Health and Lifestyle Survey, the Cumulative Incidence of PTSD 2001 – 2008 Report, the Canadian Forces Base Gagetown 2010-2011 OSI Incidence Study and others. And the research results contributed to positive changes to mental health configurations, methodologies and protocols. However, these individual inputs were not independent, nor did they systematically assess the CF's holistic mental health capability, which the 2012 Statistics Canada survey will.

100 A decade is a long interval between comprehensive benchmarks, especially during one of the most turbulent periods in Canadian military history. Waiting a full ten years before validating a capability identified as a top institutional priority appears disproportionately long. This delay may have limited the CF's ability to make key adjustments to its mental health capability during this crucial phase.

101 Recommendation 4: Accommodation policy

In December 2008 *A Long Road to Recovery* recommended:

Any changes – formal or informal – to the Accommodation Policy (or the approach taken by the Canadian Forces to wounded members who want to continue their military careers) be applied equitably to Canadian Forces members with both mental health and physical injuries.

This follow-up review has determined that this recommendation has been met to the extent that it could be.

102 **Assessment**

103 The CF has put in place or enhanced a number of measures designed to assist ill and injured members return to military service or civilian life.

104 The formalization in 2011 of the *Caring For Our Own* comprehensive approach for the care of ill and injured members and their families is one enhancement. It provides a coherent mapping of the CF's focus on *recovery* from illness or injury, *rehabilitation* to an optimal level of health, and *reintegration*, preferably to military service.[36] *Caring For Our Own* articulates a commitment by the CF to provide all necessary care and support for serving members and their families in the event of illness or injury.

105 This is achieved by providing the most current, evidence-based treatment designed to return the member to full health and normal military duty. If this is not medically possible, the objective shifts to achieving an optimal level of recovery and returning to normal military duty. And in situations where this remains unattainable, the goal becomes maximizing recovery and preparing the member for transition to civilian life.

106 In terms of timeframe, the 2011 directive on *Complex Cases* provides ill and injured members who have permanent Medical Employment Limitations an extended period of retention in the CF for up to three years if they are deemed to have complex transitional needs, which appears to be the case for a preponderance of OSI sufferers.[37] This extended period of retention allows members to benefit from prolonged treatment and rehabilitation, and increased preparation for transition to civilian life.

107 The CF's recent decision to make both the Cadet Organizations Administrative and Training Service and the Canadian Rangers organization available to ill and injured members unable to reintegrate into the Regular Force and Primary Reserve provides an additional employment option.[38]

108 Though designed as a transitional measure, the *Return To Work* program, the CF's vocational rehabilitation program, assists ill and injured members restore their health through reintegration into an appropriate workplace and progressive resumption of duties. The program incorporates an array of private sector organizations and companies in order to provide a broad spectrum of rehabilitative opportunities. Empirical data surrounding the program is limited, precluding any viable evaluation.

109 Finally, the leadership/management of ill and injured CF personnel is appreciably more coordinated than in the past. Effective case management is a major reason for this. Medical case management integrated into the primary care capability plays a more prominent role in assuring the continuity of care for patients. Administrative case coordination embedded within the Integrated Personnel Support Centres as part of the Joint Personnel Support Unit organization connects ill and injured members to all relevant medical, vocational, financial and social resources. Whereas in the recent past ill and injured members had to seek out these various resources, often during periods in which their capacity to do so was limited, these resources now interface directly with the member through the Integrated Personnel Support Centre staff.

110 The gradual acceptance of the Integrated Personnel Support Centres/Joint Personnel Support Unit as enablers in the recovery, rehabilitation and reintegration of ill and injured members by a growing proportion of the chain of command appears to be serving ill and injured members effectively, though perspectives still vary drastically. [39] Some elements of the chain of command were convinced that the Joint Personnel Support Unit structure provides the ill and injured with the qualified, focused attention and resources they require. Others felt strongly that removing ill and injured members from the 'family structure' that is the unit and peers during a period of increased vulnerability and need was an abdication of the fundamental leadership principle of caring for one's own.

111 Another irritant undermining the Joint Personnel Support Unit structure is the loss of allowances tied to active status within a unit.[40] Losing one's Land Duty Allowance, flight or sea pay, or similar allowance as a consequence of coming forward to seek mental health care and eventually being posted to the Joint Personnel Support Unit, however temporarily, removes money from a military family's income and as such is a major disincentive.

112 Overall, the CF has demonstrated a concerted effort to enable ill and injured members by putting in place a number of measures which potentially favour them *without* encroaching upon foundational institutional principles and policies, beginning with the universality of service.[41]

113 These measures are not ideal however. Opening up the Cadet Organizations Administrative and Training Service/Canadian Rangers option to members no longer able to meet universality of service requirements is not a game-changer, either quantitatively or qualitatively. And the three-year transitional period (for those who qualify) is certainly helpful to members no longer able to be retained in the Regular Force or Primary Reserve, but in most cases it simply delays what is invariably an unwanted and unwelcomed result – release from the Canadian Forces as a result of injury or illness, and with it the loss of career and potentially of livelihood.

114 **Concern**

115 Repeated evidence from multiple sources suggests a fundamental and growing institutional tension between the requirement to respect the principle of the universality of service, and the CF's long-standing moral obligation to take care of those it sends in harm's way.[42] (This tension is examined in greater detail in section 4). The measures outlined above appear to have exploited all of the available space around the margins of universality of service. Further forward movement seems impossible without coming into direct conflict with it.

116 **Observations**

117 The dichotomy of views on the Joint Personnel Support Unit concept is understandable as it is a new and innovative construct inserted within an already large and complex structure. In many locations it is still in its infancy and cultural acceptance has yet to consistently take root.

118 A second observation is the prevailing perception at the grassroots level that members suffering from mental health injuries are released from the CF more swiftly than those with physical injuries.[43] This perception was noted on numerous occasions from a variety of sources. An analysis of available information indicates that this is inaccurate, and in fact the opposite scenario is more prevalent. OSI sufferers facing release are regularly deemed 'complex cases' and as such are eligible for part or all of the three year transitional period. Moreover, the administrative review which determines suitability for continued service and triggers release cannot be initiated until a reliable prognosis of health and functional capacity has been made by the relevant medical authority. Due to the complexity of OSIs, this stabilization period necessary before a definitive prognosis can be made is generally longer than that for physical injuries. Accordingly, the overall period leading to medical release from the CF appears to be generally longer for members suffering from mental health injuries, though the CF has yet to formally measure this.[44]

119 As for the possibility that the CF is more disposed to releasing members suffering from permanent mental health injuries over those with permanent physical injuries, no concrete evidence of this was discovered. The philosophy that '*an injury is an injury*' seems to govern the personnel management process, starting with Director Casualty Support Management who as the Joint Personnel Support Unit Commanding Officer is theoretically responsible for the management of all ill and injured with a second temporary or a permanent medical category.

120 Additionally, there is a palpable frustration amongst some members suffering from OSIs toward the verbal commitment of the former Chief of the Defence Staff with regard to permanently retaining those ill and injured whose conditions were caused as a result of deployed operations.[45] Without debating the merits of the declaration, the fact is that there is a sense on the part of some that an organizational promise was made and then reneged upon.

121 Finally, the term 'return to civilian life' is sometimes employed by CF leaders and administrators. It completely misrepresents the reality facing most members afflicted with OSIs and no longer fit to serve. Though demographics are shifting, a preponderance of CF members still joined the military in early adulthood and know only what it is to be a sailor, soldier or airman/woman. Not only has their military career been the only one they have ever had, but it is a major part of their identity. As a result, the notion of 'returning to civilian life' is invariably more complex and cathartic than the term suggests.[46] More often than not it is an *arrival* to adult civilian life rather than a *return*, with all the uncertainty and trepidation that such entails.

122 Moreover, the stripping away of an important part of one's identity inherent in release from the CF can be as difficult to deal with as the long-term effects of the injury or illness which provoked it. It seems that this is especially the case when the decision to leave is imposed upon a member as a result of injuries or illness incurred in the conduct of duty. The resultant sense of loss, coupled with permanent injuries which often limit post-military career opportunities and overall quality of life, can be devastating to OSI sufferers released from the CF.

123 Recommendation 5: Occupational Transfer policy

In December 2008 *A Long Road to Recovery* recommended:

The rules regarding occupational transfer be changed to accommodate, in an efficient manner, members diagnosed with post-traumatic stress disorder or other operational stress injuries who could continue their military service if they transferred to another military occupation.

This follow-up review has determined that this recommendation has been met to the extent that it could be.

124 **Assessment**

125 There have been no substantive changes to the Occupational Transfer policy or methodology concerning CF members deemed unemployable or non-deployable as a result of OSIs. The obstacle is the immutability of the universality of service principle. In the existing military employment structure, there are no viable options to move ill/injured members who no longer satisfy the terms of the universality of service from one occupation to another.

126 There is also little evidence that CF members suffering from OSIs do not receive equitable consideration for occupational transfer compared to personnel suffering from physical injuries, as was suggested on multiple occasions. Some members subject to medical employment limitations or temporary medical categories because of PTSD and other OSIs have responded to treatment and progressed sufficiently to have their limitations removed and categories restored, enabling full return to normal duty.[47]

127 Structurally and procedurally, the CF has instituted, formalized or enhanced a number of measures designed to assist injured or ill members recover, rehabilitate and reintegrate. The result is better stewardship of the ill and injured from both the medical and administrative perspectives. This impact of enhanced stewardship is twofold. One, it offers increased opportunity for optimal recovery, rehabilitation and reintegration to normal military duty, in an original occupation or a new one. Two, it provides a more deliberate approach throughout which the member has greater opportunity to demonstrate an acceptable level of recovery and/or rehabilitation, augmenting the probability of reintegration.

128 Medically, these structural and procedural enhancements include the stand-up of the seven Operational Trauma and Stress Support Centres across Canada in response to increases in mental health demand fuelled primarily by OSIs. The clinical treatment; resilience training and education; and psychological, emotional and spiritual support they deliver provide a more coherent,

comprehensive care package for patients, increasing the possibility of optimal recovery, rehabilitation and reintegration.

129 The establishment and refinement of a standardized diagnostic protocol for OSIs in 2008-2009 has equally contributed to recovery, rehabilitation and reintegration by establishing a CF-wide common grid within which members with OSIs can be more effectively treated and cared for. More professional medical case management also contributes to recovery, rehabilitation and reintegration.

130 Administratively, the establishment and gradual acceptance of the Joint Personnel Support Unit / Integrated Personnel Support Centre structure appears to be providing improved management of ill and injured, though as outlined earlier there is still considerable debate around the Joint Personnel Support Unit structure.

131 As the majority of these measures are relatively recent it is impossible to definitively determine that they are contributing, or will contribute to, higher rates of reintegration and retention for members with OSIs. However, isolated and anecdotal evidence suggests this could be the case.

132 **Concerns**

133 There exists a perception amongst an element of the grassroots CF demographic that once a member is posted to the Joint Personnel Support Unit and assigned to an Integrated Personnel Support Centre upon issuance of a second temporary medical category as per recent policy, he/she is unlikely to return to the unit and normal military duty.[48] Articulated otherwise, some view the Integrated Personnel Support Centre as the 'kiss of death' from a career perspective. As long as this perception persists, it constitutes a veritable barrier to care.

134 A second concern is the reticence of those elements of the chain of command who are either opposed to the Joint Personnel Support Unit approach to managing the significantly ill and injured, or have yet to embrace it.[49] If this friction is not promptly reconciled by CF strategic leadership, it is questionable whether the current approach will succeed on an institutional level.

135 Recommendation 6: National family support resource

In December 2008 *A Long Road to Recovery* recommended:

The Canadian Forces establish and properly resource an organization – at the national level – responsible for working with external agencies and all levels of government, as required, to ensure that military families and individual members of the families of military personnel have access to the broad spectrum of services and care they need.

This follow-up review has determined that this recommendation has been partially met.

136 **Assessment**

137 In 2010 the Directorate of Quality of Life was re-established after having been disbanded the previous year. The Directorate's renewed mandate is to contribute to a mission ready force by providing for the unique needs of military families and mitigating the disadvantages inherent in military service.[50] A key element of this mandate is addressing the challenges and stresses associated with frequent relocations and prolonged absences including operational deployments.

138 One of the Directorate of Quality of Life's major responsibilities is facilitating family access to external care, support and opportunities, especially in the key areas of health care, child and increasingly elder care, education, and employment/career. This entails creating and fostering relationships with appropriate entities and leveraging these to improve access for military families, wholly consistent with the recommendation.[51]

139 The complexity involved in caring for military families cannot be understated, particularly concerning jurisdictions. DND/CF acknowledges both its policy responsibilities and moral obligation to provide support and services to military families to address the stresses unique to military life, and appears committed to delivering. However most of the key areas involved: (i.e., medical care, education, family care (child and elder), and employment continuity including professional equivalencies, certification and seniority), are largely the purview of public or private entities falling beyond the federal sphere of responsibility. Accordingly, the solutions to military family imperatives are rarely simple and usually involve extensive effort.

140 The Directorate of Quality of Life enjoys a symbiotic relationship with the Directorate of Military Family Support, which is focused primarily on service delivery of programs and initiatives serving military families.

141 The effectiveness of this renewed Directorate of Quality of Life construct is inconclusive at this juncture. The period since its regeneration (mid-2010) is very short, especially in light of the complex nature of the mandate.

142 **Concerns**

143 A major preoccupation regarding national support to military families is the Directorate of Quality of Life's current capacity. At the moment of disbandment in 2009 it had 25 personnel to execute its former mandate. At present the Directorate has just 10 positions to achieve its new mission (which is different but does not seem appreciably less challenging than the former), only four of which are baseline funded.[52] This is almost certainly inadequate to execute the mission it has been accorded.

144 A second concern is timeframe. The reality is that DND/CF's national coordinating structures responsible for serving military families are still in considerable flux in 2012, more than a decade after the commitment to sustained operations in Afghanistan. As outlined, the Directorate of Quality of Life was disbanded in 2009 and re-established in 2010. This reversal has resulted in confusion and dislocation. Moreover, the present Directorate of Quality of Life / Directorate of Military Family Support configuration appears to be in transition, with each directorate technically operating independently yet under the direction of the same director.[53] The evidence was unclear whether this was intended as a temporary measure or a transition to a further organizational mutation. Regardless, it has created uncertainty at a time when both the Directorate of Quality of Life and the Directorate of Military Family Support roles are critical, and require stability and focus.

145 Coherence is a further concern. One of the drivers of the re-establishment of the Directorate of Quality of Life was the concern amongst CF strategic leadership that support and services for military families might lack coherence. The array of family-centric initiatives since 2008 is considerable. And while any action designed to support families is admirable, there is a concern about whether the rash of recent initiatives fit with and leverage one another. It is unclear at this juncture whether the Directorate of Quality of Life will be responsible for overall coherence of family initiatives and services however this certainly seems to be a pressing requirement.

146 A related concern expressed repeatedly by serving members, families, and Military Family Resource Centres employees was communication. The evidence suggests that many members and their spouses are unaware of the various services and programs available to them, especially those residing off base.[54] If family initiatives are ineffective in connecting with the very constituents they exist to serve, they are of limited value.

147 It must be noted that the Military Family Resource Centre, which is the hub for most of the information disseminated around family services and programs, outlined challenges in obtaining information from units which they required in order to reach out to families.[55] Clearly, if the Military Family Resource Centres are not properly enabled and equipped to communicate successfully, it is very difficult for them to connect with their constituents effectively.

148 Another impediment to communications observed in this study is CF members themselves, who either out of a desire to shield their families from their afflictions or out of simple omission or neglect, often fail to pass on key information to the family unit. One senior serving member noted that while families are better informed than they have been in the recent past, the CF still does not view them as the "trusted agents" they truly are. As a result, too much information is still bottlenecked through serving members instead of communicated more directly to families.

149 **Observation**

150 The Family Secretariat, which was identified as a central component of DND/CF's ability to support military families, as stated by the Minister of National Defence in his response to *A Long Road to Recovery* in February 2009, experienced a very short existence.[56] The role appears to have been subsumed within the Directorate of Quality of Life in supporting the National Military Family Council.

151 Recommendation 7: Appropriate funding

In December 2008 *A Long Road to Recovery* recommended:

The Canadian Forces provide an appropriate level of funding across the country for the identification, prevention and treatment of post-traumatic stress disorder and other operational stress injuries.

This follow-up review has determined that the extent to which this recommendation has been met is inconclusive.

152 **Assessment**

153 Precisely identifying the investment that DND/CF has made, and continues to make, in addressing the PTSD/OSI imperative is challenging due to the number of variables involved. Chief among these is the fact that the investment specific to care and treatment of members suffering from OSIs is not isolated within the more global mental health funding, and cannot be specifically captured. As well, a significant number of mental health-related costs integral to caring for members suffering from PTSD and other OSIs such

as training and family support are not captured by the financial system under the mental health function.[57]

154 DND/CF's commitment to mental health for fiscal year 2012-2013 is $38.6M, representing just under 10% of the overall CF Healthcare budget, and 0.2% of the overall DND budget.[58] This excludes military pay, as well as costs related to certification and licensure, command and control activities, continuing professional education of military and civilian personnel, and various ancillary expenditures. This commitment has been consistent during the past two years. Overall the annual outlay has increased cumulatively by over $100M during the five-year period of fiscal year 2007-2008 to fiscal year 2012-2013.[59]

155 This increased commitment to mental health care has resulted in a capability designed to identify, prevent and treat post-traumatic stress disorder and other operational stress injuries throughout the Canadian Forces. The structure consists of 26 Mental Health clinics located across Canada, augmented by seven OSI-centric Operational Trauma Stress Support Centres. CF mental health personnel also deploy on major operations, providing forward prevention, care and treatment.

156 All care providers implement the Mental Health Service Delivery Model, featuring the standardized assessment and treatment protocols tailored specifically to the nature and challenges of OSIs.

157 The CF mental health capability has incorporated limited modern technologies, such as the Tele-Medicine initiative and the Computer Assisted Rehabilitation Environment platform. An internal professional technical network has also been established to leverage best practices and lessons learned. It is intended to enhance the range of expertise, experience and depth of individual caregivers.

158 Education and training has been an important element of the CF mental health effort, aimed at increasing resilience, enhancing prevention and reducing the barriers to care. This includes the *Road to Mental Readiness* curriculum. Research, both internal to DND/CF and in partnership with allies, academe and medical professional organizations, is conducted to better understand how mental health imperatives generally, and OSIs more specifically, impact the fighting force of today and tomorrow.

159 Though this progress is substantial, it is not a measure of whether current funding levels are appropriate. In fact, at present it is not possible to determine the suitability of current mental health funding.

160 This is due primarily to the chronic under-manning of the CF mental health capability. In 2005, DND announced the approval of an increase in the

number of mental health care providers and integrated support staff from the existing establishment of 229 to one totalling 447. This represented a 95% increase in manning, and engendered a financial commitment of $98M over the five-year period of 2005-2009 during which this increase was to occur.[60]

161 This enhanced mental health establishment was borne from the Rx2000 Mental Health Initiative, which was influenced in large measure by the results of the joint *2002 Statistics Canada Community Health Survey – CF Supplement on Mental Health*. This analysis pegged the optimal structure for a steady-state CF activity level at 447 care providers and integrated supporters. Despite the incidental timing, the enhanced establishment was *not* related to sustained operations in Afghanistan.

162 Unfortunately, the CF was unable to meet the 447 manning objective in the anticipated 2005-2009 period despite protected funding for it. The timeframe was extended to 2010, yet the target was still not met. In fact, as of mid-2012 this 447 mental health practitioner/supporter establishment has not been achieved, and it is not expected to be in the foreseeable future.[61] A sizeable manning shortage persists for reasons identified in the next recommendation.

163 Specifically, the CF's mental health manning level has been stalled in the 350-378 range for well over two years now; it varies upwards or downwards from month to month without moving beyond the range's upper limits.[62] The result is a manning shortfall of between 15 and 22% of the level deemed necessary to execute the CF's mental health program during a steady state period.

164 This chronic personnel deficit has strained the mental health system and is at the root of its most pressing challenges. In the face of a demand that is acute, complex and unrelenting for the foreseeable future, operating at an average effective strength of just over three-quarters to four-fifths of the established strength across the structure is causing strain on mental health professionals to execute the mission. Moreover, this 15-22% shortfall is almost certainly substantially higher in reality as the prolonged real-time and latent exigencies of a decade of operations in Afghanistan have assuredly exceeded the steady-state conditions upon which the current post-Rx2000 capability was modelled.[63]

165 Until this chronic manning shortfall is addressed, it will continue to obscure the effectiveness of the mental health capacity and preclude any detailed assessment of the appropriateness of overall program funding for PTSD and other OSIs. As long as a substantial proportion of the mental health structure remains unmanned for reasons other than funding as is currently the case, it is not possible to definitively attribute capability successes or deficiencies to any particular factors, including funding.

166 **Concerns**

167 Despite the rapid growth of the CF's current mental health function into a comprehensive capability fuelled largely by an influx of new base-lined and incremental funding, there are several indications of funding strain. It must be noted that the evidence does not provide sufficient clarity to determine whether these are the result of inadequate overall funding or are symptoms of challenges in allocating funds. Nonetheless, they are indicative of some degree of funding pressure.

168 A number of concerns were recently identified in the current Directorate of Mental Health business planning process regarding in-year funding. Overall, the Directorate of Mental Health's budgetary allocation was deemed insufficient as forecast, and a number of key Directorate of Mental Health activities and initiatives were identified as potentially vulnerable if the anticipated funding level was not increased forthwith. Included in this list was the Directorate of Mental Health's own directorate staffing, currently short 11 of 27 positions due to insufficient funding (unlike the general care provider manning shortfall).[64] Failure to redress this 41% manning deficiency was considered to have the "potential to negatively impact on the standardization and delivery of care."

169 The Canadian Forces Member Assistance Program, a contracted program designed to provide CF members and their families with short-term, non-therapeutic problem-solving counselling, has been chronically under-funded for several years including the current fiscal year, impacting its ability to serve as intended. The proposed expansion of the technologically-focused Tele-Medicine program, linking remote bases to large regional mental health centres to reduce wait and travel times for both patients and clinicians, is not fully funded for the current fiscal year. Mental health training and education is also identified as under-funded, with the anticipated result of fewer qualified individuals able to develop curriculum for pre-deployment training packages, and deliver mental health instruction and awareness at CF leadership courses and Third Location Decompression events. Allocated funding was deemed inadequate for the development of a Clinical Outcome Measurement System, pivotal to shifting from purely empirical performance measurement to a balanced blend of quantitative and qualitative evaluation. Finally, revisions to the Addictions Program, considered a priority need, are insufficiently funded for the current fiscal year.[65]

170 Other indicators of financial strain were observed beyond the Directorate of Mental Health. The Joint Speaker's Bureau, the organization responsible for delivering much of the mental health awareness training to both CF members and military families, is not sufficiently base-line funded and thus vulnerable from year to year.[66] The Chief of the Defence Staff-initiated *Be The*

Difference anti-stigma campaign was discontinued in 2011 due to a decision to re-allocate its funding to another activity. While the campaign is still referenced at the national level, the intended level of grassroots penetration to the sailor-soldier-airman/woman was not observed over the course of this study. To the contrary, most members contacted up to and including the unit commanding officer level were completely unaware of the program.

171 Many Military Family Resource Centres, vital cogs in supporting families, experienced small or no budget increases during the period of 2007-2012 despite large increases in demand, and several indicated that they were experiencing funding strain.[67] As outlined, the re-established Directorate of Quality of Life appears to be severely undermanned with just 10 positions, of which only four are baseline funded as of mid-2012. And the Directorate of Military Family Support was required in recent fiscal years to "implement a low cost/no cost approach to programming" due to financial pressures.[68]

172 These are several examples of funding pressures that are negatively impacting the provision of mental health care and support to CF members with OSIs or their families. All have the potential to negatively affect this care and support.

173 The personnel deficit aside, the capacity to evaluate whether the resourcing of the mental health effort is sufficient is tied directly to the CF's ability to evaluate its performance. Unfortunately, performance measurement of the CF mental health capability is very limited. At present, validation of the capability is almost exclusively empirical, providing only a quantitative perspective of performance. Metrics such as wait times to various consultations and the frequency of consultation are tracked and monitored nationally, though not without considerable difficulty and not to the accuracy required, as explained in detail in recommendation 2.

174 Those inputs which have focused on the *quality* of care and treatment outcomes, such as a number of clinic-specific patient out-surveys, have been locally-generated and sporadic.[69] As a consequence, their value has been limited to providing small glimpses of the effectiveness of the CF mental health function, restricted by both time and space. Extrapolation of these results on an institutional scale has not been viable.

175 Functional leadership has recognized the importance of conducting systemic qualitative performance measurement of the CF's PTSD/OSI actual capacity.[70] It is readily acknowledged that too much of the contemporary management of the mental health function to date has been based primarily upon numbers. In response, the Directorate of Mental Health is actively moving on a number of outcome measurement tools. However, it will be a period of at least one year and more likely several before any such tools are

fully implemented, and comprehensive institution-wide qualitative performance evaluation conducted.

176 **Observations**

177 In the absence of a more fully staffed capability *and* the ability to qualitatively validate its effectiveness in providing the care that CF members suffering from PTSD and other OSIs need and deserve, DND/CF strategic leadership cannot know for certain whether the current funding level attributed to mental health care is sufficient. Definitive assertions that current funding levels are satisfactory to deliver the requisite care simply are not supported by holistic validation at this juncture, and won't be until manning is bolstered to levels approaching the established strength *and* systemic qualitative performance measurement is implemented.

178 On a related note, one message regularly communicated in qualifying the state of the CF's mental health capability is that *CF members are able to access mental health care more readily than the civilian population*.[71] Though compelling, the comparison appears to be of little tangible value. As long as the Government of Canada continues to send CF members into harm's way in order to protect Canadians and Canadian interests, and in so doing subjects them and their families to the mental stresses and consequences of modern military operations, then it is morally obligated to provide said members and families with a significantly more responsive care capability than that of the average citizen.

179 In the aftermath of the drawdown of operations in Afghanistan, and in the midst of significant fiscal constraints across the federal government, it is possible that pressure to scale back the mental health capability is brought to bear. The latent nature of OSIs during the post-mission phase of major operations, and the historical probability that the next major CF operation is both not far in the offing and likely to require a robust mental health capacity, should be kept in full view in responding to any such pressures.

180 Recommendation 8: Additional mental health providers

In December 2008 *A Long Road to Recovery* recommended:

The Canadian Forces monitor and assess the requirement for additional mental health care professionals should the challenge associated with mental health injuries continue to grow.

This follow-up review has determined that the extent to which this recommendation has been met is inconclusive.

181 **Assessment**

182 The recommendation is deemed inconclusive because it is simply not possible to determine if the CF mental health end-state of 447 mental health providers and integrated supporters is the proper effective strength *until* this manning level is achieved and the resultant outcome evaluated.

183 As outlined, not only has full manning not been attained, but it has flat-lined at 350-378, 15-22% below the established, funded manning level. This is of course an average. A closer examination of the numbers reveals that on some of the higher intensity CF bases and wings, especially those challenged by geography, the percentages are even more problematic. Canadian Forces Base Petawawa is an example. Despite having one of the most acute mental health demands, both in qualitative and quantitative terms, it has operated at approximately 25% short of its approved complement of mental health care providers for most of the period of 2008 to the present. Canadian Forces Base Valcartier is another example, operating at up to 50% below its established mental health manning for part of the 2008-2012 period.[72]

184 These are serious shortfalls, especially considering that the approved capacity was based upon the Rx2000 Mental Health Initiative, and not operations in Afghanistan. As a result, it was designed to provide the CF with a steady-state capability able to weather cyclical operational surges and consolidate during intervening lulls.[73] The evidence strongly suggests that providing mental health support for sustained operations in Afghanistan for a decade while functioning at between 15-22% under steady-state manning has imposed significant strain on the capability**.**

185 Moreover, the well-established post-operational latency of OSIs means that this sustained demand will continue well into the foreseeable future. Furthermore, recent history suggests that this latent requirement may well extend *into* the next major CF operation. What this means is that there is likely little respite on the horizon for an undermanned CF mental health capability.

186 There are a number of reasons for this persistent manning shortfall, several of which are beyond DND/CF's control. The most prevalent is the relative dearth of mental health professionals across the country. All of the nation's major health systems are scrambling to secure and retain these rare high-value practitioners. Twinned with this is DND's competitive disadvantage in challenging its various competitors for these professionals. Public service hiring guidelines are long and unwieldy, and the time it takes to identify and hire a civilian medical professional often exceeds the period that such professionals are available. Plus, compensation for medical professionals is capped at much lower rates than they can otherwise generate.

187 Additionally, the geographic limitations of some of the most pressing target CF locations are problematic. A number of bases and wings are not necessarily the most attractive locales for medical professionals with multiple career options.

188 There is an argument that the scope of the CF's mental health function is an enticement for some mental health professionals, and this is likely true. However, it also appears that one of the reasons the CF mental health structure is undermanned is because it is undermanned. That is, the pressures and stresses caused by a professional environment in which demand consistently exceeds capacity adversely affects both the recruitment of new professionals and the retention of those already employed, in turn adding to the manning shortfall.

189 Growing resources organically is a partial option, but the gestation period to produce home-grown mental health professionals is very long. As such, although this may be part of the solution it is neither speedy nor agile.

190 The numbers only tell part of the story. Exacerbating the chronic personnel deficit is the manning instability that it fuels. Periods of intensive operations create enhanced personnel dislocation, especially for uniformed personnel. More frequent postings, deployments, training and operationally-related taskings have resulted in pronounced instability in some locations. Multiple instances of mental health clinic managers and team leads rotating at two-year intervals, with six-month deployments (and their additional 3-6 month preparatory, decompression and post-operational leave commitments) sandwiched in between were observed.[74] Additionally, operational and training requirements teamed with the propensity for military practitioners to hold supervisory or lead roles has resulted in the requirement to reflect most uniformed caregivers as half resources as opposed to full-time resources. In actual practice, this partial accounting is not always captured, further widening the gap between actual practitioners and established positions.

191 In general, the evidence collected in this review strongly suggests that the combination of under-manning and instability has generated enormous strain on the mental health capacity.

192 The results have been predictable. Both frontline providers and senior staff disclosed that patient wait times for consultations with mental health providers are longer than they should be. This in turn creates increased anxiety and frustration in some patients, often aggravating their condition.[75] It has also resulted in an increased need for clinical support to manage extended waiting periods, and in some cases emergency care. This has added to the already considerable burden of care.

193 Moreover, in some instances patient consultations are shortened because of the constraints of supply and demand. Similarly the intervals between follow-up consultations are at times longer than providers would like because of the size of the caseloads they routinely carry. This mix of longer wait times, shorter session times, and/or longer intervals between consultations negatively impacts the quality of care.

194 The chronic manning shortfall has also impacted the continuity of mental health care.[76] Team-based care is adversely affected because excessive caseloads often prevent providers from having the time needed to consult with caregiver colleagues about individual patients. This necessarily negates much of the benefit of the team approach for both patient and care provider.

195 Additionally, insufficient clinical resources have generally resulted in a greater propensity for outsourced treatment.[77] This has complicated continuity of care due to the tenuous links some external professionals maintain with CF mental health providers and supporters when they treat CF personnel.

196 Finally, geography is problematic, especially for CF members in isolated locations where access to mental health care is limited by the small pool of external medical professionals. In some instances, outsourcing external care for CF members suffering from OSIs has resulted in reduced access to these same caregivers for their families.[78] This unintended competition between serving member and family is obviously counter-productive.

197 **Concerns**

198 The chronic mental health personnel shortage has persisted for well over five years, and it is difficult to anticipate how much longer it will take to generate the 60-90 positions which remain unfilled. While it would be naïve to believe that there was a magic solution available to rapidly fill this shortfall, there must not be an institutional resignation that little can be done. This is a serious concern.

199 The solutions are not obvious and will certainly require innovation and assertiveness. They may even necessitate shifting long-accepted paradigms. Achieving this will require renewed focus by CF strategic leadership. The evidence gleaned in this investigation indicated that in spite of the often expressed importance of tackling the mental health personnel deficit, the measures in place or forecast appear quite conventional and seem unlikely to deliver decisive results in the prevailing conditions.[79]

200 The CF has a moral remit to its members to provide them with comprehensive mental health care commensurate with repeatedly being sent into harm's way. Superfluous comparisons with civilian access to mental health care are not

sufficient. What is needed is greater leadership impetus and innovation in breaking the mental health recruiting logjam. Reaching the 447 threshold, or at a minimum coming much closer to it, must be achieved at the earliest opportunity.

201 A secondary concern is the recurring lament investigators heard that mental health clinics were not only short of care-giving professionals and managers, but also of clerical staff, namely clerks and receptionists. This gap often required caregivers to make phone calls, coordinate appointments or execute similar administrative tasks, eating into their already compressed consultation schedules. Though it was not possible to quantify the extent of this shortage (clerical staff do not count on the 447 mental health capability's establishment, making their projected and actual numbers more challenging to track) it was a concern expressed by a number of the mental health clinics and Operational Trauma Stress Support Centres canvassed in this study.

202 As outlined, it is not possible to fix the caregiver manning issue simply by throwing money at the problem for the reasons previously discussed. However, it is unclear why there are persistent shortfalls of clerks and receptionists when they are more readily available in the workforce. Funding should be sufficient to solve this problem.

203 **Observation**

204 Despite the chronic manning deficit of 15-22% for most mental health Clinics and Operational Trauma Stress Support Centres, the capability has continued to function. This is an unequivocal tribute to the tireless dedication and commitment of the care providers and supporters who have delivered unconditionally during the past ten years, and continue to deliver. These men and women deserve the organization's inestimable appreciation for such devotion to the mission.

205 Recommendation 9: Develop a national program to mitigate caregiver burnout

In December 2008 *A Long Road to Recovery* recommended:

The Canadian Forces develop and implement a national program or initiative aimed specifically at assisting and preventing stress and burnout among the mental health care community.

This follow-up review has determined that this recommendation has been partially met.

206 **Assessment**

207 DND/CF has maintained a decentralized approach in which the well-being of mental health caregivers is the inherent responsibility of the chain of

command, as it is for the care and well-being of all CF personnel regardless of occupation, function or rank.[80]

208 This approach has been buttressed by a series of national enablers designed to mitigate some of the most prevalent stressors particular to mental health caregivers.

209 Three key enablers have been instituted or formalized in recent years. The first is the establishment of the Directorate of Mental Health in January 2009, followed by the creation of the Mental Health and Psychiatry Advisor position in 2010. The latter serves as the de facto institutional champion of caregiver wellness across the CF mental health community, though both contribute directly to the professional operating environment. They monitor the care community through statistical tracking and regular personalized contact. This tracking will be enhanced in the short-term by more effective empirical collection of mental health clinic activity levels as outlined at recommendation 2. The improvement should equip the Director of Mental Health and the Mental Health and Psychiatry Advisor with a more structured ability to calibrate work loads and adjust resources accordingly in the overall aim of maintaining a balanced, healthy professional environment.

210 The second is the transition to the team-based care approach in which numerous multi-disciplinary care providers attend to the various needs of individual patients in a collaborative manner.[81] This approach has provided a number of advantages. From the clinician's perspective, it has removed the full burden of a patient's care from the shoulders of a single provider. It has also enhanced consultation and collaboration, strengthening working relationships and leading to healthier work environments along the way.

211 Thirdly, the May 2012 formalization of the 20-hour per week guideline governing mental health provider-patient consultation (*face-time* in clinical terminology) is intended to reduce workload imbalances, limiting the fallout which includes extended working hours, insufficient opportunity to consult with team members, poor preparation, arrears in case/file management, shortened consultations, and care provider frustration.[82]

212 Another enhancement designed to alleviate mental health caregiver frustration and contribute to a more cohesive, positive environment is improved relationships with the primary care community. There has been a recent push both nationally through the Director of Mental Health and the Mental Health and Psychiatry Advisor and locally through clinic managers and team leads to reach out to primary care providers and improve mutual understanding and cohesion.[83] Again, results are largely embryonic at this early juncture but the effort appears well in train.

213 There has also been an increased focus on caregiver awareness in some quarters of the care community, including the benefits of self-care in which providers are given a better understanding of the warning signs of workplace stress and taught mitigating techniques to ward off burnout. *Buddy care*, in which practitioners are encouraged to actively look out for one another, is also encouraged. It should be noted that a number of caregivers conveyed that *buddy care* was a measure often employed with co-workers as a last resort in the absence of structured initiatives to mitigate workplace stress and burnout.

214 Finally, a number of local and intra-community initiatives are being studied for wider application across the CF mental health structure. One such initiative is the *Care for the Caregivers* program instituted for the chaplain community. The Operational Stress Injury Social Support network has implemented its caring and resiliency program, and the Joint Personnel Support Unit recently developed its own resiliency plan.

215 **Concerns**

216 The approach outlined above is sound, and the commitment to improving mental health caregiver well-being is substantial. However, as long as the chronic personnel shortage persists, even the most inventive, rigorous caregiver frameworks will not succeed in mitigating the major cause of burnout: sustained, excessive workload.

217 The evidence strongly indicates that a preponderance of mental health caregivers continues to experience excessive workload and professional fatigue, precluding the possibility of a healthy, nurturing work environment. These providers are often unable to limit face-time to 20 hours, and often work extended hours. Moreover, the repercussions that chronic under-manning often has on the quality and continuity of care places an additional burden on these providers. The pressure many of them attest to experiencing on a constant or recurring basis is considerable, undermining morale, sapping motivation, and tarnishing the general professional setting.[84]

218 Until DND/CF is able to achieve a better balance between supply and demand by attaining its full personnel complement (or coming much closer to it), caregiver burnout will almost certainly continue to be prevalent. This, in turn, will further drive the shortfall as practitioners suffer decreased productivity out of frustration, exhaustion, or both, or worse yet depart altogether.

219 Another concern is caregiver stigma, the hesitation amongst mental health providers to recognize signs of excessive professional fatigue or frustration and reach out for support in response to warning signs of possible burnout, continues to be problematic.[85] The evidence culled from a sizeable sampling of caregivers indicates that they are largely resistant to self-identifying and/or

seeking counsel or care. There is a general sense of having to tough it out. Part of this is, once again, a function of chronic under-manning as overburdened providers recognize that their peers will have an even greater workload if they are unable to perform for even the shortest interval. Another element of this caregiver stigma is concern by care providers about letting their patients down by not being there for them. And still another is the sense that professional caregivers should not succumb to mental health issues themselves, lest it reflect poorly on their competence.

220 Additionally, while the approach of delegating caregiver well-being to the chain of command is both reasonable and consistent with accepted military practice, there is a question of whether mental health providers in leadership or supervisory roles are suitably equipped to execute the responsibility effectively. The transition from the pre- to post-Rx2000 structure has increased the demands on the mental health chain of command, without any commensurate increase in formal supervisor and leadership preparation or training.[86] Clinic leaders who would have been responsible for five or six care providers and supporters in 2002 are now supervising teams of 15 to 25 personnel, even accounting for the manning shortfall. This transformation has occurred very rapidly, and the military mental health caregiver cadre has not necessarily been properly prepared to take on this added leadership responsibility.

221 Add to this the flux in mental health provider manning, especially uniformed personnel, often characterized by two year rotations with an operational deployment interspersed. Many of the clinic leaders or team lead positions have been 'rotating doors'[87] for extended periods, complicating the exercise of sound military leadership. As an example, the mental health clinic of a major Army base has had three different clinic managers in less than four years. Another clinic experienced no less than 15 different managers over a 10-year period.

222 Though the emphasis is rightly on mental health care providers, supervisors and managers, clerical staff (clerks and receptionists) is not immune to caregiver burnout and must not be overlooked. These individuals often take on added responsibilities to alleviate excessive caregiver case burdens, increasing their own workloads and stress levels in the process.[88] Moreover, clerical staff is regularly the first point of contact between patients (potential and actual) and mental health resources. As such, they often take the brunt of patient frustration and anger. This is especially the case when they are saddled with the unenviable task of communicating unwelcomed information regarding long wait times or caregiver availability, or must advise a patient that they are seeing yet another different caregiver for the next consultation. These clerks and receptionists fulfill a key function, and their well-being is important.

223 ## Recommendations – Canadian Forces Base Petawawa Case Study

224 Recommendation PETAWAWA-1: Increase the number of mental health care providers

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces take immediate action to match the numbers of care provider positions to the needs of Canadian Forces Base Petawawa given the size, operational activity and location of the base.

This follow-up review has determined that this recommendation has been partially met.

225 **Assessment**

226 Any discussion about mental health caregiver manning must address two dimensions; established strength (the positions created and funded) and effective strength (the positions actually filled).

227 The established strength of mental health care providers and supporters at Canadian Forces Base Petawawa has increased during the 2008-2012 timeframe by 2.0 full time employees.[89] This represents a 6.5% increase of the overall complement.

228 This growth must be considered within the larger context of Petawawa's mental health expansion during the post-Rx2000 timeframe of the early-2000s to 2008. Over this period, the established mental health care provider/supporter strength jumped 150% from 12.7 providers to 31.7. By any standard this represents major growth.

229 The increase in effective strength (actual capacity on the ground) is more relevant and more dramatic. The number of active mental health providers/supporters at Canadian Forces Base Petawawa tripled from 6.0 to 18.1 between the early 2000s and 2008. Moreover, it grew by a further 40% from 2008 to 2012.

230 Finally, a review of the resultant proportion of filled positions to established positions shows that in the immediate post-2000 period Petawawa's mental health capability was staffed at 47%. In 2008 (at the time of the Petawawa case study) this percentage had grown to 57%. And in 2012 it reached 75%.

231 The steadily growing number of established positions twinned with the rising rate of filled positions has provided Petawawa with a more robust mental

health function in 2012 than it possessed in 2002 and in 2008. The increase in providers on the ground from 6.0 in 2002 to 18.1 in 2008 and 25.3 in 2012 is significant.

232 This stated, the evidence plainly shows that the positive impact this growth in capacity has had on the delivery of PTSD and OSI-related care at Canadian Forces Base Petawawa has been incremental because of the concurrent increase in demand over the same period.

233 The figures outlined above are summarized in the following chart:

Canadian Forces Base Petawawa Mental Health Manning

	2000+			**2008**			**2012**	
Established Strength	**Effective Strength**	**Vacant Positions**	**Established Strength**	**Effective Strength**	**Vacant Positions**	**Established Strength**	**Effective Strength**	**Vacant Positions**
12.7 (100%)	**6.0** (47%)	**6.7** (53%)	**31.7** (100%)	**18.1** (57%)	**13.6** (43%)	**33.7** (100%)	**25.3** (75%)	**8.4** (25%)

234 A comparative analysis pitting Canadian Forces Base Petawawa's 2012 established mental health manning against those of bases of comparable scope and size, namely Valcartier, Edmonton and to a degree Gagetown, aligns Petawawa favourably. Valcartier and Edmonton's established strengths are noticeably higher because of their regional responsibilities, which Petawawa does not possess.

235 This evaluation is presented below:

*Comparison of Mental Health Establishments – Major Army Bases******

	Edmonton**	Gagetown	Petawawa	Valcartier**
Mental Health Established Strength	**33.3**	**25.0**	**28.7**	**39.2**

* *These figures represent clinicians and management positions only.*

Clerical positions (clerks and receptionists) are not included.

** *Denotes bases with regional mental health responsibilities*

236 It should be noted that the comprehensive metrics for the period of 2008-2012 comparing precise size of constituency, percentage of constituency deployed

on operations, and resultant OSI incidence rate were either unavailable or not available with sufficient consistency to pursue this inter-base comparison any further. Thus, it is useful as a general indicator only.

237 Petawawa's gains are substantial by any measure. However, they are not necessarily indicative of whether either of the two 2012 figures (established strength or effective strength) meets the requirement. A more resourced situation is clearly better than a less resourced one, but it may nonetheless remain insufficient. This is especially possible owing to the important increase in mental health demand at Petawawa over the same period, which has grown tremendously over the past ten-plus years.

238 Assessing the established strength brings with it the same challenge as that on the national scale, identified in the discussion of recommendation 8. Canadian Forces Base Petawawa's current manning is still too far from its established strength to accurately assess whether a total of 33.7 mental health professionals and supporters fully meets the base's OSI needs.

239 The lack of qualitative performance measurement of the effectiveness of Petawawa's mental health function further complicates any determination of how many providers are needed to care for the base's constituents suffering from OSIs and their families.

240 As for its effective strength, while 25.3 providers/supporters in action is clearly a major improvement over 18.1, it still represents a 25% manning shortfall of the established strength. The real delta between *have* and *need* is almost certainly significantly higher than this, owing to the earlier observation that the established strength was developed from the Rx2000 Mental Health Initiative based on steady-state needs. Petawawa's operational contribution since 2002 and the resultant mental health imperative, current and latent, are most assuredly far from steady-state. The increase to 25.3 actual caregivers is significant, but it still appears to be insufficient to meet Petawawa's demand over a sustained period.

241 The impacts of this deficit have been felt on the ground at Petawawa for much of the past decade, and continue to manifest. They include extended patient wait times and intervals between consultations, excessive mental health provider workloads, caregiver frustration and stress, and substantial outsourcing of treatment. Outsourced treatment provides only partial relief due to the lack of external resources in the Pembroke area.[90]

242 In short, the mental health capability at Canadian Forces Base Petawawa has increased appreciably and is functioning in terms of providing the base's members suffering from PTSD and other OSIs and their families with care. Whether this care is of the quality and continuity Petawawa's members need

and deserve, however, remains questionable due to the continued gap between capacity and demand. The empirical and experiential evidence demonstrates unequivocally that though it is improved, Petawawa's mental health capability is under considerable and sustained strain.

243 **Observations**

244 The most difficult mental health specialty to fill at Petawawa, as well as several other geographically challenged locations, is psychology.[91] A major reason for this is the absence of a psychologist military occupation. Creating uniformed psychologists would likely increase the number of these specialists able and willing to serve the Canadian Forces in isolated locations like Petawawa, as it does for psychiatrists.

245 The longer this chronic manning shortfall persists without effective solutions in sight, the less relevant the established strength becomes.

246 Recommendation PETAWAWA-2: Establishment of a national family support resource

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces establish and properly resource an organization – at the national level – responsible for working with external agencies and all levels of government, as required, to ensure that military families and individual members of the families of military personnel have access to the broad spectrum of services and care they need.

This follow-up review has determined that this recommendation has been partially met.

247 (Note: This recommendation is identical to recommendation 6 of *A Long Road to Recovery*. Refer to the discussion at recommendation 6)

248 Recommendation PETAWAWA-3: Permanent family liaison and family resource

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces provide the permanent resources that would enable Canadian Forces Base Petawawa to liaise with local agencies and municipal governments to identify and to coordinate the care required by and available to military families and family members of military personnel.

This follow-up review has determined that this recommendation has been met.

249 **Assessment**

250 A number of resources have been established or enhanced at Canadian Forces Base Petawawa to facilitate families of members suffering from OSIs access available care and support from external (and internal) sources. The most integral of these is the Family Liaison Officer. Created in 2008 in response to the mushrooming needs of affected families, Family Liaison Officers are qualified social workers mandated to identify and coordinate family care for the ill and injured at the local level. They connect family members to a wide range of external programs and resources that otherwise would be difficult to learn of and/or access. Family Liaison Officers belong to the Military Family Resource Centres but operate out of the Integrated Personnel Support Centres, bridging these two key entities.[92]

251 While bases are intended to have only a single Family Liaison Officer position, Petawawa added a second one in 2012, an acknowledgement of the community's sustained demand and a reflection of the function's positive impact.

252 For its part, the Petawawa Military Family Resource Centre continues to deliver much-needed support to the community's families. A recent increase in funding and a consolidation of some of its services have allowed it to expand the scope of its offerings. This includes the intention to add five additional staff to better serve its constituency.[93]

253 The Petawawa Integrated Personnel Support Centre, inaugurated in December 2008, has as its mission the provision of cohesive, coordinated care and support to ill and injured CF members and their families. As outlined, there is still considerable scepticism within elements of the chain of command surrounding the Joint Personnel Support Unit construct. Some units have been working cohesively with the Petawawa Integrated Personnel Support Centre, while others have not.

254 The Base Commander and senior staff have taken an active role in developing partnerships with external organizations, and expanding care and support opportunities for families. Much of this engagement is channelled through the Community Response Team.

255 Peer support plays a contributing role in supporting Petawawa's families and connecting them to the resources they require. The Operational Stress Injury Social Support Family Peer Support Coordinators continue to play a pivotal role.

256 **Concerns**

257 Regardless of how effective Family Liaison Officers, Military Family Resource Centres, Integrated Personnel Support Centres, Family Peer Support Coordinators, senior leadership, and the mental health community are in engaging external assets, the availability of external care and support in smaller, geographically isolated locations such as Petawawa will continue to be a major limitation. Services which do not exist or exist only in very short supply cannot be exploited by a sizeable military family population over a sustained timeframe.

258 If it is determined that family needs cannot be satisfied by available external resources in a given geographic location, measures to provide for such needs internally will have to be considered.

259 Cost is a constraint for many military families suffering through OSIs. Some external services are not covered by provincial and public service health plans, making them unaffordable to some families. Those services that are covered often require up-front payment, which can be prohibitive as well.[94]

260 One of the biggest barriers to care and support for families is their CF spouses, upon whom they depend for much of their information and situational awareness concerning available programs and services. Experience has shown that CF members who shut out their families as they attempt to deal with the effects of PTSD or other OSIs often hurt both themselves and their loved ones.[95]

261 Stigma transference, the perception amongst some serving members and/or their families that reaching out for care will negatively affect the CF spouse's career, is another barrier to accessing external support for some families.

262 Lastly, despite the cumulative commitment by local leadership (command and medical) to facilitate family access to external care through outreach, excessive workloads regularly get in the way. When clinical demand exceeds capacity, as is frequently the case for undermanned mental health providers, outreach is often one of the first activities to be shifted to the right or abandoned altogether.

263 Recommendation PETAWAWA-4: Implement interim care solutions

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces find interim approaches to providing sufficient local health care while waiting for long term solutions to take effect.

This follow-up review has determined that this recommendation has been met.

264 **Assessment**

265 A number of punctual interim approaches were put in place to alleviate some of the strain on the mental health capability identified in the 2008 case study.

266 One measure was augmenting Petawawa's mental health capacity by sending in caregivers from Ottawa and other bases in small teams and individually for short support stints, reducing the workload there. This augmentation, combined with the rapid posting of three additional mental health professionals to Petawawa in the 2008 posting season, provided some relief.[96]

267 Another interim approach was the establishment of the Ottawa satellite clinic, servicing Petawawa patients from Ottawa where two to three contracted psychologists were available. This further lessened the Petawawa mental health caseload.[97]

268 Treatment for members suffering from PTSD and other OSIs was outsourced to external mental health professionals in the local region when possible, although the lack of Pembroke-area resources limited this option.[98]

269 The remote Tele-Medicine system was implemented, employing video-conferencing technology to deliver treatment at a distance.[99] This increased access to care while reducing the time and logistics involved in travel between Petawawa and Ottawa.

270 The effectiveness of these interim approaches varied, though the evidence indicates that their cumulative effect was positive. This study was unable to definitively quantify the extent to which they alleviated the strain on Petawawa's mental health capability.

271 **Concerns**

272 Most of these measures suffered from the constraints inherent in interim approaches.

273 The punctual augmentation of the mental health capability through short-term practitioner support from other bases complicated functional clinic cohesion.

The evidence shows that maintaining consistent quality and continuity of care when patients were repeatedly handed off from one caregiver to another was difficult. While the concern was serious, the alternative was inordinately longer waits for treatment.

274 The Ottawa satellite clinic increased Petawawa's psychologist capacity, though travel to and from Ottawa was an issue for many. Base transportation was provided, but was shunned by some patients because taking it was seen as an open admission of a mental health problem. Patients were free to use their own vehicles and many did. The drive, however, was often challenging and even dangerous, especially on the return leg when patients could be quite distraught. Investigators were told of several instances when patients realized mid-trip that they had mentally checked out for part of the drive because of the anxiety or frustration experienced following a consultation.[100] Additionally, travel back and forth proved time-consuming and expensive.

275 Clinic coherence and practitioner oversight were also problematic for the satellite clinic due to the geographic separation.

276 Increased treatment outsourcing brought its own challenges. A lack of cultural understanding between the external civilian caregiver and the military patient was a major hurdle. Also, the suitability of the treatment delivered and the continuity of that care were generally much more difficult to ensure than for in-sourced treatment.

277 Tele-Medicine eased the challenges of time and space, though some patients struggled with the impersonal format. Sharing sensitive sentiments with a caregiver appearing on a television screen was an obstacle for some patients.

278 **Observation**

279 Recent events relative to the announced transfer of the satellite clinic in Ottawa have caused concern in the Petawawa area. DND officials advised that this decision was designed to augment Petawawa's local capability, though there is scepticism in some quarters. As the implementation of this decision is ongoing at the time of the writing of this report, the impact or effectiveness of this transfer cannot be evaluated.

280 Recommendation PETAWAWA-5: Enhanced chaplain support

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces provide resources for additional paid administrative and program assistance to enable the chaplains to minister more effectively to the spiritual needs of military personnel and their families.

This follow-up review has determined that this recommendation is no longer valid.

281 **Assessment**

282 The Brigade Chaplain indicated that his group possessed the administrative staff needed to function effectively. The availability of volunteers to support several chaplain programs during the period of the mid-2000s onward had declined markedly as Canadian Forces Base Petawawa's operational tempo peaked, straining the chaplaincy's ability to execute these programs. However, this aberration appears to have passed since summer 2011, negating the requirement for additional funding.

283 **Observation**

284 If Petawawa reverts to an exceptionally high operational tempo over a sustained period similar to that endured over much of the past decade, additional funding should be considered to offset renewed volunteer shortfalls in supporting chaplaincy programs.

285 Recommendation PETAWAWA-6: Multi-disciplinary governance

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces establish a clear governance structure, with clear responsibilities and accountabilities, for the provision of effective and efficient multi-disciplinary care for military personnel and their families at Petawawa.

This follow-up review has determined that this recommendation has been partially met.

286 **Assessment**

287 There are indications that the governance structure for multi-disciplinary care at Canadian Forces Base Petawawa has significantly improved.

288 The major catalyst for this was the establishment of the Mental Health Lead position in 2008, which created a structural focal point through which effective governance could be exercised.[101]

289 The recent stand-up of Petawawa's Operational Trauma Stress Support Centre in mid-2011 should enhance the structural cohesion necessary for sound governance, though it is too early to assess this at present.

290 National initiatives have contributed as well. The appointment of the Director of Mental Health and the Mental Health and Psychiatry Advisor has added pan-CF oversight to the execution of coherent mental health care. Understanding and respecting professional practice boundaries has been a recurring point of emphasis at the national level – interdisciplinary care was the central theme for the inaugural Canadian Forces Mental Health Workshop in 2009, and governance has been a focal point of subsequent national workshops.

291 Directorate of Mental Health Staff Assistance Visits conducted by mental health professional technical teams have provided in-location assessments of the strengths and weaknesses of multi-disciplinary care delivery at a number of mental health clinics across the country since 2009. Petawawa underwent a Directorate of Mental Health Staff Assistance Visit in April 2012, the second such examination in the past five years. Governance was one of the visit's areas of focus.[102]

292 From a practice perspective, the stabilization of the medical case management role is showing positive effects on functional cohesion by providing a centralized hub for the coordination of mental health care. This has alleviated some of the impediments to efficient governance.

293 Another noteworthy contributor to functional cohesion and governance has been the Standardized OSI Assessment and Treatment Protocol refined in 2011. It has increased commonality of practice amongst mental health professionals and teams, simplifying the governance imperative.

294 Finally, the work of clinic managers and team leads in improving awareness of individual roles and functions has reduced much of the friction which dogged the leadership, management and coherence of multi-disciplinary care delivery in the recent past at Petawawa and elsewhere.

295 As the recent Directorate of Mental Health Staff Assistance Visit confirmed in mid-2012, there are still frictions in the governance of multi-disciplinary care at Petawawa, and continued attention is warranted. However, the stovepipes that were rife in 2008's *A Long Road to Recovery* are less prevalent in 2012.

296 **Concerns**

297 One of the leading causes of governance friction is chronic under-manning. No matter how cohesive the governance structures and how effective the leaders put in place, a persistent deficit in the number of mental health care providers will result in challenges to governance. As long as Petawawa's mental health team is 25%-plus short of its established manning level, governance is likely to be a problem.

298 As stated, the creation of the Operational Trauma Stress Support Centre should become an important part of the governance solution, though its inception was problematic. Communication around its opening in June 2011 was disjointed, with several Petawawa stakeholders learning of the conversion just before it occurred. Furthermore, there was a perception amongst some practitioners that the Operational Trauma Stress Support Centre stand-up was little more than a name-change designed to *show* forward progress rather than *deliver* it. The inherent concern was that the heightened responsibilities and expectations of an Operational Trauma Stress Support Centre designation were not matched by a commensurate increase in resources, including additional mental health providers and training. Some of these perceptions still persist, undermining caregiver morale and likely holding back the capacity of the Operational Trauma Stress Support Centre to reach its full potential.

299 Another concern is the function of Base/Wing Surgeons. Specifically, it was observed that their prominence in serving in a senior advisory role at the base and wing level across the CF has diminished in recent years as a function of two realities. The first is that Base/Wing Surgeons are generally much less experienced and often much younger than their predecessors in the pre-Rx2000 era. The resultant lack of seniority makes it difficult for them to execute their advisory role effectively. Secondly, the rotation rate of Base/Wing Surgeons has been exceedingly high since 2002, making it difficult for them to become entrenched and properly invest in their roles and responsibilities. As a result of this diminished senior advisory capacity, Base/Wing Surgeons appear less effective in contributing to the multi-disciplinary care dynamic, including serving as intermediary when appropriate.

300 **Observations**

301 The inter-disciplinary care governance challenges Canadian Forces Base Petawawa continues to face are not unique to Petawawa, nor are they entirely without reason. The rapid expansion of any capability invariably brings enhanced challenges in leading and managing it, especially for a function as complex as mental health with its many interdependencies and intricacies.

302 As observed in previous reports, there were some difficulties relative to individual approaches and personalities which adversely impacted mental health care governance at Petawawa. The professional climate improved markedly once these personnel problems were attended to. However, the governance problem affecting mental health care in Petawawa was more pervasive than a couple of caregivers who couldn't get along. These individuals were part of the problem; they were not the whole problem.

303 Recommendation PETAWAWA-7: Care provider relationships

In December 2008 the Canadian Forces Base Petawawa case study *Assessing the State of Mental Health Services in Petawawa* recommended:

The Canadian Forces take positive action to assist the members of the care giving community at Petawawa to re-build interpersonal and inter-speciality relationships that are courteous, respectful, trustworthy, cooperative and supportive.

This follow-up review has determined that this recommendation has been met.

304 **Assessment**

305 The lack of trust and respect within Petawawa's caregiver community prevalent in 2008 was not observed in 2011-2012. The operating environment generally appeared professional and respectful.

306 One exception was a concern voiced by several mental health providers of friction from some primary care professionals. There is a sense that in certain instances the professional judgement of mental health care providers is discredited or dismissed outright by primary care providers.[103] The veracity of such claims was impossible to assess precisely. Overall, it was evident that the professional care environment in Petawawa is healthier than it was in 2007-2008.

307 A number of factors have contributed to this improvement. One is the prompt removal of personnel deemed to have instigated or contributed to these relationship issues. Another is the focus on interdisciplinary care emphasized at the national level.[104]

308 Much as with the governance imperative, care provider outreach, especially at the team lead and clinic manager levels, appears to be having a positive effect on enhancing awareness and improving relationships. Various local joint awareness initiatives at Petawawa such as the Brigade Mental Health Day have been executed to this end.[105]

309 **Concerns**

310 Chronic under-manning and sustained high demand for care is a toxic combination which fuels fatigue, frustration and stress, and erodes professional relationships. Mental health leadership must remain attentive to professional relationships as long as there is a substantial disparity between effective and established strengths.

311 Chronic under-manning also limits the ability of providers to invest in reaching out to the community of practice, which is considered pivotal to cohesive relationships.

312 High turnover, which has been a staple of Petawawa's mental health capability for much of the past decade, is equally detrimental to positive professional relationships. Many practitioners, especially those in leadership roles who experience a much higher movement rate due to posting, deployment, training and tasking, simply lack the time to establish, nurture and leverage productive professional relationships.

313 **Observations**

314 There will always be an element of professional friction between primary care and mental health providers because of the occupational health dimension of CF health care. Primary care providers make the final call regarding the proper balance between developing optimal health outcomes and delivering the care necessary for a return to normal military duty. This is unavoidable and necessary. It is tensions from sources other than this which must be addressed.

315 Finally, friction between primary care and mental health care providers is not specific to Canadian Forces Base Petawawa or the Canadian Forces – it appears to exist across the North American health care community. And as with other stigmas, it is partly generational. Medical schools now provide general practitioners with more mental health training, equipping them to treat basic mental health needs. This will inevitably strengthen the relationship between the primary care and mental health care communities over time.[106]

316 <u>Final Notes on Canadian Forces Base Petawawa Case Study Recommendations</u>

317 Two notes must be highlighted in closing out this discussion. The first is that the situation at Canadian Forces Base Petawawa is not unique, as was strongly suspected in the 2007-2008 timeframe when the second follow-up *A Long Road to Recovery* was researched and developed. The evidence for this report,

culled in 2011-2012, shows that Petawawa's situation is quite comparable to several similar bases of like size and scope.

318 This does not mean that all is well. As explained, the mental health capacity at Petawawa is functioning, delivering care and support to its members suffering from OSIs and their families. However, there is no clear measure as to whether it is doing so sufficiently well.

319 Moreover, Petawawa's mental health care capacity is showing much strain. It is open to question whether the current operating environment can be sustained indefinitely.

320 Much as with the mental health capability CF-wide, mental health care at Petawawa is well ahead of where it was in 2002 and 2008, though fundamental challenges remain.

321 The second point to note is that, like the institutional mental health capability, most of the issues plaguing Petawawa are either directly attributable to, or significantly aggravated by, *chronic caregiver under-manning*. If DND/CF can eliminate or alleviate this personnel gap, most of the stresses and impediments affecting CF mental health care at Canadian Forces Base Petawawa will almost certainly diminish substantially.

322 # Section 3: Findings

323 ## Beyond the Recommendations of *A Long Road to Recovery*

324 > *"Things alter for the worse spontaneously, if they be not altered for the better designedly."*
>
> – Francis Bacon, English philosopher and statesman (1561-1626)

325 **FINDING: Comprehensive operational stress injury care capability**

326 It is indisputable that the Canadian Forces (CF) mental health care capability for members suffering from post-traumatic stress disorder (PTSD) and other operational stress injuries (OSIs) has improved since 2008, when it was assessed in *A Long Road to Recovery*. It is equally evident that this capability is far superior to that of 2002, when it was first reviewed in *Systemic Treatment of CF Members with PTSD.*

327 This current Canadian Forces mental health capability begins with CF members themselves. From the very start of their careers now, Canada's sailors, soldiers and airmen and women are informed and instructed about the mental health concerns involved in modern military service. This instruction continues throughout the member's career, both as part of career training and professional development, as well as mission-specific training.[107] The result is twofold. First, it better equips members to understand what they, their peers and their subordinates might experience from a mental health perspective throughout their careers. Second, it reduces the stigma around mental health injuries and illnesses that previously held many members back from seeking care. The fact that today's CF member has a more informed and mature perspective on post-traumatic stress disorder and other operational stress injuries has not occurred haphazardly.

328 As for its capability to deliver the care that CF members suffering from OSIs need and deserve, the Canadian Forces has now integrated mental health into every major CF garrison and deployed organization. Smaller establishments and deployment configurations without organic mental health resources have primary care assets able to connect to mental health professionals. The current network of 38 primary care clinics, 26 mental health clinics of which five are regional clinics, and 7 Operational Trauma Stress Support Centres, augmented by mission-tailored deployed primary and mental health care

elements, provides the CF with a broad geographic footprint within which every serving member has access to professional mental health care.[108]

329 Moreover, the inter-disciplinary composition of these various mental health constructs brings together psychiatrists, psychologists, social workers, mental health nurses, addictions counsellors and health services chaplains. This allows all pertinent specialities to be brought to bear in providing care for CF members suffering from OSIs. It is the cornerstone of the CF's team-based care approach to providing comprehensive, evidence-based treatment for Post Traumatic Stress Disorder (PTSD) and other OSIs.

330 This structure has been augmented by incorporating some modern technologies to both reduce the challenges of time and space, and provide patients with environments conducive to positive health outcomes.

331 Innovative research measuring the incidence of OSIs in modern operational landscapes and related areas of study is helping inform the CF's future, arming strategic leadership with a stronger understanding of the impacts of mental health injuries and illnesses tomorrow and beyond.

332 The CF's mental health care structure also incorporates a social non-clinical component which provides emotional support, treatment-seeking behaviours, and assistance to individuals in coping and adjusting to their affliction, and its career and life consequences. This peer support, delivered mainly through the Operational Stress Injury Social Support network, has been an instrumental element of the CF's holistic approach to PTSD and other OSIs from the early 2000s on.

333 The Canadian Forces has a better appreciation of the connection between a member afflicted with an OSI, the impacts this has on the member's family, and the prospects of positive health outcomes. Consequently, it has made a concerted effort to expand the range of support and services available to families dealing with OSIs.

334 As with most rapid major organizational change, maintaining coherence has been a key challenge for the CF's mental health capability. The establishment of the Mental Health Directorate and the Mental Health and Psychiatry Advisor in 2009 and 2010 has provided the Department of National Defence (DND) and the CF with a single point of focus for the mental health function. This has triggered the function's transition, still ongoing in the view of this analysis, from 26 individual delivery points to a single, cohesive system.

335 The CF's mental health care capability is structured to deliver the integrated, holistic care that CF members suffering from PTSD and other OSIs need and

deserve. It has evolved from the "ad hoc system" it was evaluated to be in 2008 into a comprehensive care capability.

336 However, as outlined repeatedly throughout this report, there remains an important gap between the intended *capability* and the actual *capacity* to deliver it. The persistent inability to fully staff the approved and funded CF mental health structure, providing it with the horsepower designed specifically for it, continues to exert enormous strain on the system and especially on the caregivers and supporters who make it work. This stress adversely affects the quality and continuity of care that DND is committed to providing, and CF members need and deserve.

337 **FINDING: Strategic leadership commitment**

338 The dramatic expansion of the CF's mental health structure between 2002 and 2012 largely in response to PTSD and other OSIs could not have been accomplished without a firm commitment from the institution's strategic leadership.[109] That the mental health imperative inherent in modern military service has become institutionalized over a single decade in an organization as traditional as the Canadian Forces is clear evidence of this engagement.

339 So too was the decision to virtually double the CF's stable of mental health practitioners and supporters in a single bound. Such dramatic growth in a persistently resource-constrained environment could occur only in response to decisive leadership on OSIs.

340 The Chief of the Defence Staff has been an ardent advocate of the operational stress injuries issue. He has made it a central tenet of his leadership, both in terms of ensuring the systematic provision of appropriate care, and removing the institutional and perceptual barriers separating CF members from this care. He has also sought to ensure that CF members suffering OSIs from operations pre-dating 2001 have not been neglected in the exuberance to meet the challenges borne from a decade in Afghanistan.[110]

341 Successive Chiefs of Military Personnel have championed more comprehensive care for suffering CF members. The scope of the structural and functional change within the CF's mental health care community, and the trade-offs such change invariably engender, could not have transpired without deep-rooted commitment.[111]

342 Despite this engagement, there have been a number of important strategic leadership challenges. Support to families has improved but still requires additional contemplation. The care delivered to Reservists (the subject of a forthcoming independent analysis by the Office of the Ombudsman) appears to have been inconsistent compared with that provided to Regular Force

members. The funding pressures outlined earlier which have left several of the CF's major OSI-related programs and initiatives vulnerable in the present cost-cutting environment are a reflection of DND/CF leadership on the issue. So, too, is the fact that two of the institution's key players in the provision of care and support to CF members with OSIs and their families, the Directorate of Mental Health and the Directorate of Quality of Life, are visibly under-staffed, under-funded, and in the case of the latter still experiencing organizational flux.

343 Though these are all important, the two most pressing strategic leadership concerns pertaining to OSIs are (1) the lack of progress in addressing the chronic manning shortfall of CF mental health professionals since 2008, and (2) the absence of qualitative performance measurement of the CF's effectiveness in providing the care that members suffering from OSIs need and deserve. These issues are fundamental, decisively impacting the CF's PTSD/OSI capacity.

344 A third key leadership challenge looms moving forward, and that is the requirement to maintain the institution's focus on OSIs over the short and mid-terms. The current operational pause following a decade of sustained operations in Afghanistan and two decades of near-continuous operations in hotspots around the globe is much needed. The fatigue that this operational cadence has inflicted on CF members and their families is palpable. However, in terms of operational stress injuries the CF is still very much at peak operational tempo due to the latent nature and cumulative effect of PTSD and other OSIs.

345 So while the CF experiences a deceleration post-Afghanistan – understanding full well how operational pauses are rarely as they appear due to the backlogs of tasking, training, and professional development priorities, the mental health community remains firmly in the thick of it and will for some time yet. By most learned estimates, the current Afghan-generated OSI operational tempo will continue unabated for another several years still before it subsides, likely in the mid-2010s.[112] And if recent history is an indicator, Canada may well be committed to new operations by then or shortly thereafter.

346 The challenge for DND/CF strategic leadership is thus sustaining the intensity of the OSI/mental health effort during a timeframe when many other operationally-related activity areas have wound down to a degree.

347 **FINDING: Caregiver professionalism, passion and dedication**

348 In the face of consistently high demand (both quantitative and qualitative) and chronically short supply (an average deficiency of 20% under steady-state strength and probably much higher in real terms as a result of Afghanistan) the

one element that has allowed the CF mental health care system to function has been the professionalism, passion and dedication of its care providers, both military and civilian.

349 These practitioners have continued to *make it work* despite consistently excessive workloads, increasingly complex cases, often distraught and frustrated clienteles, transitory local leadership, and organizational flux. Their commitment to their patients and their profession has been exceptional.

350 It is clear that this commitment has come at substantial professional and personal cost to many care providers. Stress and fatigue, frayed working relationships and workplace tension, blurred practice boundaries, and caregiver burnout are some of the symptoms many mental health caregivers and clerical staff have dealt with, or are dealing with. These effects have had a multiplying effect, further stressing an already strained function. They are almost certainly a contributor to the manning gap which continues to dog the capability.

351 Not to be underestimated in this cycle of continuously running at or near full speed with reduced resourcing is its impact on caregiver morale. Instances of frustration amongst mental health professionals at knowing or sensing that the strained environment adversely impacts patient care were related.[113] One example is the requirement to administer supportive care to some patients in order to tide them over to their initial consultations. If wait times were more reasonable much of this care, which is designed only to buy time until a patient receives treatment specific to his/her condition, would be unnecessary. Another frustration practitioners experience as a result of the strained clinical environment is the need to outsource a significant proportion of treatment, with the limitations involved as outlined earlier.

352 **FINDING: Reduced barriers to care**

353 The barriers to care for CF members suffering from PTSD and other OSIs appear to be much reduced relative to 2008 and especially 2002.

354 The biggest change has been in peer and supervisor stigma – the negative perceptions from the immediate chain of command and colleagues/co-workers towards members who reach out for help for a mental health problem. Health care providers, the chain of command at all levels, and most pertinently members themselves, both those suffering from OSIs and those not, attested to this new open-minded culture. In the words of one senior serving CF member, "*Having an operational stress injury is no longer a sign of weakness.*"

355 This is not to suggest that peer and supervisor stigma have disappeared completely – they have not. The investigation was made aware of instances in

recent years of members being denigrated or openly ostracised as a result of mental health injuries. Incidents like this are probably still occurring. Additionally, well-worn notions like the *walk of shame* appear to persist in some quarters, though these seem increasingly isolated. There is a reason why some CF members still pull up to base mental health clinics intending to consult, spend a period of time sitting in their vehicle mulling it over, and then drive off without going in, as was repeatedly related.

356 Categorical empirical analysis on the issue of stigma was not physically possible, but all indications point to substantive progress in the CF's effort to institute generational change over the better part of the past decade. It is clear though that supervisor/peer stigma requires continued attention.

357 It is equally evident that no matter how successful the CF is in increasing awareness and reducing stigma, it is unlikely to ever completely disappear. 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. As such, continued diligence towards stigma is all the more important.

358 The other major barrier that has diminished is access to care. Stepping forward and reaching out for help was complicated in the past. It appears less so now. The evidence, largely anecdotal, suggests that at most CF installations physically connecting with mental health professionals is more straightforward and less intimidating than it was.[114]

359 The Operational Stress Injury Social Support peer network has contributed to this through its continued encouragement of OSI sufferers to seek professional medical care. The inclusion of family components to mental health resiliency training is a recent development.[115] It is intended to assist families support their CF loved ones in identifying the need for help. This programming has yet to be fully implemented or evaluated.

360 Overall the evidence suggests that major barriers to care are less prevalent than they were in 2008. This is buttressed by experiential feedback from frontline caregivers that members suffering from PTSD and other OSIs are presenting for care and treatment much earlier in the latency period than the 5.5 years observed for OSIs triggered in the 1990s.[116] This could well be an indicator that members are more confident coming forward than they were previously. It is noteworthy that the new latency period is intended to be a subject of detailed CF research in the near-term.

361 That stated, stigma remains an impediment for CF members accessing timely care. As with any invisible ailment or injury, there are still some who are sceptical of the motivations of members who present for mental health care.

The evidence suggested that intermediate leaders at the sub-unit and unit levels, both officers and NCMs, are more prone to harbouring such stigma, especially as it concerns their subordinates.[117]

362 A major barrier to care remains the *fear* that coming forward with a mental health injury or illness will adversely affect, or even end, one's military career. In the highly competitive performance evaluation process where decisions are often based on single point differentiations, there is a sense that any medical limitations, however temporary, can be the difference in being promoted or appointed.[118]

363 Even more fundamentally, some members (especially in the Army) believe that a diagnosis of PTSD or other OSI constitutes career suicide. There is a perception that the member becomes readily expendable to the CF once he/she is saddled with a mental health issue or limitation. This is in spite of the reality that some OSI sufferers have successfully responded to treatment and reintegrated their units without restriction in recent years. The fear of damaging one's career and potentially jeopardizing one's livelihood appears to be pervasive as it was repeatedly cited as an obstacle to seeking mental health care.[119]

364 Another impediment is self-stigma. While a preponderance of supervisors and peers now appear to understand that operational stress injuries are an inherent by-product of modern military service, many refuse to accept that it is an affliction that might happen to them; *OSIs only happen to others*. Again this was principally observed within the Army context. Continued leadership, awareness and training are required to erode self-stigma.

365 The CF's allowance structure is another important disincentive to seeking care and counsel for an OSI. Allowances such as field, flight and sea pay are all dependent upon members actively performing their duties within the unit structure. In most instances, members who are posted to the Joint Personnel Support Unit, however temporarily, see these allowances ceased.[120] Due to the sustained operational tempo of the past two decades, many have come to depend on these allowances and cannot afford to live without them. This has caused reticence to come forward, and is likely continuing to do so.

366 Language is a further barrier. Members posted to regions in which their second language prevails have found it difficult to receive mental health care in their primary language. This matters because, unlike describing a knee or shoulder injury, opening up about a mental health concern is quite often challenging in the best of circumstances. Doing so in one's second language, especially if that second language is not completely mastered, is much more difficult. In all likelihood this is causing some members to avoid seeking care.

367 **FINDING: Improved family support**

368 The CF has made some progress in attending to the needs of families dealing with CF members suffering from OSIs. Fundamentally, the organization has recognized that military families, already under considerable strain to access acceptable levels of medical care and support due to frequent relocations and the realities of living in isolated geographic areas, experience additional stress during periods of sustained operations. This struggle is even more daunting for military families forced to cope with CF members suffering from OSIs. As a consequence, these families need additional attention, support and coordination.

369 The complexity inherent in caring for families must not be underestimated. The Canadian Forces has no mandate per se to provide medical care for civilians, who are covered by provincial health services. Yet the CF acknowledges its moral obligation to provide support and care for families whose needs are exacerbated by the burden of caring for a serving loved one suffering from PTSD or other OSI.

370 In addition to this obligation there is the pragmatic operational reality that effective treatment of members with OSIs is often predicated on a healthy, supportive family environment. Treating a CF member without addressing the family's needs in coping with an OSI reduces the possibility of a successful return to normal military duty.

371 The CF's commitment to families was formalized in the 2008 *Family Covenant*, which serves as its compass on all matters related to military families.[121] It provides the social and moral foundations for military family policies, programs and services.

372 **The institution's challenge is translating this moral commitment into effective action.**

373 In response to the heightened family challenge, the Canadian Forces Health Services Group developed the *Member Focused Family Care* policy in 2007, and revised it in May 2011.[122] This directive has enabled the military health system to offer families a number of limited medical services linked to the treatment and care of CF members with OSIs. These include psycho-education, marital counselling and family counselling.

374 It must be underscored that this medical support is dependant upon members suffering from OSIs themselves seeking care. If the OSI-sufferer does not seek care for whatever reason, then family members cannot access this CF medical system support. This pre-condition effectively bottlenecks family access to

support with the serving member, and is the source of considerable frustration amongst families.[123]

375 In terms of non-medical support to military families coping with OSIs, chaplains continue to provide invaluable support and care as they traditionally have. Also, the Operational Stress Injury Social Support network now has qualified family peer support providers at all major military installations to assist families struggling with OSIs.

376 The Military Family Resource Centres, located on each base and wing, continue to deliver a range of services to all military families. The recent *Military Family Services Program* for families of ill and injured members is designed to keep the ill and injured connected to, and supported by, their families during periods of heightened need.[124] The services it provides are awareness, guidance and some respite support.

377 Evidence from members with OSIs and their families suggests that one of the most productive measures to support families has been the establishment of the Family Liaison Officer in 2008. These social workers, who belong to the Military Family Resource Centres but operate within the Integrated Personnel Support Centres, are qualified to provide responsive care to families of the ill and injured throughout the *recovery-rehabilitation-reintegration* process. It appears that Family Liaison Officers are having an important impact on military families struggling to cope with OSIs.

378 The Canadian Forces Member Assistance Program, which provides CF members and their families with confidential off-site counselling from civilian caregivers, is on offer for both members and their families.[125] Though it is intended only as short-term counselling to resolve stresses, its ready access and separation from formal mechanisms and command chains are attractive. There are reported problems with the service, however. One is the apparent frustration families experience in having to explain the realities of CF life to practitioners who possess little understanding of the military environment and of the unique challenges facing military families. The numbers show that CF personnel and family members employ the program for an average of 3.5 sessions, when the permissible maximum is 6-8 sessions.[126] Feedback indicated that many disengaged earlier than the 6-8 session ceiling because they didn't sense an adequate level of understanding from the caregiver. Amongst those not disengaging from the service, there was some frustration that the maximum number of sessions was capped, though in theory it can be extended in exceptional circumstances. Lastly, the program's overall status is precarious as it is not fully-funded and has not been in several years, as identified in recommendation 7.

379 The CF has also moved to better understand and incorporate military family concerns at the strategic leadership level through the creation of the National Military Family Council, an advisory body designed to provide a voice for military families to strategic CF leadership through senior venues like Armed Forces Council.[127] Its objective is to supply the Chief of the Defence Staff, the Chief of Military Personnel and other key leaders with a unique insight into the challenges of military family life, including that of dealing with OSIs.

380 It is apparent that the CF views families differently than it once did. Whether the CF has done enough in support of families, however, is far from clear. The evidence suggests that while there are more services and programs on offer to military family members, especially for those coping with loved ones with OSIs, families continue to struggle and suffer. The anecdotal information in this regard was both considerable and vivid.

381 Additionally, there are apprehensions about the overall coherence of the numerous programs, entities and resources that have been put in place for families over the past five years. Developing family-centred initiatives seems to have become a cottage industry during this span, leading to valid concerns about how well the various pieces fit together and whether they truly meet military family needs.

382 Military families are better understood and supported by DND/CF than they were in 2002 and 2008, though again the question is whether *better supported* means *sufficiently supported*.

383 This will be explored in much greater detail in the forthcoming Office of the Ombudsman systemic review of the challenges facing military families, which will be completed in 2013.

384 **FINDING: Chronic manning shortfall**

385

> *"The situation is simple; we are under-staffed and overworked."*
>
> – CF mental health caregiver, 2011

386 The persistent personnel shortfall of the CF's mental health capability was outlined in detail in recommendations 7 and 8, and is referenced throughout this report. This is not coincidental; the manning deficit is unequivocally the most significant hurdle to delivering comprehensive, high-quality care and treatment to CF members suffering from PTSD and other OSIs.

387 More specifically, the manning shortfall crosscuts the following key areas:

388 - quality of care
389 - continuity of care
390 - caregiver morale, fatigue and burnout
391 - caregiver leadership and management
392 - information and data management
393 - timely support to families
394 - mental health governance
395 - professional relationships
396 - local/tactical outreach and research
397 - systemic performance measurement

398 The 15-22% difference between established and effective strength (350-378 versus 447) – which as explained is almost certainly higher in real terms, reverberates throughout the CF's mental health structure. This was re-confirmed at the May 2012 National Mental Health Workshop, where the 17 participating clinics presented their three most significant challenges.[128] The results are charted below:

399

Significance of Mental Health Manning Challenge	Number of Mental Health Clinics
Single most important challenge	10 out of 17 reporting clinics
Second most important challenge	4 out of 17 reporting clinics
Third most important challenge	2 out of 17 reporting clinics
Not among top three challenges	1 out of 17 reporting clinics

400 As shown, of the 17 reporting clinics, 16 identified manning as a top priority (with 10 identifying it as the single most important priority). Only one reporting clinic out of 17 did not identify manning as a top three challenge.

401 The CF has not been indifferent to this situation. Mitigation measures such as wide-scale treatment outsourcing and a larger contribution by primary care providers have been implemented, but these are only partial responses. More permanent solutions are required.

402 DND/CF is actively pursuing additional caregivers through a number of initiatives, though the results have been limited in recent years. Since 2010, the CF's mental health personnel strength has flat-lined under the 380 mark, well below the established strength of 447 practitioners.

403 As outlined, there is no quick fix – the root causes of this chronic under-manning are just too complex. However, some elements of the institution appear to be increasingly resigned to the manning problem persisting indeterminately. For instance, of the 27 prioritized objectives identified in current Directorate of Mental Health campaign planning, only two address the strength deficit, and they are objectives 14 and 25.[129] Moreover, remedial initiatives in train or planned by DND/CF to alleviate this shortfall do not seem nearly innovative or assertive enough to yield conclusive results.

404 If decisive solutions are not soon found, wait times will continue to be longer than they should, and consultations shorter and less frequent than they could. Furthermore, the existing dependence on outsourcing much of the treatment for OSIs will continue.

405 As was observed in recommendation 7, one recurring reflex from a number of CF leaders and officials in addressing the manning issue has been to invoke the comparison between access of CF members to mental health care with that of regular Canadians. As one senior leader recently stated: "*More mental health care providers would be great but wait times for CF members are less than they are for the civilian population*."[130] Indeed, it could be interpreted that this oft-repeated comparison has served as a validation of sorts of the effectiveness of the CF's mental health capacity *in spite of* the persistent personnel deficit.

406 This comparison is misleading at best for as long as the Government of Canada continues to send CF members into harm's way, as it has done practically without interruption for the past two decades, it has an obligation to provide the medical care commensurate with such duty. Any association with civilian access to mental health care is completely incongruous, and does not by any reasonable measure validate the effectiveness of the CF mental health care capacity.

407 **FINDING: Extensive outsourcing of treatment**

408 One of the most noteworthy impacts of chronic mental health under-manning is the need to outsource a considerable proportion of treatment for military members suffering from OSIs. While this proportion is not precisely known by the CF (which in and of itself is disconcerting), the evidence gleaned from individual clinics and practitioners suggests that it is extensive.[131] Several senior clinicians characterized the preponderance of outsourced care as "too high".

409 Outsourcing treatment is a pragmatic choice the organization has made. It is seen as preferable to the appreciably longer delays which would result from internally sourcing all OSI-related treatment at present manning levels.

410 From a clinical perspective, outsourcing the *treatment* function is favoured over the *assessment* function due to the importance of consistency in diagnosing OSIs.[132] This consistency is achieved through the CF's standardized assessment protocol, which provides a common framework across the institution. The trade-off for performing all diagnosis in-house is the requirement to outsource much of the subsequent treatment.

411 Outsourced treatment brings with it a number of issues. One is continuity of care. External mental health caregivers are required to provide regular feedback to the member's supervising practitioner, usually no less than every ten consultations. In practice, this does not always occur because not all outsourcing providers are willing to take the time to do so. Complicating this, CF providers are often reluctant to press external caregivers too hard for such feedback because doing so comes at the risk of losing that external provider's services altogether. This is especially tenuous in geographically challenged locations where the number of external providers is very limited to begin with. Workarounds are being employed in some locations, such as meeting with members at fixed intervals to discuss the external treatment they are receiving. But they are mitigating the problem rather than addressing it.

412 According to a number of frontline providers, the quality of care is also adversely affected in some instances of outsourced treatment, primarily because the external caregiver usually understands little about the military environment and the CF members they treat. Moreover, CF practitioners have acquired an expertise and experience in treating OSIs over the course of the last 20 years; they are Canada's experts in operational stress injuries. Yet this proficiency is not fully leveraged when treatment is outsourced.

413 Another challenge to outsourcing treatment is maintaining the required balance between occupational medicine and pure patient advocacy.

The evidence suggests that some external care professionals struggle with this balance, especially those with limited knowledge of the CF environment.[133]

414 **FINDING: Poor situational awareness**

415 As explained in recommendation 2, the CF's ability to systematically track the OSI imperative as it evolves over time is limited.

416 At the national level, the Canadian Forces Health Information System is not a comprehensive OSI reporting tool, is not currently anticipated to become one, and will take several years to convert if and when such a decision is taken. CF Mental health research is largely predictive, designed to inform the future rather than reflect the present. The enhanced post-deployment screening process is hampered by a deficient return rate and suspicions that it can be manipulated. And the Health and Lifestyle Information Survey provides only a slice of the mental health picture at protracted four-year intervals.

417 At the local clinic level, the portrait is no more comprehensive. Regular, precise reporting remains a challenge for many clinics that are under-manned and burdened by consistently excessive caseloads. The lack of a common, effective clinic data management system exacerbates the challenge. As a result, incomplete or dated statistics are frequently rolled into national reports, skewing this collective representation. Moreover, until very recently (May 2012) the CF was tracking the wrong metric as its key mental health indicator.

418 It was observed that part of the national OSI portrait is obtained from continuous interactions between the Director of Mental Health/the Mental Health and Psychiatry Advisor and mental health clinics and practitioners.[134] This finger-on-the-pulse information is clearly valuable, and is an important part of the mix. Yet it is only a slice of the overall picture, and must be bolstered by timely, reliable *quantitative* and *qualitative* inputs, which it currently is not.

419 The overall result is an ongoing inability to maintain a current national understanding of the scope of the operational stress injuries requirement as it evolves over time. DND/CF strategic leadership's situational awareness in developing and refining OSI policies, allocating priorities, and re-calibrating resources has been less than complete. This is entirely inconsistent with the institutional importance accorded to the issue, and the investment DND/CF have made to manage it.

420 **FINDING: Ad hoc performance measurement**

421 The current CF mental health capability has been ten years in the making. It was forged largely by the results of the 2002 Statistics Canada CF Mental Health Supplement to the Canadian Community Health Survey, and planned

under the Rx2000 Mental Health Initiative. It has undergone a significant number of adjustments since its inception in 2002-2003, though these have been pragmatic in response to punctual requirements.

422 As described earlier, feedback on the capability has come from a mix of quantitative data of varying degrees of precision, interspersed with slices of qualitative information and research. While these have provided snapshots of elements of the system's functionality and effect, they have not delivered a pan-organizational systemic measurement of its performance. A particular blind spot has been clinical outcomes – very little structured information has been gleaned in this area on a system-wide basis.

423 In short, the CF mental health capability has not undergone recurring, qualitative system-wide performance measurement between 2002 and 2012 despite the tremendous money, time and energy invested in the capability, and the fact that OSIs has been one of the institution's top priorities throughout this period.

424 Context is pivotal in understanding why this could be so. In the early years, the absence of systemic comprehensive performance measurement was likely the result of the timeframe in which Rx2000 was implemented. This new CF mental health construct was put in place at exactly the same period as the burgeoning mental health exigencies of operations in Afghanistan merged with the latent PTSD/OSI requirements of the various operational missions of the 1990s.[135] The resultant pressure to hit the ground running with this new capability in the midst of this unprecedented demand was enormous. It was almost certainly analogous to changing the tire while the vehicle continued to move at top speed. Accordingly, virtually all attention and resourcing was focused on getting the new construct implemented and operational, and not on validating it.

425 The absence of structured systemic validation in the years following Rx2000 implementation is more difficult to understand, though the manning shortfall and the punctual pressures it has caused and continues to cause is assuredly a major factor. The evidence indicates that the ongoing preoccupation with increasing mental health manning levels while simultaneously containing the functional stresses that this shortfall has led to has monopolized leadership and senior staff attention, leaving insufficient focus to advance the systemic performance management requirement.

426 Regardless of why this has come to pass, the reality is that there is no structured system-wide performance measurement of the CF's mental health capability at present. In its absence, incomplete indicators have taken on larger importance, as explained earlier. So too have external accolades and comparisons. The recent accreditation of the CF medical system (of which

mental health care was a subset) is an example. While this endorsement by Accreditation Canada is a significant achievement for the Canadian Forces, it is a validation that the CF medical capability has the structures and processes in place *to be able to deliver* effective care and treatment. It is not a measure of how effective the *actual delivery* of this care has been or currently is.[136] And yet, accreditation has been trumpeted by senior CF leaders as proof of the effectiveness of the CF's mental health capability.

427 Positive comparisons with organizations of similar scope or mission such as Canada's military allies seem to have similarly increased the level of institutional confidence in the CF's mental health capability.[137] Again, though positive (better to be favourably compared than unfavourably compared), these comparisons are totally relative. *A* may be judged appreciably better than *B* or *C*, but this does not validate that *A* is as effective as it needs to be to achieve its mission. Neither *improved* nor *better* necessarily confirms *good enough*.

428 Without structured, comprehensive qualitative performance measurement, the effectiveness of the CF's mental health capability in delivering the care that CF members suffering from PTSD and other OSIs need and deserve simply cannot be definitively assessed.

429 In recent years DND/CF's strategic leadership has acknowledged the pressing need for systemic performance measurement.[138] The Directorate of Mental Health has been tasked with developing this validation function and is actively doing so. One clinical outcome measurement system has been in service at Canadian Forces Base Halifax's mental health clinic on a trial basis for some time, and national system-wide application is being evaluated. Other qualitative assessment tools are equally under consideration.

430 There is an argument that this finding is moot due to the pending 2012 Statistics Canada CF Mental Health Supplement to the Canadian Community Health Survey. The thinking is that this *after* benchmark to the 2002 survey that was the genesis for the current CF mental health capability will provide all the performance measurement needed. Though the 2012 Statistics Canada survey will be pivotal in providing an updated baseline against which the effectiveness of the capability will be qualitatively measured, executing comprehensive performance measurement on a critical system at ten year intervals is simply not sufficient. A more regular, structured validation of the CF's mental health capacity is required as a top priority.

Section 4: Recommendations

Strategic Imperatives for 2012 and Beyond

> *"We ask members of our military to risk their lives, limbs and mental health by defending Canada's interests abroad. They can pay a terrible price for that service. When they return with disabilities, physical or psychological, they should get the help they need, not more monuments."*
>
> – Editorial from a major Canadian daily newspaper, May 5th, 2012

Ultimately, a report such as this matters only to the extent that its conclusions, concerns and observations can be distilled into clear advice or direction – the critical *'so what'* in soldier speak.

The over-arching conclusion to be drawn from *Fortitude under Fatigue* is this:

> *The Canadian Forces' (CF) mental health capability – mandated to deliver the care that CF members suffering from PTSD and other OSIs need and deserve, is dramatically improved over those of 2002 and 2008, largely because it is populated by passionate caregivers fully dedicated to their patients and profession. However, the execution of the function during the past decade has been overly pragmatic and tactical, and continues to be, to the detriment of suffering CF members and their families, as well as caregivers.*

The absence of a high degree of situational awareness, coupled with the lack of structured, systemic performance measurement has undoubtedly obstructed the CF strategic leadership's ability to accurately determine the quantitative scope of the OSI imperative as it evolves over time (*how big*), against how effective the CF has been qualitatively in responding it (*how well)*.

As a result, the leadership and management of the CF's mental health capacity have been driven principally on thin-sliced research, partial data, and isolated performance measurement. This isn't sufficient; the OSI imperative is too important to the institution, and the level of investment too great, to be executed so pragmatically.

DND/CF strategic leadership is seized of this fundamental limitation, and measures are already in train or intended to enable a more strategic execution of the capability.[139]

440 These are unlikely to have a decisive effect, however, unless the persistent manning quandary that has contributed to, if not fuelled, this pragmatism is alleviated substantively and soon. The prevailingly high levels of demand will not decrease appreciably in the foreseeable future. Finding the missing 70-plus mental health providers that have so far eluded the organization will call for fresh ideas and new paradigms. There is no way around it; in the current conflict environment, the challenge of operational stress injuries cannot be met without a critical mass of qualified, experienced professional practitioners.

441 Until this occurs, the mental health professionals and supporters who have distinguished themselves over the past decade will continue to bridge the *capability-capacity* gap and make it happen on the ground. This fortunate reality must be viewed by the institution as time and space within which to find enduring solutions, and not a de-facto end-state. The CF owes as much to both the CF members who suffer from operational stress injuries and their families, as well as those mental health care professionals and supporters who care for them under such daunting circumstances.

442 This analysis fully acknowledges that the OSI issue is but one of a number of post-Afghanistan organizational pressures that the CF must risk-manage in this renewed era of fiscal restraint. There is no pretension that it can be contemplated in isolation. Nonetheless, the institutional and operational consequences inherent in the OSI challenge are profound, and could impact the CF for several professional generations.

443 In going forward, the Office of the Ombudsman for the Department of National Defence and the Canadian Forces recommends the following:

444 **Recommendation 1: Sustained CF focus on OSIs.**

445 It is recommended that the Canadian Forces maintain the current intensive institutional focus on the provision of appropriate care, treatment and support for CF members suffering from post-traumatic stress disorder and other operational stress injuries, in spite of the natural post-operational deceleration following Afghanistan and renewed federal fiscal restraint.

446 Because the OSI challenge remains at peak intensity due to its latent nature and cumulative effect – an intensity which is unlikely to subside significantly until at least the mid-2010s, strategic leadership should ensure that the institutional focus of the past decade continues at the current level of intensity for the foreseeable future. Fiscal and post-operational pressures pushing for a diminished focus on the OSI imperative should be resisted.

447 **Recommendation 2: Assertive, innovative mental health practitioner recruiting**

448 It is recommended that the CF formulate a renewed recruiting campaign aimed at increasing the number of DND/CF mental health practitioners, narrowing the current manning shortfall at the root of most of the capability's shortcomings.

449 This initiative should be driven by strategic leadership as a top institutional priority, with an onus on innovative, assertive solutions as opposed to the predictable approaches currently being pursued. A fresh CF Health Services recruiting strategy targeting mental health professionals and support staff should be the centrepiece of this effort. Campaign implementation should occur within a year of the publishing of this report.

450 Pivotal to the success of this endeavour is the protection of resourcing for the current establishment of 447 practitioners for fiscal year 2013-2014 and beyond.

451 **Recommendation 3: Systemic qualitative performance measurement**

452 It is recommended that the CF implement systemic qualitative performance measurement forthwith, aimed at tracking OSI program effectiveness based in large part on clinical outcomes.

453 This systemic functional validation will enable tighter strategic oversight and more decisive leadership of the mental health system's capacity to meet the OSI imperative. It should be established and implemented within one year of this report, and bench-marked and reported to internal and external stakeholders annually thereafter.

454 **Recommendation 4: Holistic re-evaluation of CF OSI capability**

455 It is recommended that the CF conduct a holistic re-evaluation of the overall coherence of the institution's capacity to respond to the PTSD/OSI challenge.

456 Implementation of the preceding three recommendations is pivotal. The institution must sustain its focus on OSIs during this intensive timeframe, the chronic manning shortfall must be addressed decisively, and the CF's success in meeting the OSI challenge must be qualitatively measured.

457 The final requirement will be for DND/CF to take a step back as an institution and holistically re-evaluate the coherence and effectiveness of its current mental health capability a decade-plus after initial implementation.

458 The results in 2013 of the 2012 Statistics Canada CF Mental Health Supplement to the Canadian Community Health Survey (the systemic after benchmark for the CF mental health function) presents an ideal opportunity for this system-wide re-evaluation, one the CF should seize upon.

459 **Recommendation 5: Examination of OSI-related command frustration**

460 It is recommended that the CF's strategic leadership examine the palpable and growing tension between commander and clinician as well as commander and administrator relative to OSI medical treatment and administrative support.

461 This study was made aware of a palpable and growing tension affecting a proportion of the chain of command, especially in the Army. The evidence revealed a mounting sense among commanders at various levels (though primarily at the unit level and below) that the core command responsibility of protecting the safety and well-being of those under one's charge – the fundamental pledge between commander and subordinate, is being abrogated in the modern application of military medical care, especially vis-à-vis operational stress injuries.[140]

462 This apprehension is fuelled by the cryptic nature of the current medical reporting system. In order to fully comply with patient-practitioner confidentiality, information about medical issues is communicated almost exclusively through medical employment limitations. As the name implies, these missives outline to the patient's chain of command the restrictions that the medical issue imposes from an employment perspective.[141] This articulation is cursory by design as it must preclude addressees from deciphering the medical affliction involved. This is often the extent of communication between the medical practitioner and the chain of command unless the situation worsens, at which point the commander will likely receive updated medical employment limitations, or notice of a temporary or permanent medical category.

463 The commander's challenge is to lead ill or injured subordinates without knowing anything more about their conditions other than the information contained in the medical employment limitations. The absence of direct contact between the medical practitioner and the commander, which increasingly has become the norm, has generally made it more difficult for the latter to understand the broader scope and impacts of a subordinate's medical condition, complicating the exercise of sound leadership.

464 This situation has been aggravated by the removal of the medical officer from the unit structure as part of the Rx2000 initiative. A unit commander no longer receives a fulsome understanding of a subordinate's medical condition from a

source that (1) is known and trusted at the unit level, and (2) understands the unit and its members. The link that connected a unit commander to his/her subordinates when they had medical issues has been severed, replaced by cryptic written interactions from caregivers who often know little of the units they service and personnel they treat, and vice-versa.

465 In the eyes of a preponderance of operators engaged for this report, this shift has forced commanders to lead their people with very limited visibility once they become ill or injured.[142] One operator referred to it as "leading blind." The responsibility for the member's safety and well-being still resides with the commander, squarely as it should in the view of most. However, it is arguable to some whether the modern commander is equipped with the situational awareness needed to make sound decisions serving both the unit and the member. This circumstance appears to be causing growing frustration.

466 There was no indication that those concerned by this situation yearned for a return to the era of the integrated unit medical officer who provided full disclosure on all medical conditions within the unit to the commanding officer. It was repeatedly acknowledged that patient confidentiality is functionally and legally necessary, and that the old rules likely kept members from seeking medical assistance for fear of negative career implications.

467 Instead, there appears to be an expectation or hope on the part of operators for a compromise; a more tailored military application of the principle of patient-caregiver confidentiality which protects the member without depriving the commander of the information necessary to lead successfully.

468 There is some middle ground in the current application of medical limitations. In certain situations, the CF patient allows the care provider to communicate partial disclosure of the medical condition and its implications to the chain of command. This generally involves conveying more information than that contained in medical employment limitations, without disclosing the diagnosis.

469 Moreover, an increasing number of practitioners seem to be encouraging their patients to grant permission to partially disclose, believing that a more symbiotic interaction between patient, practitioner and commander can result in better health outcomes.[143] However, such encouragement is not required of the caregiver. And the member is completely within their right to refuse this suggested disclosure when it is offered.

470 It would seem that a form of partial disclosure offers the potential for a tailored CF application of the principle of patient-caregiver confidentiality; one that would provide commanders with a more acceptable degree of situational awareness while protecting patient rights. Of course, any modified

application would have to satisfy pertinent legal requirements regarding patient consent.

471 Until this growing tension between commander and clinician is better understood by the institution, the chain of command's frustration at "commanders having their hands tied" as several operators described it, may well continue to grow.[144]

472 A related source of command tension revolves around the recent policy of posting members from their unit to the Joint Personnel Support Unit when they are medically unfit and assigned a temporary or permanent medical category precluding the performance of duties in their current military occupation. A majority of unit and sub-unit commanders engaged in this analysis expressed the sentiment that the most nurturing environment for a CF member is within the familiar confines of the unit, a notion inculcated from basic training onward. And yet members suffering from OSIs are now routinely pulled from that familiar unit environment and inserted into a construct that they know little about, and one that knows little of them.

473 Several characterized this as a management solution to a leadership imperative. Others feel it is a contradiction of the notion of family upon which the military unit structure is anchored.[145] There is a sense that the core relationship linking commander to subordinate – the obligation of the former to ensure the care and well-being of the latter, is being eroded by medical and personnel policies which do not sufficiently reflect the foundational principles of military leadership.

474 It must be noted that this view was not unanimous among those consulted on the issue. A number of commanders indicated satisfaction and even relief that members with medical challenges including OSIs were shifted to environments better able to focus on their needs.

475 Yet overall, there appears to be considerable tension between elements of the chain of command and the clinical and personnel communities with regard to the care and administration of OSI sufferers. In multiple instances, this frustration was expressed viscerally out of concern that foundational military leadership is being eroded. There is thus merit in the CF's strategic leadership giving this situation consideration.

476 **Recommendation 6: Contemplation of a more modern application of the Universality of Service.**

477 It is recommended that the CF's strategic leadership consider the viability of a more modern application of the principle of universality of service.

478 The principle of the universality of service is a necessary cornerstone upon which a modern fighting force is based and built. The requirement for all CF members to perform basic military duties and skills regardless of occupation, location and environment is essential to the organization's effectiveness.

479 Like most professional military forces, the CF has traditionally maintained a sacred trust with its members. In return for accepting the realities of being sent into harm's way regardless of circumstance or peril, and making whatever sacrifice necessary to achieve the mission, the institution committed to taking care of the member. In the eyes of many military professionals and observers, it is this *sacred trust* or *social contract* between the institution and its members that inspires the selfless service which separates the profession of arms from almost every other.[146]

480 The application of this sacred trust/social contract was more easily achieved in previous periods of the CF's modern history when operational commitments were less numerous and less intensive.[147] The number of permanently ill and injured from operational duty was traditionally very low. As a result, reasonable solutions could normally be found for most members who were no longer fit to fight without jeopardizing the sanctity of the universality of service.

481 The operational tempo of the past two decades, and the attendant mushrooming of casualty rates including those incurring permanent illness and injury, has changed the landscape dramatically. A more systemic approach has been required to deal with the much higher numbers of members no longer able to meet the conditions of the universality of service. This has led to a rigid structure which spells out in the clearest of terms the limited options available to those deemed no longer fit to fight.

482 The net result is a sense amongst a number of those broached for this report that in creating this systemic approach, the CF's moral obligation to its members that has historically bound the Canadian military together is waning. There is a sentiment that while loyalty and dedication upwards towards the institution are still demanded, probably more so now in this era when CF members are being sent into harm's way more often than in several professional generations, this loyalty is no longer reciprocated downwards to the same degree.[148] Some see it as an outright betrayal; members are valued

until they become ill or injured as a result of operations. If they cannot be patched up and returned to the fray, they are "thanked for coming out and kicked to the curb."

483 The extent to which this perception is prevalent across the CF could not be quantified within the scope of this report, though those who voiced it were experienced, respected, decorated and highly credible serving and recently serving CF members. Several of these characterized this sentiment as deep-rooted and growing, one which is perceived to be affecting both morale and retention. As one member bluntly put it, "Soldiers are starting to ask themselves what the hell they are doing this for." [149]

484 This is not to suggest that the principle of the universality of service is not pivotal. The CF can never become an employment agency. And the impacts of potentially deviating from the foundation of being fit to fight must be measured not only as a function of the ill and injured but also as it affects healthy serving CF members. Yet there appears to be an increasing sentiment from those in uniform that a more modern application of this keystone principle is possible and required if the CF is to uphold its moral obligation to take care of its members – one that reflects the realities of modern military service today and tomorrow without taking the *fight* out of the fighting force.

485 Strategic leadership should consider examining this issue further as the CF moves forward as it has the potential to reverberate on an institutional scale.

486

> *"Soldiers don't break themselves."*
>
> – A decorated, highly respected CF member with over 20 years of distinguished service

487 It is clear that the capacity of the Department of National Defence and the Canadian Forces to provide CF members suffering from post-traumatic stress disorder and other operational stress injuries with the care, treatment and support they need and deserve has improved steadily over the past decade. The comparison of this report's results with those of 2002 and 2008 demonstrates this improvement unequivocally.

488 The CF currently possesses a comprehensive operational stress injury care capability, evolving from the "ad hoc" system it was previously. The caregivers who populate it are proven, passionate professionals who have exhibited relentless dedication to their patients and profession in very daunting circumstances. The barriers impeding CF members from accessing care for OSIs, including stigma, have decreased markedly in recent years. And

support to the families of CF members suffering from OSIs has become an organizational focal point and is much improved over the last ten years.

489 That stated, there is still much to be done. As the Chief of the Defence Staff has expressed repeatedly, the CF's mental health capability in response to operational stress injuries is not perfect and requires continued attention. The chronic manning shortfall is the most critical issue, creating a series of related trickle down impediments. The preponderance of outsourced treatment remains too high, affecting the quality and continuity of the care delivered. Strategic and functional leadership does not possess a sufficiently current and complete situational awareness of the OSI issue. And the institution does not definitively know how successful the CF mental health capacity actually is in meeting the OSI challenge, due to the almost complete absence of systemic qualitative performance measurement.

490 It is crucial that the organization harness the institutional momentum of recent years and continue enhancing its mental health capacity because there is nothing faddish or fleeting about operational stress injuries. Evidence of them dates back as far as the profession of arms itself. They are not the flavour of the day, or of the decade as might be perceived in the current timeframe.

491 Moreover, it is now widely accepted that sustaining a modern, professional fighting force ready to defend a nation's values and vital interests in the contemporary conflict environment requires mental resilience and endurance. Recent history has proven that the pressures of modern war-fighting in its various derivative forms are extreme and growing. Operational stress injuries are an intrinsic component of modern military operations, including those the CF is likely to continue conducting over the foreseeable future at the nation's behest.

Annex A: Progress Report Summary

Assessment of Recommendations made in *A Long Road to Recovery*

Recommendation 1

A full-time position of National Operational Stress Injury Coordinator be created, reporting directly to the Chief of the Defence Staff and responsible for all issues related to operational stress injuries, including the quality and consistency of care, diagnosis and treatment, and training and education across the Canadian Forces.

Status: Recommendation MET

Concern:

- The decision not to renew the OSI Special Advisor could limit the extent of non-clinical 'operator' input the Chief of Military Personnel receives.

Recommendation 2

The Canadian Forces develop a database that accurately reflects the number of Canadian Forces personnel, including members of both the Regular and Reserve Forces, who are affected by stress-related injuries.

Status: Recommendation NOT MET

Recommendation 3

The Canadian Forces conduct an independent and confidential mental health survey, which should include current and former Canadian Forces members from both the Regular and Reserve Forces.

Status: Recommendation BEING MET

Concern:

- The 10-year interval between serials of the cornerstone Statistics Canada national independent mental health survey is of concern, especially during a period of significant organizational strain punctuated by sustained operations in Afghanistan. CF research projects executed in the interim were not independent, nor did they systematically assess the CF's holistic mental health capability.

Recommendation 4

Any changes, formal or informal, to the Accommodation Policy (or the approach taken by the Canadian Forces to wounded members who want to continue their military careers) be applied equitably to Canadian Forces members with both mental health and physical injuries.

Status: Recommendation MET TO THE EXTENT THAT IT COULD BE

Concern:

- There is a fundamental and growing institutional tension between the requirement to respect the principle of the universality of service, and the CF's long-standing moral obligation to take care of those it sends in harm's way.

Observations:

- The dichotomy of views on the Joint Personnel Support Unit concept is not unexpected as it is a new and innovative construct.

- The prevailing perception that members suffering from mental health injuries are released from the CF more swiftly than those with physical injuries is deemed inaccurate and in fact the opposite scenario appears more prevalent.

- The verbal commitment made by a former Chief of the Defence Staff to retain ill and injured members whose conditions were attributable to deployed operations has caused a palpable frustration.

- Many CF members joined the military in early adulthood and know only what it is to be a sailor, soldier or airman/woman. The notion of 'returning to civilian life' is invariably more complex than the term suggests. Releasing from the CF often strips away an important part of a military member's identity.

Recommendation 5

The rules regarding occupational transfer be changed to accommodate, in an efficient manner, members diagnosed with post-traumatic stress disorder or other operational stress injuries who could continue their military service if they transferred to another military occupation.

Status: Recommendation MET TO THE EXTENT THAT IT COULD BE

520 **Concerns:**

521 • Some view being posted to the Joint Personnel Support Unit as the 'kiss of death' from a career perspective. As long as this perception persists, it constitutes a barrier to care.

522 • There is reticence among some elements of the chain of command who are opposed to the Joint Personnel Support Unit approach to managing the significantly ill and injured.

523 **Recommendation 6**

524 The Canadian Forces establish and properly resource an organization, at the national level, responsible for working with external agencies and all levels of government to ensure that military families and individual members of the families of military personnel have access to the broad spectrum of services and care they need.

525 **Status:** Recommendation PARTIALLY MET

526 **Concerns:**

527 • The Directorate of Quality of Life has just 10 positions to achieve its mission, only four of which are baseline funded. This seems clearly inadequate to execute its mission effectively.

528 • The disbanding and re-establishing of the Directorate of Quality of Life under a new mandate and the apparent transition of the Directorate of Quality of Life/Directorate of Military Family Support configuration has created uncertainty at a time when their roles are critical and require stability and focus.

529 • Although the array of family-centric initiatives launched since 2008 is impressive, there is a concern about whether they fit with and leverage one another.

530 • Many members and their spouses are unaware of the various services and programs available to them, especially those residing off base, limiting the value of the services offered. Quite often it is members themselves who fail to pass on key information.

Observation:

- The Family Secretariat identified by the Minister of National Defence in his response to *A Long Road to Recovery* in February 2009 as integral in providing support to military families experienced a very short existence.

Recommendation 7

The Canadian Forces provide an appropriate level of funding across the country for the identification, prevention and treatment of post-traumatic stress disorder and other operational stress injuries.

Status: INCONCLUSIVE

Concerns:

- There are several indications of funding strain including the Directorate of Mental Health's own directorate staffing, currently short 11 of 27 positions due to insufficient funding. The Canadian Forces Member Assistance Program, the Tele-Medicine program, and the mental health education program are not fully funded. The allocated budgets for the development of the Clinical Outcome Measurement System and for important modifications to the Addictions Program are deemed insufficient.

- Many Military Family Resources Centres received small or no budget increases in the last five years despite large increases in demand. Only four of 10 positions in the Directorate of Quality of Life are baseline funded. The Directorate of Military Family Support was required in recent fiscal years to implement a low cost/no cost approach to programming due to financial pressures.

- The capacity to evaluate whether the resourcing of the mental health effort is sufficient is tied directly to the CF's ability to evaluate its performance, which is very limited.

Observations:

- In the absence of a more fully staffed capability *and* the ability to qualitatively validate its effectiveness in providing the care, DND/CF strategic leadership cannot know for certain whether the current funding level attributed to mental health care is sufficient.

542 • One message regularly communicated in qualifying the state of the CF's mental health capability is that *CF members are able to access mental health care more readily than the civilian population*. Comparisons with access to the Canadian public health care system are incongruent and in no way measure the effectiveness of the CF mental care capacity.

543 • The latent nature of OSIs during the post-mission phase of major operations, and the historical probability that the next major CF operation is both not far in the offing and likely to require a robust mental health capacity, should be kept in full view in responding to pressures to reduce the intensity of the CF response to the OSI requirement.

544 **Recommendation 8**

545 The Canadian Forces monitor and assess the requirement for additional mental health care professionals should the challenge associated with mental health injuries continue to grow.

546 **Status:** INCONCLUSIVE

547 **Concerns:**

548 • The chronic mental health personnel shortage has persisted for well over five years, and it is difficult to anticipate how much longer it will take to generate the 60-90 positions which remain unfilled.

549 • Mental health clinics were not only short of care-giving professionals and managers, but also of clerical staff. It is unclear why shortfalls of clerks and receptionists, who are more readily available in the workforce, cannot be satisfactorily solved.

550 **Observation:**

551 • Despite the chronic manning deficit of 15-22% for most mental health clinics and Operational Trauma Stress Support Centres, the mental health capability has continued to function due to the tireless dedication and commitment of the mental health care providers and support staff.

552 **Recommendation 9**

553 The Canadian Forces develop and implement a national program or initiative aimed specifically at assisting and preventing stress and burnout among the mental health care community.

554 **Status:** Recommendation PARTIALLY MET

Concerns:

- As long as the chronic mental health personnel shortage persists the most inventive and aggressive caregiver frameworks will not succeed in mitigating the major cause of burnout; sustained, excessive workload.

- Caregivers appear to be largely resistant to self-identifying and/or seeking counsel or care. Not wanting to contribute to the manning shortage, to let their patients down, or to appear incompetent are all elements of caregiver stigma.

- While the approach of delegating caregiver well-being to the chain of command is both reasonable and consistent with accepted military practice, there is a question of whether mental health providers in leadership or supervisory roles are suitably equipped to execute the responsibility effectively.

- Though the emphasis is rightly on mental health care providers, supervisors and managers, clerical staff is not immune to caregiver burnout and must not be overlooked.

Assessment of Recommendations made in *Assessing the State of Mental Health Services in Petawawa*

Recommendation 1

The Canadian Forces take immediate action to match the numbers of care provider positions to the needs of Canadian Forces Base Petawawa given the size, operational activity and location of the base.

Status: Recommendation PARTIALLY MET

Observations:

- The most difficult mental health specialty to fill at Petawawa, as well as several other geographically challenged locations, is psychology. A major reason for this is the absence of a psychologist military occupation. Creating uniformed psychologists would increase the number of these specialists able and willing to serve the Canadian Forces in isolated locations like Petawawa.

- The longer this chronic manning shortfall persists without effective solutions in sight, the less relevant the established strength becomes.

Recommendation 2

The Canadian Forces establish and properly resource an organization, at the national level, responsible for working with external agencies and all levels of government to ensure that military families and individual members of the families of military personnel have access to the broad spectrum of services and care they need.

Status: Recommendation PARTIALLY MET

Note: This recommendation is identical to recommendation 6 of *A Long Road to Recovery*.

Recommendation 3

The Canadian Forces provide the permanent resources that would enable Canadian Forces Base Petawawa to liaise with local agencies and municipal governments to identify and to coordinate the care required by and available to military families and family members of military personnel.

Status: Recommendation MET

Concerns:

- The availability of external care and support in smaller, geographically isolated locations such as Petawawa will continue to be a major limitation.
- Some external services are not covered by provincial and public service health plans, and those services that are covered in part or in whole often require up-front payment, making them unaffordable to some families.
- One of the biggest barriers to care and support for families is their CF spouses, upon whom they depend for much of their information and situational awareness concerning available programs and services.
- Stigma transference - the perception amongst some serving members and/or their families that reaching out for care will negatively affect the CF spouse's career, remains a barrier to care.
- Despite the cumulative commitment by local leadership (command and medical) to facilitate family access to external care through outreach, excessive workloads regularly get in the way.

580 **Recommendation 4**

581 The Canadian Forces find interim approaches to providing sufficient local health care while waiting for long term solutions to take effect.

582 **Status:** Recommendation MET

583 **Concerns:**

584 • The punctual augmentation of the mental health capability through short-term practitioner support from other bases complicated functional clinic cohesion and created some difficulties concerning quality and continuity of care.

585 • The Ottawa satellite clinic increased Petawawa's psychologist capacity, though the travel to and from Ottawa was an issue for many as it was time-consuming and in some instances physically dangerous for distraught patients.

586 • A lack of cultural understanding between the external civilian caregiver and the military patient was a major hurdle, as was ensuring continuity and suitability of treatment of out-sourced care.

587 • Tele-Medecine alleviated the challenges of time and space, though some patients struggled with the impersonal format.

588 **Observation:**

589 • Recent events relative to the announced transfer of the satellite clinic in Ottawa have caused concern in the Petawawa area. As the implementation of this decision is ongoing at the time of the writing of this report, the impact or effectiveness of this transfer cannot be evaluated.

590 **Recommendation 5**

591 The Canadian Forces provide resources for additional paid administrative and program assistance to enable chaplains to minister more effectively to the spiritual needs of military personnel and their families.

592 **Status:** Recommendation NO LONGER VALID

593 **Observation:**

594 • If Petawawa reverts to an exceptionally high operational tempo over a sustained period similar to that endured over much of the past decade, additional funding should be considered to offset renewed volunteer shortfalls in supporting chaplaincy programs.

595 **Recommendation 6**

596 The Canadian Forces establish a clear governance structure, with clear responsibilities and accountabilities, for the provision of effective and efficient multi-disciplinary care for military personnel and their families at Petawawa.

597 **Status:** Recommendation PARTIALLY MET

598 **Concerns:**

599 • As long as Petawawa's mental health team is 25%-plus short of its established manning level, governance is likely to be a problem.

600 • The launch of the Operational Trauma Stress Support Centre was problematic as communication around its opening in June 2011 was disjointed. There was a perception amongst some practitioners that the Operational Trauma Stress Support Centre stand-up was little more than a name-change designed to *show* forward progress rather than *deliver* it.

601 • The prominence of the Base/Wing Surgeon in serving in a senior advisory role at the base and wing level generally across the CF has diminished in recent years. They are generally much less experienced and often much younger than their predecessors of the pre-Rx2000 era making it difficult for them to execute their advisory role effectively. Moreover, the rotation rate of Base/Wing Surgeons has been exceedingly high since 2002, hindering their ability to properly invest in their roles and responsibilities.

602 **Observations:**

603 • The inter-disciplinary care governance challenges Canadian Forces Base Petawawa continues to face are not unique to Petawawa, nor are they entirely without reason as the rapid expansion of any capability invariably brings enhanced challenges in leading and managing it, especially for a function as complex as mental health.

604 • As noted in previous reports, there were some difficulties relative to individual approaches and personalities, which adversely impacted mental health care governance at Petawawa. The professional climate improved markedly once these personnel problems were attended to. However, the governance problem affecting mental health care in Petawawa was more pervasive than a couple of caregivers who couldn't get along.

605 **Recommendation 7**

606 The Canadian Forces take positive action to assist the members of the care giving community at Petawawa to re-build interpersonal and inter-speciality relationships that are courteous, respectful, trustworthy, cooperative and supportive.

607 **Status:** Recommendation MET

608 **Concerns:**

609 • Chronic under-manning and sustained high demand for care is a toxic combination which fuels fatigue, frustration and stress, and erodes professional relationships.

610 • Chronic under-manning limits the ability of providers to invest in reaching out to the community of practice, which is considered pivotal to cohesive relationships.

611 • High turnover, which has been a staple of Petawawa's mental health capability for much of the past decade, is equally detrimental to positive professional relationships.

612 **Observations:**

613 • There will always be an element of professional friction between primary care and mental health providers because of the occupational health dimension of CF health care.

614 • Tension between primary care and mental health care providers is not specific to Canadian Forces Base Petawawa or the Canadian Forces – it appears to exist across the North American health care community.

Annex B: Summary of Findings

- Comprehensive operational stress injury care capability
- Strategic leadership commitment
- Caregiver professionalism, passion and dedication
- Reduced barriers to care
- Improved family support
- Chronic manning shortfall
- Extensive outsourcing of treatment
- Poor situational awareness
- Ad hoc performance measurement

Annex C: Summary of Recommendations

Recommendation 1: Sustained CF focus on OSIs.

It is recommended that the Canadian Forces maintain the current intensive institutional focus on the provision of appropriate care, treatment and support for CF members suffering from post-traumatic stress disorder and other operational stress injuries, in spite of the natural post-operational deceleration following Afghanistan and renewed federal fiscal restraint.

Recommendation 2: Assertive, innovative Mental Health practitioner recruiting

It is recommended that the CF formulate a renewed, more assertive recruiting campaign aimed at increasing the number of DND/CF mental health practitioners, narrowing the current manning shortfall at the root of most of the capability's shortcomings.

Recommendation 3: Systemic qualitative performance measurement

It is recommended that the CF implement systemic qualitative performance measurement, aimed at tracking OSI program effectiveness based in large part on clinical outcomes.

Recommendation 4: Holistic re-evaluation of CF OSI capability

It is recommended that the CF conduct a holistic re-evaluation of the overall coherence and effectiveness of the institution's capacity to respond to the PTSD/OSI challenge.

Recommendation 5: Examination of OSI-related command frustration

It is recommended that the CF's strategic leadership examine the palpable and growing tension between commander and clinician as well as commander and administrator relative to OSI medical treatment and administrative support.

Recommendation 6: Contemplation of a more modern application of the Universality of Service.

It is recommended that the CF's strategic leadership consider the viability of a more modern application of the principle of universality of service.

Endnotes

[1]The term *Fortitude Under Fatigue* is extracted from the Napoleon Bonaparte quote; "*The most important qualification of a soldier is fortitude under fatigue and privation.*" In many ways it represents CF members in the immediate post-Afghanistan era, including those suffering from OSIs. There are also parallels with the present state of the CF Mental Health care system, especially in light of its chronic under-manning.
[2] General Walter Natynczyk, Chief of Defence Staff, during a media briefing regarding the Canadian Forces' support for ill and injured military personnel, 04 May 2012.
[3] André Marin, *Systemic Treatment of CF Members with PTSD;* Systemic Report of the Ombudsman for the Department of National Defence and the Canadian Forces (February 2002).
[4] André Marin, *Follow-Up Report: Review of DND/CF Actions on Operational Stress Injuries;* Follow-Up Report of the Ombudsman for the Department of National Defence and the Canadian Forces (December 2002).
[5] Mary McFadyen, *A Long Road to Recovery: Battling Operational Stress Injuries;* Follow-Up Report of the Ombudsman for the Department of National Defence and the Canadian Forces (December 2008).
[6] Mary McFadyen, *Assessing the State of Mental Health Services at CFB Petawawa;* Case Study Report of the Ombudsman for the Department of National Defence and the Canadian Forces (December 2008).
[7] House of Commons, Standing Committee on National Defence, *Doing Well and Doing Better - Health Services Provided to Canadian Forces Personnel with an Emphasis on Post-traumatic Stress Disorder* (Public Works and Government Services Canada, June 2009).
[8] Office of the DND/CF Ombudsman, Word document: Data Capture (18 May 2012).
[9] Office of the DND/CF Ombudsman, Word document: Binder Log V2 (05 April 2012).
[10] These definitions are adapted from those sourced in Chief Force Development's *Capability Based Planning Handbook*
[11] McFadyen, *A Long Road to Recovery*, 5.
[12] Peter McKay, Minister of National Defence, Letter to Interim Ombudsman (27 February 2009).
[13] General Walter Natynczyk, Chief of Defence Staff, CDS Letter to DG Operations DND/CF Ombudsman (27 October 2008).
[14] CANFORGEN 093/08 CDS /11/08 121629Z MAY 08 NEW INITIATIVES RELATED TO MENTAL HEALTH FITNESS OF THE CANADIAN FORCES.
[15] CANFORGEN 007/09 CMP 005/09 161357Z JAN RR ESTABLISHMENT OF DIRECTOR OF MENTAL HEALTH.
[16] Rear Admiral Andrew Smith, Chief Military Personnel, Interview (08 July 2011).
[17] General Walter Natynczyk, Chief of Defence Staff, speaks about "Be the Difference" (25 June 2009).
[18] RAdm Smith, Interview (08 July 2011).

[19] *Operator* is a term frequently used within the CF community. It is generally understood to denote members of the Navy, Army and Air Force who serve in core functional roles as opposed to specialist, support or ancillary functions.
[20] Colonel Darch (Director of Mental Health) and Colonel Jetly (Mental Health and Psychiatry Advisor), Interview (08-09 May 2012). The recent request by the Director of Mental Health to assume responsibility of the Joint Speakers Bureau, presently lead by the Director of Casualty Support Management, is an example of the increasing clinical focus applied in leading and managing the OSI imperative at the national level. A final decision in this regard had not been taken at the time of writing of this report.
[21] Based on interviews with a senior epidemiologist (23 August 2011) and select members of the Canadian Forces Health Information System Project Team (30 April 2012).
[22] Ibid.
[23] David Boulos, Epidemiologist and Doctor Mark Zamorski, Deployment Health Section Head, *Cumulative Incidence of PTSD and Other Mental Disorders in Canadian Forces Personnel Deployed in Support of the Mission in Afghanistan, 2001-2008* (November 2011).
[24] Doctor Mark Zamorski, Report on the Findings of the Enhanced Post-Deployment Screening of those Returning from OP Archer/Task Force Afghanistan/OP Athena as of 11 Feb 2011 (March 2011).
[25] Doctor Mark Zamorski , Deployment Health Section Head, Interview (20 June 2011).
[26] This claim was made by a number of CF members deployed to Afghanistan during the 2008-2010 timeframe, and reinforced by several senior medical professionals, including Commodore Hans Jung, Surgeon General.
[27] Canadian Forces Health Services Group, Results from Health and Lifestyle Information Survey of Canadian Forces Personnel 2008/2009 Regular Force Version (January 2011).
[28] Col Darch and Col Jetly, Interviews (03 August 2011, 17 January 2012).
[29] Ibid (08-09 May 2012).
[30] Col Darch and Col Jetly, Interview (17 January 2012).
[31] Captain Christiane Girard, Directorate of Mental Health Staff Officer, *Monthly Mental Health Report*, Presentation at Directorate of Mental Health 2012 Mental Health Workshop (May 2012).
[32] Feedback from multiple frontline mental health practitioners at various bases.
[33] Inputs from two separate mental health clinic managers/team leads.
[34] Directorate of Mental Health, Excel document: Wait Time Tracksheet (24 February 2012).
[35] As the target population for Statistics Canada's periodic Canadian Community Health Surveys (CCHS) excluded full-time members of the CF, DND partnered with Statistics Canada in 2002 to conduct a special survey supplement on mental health with a representative sampling of CF members, both Regular and Reserve Force members. The survey, known as the Canadian Forces 2002 CCHS Supplement**,** had largely similar objectives and content as the regular CCHS surveys but was adapted to reflect the specifics of the CF and military life.

[36] Department of National Defence, *Caring for Our Own: A Comprehensive Approach for the Care of CF Ill and Injured Members and their Families* (March 2012).
[37] CANFORGEN 183/11 CMP 089/11 111502Z OCT 11 CAREER TRANSITION SUPPORT POLICY FOR SEVERELY INJURED OR ILL CF MEMBERS.
[38] Ibid.
[39] Information gleaned from interviews with a cross section of CF members of various ranks filling or having recently filled (2008-2012) junior and senior command positions.
[40] Information obtained through interviews with a cross section of CF members of various ranks, functions and backgrounds filling a variety of functional roles.
[41] The principle of universality of service holds that CF members are liable to perform general military duties and common defence and security duties, not just the duties of their military occupation or occupational specification. This may include, but is not limited to, the requirement to be physically fit, employable and deployable for general operational duties (Defence Administrative Order and Directive 5023-0, Universality of Service).
[42] Information obtained from a cross section of CF members.
[43] Ibid.
[44] Commodore Hans Jung, Interview (29 June 2011).
[45] Information obtained from a cross section of CF members.
[46] Information obtained for a sampling of recently retired CF members.
[47] Cmdre Jung, Surgeon General, "Canadian Forces Health Services Presentation to Ombudsman Advisory Council", Presentation (October 2010), slide 11, and input from frontline CF mental health practitioners.
[48] Information obtained from a cross section of CF members.
[49] Information obtained from a cross section of CF members.
[50] Colonel Russell Mann, Director Quality of Life, Interview (26 July 2011).
[51] Ibid.
[52] Ibid.
[53] Major MT Kaduck, Director Quality of Life Deputy Director, "RE: Information Request: Ombudsman Investigation on Mental Health". Email to Mary Kirby (23 May 2012).
[54] Information obtained from a cross section of CF members, and reinforced with testimonials from military families during various Ombudsman outreach sessions.
[55] Ibid.
[56] Lieutenant-Colonel Cheryl Baldwin, Director Military Family Services Deputy Director, Telephone Conversation with Christine Desjardins (24 May 2012).
[57] Col Darch, "RE: Ombudsman Investigation: Request for Information". Email to Christine Desjardins (31 May 2012).
[58] Ibid, reinforced in the *2012-13 Report on Plans and Priorities: National Defence* (May 2012), p.15.
[59] Colonel Jean-Robert Bernier, Deputy Surgeon General, during a media briefing regarding the Canadian Forces' support for ill and injured military personnel, 04 May 2012.

[60] CMP written response to Office of the Ombudsman question set dated 27 June 2011
[61] Col Darch and Col Jetly, Interview (08-09 May 2012)
[62] Ibid
[63] Based on inputs and feedback from multiple CF Mental Health Clinics from July 2011 to February 2012 indicating that their operational tempo generally exceeded that anticipated.
[64] Based on document; Business Planning – FY 12/13, Level 4 Planner – Directorate Mental Health
[65] Ibid
[66] Colonel Gerry Blais, Director Casualty Support Management, Interview (21 June 2011)
[67] Feedback from multiple MFRCs
[68] Celine Thompson, Director Military Family Support, Interview (September 2011)
[69] Col Darch and Col Jetly Interview (08-09 May 2012)
[70] Ibid
[71] This analogy has been employed repeatedly by a number of senior DND and CF leaders in internal and external stakeholder engagements and speaking opportunities over the period of 2008-2012.
[72] Based on feedback from CFB Valcartier mental health providers during Ombudsman investigative team visit (November 2011)
[73] A majority of frontline mental health practitioners engaged during this study indicated they had experienced few if any significant lulls during the period of 2008-2012, especially for those bases directly involved in supporting operations in Afghanistan.
[74] This information was obtained from multiple frontline Mental Health providers who had experienced it first-hand, and was corroborated by the Director of Mental Health. It was a recurring theme amongst providers.
[75] Gleaned from multiple frontline Mental Health providers.
[76] Gleaned from multiple frontline Mental Health providers and corroborated by the Director of Mental Health.
[77] Col Darch and Col Jetly, Interview (07 March 2012)
[78] Observation provided by two separate frontline Mental Health providers operating at bases located in isolated regions.
[79] The initiatives presently in train focus primarily on outreach to professional associations and academic institutions, as well as recruiting bonuses. Both have been in place for some time now without yielding significant results.
[80] Col Darch and Col Jetly, Interview (17 January 2012).
[81] Col Darch/Col Jetly, Interviews (07 March and 08-09 May 2012).
[82] Ibid.
[83] Ibid.
[84] Gleaned from multiple frontline Mental Health providers and corroborated by the Director of Mental Health.
[85] Gleaned from multiple frontline Mental Health providers and corroborated by the Mental Health and Psychiatry Advisor.

[86] This concern was voiced by several frontline Mental Health providers. Director Mental Health conceded that while medical training provides CF Mental Health with supervisory experience, the leadership profile of today's military medical professional is probably not as fulsome as that of previous generations of medical officers.
[87] The term 'rotating door' was employed by one frontline Mental Health provider and appeared to be consistent with the testimony of many frontline providers in the context of the instability of uniformed providers filling leadership/supervisory roles.
[88] Gleaned from multiple frontline Mental Health providers and corroborated by the Director of Mental Health.
[89] The figures employed throughout this recommendation were sourced from various manning reports provided by the Directorate of Mental Health as well as the Minister of National Defence's formal response to the 2008 Petawawa Case Study.
[90] Gleaned from multiple CFB Petawawa frontline Mental Health providers and corroborated by the Mental Health and Psychiatry Advisor.
[91] Based on an analysis of vacant Mental Health provider positions as of 2011.
[92] Director Military Family Services, Military Family Resource Centre Family Liaison Officer Terms of Reference (14 March 2011).
[93] Kim Hetherington, Petawawa Military Family Resource Centre Executive Director, "Open Letter to Canadian Forces Families in Renfrew County" (31 January 2012).
[94] National Joint Council, Public Service Health Care Plan Directive (01 April 2006).
[95] This concern was voiced by several CF members as well as frontline caregivers.
[96] Col Darch and Col Jetly, Interview (17 January 2012).
[97] Major Carl Walsh, Former Petawawa Mental Health Lead, Interview (08 July 2011).
[98] Ibid.
[99] Col Darch and Col Jetly, Interview (07 March 2012).
[100] This experience related by a serving CF member suffering from an OSI and travelled to Ottawa for treatment. It was characterized as an experience not unique to him.
[101] Major Carl Walsh, Former Petawawa Mental Health Lead, Interview (08 July 2011).
[102] Col Darch and Col Jetly, Interview (08-09 May 2012).
[103] This information was obtained from multiple frontline Mental Health providers and corroborated by the Director of Mental Health.
[104] Col Darch and Col Jetly, Interview (03 August 2011).
[105] Col Darch and Col Jetly, Interview (08-09 May 2012).
[106] Ibid.
[107] Joint Speakers Bureau, Word Document "Annex C-JSB Courses" (20 June 2011).
[108] Department of National Defence, BG11.012 Backgrounder on Post-Traumatic Stress Disorder (15 November 2011).
[109] Canadian Forces Health Services Group, Mental Health Closure Report (01 April 2009).
[110] In 2009 General Natynczyk won a Champions of Mental Health award from the Canadian Alliance on Mental Illness and Mental Health for his leadership role in launching the CF's Mental Health Awareness Campaign. More significantly, he has engaged CF members and their families on the PTSD/OSI imperative relentlessly during his tenure as CDS.

[111] Both Rear-Admiral Andrew Smith, current Chief of Military Personnel and his predecessor, Lieutenant-General Walter Semianiw, made mental health one of the institution's top priorities.
[112] This is widely accepted in academic and professional circles, and has been remarked upon by various frontline Mental Health providers, operators and strategic leadership. Where there is less unanimity is in the scope of the post-operation intensity of OSIs, specifically whether it manifests in a continuous surge, a rising bow wave or a dramatic tidal wave or tsunami.
[113] Gleaned from multiple frontline Mental Health providers
[114] Other than for psycho-social services, members require a referral from a Medical Officer to access mental health care. Unaware of this process, many members will present at the mental health clinic seeking help. As a result, most bases will either have a mental health practitioner present during sick parade or will rotate mental health personnel to deal with walk-ins.
[115] The Canadian Forces Health Services Group maintains a comprehensive website on the Road to Mental Readiness program, including a section dedicated to family members. http://www.forces.gc.ca/health-sante/ps/mh-sm/r2mr-rvpm/default-eng.asp
[116] Cmdre Jung, Surgeon General, "Canadian Forces Health Services Presentation to Ombudsman Advisory Council", Presentation (October 2010), slide 39.
[117] The evidence indicated that intermediate leaders were generally more apt to harbour traditional views toward invisible injuries such as OSIs.
[118] This was corroborated by several senior NCMs and officers in command positions.
[119] This concern was consistently noted as a barrier to care by junior and senior members, family members, and frontline mental health care providers, and was corroborated by strategic level leadership.
[120] Department of National Defence, Compensation and Benefit Instructions, Chapter 205-Allowances for Officers and Non-Commissioned Members (23 June 2008), paras 205.33-7.
[121] CANFORGEN 193/08 CMP 083/08 211848Z OCT 08 CANADIAN FORCES (CF) FAMILY COVENANT.
[122] Canadian Forces Health Services Group, Instruction 5100-07 Member Focused Family Care (25 June 2007).
[123] Conveyed by several CF members.
[124] Department of National Defence, *Caring for Our Own: A Comprehensive Approach or the Care of CF Ill and Injured Members and their Families* (March 2012).
[125] Canadian Forces Health Services Group, Instruction 5100-09 Canadian Forces Member Assistance Program (20 October 2002).
[126] Henry Matheson, CFMAP Coordinator, Interview (19 January 2012).
[127] Colonel Russell Mann, Director Quality of Life, Interview (26 July 2011).
[128] Discussed at the 2012 DMH-sponsored CF Mental Health Workshop (May 2012).
[129] Directorate of Mental Health, Mental Health Campaign Action Plan (23 February 2012).
[130] Col Blais, Interview (11 June 2011)

[131] This information was obtained from multiple frontline Mental Health providers who had experienced it first-hand, and corroborated by the Director of Mental Health.
[132] Col Darch and Col Jetly, Interview (17 January 2012).
[133] Gleaned from multiple frontline Mental Health providers, and corroborated by the Director of Mental Health.
[134] Col Darch and Col Jetly, Interview (07 March 2012).
[135] Canadian Forces Health Services Group, Concept for Canadian Forces Mental Health Care (08 September 2003).
[136] Col Darch and Col Jetly, Interview (17 January 2012).
[137] Examples of this abound. A recent one was Colonel Jean-Robert Bernier, Deputy Surgeon General, during a media briefing regarding the Canadian Forces' support for ill and injured military personnel, 04 May 2012.
[138] Col Darch and Col Jetly, Interview (08-09 May 2012).
[139] Ibid.
[140] Information gleaned from interviews with a cross section of CF members with recent command experience.
[141] Canadian Forces Instruction; *Commanding Officers Guide – Casualty Support and Administration of the Ill and Injured*.
[142] Information gleaned from interviews with a cross section of CF members with recent command experience.
[143] This was related by several frontline mental health practitioners.
[144] This expression was used by several CF members engaged on this subject.
[145] Information gleaned from input from a cross section of CF members with recent command experience.
[146] This notion has been explored by a myriad of learned observers over the years, including Dr. Richard A. Gabriel, General Sir Rupert Smith and General Sir John Hackett to identify but three.
[147] In reality, the period since the Korean conflict has generally featured limited numbers of ill and injured as a direct result of operations.
[148] Information obtained from a cross section of CF members
[149] Quote articulated by a well regarded serving senior non-commissioned member with over 25 years experience and multiple operational tours.