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Défense nationale et Forces canadiennes

Follow-up Report

Review of DND/CF Actions on Operational Stress Injuries

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Canada

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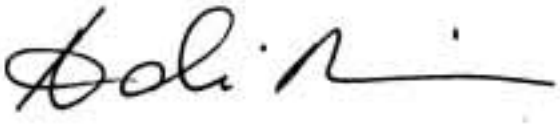
When I released my special report, *Systemic Treatment of CF Members with PTSD*, I committed to re-assess the issues nine months later. This report, delivered to the Minister of National Defence on the day marking the nine-month anniversary of the first report, meets that commitment.



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Executive summary

1 Overall, the Canadian Forces (CF) has indeed made progress in the implementation of a number of initiatives designed to deal with operational stress injuries (OSIs) since the release of my report in February 2002. When taken together, these initiatives will eventually go a long way towards improving the welfare of the men and women who generate the combat capability of the CF. A significant number of these initiatives flow from the recommendations I made in the original report. I am also pleased that there has been some acceleration in the implementation of initiatives that were under way before my report was released.

2 I recognize that changes in an organization as large as the Department of National Defence (DND) take a long time to become effective. Indeed, I anticipated that many of the changes I recommended would take much longer than nine months to implement. However, nine months is a considerable period of time and more than sufficient for some very significant things to happen. This report is designed to gauge the level of CF progress in implementing the recommendations.

Improved deployment-related procedures

3 During the course of this investigation, it became clear to me and to my investigators that the level of awareness of stress-related injuries in the CF has improved markedly. For example, with Rotation 9 and 10 of OP PALLADIUM deployed to Bosnia in 2001 and 2002, changes in the level of psychological support for the Battle Group drawn largely from personnel at Canadian Forces Base (CFB) Valcartier were beginning to become evident. The decision to deploy a Canadian Battalion Group to Afghanistan to help combat terrorism provided a further opportunity for the CF to demonstrate a commitment to deal with the issue of stress reduction during operations and on redeployment in a number of ways — such as the decompression time in Guam and the gradual reintegration of members with their families. While the confirmation of the success of those initiatives must await further examination, it is clear that so far the majority of CF members and their families view these actions as very positive.

CF review of OSI training and education

4 When I drafted the recommendations in the first report, I deliberately used language that, while identifying a problem and broad solutions, gave the CF considerable latitude to create practical solutions that achieved the desired result. I believe this approach has borne fruit, especially in response to my recommendations on training and education. After my report was released, the CF commissioned a comprehensive review of the current state of training and education about OSIs in the CF. The review, which took four months to complete and was finalized in September 2002, made 25 recommendations, which mirrored those that we had made. It is my understanding that the CF will implement those recommendations.

Social work conference

5 I was also pleased that a training session was held for CF social workers, which included a segment on post traumatic stress disorder (PTSD), as per my recommendation. I strongly recommend that this exercise be repeated annually.

Successful OSI social support program

6 On another positive note, the Operational Stress Injury Social Support (OSISS) project has been a tremendous success. OSISS has a mandate to provide peer counselling and support for members who may have an OSI, and to conduct education and training about OSIs for CF members and others. Its success is owing not only to the dedication of its staff but also to the championing it has received from the highest levels of the chain of command, in particular from the Assistant Deputy Minister (Human Resources — Military) [ADM (HR-Mil)]. The CF deserves tremendous credit for this initiative and I encourage the organization to provide OSISS with the resources it needs to realize its full potential.

Negative attitudes prevail

7 Unfortunately, very little progress has been made in a number of important areas. For example, in the critical area of culture change, the all-important peer attitude remains largely negative. Resource shortages and high workloads will continue to make it difficult to change attitudes and improve acceptance of members suffering from an OSI. Units are not generally requesting the outreach training that I believe will start changing the culture of ostracism and stigma that was so apparent in my original investigation.

Effective co-ordination needed

8 One of my key recommendations was that the CF should introduce the position of PTSD co-ordinator reporting directly to the Chief of the Defence Staff (CDS). This was needed to deal with the many disparate interests and organizations within the CF that have input into how the institution deals with OSI issues. For example, the Army, Navy and Air Force (the Environmental Chains of Command), the organization responsible for deployment (the Deputy CDS), and the medical, training and education systems all report through different chains of command. I strongly encouraged the CF to adopt a holistic approach to tackle these complex issues, which is why I recommended the creation of a PTSD co-ordinator who reports directly to the CDS. The CF, while acknowledging that there was a pressing need for co-ordination, wanted to deal with this issue within existing frameworks.

9 In my discussions with senior health officials from DND/CF, I have noticed a reticence to launch a blitz on the OSI issue. The rationale appears to be that there are many serious health issues in the organization, all of which require prompt redress, and that singling out one problem as more pressing than others would somehow be unfair to those suffering other illnesses. With respect, I disagree with that proposition. What is unfair is to treat each problem equally without regard to the severity of individual issues. To do so would result in OSI not receiving proper consideration. In my view, the poor treatment historically afforded those suffering from an OSI make it stand out from other problems facing senior health officials. Therefore, it deserves special attention.

10 I therefore pursued the recommendation to create the position of PTSD co-ordinator with the CDS on several occasions after the release of the report in February 2002. As a result, the CDS created the position of Special Advisor to the CDS for Operational Stress Injury (SA CDS [OSI]), who will report directly to him. The ADM (HR-Mil) created the Operational Stress Injuries Steering Committee that is designed to bring all the stakeholders within the CF around the same table.

11 It is premature to pass final judgement on the efficacy of this system. It is worth noting, however, that the OSI Steering Committee has met only twice since its creation and the Special Advisor, who has other primary duties, has yet to get fully up to speed on the issues, though she has indicated that she intends to go into the field and explore first hand what is happening.

12 There is certainly still a need for effective co-ordination of the CF response to OSIs. Consistent and co-operative communication among agencies and personnel that share the caregiving responsibility is still lacking. In some locations, work therapy opportunities in the form of occupational transfers are ignored owing to the lack of understanding of the Service Personnel Holding List (SPHL) capabilities. As a result, potential work therapy opportunities are being missed in locations that have jobs that need to be filled.

Reluctance to seek treatment

13 Many CF members are still reluctant to come forward and seek treatment, and in some areas, treatment is difficult to access. I am particularly disappointed at the lack of progress made in initiating a pilot project that locates one Operational Trauma and Stress Support Centre (OTSSC) off-base. The object of this recommendation was to attempt to provide an alternative for the significant number of members who refused to seek, or delayed seeking, treatment because the OTSSCs were all in highly visible locations on bases. The CF undertook to examine in detail this recommendation to create a pilot project, and I understand that its analysis will not be completed until March 2003. The need for an off-base OTSSC is still as acute as it was when my first report was released. During the course of this investigation, it was still clear that the vast majority of members and a significant number of caregivers supported the idea. Worryingly, we were advised that several members who had recently returned from Afghanistan

wanted assistance, but were refusing to seek treatment at the OTSSC because of the stigma associated with being seen there and concerns they had over the confidentiality of their medical records. This makes the need to try a pilot project even more acute, and I am baffled and concerned by the lack of progress to seek solutions.

14 I have been informed that a query by National Defence Headquarters prompted OTSSC officials to clearly indicate that if a patient expressed a desire to receive treatment from outside a military clinic, the OTSSCs would happily draw on resources from the civilian community. This, however, does little to reach out to those who are staying away from military clinics owing to the prevailing stigma in the military surrounding those suffering from OSI. The whole point of locating an OTSSC off-base was to make it easier for patients to seek treatment by removing the fear that they would be seen and then labelled as weak soldiers.

Better data gathering needed

15 I am concerned at the lack of progress made in collecting statistics from OTSSCs, and that only rudimentary steps have been taken to ensure the CF has an accurate statistical foundation on which to base policy and practice. OTSSCs have no internal electronic databases and have to collate statistics manually, which is unnecessarily time consuming.

Requirements for unit support ignored

16 I am frustrated that units are, generally speaking, still not keeping in regular contact with members on the SPHL, and are ignoring CF-wide and local requirements for them to do so. The situation for Reservists has also not improved quickly enough.

Valuable members lost

17 I am also concerned that the CF continues to lose valuable and trained members as a result of rigid and complicated rules surrounding the ability of members suffering from OSIs to transfer occupations. This is of particular concern in light of recent reports that the CF continues to experience shortages of trained personnel.

I fully understand that this is a complex issue but more work must be done to ensure that experienced, qualified and capable members are retained in the CF. More attention also needs to be paid to the caregiver burnout problem. Too many dedicated people are themselves becoming victims.

18 Although the OSI Steering Committee is undertaking the development of "communication strategies to get the message out," on occupational transfers, I do not believe the issue is simply a matter of being misunderstood. To this day, too many soldiers are simply released because the occupational transfer process is far too complicated.

19 The Auditor General of Canada emphasized the need to recruit and retain CF members to fill existing shortages in the April 2002 report to the House of Commons. In my original report, I emphasized that the CF will ultimately save significant resources currently spent on recruiting and retention if it can retain experienced members who have an OSI. To do so will require a continuing focus on first-class treatment for members who do come forward. It will also require that the CF create a culture where members who may have an OSI are confident that seeking treatment is not a 'one-way ticket' out of the CF. I am also concerned that, given the experience of other military organizations, the CF may become increasingly embroiled in very expensive litigation, initiated by members who believe the CF has been negligent in responding to OSIs.

Senior leadership's commitment

20 I am encouraged by the commitment of senior CF leadership to provide the necessary resources to achieve the goal of acting diligently to help members suffering from OSIs. Two days after the release of my first report on this issue, I was called to testify at the Standing Committee on National Defence and Veterans Affairs (SCONDVA). SCONDVA also heard from senior CF leaders that day, including the ADM (HR-Mil), who indicated that DND/CF "is committed to provide necessary resources that we need to attack this problem."

21 Overall, and encouragingly, my investigators have sensed a renewed determination at the senior levels within the organization to move this issue forward, and some tangible movement has been evident. However, we should not underestimate the difficulty of

changing entrenched ideas and ultimately the culture in the field, without immediate and constant pressure. In my opinion, the situation is somewhat analogous to the heart (the strong support of senior management) pumping, but major problems with the blood getting to the extremities (the culture in the field) where it is needed. In this case, the clogged arteries that are causing the slowdowns and blockages are lined with bureaucracy. The longer it takes to clear the arteries and start some of these improvements, the more difficult it will be to deal with the entrenched problems.

Introduction

22 On 5 February 2002, I released a report to the Minister of National Defence on the systemic treatment of Canadian Forces (CF) members with post traumatic stress disorder (PTSD). The report focussed on the CF's treatment of Corporal (Cpl) Christian McEachern, a young soldier and former member of the 1st Battalion of the Princess Patricia's Canadian Light Infantry (1 PPCLI) who was diagnosed with PTSD in the fall of 1997 and released from the CF in July 2001. As the investigation into his treatment progressed, it became apparent that a number of the issues arising from his complaint were systemic in nature.

23 The report concluded that Cpl McEachern's complaints were justified. As is the case for many CF members who suffer from stress-related injuries including PTSD, he was stigmatized and isolated from his unit, without the peer support that could have sustained him. The report made 31 recommendations designed to assist the CF in improving the way it deals with stress-related injuries. The CF has accepted all of these recommendations, in whole or in part.

24 Recognizing the importance of this issue, I committed to publish a follow-up report within nine months on the organization's progress in improving the welfare of its members with PTSD and other operational stress injuries. This report, delivered to the Minister of National Defence on the day marking the nine-month anniversary of the first report, meets that commitment and reflects the organization's progress. My investigators examined each recommendation in turn, identified the CF's actions in response to the recommendation, and then evaluated the progress and results of the implementation.

25 During the course of this follow-up investigation, concerns were raised about the use of the term "post traumatic stress disorder" or PTSD. Several people, including professional caregivers, service personnel, families and members of the chain of command, felt that the term PTSD was too specific, as it failed to capture the entire range of stress-related issues. The exclusive use of the term PTSD left many people with the impression that unless an individual was actually diagnosed with PTSD, he or she was not suffering from stress-related injuries. "Operational stress injury" is in common usage among many of the groups we talked with, and the CF is using this term in its responses to the recommendations in the first report. To avoid any confusion, throughout this report, I have adopted the term operational stress injury (OSI).

Investigative process

26 I assigned this follow-up investigation to the Special Ombudsman Response Team (SORT), headed by Director Gareth Jones. SORT was charged with the initial investigation into CF treatment of members with PTSD. Overall, a team of dedicated and committed investigators conducted the investigation and drafted this follow-up report. The principal investigation was conducted by Mr. Jones, Brigadier-General (BGen) (Retired) Joe Sharpe (my Special Advisor on PTSD) and Investigator Brigitte Bernier. A number of Ombudsman investigators across the country, including George Dowler in Halifax, Liz Hoffman and Bob Howard in Winnipeg, and Guy Parent in Ottawa, also contributed time, energy and ideas.

27 The investigative team interviewed or consulted with approximately 300 people in Comox, Esquimalt, Edmonton, Winnipeg, Shilo, Trenton, North Bay, Valcartier, Québec City, Halifax, Sydney, Debert, Shearwater, Gagetown and Ottawa. The interviewees included:

28 • a cross-section of Commanding Officers (COs), Base Commanders, senior-ranking Non-Commissioned Members (NCMs) and members of field units based at Valcartier, Winnipeg, Shilo, Halifax, Gagetown and Edmonton;

29 • management and staff at Operational Trauma and Stress Support Centres (OTSSCs) in Halifax, Valcartier, Edmonton and Esquimalt;

30 • senior members of the CF Health Services and CF Medical Group Headquarters (CFMGHQ), including the Director General Health Services (DGHS), the Surgeon General (Surg Gen), the Deputy Chief of Staff Health Service Delivery, Director of Social Work Policy and Standards, the Director Casualty Support and Administration (DCSA);

31 • senior National Defence Headquarters (NDHQ) staff, including the Special Assistants to ADM (HR-Mil);

32 • the Special Advisor to the CDS for OSI and the Assistant Special Advisor to the CDS for OSI;

33 • staff at Military Family Resource Centres (MFRCs) across Canada;

34 • personnel from the Occupational Stress Injury Social Support (OSISS) project;

- Veterans Affairs Canada (VAC) employees;
- the Royal Canadian Legion;
- Military Police officers;
- members and former members diagnosed with PTSD and, in some instances, their family members;
- the Commander and Deputy Commander Land Forces Western Area;
- CF military and civilian social workers, general practitioners, base surgeons, mental health nurses, psychologists and other caregivers; and
- soldiers, sailors, airmen and airwomen deployed on OP APOLLO, both in the Persian Gulf and at Kandahar.

42 In September 2002, I met with senior officials from the United Kingdom Ministry of Defence, the Royal Navy, the Royal Marines, New Scotland Yard and the Irish Defence Force to determine how other military and para-military foreign agencies deal with OSIs.

43 The investigative team obtained and examined a large number of documents, including the minutes of the OSI Steering Committee meetings, terms of reference for various individuals and committees (including the Special Advisor to the CDS for OSI), and OTSSC statistical and budget information. They reviewed the needs assessment of training and education on OSIs prepared by the Director Training and Education Policy (DTEP) in response to my original report, and the action plan prepared by ADM (HR-Mil) in response to the recommendations.

44 Despite raised eyebrows by some at higher levels who questioned my Office's role in conducting a follow-up investigation on the implementation of my recommendations, the investigative team received exemplary co-operation from DND/CF, both in the field and at NDHQ. I wish to thank everyone who assisted my investigators for their diligence and commitment to ensuring we had the information we needed to ensure this investigation was as comprehensive and objective as possible.

45 My investigators reviewed each of the 31 recommendations in the report before beginning the interview and information-gathering process. They sought and received input from personnel within the CF, indicating how the organization was approaching the

implementation of each recommendation and updated that information in the last few weeks before completing the analysis. Then they investigated how the approach was working in the field, and assessed what they found. We have presented the results individually for each recommendation in the first report.

46 The response to the report on systemic treatment of CF members with PTSD was overwhelming. We received hundreds of faxes, emails and telephone calls from people who wished to share their experiences and to acknowledge their support for the attention being drawn to this important and serious issue. In the words of one Master Corporal, an infantry soldier and PTSD patient, the report "had bold and well-meaning ideas for the military to put into place." An experienced social worker, commenting on the first report, stated: "Reading that report was like reading the stories of many of my guys."

47 We hope this report gives an accurate account of how the CF is dealing with the challenges and opportunities to improve the welfare of its members and enhanced operational effectiveness offered in the original report.

Analysis of CF response

48 Shortly after our report was released, ADM (HR-Mil) created a chart that summarized the CF response to our recommendations. In our review of each recommendation, I have included the CF response as it appears on that chart.

Recommendation 1

49 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.

CF response

50 This recommendation is supported and will be addressed in full. Pending implementation of the CF Health Information System (CFHIS), DGHS will create and maintain a database of CF members afflicted with Operational Stress Injuries (OSI) through a manual reporting process. The precise mechanics on the data fields to capture and how the data will be reported, collated and analysed will be developed with an expected implementation of 01 Apr 02. These returns will continue until the CFHIS is in place. The OSI manual reporting process has been initiated, and more than half of the 35 bases surveyed have responded.

Analysis

51 Common sense dictates that solid data is needed to determine the prevalence of OSIs in the CF. One OTSSC staff member summed it up well, stating, “Collecting data — it’s essential, both for prevention and treatment.” It is also needed to identify the resources required to address OSI issues. Further, a comprehensive statistical base is essential to counteract many misconceptions that continue to exist about the frequency and severity of stress-related injuries. Statistics will also be beneficial for research activities planned by DGHS. The CFHIS is a multi-million dollar software-based information management system that should provide fully automated record keeping for all medical information on CF members. Although the capabilities of this system will be

impressive once it is operational, its development has experienced problems that have delayed the implementation date. According to DGHS, it will be at least two years until the system is up and running.

52 DGHS staff advised my investigators that, until the automated CFHIS is operational, they have begun collecting statistics manually on OSIs from CF health care facilities. This process began in May 2002, and includes data on Reserve and retired members if they are being seen at a CF clinic. These statistics are not collected directly from OTSSCs or mental health units, but rather through clinic managers at 35 bases across Canada. Every month each manager is sent a form requesting the number of CF members who fall into the following categories: new presentations with OSI symptoms; patients who are believed to be suffering from an OSI; patients receiving ongoing treatment for OSIs; discharges back to duty with no restrictions; and those discharged with restrictions, including those recommended for medical release.

53 As noted in the CF response above, to date approximately half the bases have responded, with the quality of information varying from "extremely accurate" to "vague," according to DGHS staff. DGHS expects the quality of the data to improve as the personnel responsible for submitting the information become more familiar with what is required. The statistics do not make a distinction between Regular and Reserve Force members, though efforts are being made to improve the process, including requesting actual diagnoses and obtaining input from VAC.

54 A senior OTSSC staff member advised us of concerns over the accuracy of the figures being sent back to Ottawa. In some instances, it was possible for numbers to be miscalculated and perhaps double counted. In fact, a DGHS staff member involved in the collection process stated that there was currently a 'fudge factor' of plus or minus 10 percent when asked if he could provide the number of CF members suffering from OSIs. The potential for double reporting was known within ADM (HR-Mil), and releasable statistics will not be available until that is rectified. As well, the OTSSCs do not currently have access to the data, making it "useless" to them, according to a senior DND mental health professional. On a positive note, the figures are being forwarded to the Special Advisor to the CDS for OSI.

55 The vast majority of OTSSC staff we spoke to thought access to up-to-date statistics was very important. In several of the OTSSCs that my investigators visited, there has been little or no progress developing an internal electronic database for collecting statistics.

All statistical information, such as the numbers of patients, diagnosis, age, gender, element and other information, must be culled manually from patients' files, which, we were advised by OTSSC staff, is an often frustrating and time-consuming process for already-overburdened clerical and management staff. There are no mechanisms in place to share information quickly and easily between OTSSCs. We found considerable frustration among managers and caregivers because they do not have the statistical tools they believe they need.

56 The original speed with which the OTSSC concept was implemented precluded the early development of an effective approach to building a database. Unfortunately, the automated CFHIS has run into a bureaucratic snag, with no firm anticipated in-service date.

Conclusion

57 Senior leadership in the department remains fully committed to implementing CFHIS. The CF has begun to manually collect statistics on OSIs, pending the introduction of CFHIS. However, OSI data collection is very much in its infancy and DGHS staff recognize that the system is still evolving and is far from perfect. It was disappointing for my investigators to return to OTSSCs and still find that there is no electronic database to give easy access to current statistics.

Recommendation 2

58 The Canadian Forces develop a database on suicides among members and former members.

CF response

59 This recommendation is fully supported and has already been addressed in part; a new project will be instituted to implement this recommendation to the greatest degree practicable. DCSA maintains a database on suicides by serving members (e.g., Regular Force and reservists on call out). Unless voluntarily reported to the CF, a former member's cause of death is unknown and not recorded. Where known, suicides of former members or reservists not on duty will be recorded and this information will be maintained by DCSA. DND will work in collaboration with VAC to establish joint procedures to address this issue. A meeting planned for 24 September [2002] with VAC was expected to develop a framework and a timeline to advance this issue, however time constraints prevented an in-depth discussion. Another meeting has been scheduled between DCSA and the VAC Director of CF Services for 4 October to further explore the issue.

Analysis

60 In the original report, I noted that statistics about suicides and attempted suicides could provide the CF with important information about PTSD-related issues. My investigators heard anecdotally that a number of members and former members who had been deployed had committed suicide. Raw data on suicides may furnish valuable information, including relationships to specific deployments or units that the CF could focus on in assessing their approach to dealing with OSIs.

61 DCSA does not produce these statistics directly. They indicated they rely on Military Police casualty or very serious injury reports and information from units and/or formations. As of August 2002, a new way of reporting data on suicides has been implemented where the information from existing databases have been

combined to provide more accurate and updated information. DCSA has been collecting data on this new database for approximately two months but as yet the database does not have any outputs identified. DCSA receives input from the Military Police and social workers on every recorded suicide in the CF, and we understand that these statistics can be provided quickly when requested. Further, my investigators were told that the number of recorded suicides within the CF averages approximately 12 a year, and that the rate of suicide when standardized for age and sex is lower on average than that of the general Canadian population.

62 If the DCSA receives a death notice where the cause of death is not indicated, it is referred to the senior social worker at DGHS for investigation. At this time, DCSA takes no formal action with the data, and the regular reports generated by the DND/VAC Centre for the Support of Injured and Retired Members and Their Families do not include suicides.

63 As noted in the first report, former members are not being tracked, nor are Reserve members who commit suicide unless they do so while they are on active duty.

64 There is no mechanism to collate suicide statistics involving off-duty Reservists or former members from provincial coroners or medical examiners' offices. We were advised it would be difficult to put in place an effective and efficient process to achieve that goal. However, we were very recently informed that DCSA will meet with VAC in the near future to discuss developing procedures to collect suicide data on former members receiving a pension.

Conclusion

65 There has been progress in implementing this recommendation with respect to serving CF members. The CF should continue efforts to maintain an accurate database on suicides and suicide attempts. This information may assist in identifying trends and ensure an early awareness of potential problems.

66 The ability to obtain accurate and timely information with respect to suicides by off-duty Reservists and retired members is limited because off-duty and former members are not actively tracked by the CF. I am pleased that efforts are being made to establish means to collect whatever data is available, particularly for former members, through arrangements with VAC.

Recommendation 3

67 The Canadian Forces conduct an independent and confidential mental health survey that includes former members, as well as Regular and Reserve components.

CF response

68 This recommendation is fully supported and has already been addressed in part. In conjunction with a Canadian mental health survey being conducted by Statistics Canada, DGHS has commissioned them to also conduct a mental health survey for serving Regular and Reserve Force members. DGHS is not however mandated to survey retired CF members. DND will work in collaboration with VAC to establish joint procedures to address this issue. DCSA is to contact VAC and investigate if they could conduct a mental health survey of veterans. DGHS is to provide regular updates to the Ombudsman on the status of the mental health survey.

69 The referenced survey was initiated in May 2002 with data collection scheduled for completion in December 2002. As of early September 2002 more than half of both the regular and reserve elements were complete. Higher than anticipated return rates are being experienced. There have also been preliminary discussions with VAC and the issue of a mental health survey of veterans was to be advanced at a meeting in late September 2002; however it has now been rescheduled due to the amount of material at the meeting.

Analysis

70 This recommendation was made to ensure accurate and timely statistics were available to the CF to make certain the appropriate level of effort was devoted to dealing with mental health issues in general and stress-related injuries specifically.

71 Representatives from my Office have regularly attended meetings of the Canadian Community Health Survey Statistics Canada/CF

Steering Committee, which is charged with overseeing the implementation of the survey, a joint Statistics Canada–DND effort. The ongoing mental health survey is progressing very well and appears to be returning good data. The targeted percentage of the sample design was 5,000 for the Regular Force and 3,000 for the Reserve Force. As of 30 September 2002, 3,911 completed responses had been received from the Regular Force and 3,049 from the Reserves, which accounts for 64 percent and 78 percent of total sample, an excellent return rate. The anticipated target date for the completion of the field data collection is mid-December 2002 and processing the data is targeted for May 2003.

72 My investigators heard about the survey from a number of personnel in the field, and while the length of time required to fill out the forms was mentioned as a concern, the overall reaction to the survey was positive. The inclusion of Reservists in the survey was particularly well received.

73 I understand that former members will not be included in the survey. As I noted in the original report, members with an OSI frequently indicate some other reason when taking their release. I believe that it is important to attempt to quantify how many former members suffered from OSIs to understand the true impact of OSIs in the CF. Although former members are seen to fall under the purview of VAC, there is clearly an important and direct interest on the part of the CF in collecting information on OSIs from those who served, particularly on deployments in the last 10 years. The fact that former members were not included in the Statistics Canada–CF survey may eventually limit the extent to which the CF can accurately compare the incidence figures obtained in the CF-wide survey to any figures available for other militaries or for the general population in Canada. For example, we understand that US authorities have published data that indicates that more veterans of Vietnam have committed suicide than were killed in the actual conflict. While VAC statistics for former members who apply for OSI-related pensions after release are useful in that regard, they do not provide all the information required and certainly not the degree of detail that will likely be available from the Statistics Canada–CF survey of currently serving members.

Conclusion

74 The survey is progressing well with excellent support and co-operation between DND/CF and Statistics Canada. I anticipate

that the results will be very useful to DND/CF in the continuing challenge it faces in response to OSIs. However, there will continue to be a significant gap in the mental health data for the CF unless retired members of both the Regular and Reserve components are surveyed.

Recommendation 4

75 The Canadian Forces examine the issue of work therapy while on the SPHL in more detail, with a view to creating policies and procedures to deal equitably with issues that arise from members on the SPHL earning secondary income from employment as part of a therapy program.

CF response

76 This recommendation is fully supported and has been addressed in part — further refinement of policies related to work therapy will take place in the near future. The concept of alternate employment as part of the work therapy or ease back process is fully supported however; any such policy should be in keeping with industry practice. Long Term Disability (LTD) programs operated by insurance companies are utilized by many employers and therefore provide useful precedent in this regard. It is common practice for LTD policies to provide for periods of work for the purpose of rehabilitation. However, as members on SPHL continue to receive 100% of pre-disability income, to be consistent with industry practice the member should not be eligible to receive additional income from the rehabilitation employment. Section 117(b) of the *National Defence Act* makes it an offence to accept compensation other than one's pay, for doing one's duty. If a member of the SPHL has a place of duty for rehabilitative reasons outside of the CF, it would be an offence for him/her to accept compensation for working there. A review of SPHL regulations will be conducted and the issue of work therapy, including the matter of income from a secondary source outside of the CF, will be better defined, communicated and embedded in the DAOD [Defence Administrative Orders and Directives] on the SPHL. The revised DAOD has been completed and is in the last round of staff review. There is still considerable work to be done to finalize a national policy/process for civilian work opportunities for members on SPHL.

Analysis

77 This recommendation was a result of a concern that meaningful employment, which many medical professionals cited as extremely beneficial to those recovering from PTSD, was not available for many injured members. The issue of compensation for such work was recognized as problematic; however, the benefits are so significant that an examination of the policy was considered relevant.

78 The CF is in the process of drafting a Defence Administrative Orders and Directives (DAOD) dealing with SPHL issues. The original draft DAOD on the SPHL provided that a member may not have full- or part-time civilian employment during scheduled working hours, unless that employment is part of a vocational rehabilitation program, assigned by the member's CO. In addition, it stated that a member who is posted to the SPHL is not permitted to accept compensation for civilian employment that is part of vocational rehabilitation.

79 The OSI Steering Committee discussed work therapy and receipt of a secondary income while on the SPHL at its most recent meeting. The revised draft DAOD is being actively worked on, but release is not expected until 2003. A copy of the draft DAOD, which dealt with SPHL issues, was provided to me in March 2002 and I submitted my observations to ADM (HR-Mil) on 2 May 2002.

80 It is evident from the many comments and observations that many of the rules governing the SPHL dealing with work therapy are neither simple to understand nor easy to resolve equitably. While industry experience can provide lessons, the situation for CF members on the SPHL differs in that in addition to the therapeutic value of the work itself, the transition to civilian life is part of the reason the SPHL exists. This aspect of the SPHL is clearly not understood by many of those who are expected to use the system wisely. In the words of a military spouse, "SPHL is a joke. You get PTSD and are sent home for one year. He got even more depressed."

81 The overall issue of the fairness and equity of the SPHL continues to be a problem. It is a serious concern as a result of the VAC policy that provides a disability pension payout to a CF member prior to release. On occasion, a CF member who has been diagnosed with an OSI can be receiving a disability benefit or other income from three separate sources — the normal salary earned as a CF

member, a VAC disability pension and possibly an income earned from employment outside the military. This has the potential to create a significant level of resentment toward the member on the SPHL, particularly at the working level where his or her absence may have increased the workload, shifting it to the rest of the unit.

Conclusion

82 Work therapy is an important aspect of the SPHL. To be effective, its importance must be clearly understood by all (SPHL members, chain of command, medical personnel and peer groups). This is not the case now, as illustrated by the following statement recently made by a medical officer: "I work to get these people rehabilitated, give them the benefit of the doubt […] the CF is becoming a big charity. How long do we want to employ these guys?" The CF is clearly not a charity, and the obligation to help those injured in the service of their country transition to a productive civilian life exceeds that of a normal industry. I am pleased to see that the CF is tackling this issue; however, considerable work remains to be done. I look forward to reviewing the next draft of the DAOD on the administration of the SPHL.

Recommendation 5

83 The Canadian Forces initiate a program whereby all units receive outreach training about PTSD via the OTSSCs.

CF response

84 This recommendation is fully supported and has already been addressed in part. All OTSSCs deliver outreach programs to the satellite bases which they serve that targets four communities: (1) health care providers (to include MFRC Prevention Intervention Co-ordinators); (2) chaplains; (3) the chain of command; and (4) service members. The frequency and breadth of the programs will be expanded as additional staff is hired at the various centres.

85 Staffing issues at the OTSSCs are being addressed which will better allow the staff to carry out their outreach activities. Direction on the type and frequency of outreach training was provided to the OTSSCs. Recent Staff Assistance Visits (SAV) by the Rx 2000 Mental Health Team will confirm that outreach programs are in place.

Analysis

86 In the original report, I noted that education and training were fundamental to creating a culture where members were not afraid to seek treatment quickly, and that the OTSSCs had a vital role to play in that process. I found units were not receiving sufficient training on OSIs. Outreach by OTSSC staff to units is a very effective way to educate CF members about the realities of OSIs and dispel some of the myths that have developed around the issue.

87 There has been no CF-wide mandated program for units to receive outreach training. Units are not obliged to request such training, nor are OTSSCs obliged to deliver it, though outreach training is acknowledged as one of the OTSSC core functions. My investigators met with staff at several OTSSCs in the course of this follow-up investigation. There has been some demand for outreach training by OTSSC staff from operational and line units, but the

frequency of requests appear to vary considerably from one location to another. One senior OTSSC administrator estimates that he received between five and seven requests to speak to units about OSIs in September 2002 alone. He indicated that this is a rising trend. He described standing up in front of groups of senior-ranking NCMs and middle-ranking officers as "the one way we can get to those middle management folks" who are key to changing CF culture. At another OTSSC, staff has conducted five presentations to CF Regular and Reserve units so far this year, along with numerous presentations to non-military bodies such as VAC and a professional association. The OTSSC has set itself a laudable goal, "to reach all serving members and Reserve units as well as professionals associated with CF members and our partners such as VAC."

88 Unfortunately, at another OTSSC, my investigators were told that they have simply not been asked by the operational units to conduct any of this training. As one OTSSC psychiatrist put it, "the demand has been underwhelming." In another area, some outreach training has been done, but primarily aimed at the caregiver community, VAC personnel and the academic community, although two smaller stations have received briefings.

89 Recently members from an OTSSC, OSISS and a local chain of command spoke to approximately 150 medical personnel at a conference on military stress at a Saint John, New Brunswick hospital. From independent accounts, this session was very successful, not only in raising awareness about OSIs, but in generally increasing the civilian community's awareness of the extreme workloads of military members. These are welcome developments.

Conclusion

90 We found no evidence that the CF has initiated a program whereby all units receive outreach training about PTSD via the OTSSCs. We had hoped to see significant improvement in the quantity of outreach training being delivered by OTSSCs, in particular to field units. This was not apparent to any great extent.

91 Training and outreach presentations appear to be delivered on a variable basis by OTSSCs based on response to specific requests. Field units in some areas do not appear to be requesting outreach training — this is of significant concern as it is quite possible that these units are the ones most in need of education.

92 There does not appear to have been any attempt to co-ordinate the provision of training and outreach CF-wide through the different commands. The onus should not be on only the OTSSCs to deliver training. In my view, there is an equal responsibility for field units to request training, which does not appear to be happening in some areas and for the CF commands to co-ordinate efforts to ensure that the training is delivered equally to all units.

Recommendation 6

93 OTSSCs be funded to a level that ensures they have sufficient resources to deliver quality outreach training to units on request.

CF response

94 This recommendation is supported and has been addressed in full to meet current CF-wide requirements. Sufficient resources are available to ensure the OTSSCs can proactively deliver outreach training in accordance with the guideline established during the Nov 01 meeting of the OTSSC Directors, as well as to react to requests for additional sessions on demand from units. Should increased demands for outreach training be received the resource requirements will be identified and funded using the existing business plan process.

Analysis

95 Senior DGHS staff told us that OTSSCs are being given more resources. The current budget for all five OTSSCs is $2.4 million. The issue of how much of these resources are being directed to outreach and training however has not been adequately addressed.

96 My investigators did not find evidence that sufficient resources are in fact being used by OTSSCs to deliver quality outreach training in all cases. For example, one OTSSC, with an operating budget of over $846,000, allocated a total of $35,000 to provide outreach training to a population of over 10,000 CF members spread across 11 bases in four provinces and two territories. As a senior staff member pointed out "You can't do a lot with $35,000." The manager of another OTSSC estimated that six to seven percent of the approximately $400,000 OTSSC budget is spent on outreach activities.

97 In the OTSSCs we visited, there was no evidence of additional hiring to deal specifically with outreach issues, although there has been some increased outreach activity over the last nine months in at least one OTSSC. At one OTSSC, two experienced clinical social workers, fully trained and knowledgeable of the military, had been identified and were willing to work on an outreach initiative but

administrative hurdles in the hiring process prevented this from happening.

98 To be fair, lack of OTSSC outreach activity is partly because some areas have had little or no demand from units for outreach training. That, combined with heavy workloads and organizational change within the OTSSCs, has created other priorities. As one OTSSC staff member stated, "We need to go to the units. We need to educate. But everything has been so crazy 'round here that we haven't had the time to focus on it."

99 Everyone we spoke to agreed that OTSSCs should be funded to conduct as much outreach training as possible. In some areas, units are not requesting training although it is in everyone's best interest.

Conclusion

100 Virtually everybody agrees that outreach training by OTSSCs to units is a good thing. Currently, outreach training is being done *ad hoc* and is suffering in some locations from being forced to compete with other priorities. The CF should dedicate sufficient funding and personnel as quickly as possible to ensure the OTSSCs can deliver the requisite training, regardless of other priorities.

Recommendation 7

101 Specific and detailed education and training objectives dealing with PTSD be included in the curricula of all Canadian Forces educational and training establishments, and that the performance measurement criteria for these organizations reflect these objectives.

CF response

102 This recommendation is fully supported and will be implemented in the near term. The CF-wide requirement for PTSD education and training will be established by 15 Aug 02 in accordance with the CF Individual Training and Education System standards to determine what skills and/or knowledge are essential, who needs them, when they need them and how they will be imparted.

Analysis

103 Shortly after the release of my report on the systemic treatment of CF members with PTSD, DTEP undertook several initiatives to respond to the recommendations about training and education. DTEP conducted an extensive review of all training and education provided by the CF related to OSIs. An OSI Training and Education Working Group comprising stakeholders from the CF health care and education community, environmental commands and members of OSISS, was created and held its first meeting on 6 May 2002.

104 The DTEP review was completed in September 2002 and made 25 recommendations. Among the key recommendations were that the CF ensures training specifications "appropriately identify the requirement for OSI skills and knowledge" and that training plans and qualification standards include "consistent and progressive" training and education about OSIs throughout the training cycle. The review also emphasized the importance of COs in particular, and leaders in general, being given appropriate OSI training. It identified gaps in the current system, noting that current training for both officers and NCMs does not provide the "practical tools" necessary to deal with OSI issues.

105 The DTEP review made recommendations regarding deployment-related OSIs. These included: that Land Force Areas consider one another's best practices, and that the CF involve experienced veterans in delivery of training and education to leaders, use mental health resources in theatre, and focus on education during the reintegration process.

106 The implementation of the recommendations was discussed by the OSI Steering Committee at its second meeting on 1 October 2002. I understand that the recommendations were accepted in principle and that plans will be drawn up to implement them. As part of this process, the OSI Steering Committee reconvened the OSI Training and Education Working Group.

Conclusion

107 The DTEP review is a comprehensive and constructive outline and analysis of the current state of education and training about OSIs in the CF. It acknowledges that the weaknesses identified by the first report are accurate and need to be tackled. It advocates steps that, if implemented by the CF, will likely go a long way to fulfilling the objectives of my recommendations relating to education and training, including this one. The key indicator as to how seriously the CF is prepared to come to grips with these issues will be the amount of resources given to implement the DTEP review recommendations.

Recommendation 8

108 Canadian Forces units be mandated to provide ongoing continuation training about PTSD to all members at regular intervals, in addition to any deployment-related training.

CF response

109 This recommendation is fully supported and will be implemented in the near term. The CF-wide requirement for PTSD education and training will be established by 15 Aug 02 in accordance with the CF Individual Training and Education System standards to determine what skills and/or knowledge are essential, who needs them, when they need them and how they will be imparted.

Analysis

110 Ongoing training is the key to culture change. The DTEP review recommended "unit annual refresher training and professional development be used as a vehicle for educating personnel about OSIs." I understand that ADM (HR-Mil) has recently authorized such training be rolled out CF-wide. The initial strategy will be for the training to be delivered as a part of the first aid training process, followed by OSI training components on professional development courses. The process will likely take two years to be fully implemented.

111 The DTEP review and recommendations are particularly welcome, given that in the areas my investigators visited, they found little overall improvement in the quantity of continuation training given to field units since the release of my original report. For example, very few of the units we contacted had organized any recent training about OSIs. An OTSSC reported that they had been "underwhelmed by the demand" for outreach training by units. A representative sampling of naval units, including Maritime Coastal Defence Vessels, indicated that no direction had been received to include OSI or stress training in any continuation training. A few units have, however, included OSI and stress awareness training in their professional development days on their own initiative. The local OTSSC has made OSI presentations at several of these training sessions.

112 Where unit training has been held, such as recently within the Administration Branch at North Bay, the feedback has been largely positive. In another situation, one member told us that the CF should "use a model analogous to ones leaders already understand: the same way we check for frost bite and trench foot or immersion foot — this is just a deadly as any bullet." A medical professional indicated that continuation training about OSIs would help reduce the stigma and maltreatment of members suffering from OSIs. A senior naval officer commented, "We need to train our NCOs and officers to recognize stress in their people as easy as they have been taught to deal with alcohol abuse."

113 The responsibility for continuation and deployment-related training belongs primarily to the organization or unit that operationally prepares and equips a force for deployment (force generator). In many cases, at the unit level they simply cannot find the time to include OSI education as part of their training programs, though paradoxically many acknowledged the importance of such education. A senior officer told us "We know we should be doing this but we don't have the time or the money."

114 Another senior officer stated that, "continuation training is cutting into my time." Regardless of the level of support, the lack of time to increase training of any kind was an issue raised by many personnel in the field.

Conclusion

115 The response to this recommendation by field units has been disappointing, though I am encouraged by the commitment of the chain of command to the findings of the DTEP review. Adding an OSI component to first aid training is an excellent initiative. It will take firm direction to units to ensure that there is a satisfactory level of continuation training across the CF.

116 I realize it is difficult to find time and resources to allocate to training when financial and human resources are admittedly tight. When tough decisions on how to spend increasingly tight budgets have to be made, it is easy to cut plans for professional development programs and training sessions that may not be viewed as directly related to operational capabilities. The preventive aspect of continuation training on OSIs needs to be officially recognized. One of the goals of continuation training on OSIs is to ensure that troops remain sensitive to the issue. It is hoped this will contribute to reducing the stigma associated with

OSIs and that in the long term, the degree and incidence of acute OSIs may be reduced. Considerable benefits will accrue in the area of reduced health care costs and increased retention of valuable trained and experienced members.

Recommendation 9

117 The Canadian Forces make PTSD a mandatory part of education and training at all ranks and that educating Canadian Forces members about PTSD be made a priority.

CF response

118 This recommendation is fully supported and will be implemented in the near term. The CF-wide requirement for PTSD education and training will be established by 15 Aug 02 in accordance with the CF Individual Training and Education System standards to determine what skills and/or knowledge are essential, who needs them, when they need them and how they will be imparted.

Analysis

119 The DTEP review outlines a strategy for improvement in educating members about OSIs, with a focus on OSI education as an integral part of all levels of leadership training. The review agrees with my finding that educating leaders is one of the first steps to changing CF culture to one that, as DTEP notes, "is more accepting of the legitimacy of OSIs and in which leaders feel empowered to help subordinates maintain their mental health."

120 The review also confirms that recruits and officer candidates also require grounding in OSIs, in particular in stress management techniques and how to recognize the signs and symptoms of OSI in oneself and others. If implemented in full, the DTEP strategy would amount to a comprehensive plan for all members of all ranks to receive education and training about OSIs throughout their careers.

Conclusion

121 Early introduction of training and education on OSIs remains the most effective way of inducing culture change in this area. Much work remains to be done to ensure this is effectively implemented. It is therefore encouraging that as recently as the OSI Steering Committee meeting on 1 October 2002, the CF has taken the

decision to roll out OSI training as part of the first aid training package given to all members.

122 The CF has taken the first step to revamp its approach to OSI education and training through the creation of the OSI Training and Education Working Group and the implementation of the recommendations of the DTEP review. Once again, the success of these initiatives will largely depend on the resources assigned and a continued commitment at the command levels to ensure success of new programs and initiatives.

Recommendation 10

123 The Office of the PTSD co-ordinator play a central role in the education and training process by acting as a resource and advisor for bases, formations and commands.

CF response

124 This recommendation is fully supported. The CF recognizes the need for co-ordination of all aspects affecting the successful treatment of PTSD (i.e., education, training, physical and mental health care, spiritual well-being, compensation and benefits, etc). All of these issues fall within the ADM (HR-Mil) responsibilities. (See Recommendation 31)

Analysis

125 The rationale behind this recommendation was that training and education is a CF-wide issue that requires co-ordination between environmental commands, the Deputy Chief of the Defence Staff (DCDS), the CF health care system, and the CF education and training system, among others. The CF created the OSI Training and Education Working Group to assist in the DTEP review process. The working group had 25 members from 16 different organizations, including DGHS, the Chiefs of Land, Air and Maritime staffs, Director General Military Human Resources Policy and Planning (DGMHRPP), DCSA and the Military Police. The scope of the different interests and responsibilities represented demonstrates a clear need for a mechanism to ensure effective co-ordination between stakeholders. A smaller advisory group was also created. The DTEP review noted that although significant progress was being made, particularly in relation to deployment-related OSI training, there appeared to be, "a lack of […] co-ordination between the many different efforts across the CF to educate personnel about OSI."

126 The creation of the positions Special Advisor to the CDS for OSI and the Assistant Special Advisor to the CDS for OSI is a positive move from the training and education perspective. However, the magnitude of the work is such that it will be very difficult to effectively perform this function as a part-time task. In this case, the primary responsibility of the Special Advisor to the CDS for OSI

as DTEP is a positive combination of duties, as training and education are so central to the eventual culture change that is necessary. At this point in time, the creation of the OSI Steering Committee is also seen as a positive step, providing the Special Advisor to the CDS for OSI with a forum to communicate issues.

127 We were unable to detect any evidence that co-ordination from the national level has an influence in the field at this time. Indeed, the majority of personnel in the field we asked who were in a position to be affected by the Special Advisor to the CDS for OSI were not yet aware of the appointment.

128 We did get frequent observations during the interviews in the field about issues that could fall under the purview of a central co-ordinator of education and training efforts. For example, one deployment co-ordinator at an MFRC recently involved with a deployment/redeployment cycle told my investigators: "There are no clear lines of responsibility to ensure various organizations work together." While not describing education directly, a Service Income Security Insurance Plan representative brought up a common theme while commenting on the current level of co-ordination and how it affects the troops: "There is no one person who is pulling things together."

Conclusion

129 Co-ordination of activities in this area is a tremendous task. Dealing with OSIs medically and operationally, tying together the education and training initiatives and interfacing with operational chains and bureaucracies are a daunting task. The DTEP review recommended that the OSI Training and Education Working Group continue, with a mandate to "ensure the development and co-ordination of effective and evidence-based OSI training and education programs and act as the central point through which all OSI-related training and education proposals would be evaluated." The review also noted that these meetings should be held "regularly" and that participants "should be empowered to make decisions on behalf of their agencies." I fully support that recommendation and analysis.

130 I recognize that the co-ordination process is in its infancy, and I look forward to seeing the Special Advisor to the CDS for OSI (who would also chair OSI Training and Education Working Group in her capacity as DTEP) play a central and significant role in implementing the DTEP recommendations. This issue is discussed further in my response to Recommendation 31.

Recommendation 11

131 The Canadian Forces include members or former members who have experience of PTSD in all education and training initiatives relating to PTSD.

CF response

132 This recommendation is fully supported. The CF-wide requirement for PTSD education and training (as identified in recommendations 7, 8 and 9) will be completed by 15 Aug 02. An outcome of this activity will be recommended delivery methods and they will incorporate the inclusion, where appropriate, of members or former members who have experience of PTSD in all education and training initiatives relating to PTSD. DND will work in collaboration with VAC to establish joint procedures to address this issue.

Analysis

133 It became apparent during the course of the original investigation that one of the most credible and effective ways of delivering OSI training was by using CF members and former members who had direct experience both in operations and of OSIs. I felt it was important these members had input into the creation of education and training initiatives from the ground up. I note that OSISS is represented on the OSI Training and Education Working Group by its project manager, Major (Maj) Stéphane Grenier.

134 There is consensus across the CF that having education and training initiatives involve members who have experienced OSIs can have a very positive effect in breaking down some of the misconceptions about stress injuries. The DTEP review reached a similar conclusion, noting that multidisciplinary teams including veterans should deliver training. The review noted that "the perspective of veterans who experienced OSI can be particularly valuable for COs." An artillery group provided us another example of the value of having someone with experience with this injury. The unit did not really believe in PTSD until "one of theirs" was invited to come and speak to them during a predeployment exercise about his own experience. On two other occasions, one of

my investigators was present when a combined team of medical personnel and members diagnosed with PTSD briefed groups of CF members. The effect was impressive. This is a powerful addition to the education and training arsenal, and should be exploited to the fullest.

135 The only serious concern we heard expressed was an apprehension that a member who is suffering from an OSI might overextend himself or herself in trying to help, and could suffer a setback. In the opinion of one psychiatrist, someone suffering from PTSD, even if treated, is still vulnerable to developing secondary traumatization and should not be involved in trauma work. It is hoped this risk can be minimized by close and careful monitoring of peer trainers and support providers, such as that being provided to participants in the current OSISS project.

136 The OSISS project is key in implementing this recommendation. The four OSISS peer co-ordinators, who are all current or former CF members with operational experience and who themselves have direct experience of PTSD, have each completed an average of 12 outreach activities since OSISS became operational in March 2002. OSISS staff have presented to a broad range of groups, including COs, senior NCMs, VAC staff and health care professionals. My investigative team has witnessed the success OSISS peer co-ordinators have had in educating CF members. Feedback from target audiences has been extremely positive, even from those who were sceptical about the legitimacy and extent of OSIs.

137 OSISS is committed to developing its outreach and training activities, and intends to create a database of current and former members who have experience with OSIs and who are willing and able to present to CF members and others about their experiences. They will not be peer co-ordinators, but will assist in training and education programs on an as-needed basis. OSISS plans to develop a standard presentation/briefing package that can be adapted to include each speaker's own experiences.

Conclusion

138 I believe having OSISS staff contribute as key stakeholders in the development of education and training initiatives is essential. I am pleased the CF has included them in the process to date, and I look forward to OSISS playing a central role in the development of education and training policy and procedures.

139 The visibility of Lieutenant-General (LGen) (retired) Roméo Dallaire's experience has encouraged a dialogue and improvement in the level of understanding of OSIs, and the release of my first report has allowed and encouraged people to talk more openly about this issue. However, the CF still is far from attaining the goal of accepting OSIs as just another serious injury. Effective education and training is the key to changing the culture that breeds suspicion of and, occasionally, open hostility toward OSIs. The need to continue to educate members remains and will require both resources and persistence. It is clear that the involvement of current or former members who have experience with OSIs is a very effective approach.

Recommendation 12

140 Multidisciplinary teams that include all of the professional specialties with an interest in PTSD diagnosis and treatment, including experienced soldiers, be used to deliver outreach training. To enhance training effectiveness and ensure standardization, such training should fall under the control of the Office of the PTSD co-ordinator.

CF response

141 A review will be conducted by 30 Jun 02 to confirm that all OTSSCs are delivering multidisciplinary team outreach training based on a standardized program and that, wherever possible, experienced service members are used in its provision.

142 Note: See Recommendations 10 and 31 "Action" *vide* 'Office of the PTSD co-ordinator'.

Analysis

143 As discussed to some extent in my analysis of the previous recommendation, it is clear that the most effective approach to OSI training for CF members will include experienced military members as part of the multidisciplinary team. One psychiatrist, although he did not support the involvement of PTSD sufferers in trauma work, did recognize that personnel with operational stress experience would have more credibility. The attitude of many members is summed up well in the words of one senior NCM,

144 This training must be meaningful to the people receiving it and the trainers must be able to equate to real life experiences. It has to be "when I was there" rather than "when I was in school." NCOs [non-commissioned officers] teaching NCOs. Officers teaching officers.

145 My investigators met with staff at several OTSSCs and spoke at length with the project manager of OSISS. Staff at both organizations stated that they are beginning to build good working relationships with each other. There was general, though not universal, agreement that it was a good idea for them to work

together to deliver outreach training and education. That is not yet happening to any great degree. As mentioned above, this may be partly due to a lack of dedicated OTSSC resources to fund outreach combined with, in many cases, heavy workloads. In addition, OSISS is still concentrating on its primary task, which is to provide co-ordination of services to members who require assistance.

146 However, as noted in the analysis of the previous recommendation, OSISS is planning to broaden its outreach activity considerably. Recently, there have been instances of an OTSSC, OSISS and a local commander delivering training on the same platform. For example, members of an OTSSC and OSISS recently spoke at a conference on military stress at a Saint John, New Brunswick hospital. This is a welcome development. Feedback was very positive, particularly with respect to the OSISS member, whose presentation affected many deeply. One audience member told my investigators that she found the "real life, first-hand experiences" of the OSISS presenter the most effective way of teaching what OSIs were really about.

147 The DTEP review also examined whether the CF should employ multidisciplinary teams to deliver education about OSIs. The reviewer reached much the same conclusion as we did, recommending that the CF

148 > use multidisciplinary teams composed of representatives of the chain of command, Health Care providers and/or veterans to deliver OSI-related training and education as appropriate for each target population. Include experiential perspective of veterans who have experienced OSIs when training and educating COs.

Conclusion

149 Clearly, outreach by multidisciplinary teams has the best chance of reaching target audiences. There is clear evidence that OTSSC staff working with other qualified personnel, in particular OSISS staff, is a very effective method to educate CF members about the realities of OSIs and to dispel some of the myths that have developed around the issue. The key component is the credibility with CF members that veterans who have experience with OSIs bring to the education and training process. I applaud and encourage the efforts of OSISS to expand its outreach activities.

150 As I have noted elsewhere, what remains to be achieved is effective co-ordination through operational commands to ensure training is available on a continuing basis to all field units across Canada, as opposed to being provided as requested.

Recommendation 13

151 The Canadian Forces allot additional resources to accelerate the implementation of the proposed mental health education initiatives developed by the Rx 2000 Mental Health Team.

CF response

152 This recommendation is fully supported and has already been addressed in full. A commitment was made to provide the OTSSCs with the additional resources they require. OTSSC staff are currently analysing their requirements.

153 ADM (HR-Mil) provided additional funding to the DGHS to support the OTSSCs through a re-profiling of QOL [Quality of Life] funds deemed surplus by VAC. This money is managed by DCOS Health Services Delivery and is being made available to enhance the programs and services provided through the OTSSCs.

Analysis

154 This recommendation was designed to encourage the CF to follow up on commitments it made in the Rx 2000 package to "develop mental health education packages and initiate lay educational packages, with a focus on leadership issues." The project manager for Rx 2000 was a member of the OSI Training and Education Working Group and contributed to recommendations of the DTEP review in that capacity. Accordingly, the Rx 2000 goals will likely be incorporated into the CF-wide training and education strategy detailed in the DTEP review recommendations, which envisage the CF health services community playing an important role in the delivery of education and training about OSIs.

155 The additional funding referred to in the CF response, which totals approximately $400,000 for service enhancement, is certainly a positive development and an indication of the senior leadership's commitment to seeing improvements in education on mental health issues and OSIs.

Conclusion

156 The mental health education and training component of Rx 2000 is being dealt with as part of broader initiatives outlined in the DTEP review. I am hopeful the CF health services community will be provided with the resources it requires to deliver OSI training and education as envisaged by the DTEP review.

Recommendation 14

157 The Canadian Forces develop a standardized screening process that involves all of the pertinent specialists and that is under the control of a single point of contact.

CF response

158 This recommendation is fully supported and its implementation is already under way. Screening of members for deployment/redeployment will be further developed under the PERSTEMPO initiative to include policy guidance for screenings on all taskings.

159 A standardised screening form is already in place for all DCDS directed international operations. However, the manner in which screening is conducted is being reviewed. DQOL [Director Quality of Life] will be hosting a best practice exchange on screening and reintegration in January 2003 with the plan to complete the review by Spring 2003. The results will be used to set a consistent process for all screenings.

Analysis

160 This recommendation was made as a result of the varied and haphazard approach to screening of troops for deployments that my investigators found during their original investigation. The problem was particularly acute for Reservists and augmentees.

161 The senior CF Social Worker is currently working on the screening process, assembling the screening concerns and options to solve them. Draft guidelines on the screening process have been developed and will be discussed at the best practices exchange meeting in January 2003 referred to in the CF response above. A core committee and a working group have been formed to deal with screening issues. The core committee consists of 10 senior officers, including senior Director General Health Services (DGHS) staff, as well as representatives from ADM (HR-Mil) and the three environments (Army, Navy and Air Force).

162 The PERSTEMPO Working Group, according to Director Quality of Life (DQOL), consists of 20 to 25 members, ranging in rank from

Captain to Lieutenant-Colonel, who represent a broad range of CF interests. They work on the issues brought forward by the core committee. Both the core committee and the working group meet once a month separately. The core committee and working group decided to implement a 'best practices forum' or 'lessons learned' initiative. They intend to examine OP APOLLO and OP PALLADIUM experiences. Planning is under way to bring everyone to Ottawa for a three-day workshop in January 2003. The committee is collecting information from the Army, Navy and Air Force. They intend to consult with a broad range of stakeholders, including planners, operators, family members, health care providers, policy and process representatives, and deployment co-ordinators.

163 I am pleased to hear of these developments since my investigators found little had changed in the field in predeployment suitability screening. We were told that often the period before a deployment was so intense, with other preparations for the deployment, final operational training or other operational commitments, that the proper amount of time was not available for the Departure Assistance Group (DAG) process. (DAG is a group that assists in the deployment process, including screening of members about to be deployed.) In the words of one senior NCM, "normally personnel are so busy trying to get ready to sail, they are not really taking the questions seriously. They just want to get it over with so they can get on with their work." We also found little evidence that MFRCs are consistently part of the screening process. Their direct involvement and access to the families could be used to the benefit of the members and the CF.

164 A mental health professional described the current screening process as brief, unfocused and unscientific. He stated that he considered screening as a "rubber stamp." His views were widely shared by a broad range of individuals with first-hand knowledge.

165 With respect to the Army Reserves, my investigators found little evidence at any level of efforts to co-ordinate the prescreening assessments of Reserve members. We were told that the co-ordination of, and in fact the whole prescreening process for the Reserves is at best haphazard. In most cases the short notice of impending deployment results in the whole process being rushed, thus making it of even less value than the method used for the Regular Force. As a result, the problems identified for the Regular Force are further compounded for the Army Reserve. One Reserve Padre concluded, "DAGs are rushed in many cases, due to the lack of time."

Conclusion

166 I congratulate the CF for the PERSTEMPO and DQOL initiatives and look forward to the results of their examination of lessons learned and best practices as I see this as a constructive initiative that will involve the right people. I believe the results will provide valuable progress in creating a standardized screening process. It appears, however, that a lot of work is still required in the field to address the crucial lack of co-ordination and sharing of information, particularly for Reserve Forces.

Recommendation 15

167 The Canadian Forces set up a pilot project to determine the most effective ways of allowing members returning from deployment to be reintegrated into family and garrison life.

CF response

168 This recommendation is supported and will be examined in detail. Through the PERSTEMPO Working Group and the Human Dimensions of Deployment Study, the reintegration process is already being reviewed, however, the setting up of a pilot project will be investigated by 30 Jun 02.

169 Due to the variance in mission factors and the time delay in establishing new procedures following a pilot project, it was determined that a more efficient means of bringing together the most effective methods for reintegration, a best practice exchange will be held in the fall of 2002. This will be used in setting consistent policy and practice through all levels of the chain of command.

Analysis

170 During the original investigation, we noted that the rapid return of the deployed member to the family without a period of time to adjust gradually, for both the member and the family, frequently caused difficulties. We suggested consideration of various approaches to post-operational leave, including decompression and gradual reintegration to normal routine.

171 This recommendation requires strong involvement with and co-operation of the force generators and the DCDS. The recent deployment to Afghanistan is a perfect example of how the CF can implement this recommendation. Returning Battle Group members were sent to Guam and given between three and five days of rest and decompression time. Those days included information and training sessions on subjects such as family and work reintegration, anger management and suicide awareness. Personal time and cultural tours were also part of the program. On their return to home base on 28 and 30 July, the soldiers worked up to seven half

days and five full days until 17 August, when a period of block leave began. This work schedule was developed to allow members time to deal with issues related to the mission and permit gradual reintegration with their families. One comment from an MFRC employee was that the "staggered work week for the first two weeks is good. Even though they want to be with their families, they feel drawn back to the units."

172 "Everyone that came back that I spoke to said it was great," said a Regimental Sergeant-Major with intimate knowledge. It should be noted, however, that the time frame of this report and the leave block allocated to the troops did not allow my investigators to get direct feedback from the soldiers from the Battle Group or their families on their impressions on the decompression time in Guam and the gradual reintegration with work and family. We did interview caregivers who were in Guam, both as part of the contingent and as guest speakers. They thought the process was extremely valuable.

173 Ultimately, virtually everyone we spoke to said this was an excellent initiative that, in principle, should be repeated with each deployment. While it may be necessary to alter the scope and duration of the redeployment phase according to the circumstances of each mission, the concept is excellent.

174 I intend to consult with contingent members and leaders at an appropriate point to obtain their input and views on this matter. This should provide a greater understanding of the need and value of such initiatives in the CF.

Conclusion

175 I congratulate the CF on the initiative with the Afghanistan contingent. I understand that the chain of command of the unit deployed (3rd Battalion of the Princess Patricia's Canadian Light Infantry) advocated and executed the plan. The DCDS and his staff also deserve credit for their role in making this happen. This is a bold step that will probably pay significant dividends. I will be looking forward to the result of the best practice exchange mentioned in the CF response.

Recommendation 16

176 The Canadian Forces provide sufficient incremental resources to permit all mental health caregivers, including padres and social workers, to access training required to deal with mental health issues.

CF response

177 This recommendation is fully supported and has already been addressed in part. A plan is presently being formulated by DGHS staff for all mental health care professionals to allow not only training and continuing medical education (CME) to occur on a regular basis but also that clinical supervision on a "one on one" basis occurs for each mental health care provider. Based on the recently appointed treatment standardization committee's recommendations and evidence-based practice, each professional will be given the appropriate training and skills to deal with mental health issues including operational trauma and PTSD. A comprehensive needs analysis for each provider group will be conducted by 15 Aug 02. Chap Gen [Chaplain General] staff have advised that not all padres should be "advanced skills" qualified. Chaplains assigned to the OTSSCs are specialty qualified at a graduate level (e.g., MA in Pastoral Counselling). The Chaplain Branch provides a general counselling course for all chaplains and specific education on PTSD for newly enrolled chaplains.

178 CFPSA [Canadian Forces Personnel Support Agency] staff has advised their personnel involved with PTSD counselling at the MFRCs should be "factored in" to the implementation of this recommendation. DGHS will examine this issue by 30 Jun 02.

Analysis

179 The rationale supporting this recommendation was the concerns caregivers expressed that they were unable to keep up with ongoing research on PTSD and OSIs. These concerns were most often articulated by CF social workers, who often had a number of

other functions to fulfill along with their role in caring for CF members with OSIs.

180 My investigators found that the CF had taken several steps to improve the quality and quantity of education and training provided to CF mental health caregivers. A conference for CF social workers was held in September 2002 (which is discussed in detail in Recommendation 17) and had presentations from experts in PTSD. The conference was by and large a great success, according to individuals who were present.

181 The CF acknowledges, however, that much work remains to be done. According to a senior ADM (HR-Mil) officer "work is ongoing at the national level and amongst the various clinical groups to better define the skills required." Continuing education will be a topic at the meeting of OTSSC managers scheduled for early November 2002 and will be reviewed at a national mental health nurses working group meeting in late November. While discussions have been held by the various disciplines, there has not yet been a consensus reached regarding the continuing education and training required, nor has a report been produced.

182 At a number of bases, my investigators were told that there is a perceived training disparity developing among staff working for DND/CF on a contractual basis through Med Emerg International (a private service provider) and DND/CF employees. DND/CF currently has approximately 700 Med Emerg employees who provide a variety of health care services. In some OTSSCs, Med Emerg employees count for a majority of the treatment providers and caregivers.

183 Med Emerg employees are given 45 paid days off per year. This includes 11 statutory holidays, six sick days, with the remaining 28 days to be used as vacation time, bereavement leave and days off for professional education and training purposes.

184 I understand DND has discretion to fund Med Emerg employees to attend courses or conferences, and this is happening in some cases, albeit unofficially. However, in a town hall meeting held earlier this year in Edmonton, Med Emerg employees were told that "DND does not have the budget for (continuing medical education) allowances." The investigative team was told that in many instances, Med Emerg employees are funding their own professional development by taking time off out of the 45-day bank to attend continuing education and training courses that are directly relevant to the work they perform for DND/CF. These employees are also paying for expenses incurred, including travel,

accommodation and meal costs. A Med Emerg representative confirmed that no funding is provided to employees for continuation training. There is a perception in the field that a two-tier system is developing, with Med Emerg contract staff becoming second-class citizens when training and education opportunities arise.

Conclusion

185 Appropriate training and education for caregivers in the field of OSIs remains an important issue for the CF. It affects both the quality of care provided to CF members suffering from OSIs and the morale of the caregivers. Some significant improvements have been noted in the availability of training to DND/CF members and employees, but work remains to be done. The need to ensure appropriate training and education of third-party contract employees must be factored into the ongoing discussion within the DGHS organization.

Recommendation 17

186 The Canadian Forces provide sufficient incremental resources to permit the Canadian Forces social work branch to hold an annual retreat for all Canadian Forces social workers. PTSD should be a significant topic at the retreat.

CF response

187 This recommendation is fully supported. An annual social worker's retreat will be scheduled. The first will occur during the last half of 2002 and as recommended will have as its primary focus PTSD. In subsequent years these retreats will be scheduled to coincide with the CF Mental Health National Meeting and the CF Operational Medicine Conference.

Analysis

188 Mental health caregivers in the CF have a tremendous workload, and to maintain effectiveness and morale they must have regular access to peers. A Social Work Training session was held during the week of 22–25 September 2002. The four-day event in Mississauga hosted approximately 90 individuals from across Canada. There were two guest speakers: Dr. Anna Baranowski presented on "Compassion Fatigue" and Dr. Donald Meichenbaum of the University of Waterloo, a leader in the field of PTSD treatment, presented on "Assessment and Treatment of PTSD."

189 Social workers currently working in the OTSSCs were not invited to attend as, according to a senior CF official, their level of understanding of PTSD was considered to be higher than that being provided at the seminar. Some MFRC social workers were not invited to attend. A number of mental health nurses, chaplains, case managers and VAC representatives were invited to attend Dr. Meichenbaum's presentation.

190 My investigators spoke to a number of social workers that attended the event. Almost universally, they indicated the event was very useful and a necessary exercise, and that it should be done regularly. Most of the participants we spoke to were particularly impressed with the quality of Dr. Meichenbaum's presentation. Participants completed evaluations on the presentations, which

were very positive. However, the organizers did not request an evaluation from participants for the entire event.

191 While everyone we spoke to was very appreciative that the CF had committed the resources to hold the event, there was some concern that the week was more of a conference than a retreat. Some participants suggested the event could have been even more valuable had the participants had a greater opportunity to exchange ideas about the local and system-wide challenges they face as social workers in a military environment.

192 Lieutenant-Colonel (LCol) Matheson, the officer responsible for the CF social work branch, advised us that there will be annual workshops and "although they may be connected to other events, such as the Annual Health Meeting or with the Op Med (Operational Medicine) conference, there will be one day strictly related to social work issues."

Conclusion

193 The CF social work branch is to be congratulated on providing the resources to hold this event. The feedback from participants was, in the main, very positive. I believe it would be of value to invite all social workers that work full time for the CF, including those on OTSSC and MFRC staff, to participate in this event in future. The value of the event was obvious and has been a morale booster for the social workers. Furthermore, the participants we spoke to felt that by having the event, the CF acknowledged that it valued the important work that social workers do. I strongly recommend a social workers' conference be held annually and independently of other conferences.

Recommendation 18

194 The rules regarding Occupational Transfer be changed to quickly accommodate members diagnosed with PTSD who would benefit therapeutically from working in another military occupation.

CF response

195 This recommendation is fully supported. The current rules fully allow the accommodation of a service member who could benefit from a Compulsory OT when he/she is able to meet the medical requirements of the other occupation. The current procedures include (in sequence): member recommended by a treating MO [Medical Officer] or a Specialist for a transfer out of MOC [Military Occupation Code]; case submitted to D Med Pol [Director Medical Policy] for approval; to DMCARM [Director Military Careers Administration and Resource Management] 3-3 for processing. The limitation on duty has to be specific and must not breach the CF Generic Task Standards. DMCARM 3-3 processing includes:

196 • obtain a PSO [Personnel Selection Officer] report listing the MOCs for which the member is suitable

197 • obtain new MOC training vacancies and course schedules from CFRETS [Canadian Forces Recruiting Education and Training System]

198 • match the member's MOC wishes with vacancies

199 • make an MOC offer to the member through the CO

200 Upon acceptance of the new MOC, a member is either sent on training or waits for training at current unit. (The waiting period is dependent on the scheduling of MOC training courses.)

201 An examination of how the Compulsory OT [Occupational Transfer] regulations/procedures could

be implemented in a more expeditious manner will be conducted by 30 Jun 02.

Analysis

202 This recommendation was made in response to the many complaints my investigators heard during the original investigation about the bureaucratic impediments to occupational transfers. Indeed, Cpl McEachern's own doctor had unsuccessfully tried to have him transferred to an occupation where he felt Cpl McEachern could have performed well. It seemed well trained and experienced military members were being forced to take a release when they were capable of continued service in another occupation.

203 We continued to receive complaints from members, medical professionals and the chain of command about the occupational transfer process as we prepared this report. The overall perception in the field is that the CF continues to waste qualified and competent members because of a bureaucratic requirement to achieve a medical category in the member's original Military Occupation Code (MOC) before being able to voluntarily transfer occupations. In one location, a retired Master Warrant Officer who was running an SPHL platoon had found a way to coerce the system into allowing voluntary occupational transfers (VOT) for three previous PTSD patients who had been on the SPHL. At another base, a soldier was not so fortunate. He had been identified as a top performer in his infantry unit, but suffered an OSI after return from his last deployment. He had been on three operational tours, including Croatia in 1993. He had managed to obtain employment as a supply technician in his unit and eventually on the base. In his own words, "Perhaps I can't be deployed any more but I sure can be employed." He had attempted a voluntary occupational transfer, with the assistance of the medical chain, but it had been denied.

204 It is clear that there is still a very serious problem with VOTs for members that have been diagnosed with an OSI. ADM (HR-Mil) staff told us that the VOT process is very different from the compulsory occupational transfer (COT) process. If a member is transferred by means of a medical COT, there are certain benefits, such as rates of pay and other protections available, that are not provided if the person voluntarily asks to be transferred. In the voluntary case, other issues such as availability of positions and the strength of the original MOC are factors that might inhibit

transfers. It is not even the same part of the organization that deals with VOTs. If the COT route is in fact the preferred methodology for those suffering from an OSI that results in a reduced medical category, a great deal of education needs to be done to make members, medical personnel and the chain of command aware of and familiar with the process.

205 In addition to the bureaucratic confusion between VOT and COT, there is a problem with attitudes in some areas that create obstacles. For example, one medical officer responsible to advise members of their options once a medical limitation becomes permanent told us, "these guys that are not making an effort: down the road, even if they are OT'd, they're going to be failures in a new trade." An infantry Major expressed a much more enlightened view, "What's the problem with having someone do another job somewhere else. Let it be. If it makes him happy and can bring him back, let him be."

206 OTs were discussed at the OSI Steering Committee meeting on 1 October 2002. The minutes noted that OTs "as they apply to members with OSI, appear to be misunderstood." The OSI Steering Committee tasked itself with developing "communication strategies to get the message out" in a simple understandable manner.

Conclusion

207 The entire topic of occupational transfer remains a very confusing and frustrating one. I applaud the OSI Steering Committee initiative as a good first step and I hope that it will bear fruit. The CF continues to lose valuable and trained members as a result of rigid and complicated rules surrounding the ability of members suffering from OSIs to transfer to less demanding occupations, where they can still contribute to the organization. The concept of the throwaway soldier still prevails in some areas, largely as a result of a far too complicated OT process as opposed to a lack of opportunities for injured members or a lack of willingness on the part of many in the field to facilitate occupational changes. This is of particular concern in light of recent reports that the CF continues to experience major problems in recruiting and retaining trained personnel. More work must be done to ensure that OSI personnel who meet occupational standards of less demanding occupations can access these occupations through a simplified and expedient transfer process.

Recommendation 19

208 The Canadian Forces audit and assess the effectiveness of policies and procedures designed to assist Reserve Force members and augmentees pre- and post-deployment.

CF response

209 This recommendation is supported in full. DGMHRPP staff will audit relevant policies and procedures related to the situation described in paragraphs 846 to 861 of the Ombudsman's report and, using their usual validation and verification procedures, advise COS (HR-Mil) [Chief of Staff (Human Resources — Military)] by 01 Sep 02 if these processes are effective for all augmentees, both Regular and Reserve Force.

Analysis

210 This recommendation was made to ensure that Reserve personnel deployed with Regular Force units are screened with the same thoroughness as their Regular Force counterparts prior to deployment and, even more important, when they return to their home unit. Since Reservists often do not have access to the same level of care available to Regular Force members once they return home, it is even more crucial they receive proper support and follow-up.

211 The policies and procedures identified for review by the DND/CF were in place before the publication of my first report. Based on the latest interviews conducted by my investigators, they are either ineffective or not being applied consistently. The three major concerns were pre- and post-deployment assessments, medical and professional treatment of Reserve members, and resource deficiencies.

212 During the month of August 2002, DGMHRPP prepared a 'Reply to recommendation 19' in a briefing note to the Chief of Staff, (HR-Mil) that made six recommendations. These were:

213 that "consideration be given to abandoning the practice of having Reservists compete during the

predeployment training phase for positions in a deploying Regular Force unit,"

214 that "education and training programs on PTSD and operational stress be expanded and made mandatory for all unit CO's and key members of the unit chain of command,"

215 that "greater flexibility in extending Class C service be practised as a means of assisting Reserve members in post-deployment screening, follow-up and treatment,"

216 that "CFHS [CF Health Services] policies and procedures be confirmed and disseminated more effectively for the treatment of Class A Reservists with injuries or illness resulting from serving on operations and for the payment of such treatment,"

217 that "adequate resources be made available for the payment of other expenses related to the treatment of Class A reservists for injuries sustained on operations" and finally

218 that "the establishment of a Service Personnel Holding List (SPHL) for Reservists be considered to facilitate their access to CF medical care, to ensure their needs are being properly followed up and to monitor their individual situation more effectively."

219 This issue was also brought forward at the OSI Steering Committee meeting held on 1 October 2002 and it was directed by the Chair that this matter be further investigated within the broader context of treatment and accommodation.

220 According to Reserve personnel, padres, health care professionals, families and Regular support staff, both the pre- and post-deployment assessments of Reservists are ineffective and in many instances, meaningless. In the case of predeployment assessments, although all the required 'checks in the box' are being done, they question the validity of these results due to the time restraints under which many are completed. In many cases the short notice of an impending deployment require these screenings to be completed quickly, with little time for any in-depth analysis of the results.

221 Family members and MFRC staff also mentioned the lack of information being given to deploying personnel. It was apparent

that some Reserve units' chain of command were not consistently supporting the MFRCs. We were told of situations where MFRC staff has not been supplied nominal rolls (as required by policy), space or even time to access members on training nights. As a result, both members and families were unaware of the MFRC resources available to them prior to, during and after a member's deployment.

222 The post-deployment screening was described as even more haphazard. Although Reserve members complete the same post-deployment process as the Regular Force, there is no follow-up on those assessments, either by the unit they deployed with or by their home unit. A Regular Force Reserve Support Staff stated "Militia Members who deployed with my unit got the same assessment as we did when we got off the plane in Canada, but unlike us, they were on a plane shortly after on their way home. I now know there is no follow up once they do get home." Back in their home units after post-deployment leave, they revert to Class "A" Reserve service, without the medical benefits and help Regular Force members can readily access.

223 If a Reservist requires medical attention as a result of a deployment or on the few occasions where a posting to SPHL is authorized, the money to do this is taken from the unit's discretionary fund, which is normally used to pay salaries. We heard from one CO that the money allocated to Reservists is so limited that the "discretionary fund will be depleted with one guy on SPHL for 6–8 months, taking off the floor five or ten guys for summer training."

224 On the Naval Reserve side, one Naval Formation has undertaken an initiative to properly DAG any of the vessels operated by Naval Reservists prior to their sailing for a major deployment. The issue of the assessment and tracking of Naval Reserves once they return to their home Naval Reserve Division (NRD) is the same as that of the Army Reserve. There is no follow-up to determine if they are suffering from any form of OSI. As one Senior Naval Reserve Officer stated, "we need some type of questionnaire put in place for when these people return to their Naval Reserve Divisions (NRDs) to help assess their mental state."

Conclusion

225 Reservists and augmentees are being treated differently from the core members of units that deploy. It is important to note that during Rotation 9 deployment to Bosnia, approximately 20 percent of the deployed forces consisted of Reservists. Even in this case, we

found no evidence that the issue of post-deployment care for Reservists is being taken as seriously as we hoped. The policies and procedures currently in place for assisting Reserve Force members prior to and on completion of major deployments appear to be non-effective. Earlier disregard for the welfare of Reservists has yet to be rectified — in the words of one senior Reserve officer, this has left us with a growing "legacy issue (with Reserves) where they're lost in the system."

226 It is encouraging to see a briefing note to the Chief of Staff ADM (HR-Mil) addressing this issue was put forward in August 2002 with recommendations addressing some of the shortcomings, but much remains to be done.

Recommendation 20

227 The Canadian Forces review policies and procedures with a view to making them as flexible as possible to accommodate the needs of members who have been diagnosed with PTSD and wish to remain with their units for as long as is possible.

CF response

228 This recommendation is fully supported. As stated in CANFORGEN [Canadian Forces General Message] 100/00, 161430Z AUG 00, ADM (HR-Mil), SERVICE PERSONNEL HOLDING LIST (SPHL) the member's chain of command is in all cases closely involved with the medical authorities to determine what is best for the member. A review of policies and procedures related to accommodating the needs of members with PTSD will take place by 01 Sep 02.

229 A review of policies and procedures related to accommodating the needs of members with PTSD was done and it has been found that current policies and procedures for accommodation, to which the Ombudsman draws attention, are effective and sufficiently flexible. Nevertheless, the process of accommodating members diagnosed with PTSD could possibly be improved by: a. developing policy and procedures for making the SPHL, or something similar, available to Reservists; and b. the introduction of an integrated return-to-work program. ADM (HR-Mil) has already begun to examine the feasibility of a return-to-work program for the CF. It is recommended that the CF continue its study of an integrated return-to-work program for its members and consider expanding the SPHL policy to include Reservists.

Analysis

230 This recommendation aimed at giving unit COs a more flexible policy regarding placing CF members with OSIs on the SPHL. It was suggested that providing COs with sufficient resources to look after their injured within the unit would be an improved approach.

231 My investigators found some instances where the approach to accommodation of injured members within the unit is taking place. Not surprisingly, accommodation efforts are having a positive effect for members. Unfortunately, the shortage of personnel in almost every location is making this very hard to do consistently. One operational unit we visited had retained as many injured members as physically possible but had reached the point where other injured personnel had to be moved to the base SPHL. As described by one spouse, "Trying to keep them in the unit is great but if he didn't fit into parade time, the unit couldn't do it."

Conclusion

232 The CF has put considerable effort in identifying and reviewing the policies currently in place and in recommending solutions to address the issues identified in the original report. These efforts have faced considerable challenges because of currently tight resources. Despite this, some progress has been made; the return to work program for example is an excellent initiative and deserves continued support.

Recommendation 21

233 The Canadian Forces review procedures for placing members on the SPHL to ensure a greater role for input from Medical Officers and Commanding Officers.

CF response

234 This recommendation is fully supported and has already been addressed. The authority to place a member on the SPHL rests with DGMC [Director General Military Careers] and career managers make decisions in accordance with CANFORGEN 100/00. As per other career administrative processes where medical authorities are involved, the final decision is made based on their recommendations with the aim of providing the best assistance to the medical treatment which can include in some cases relocation closer to medical facilities or family members. The recommendations from an individual's Commanding Officer receive similar consideration when DGMC staff makes decisions.

Analysis

235 Both COs and Medical Officers in the field told my investigators that, on occasion, Career Managers refuse or delay a member's posting to the SPHL or posting to an SPHL at a location other than the home unit, based on pressures of operational requirements, shortages of personnel and budgetary limitations on moving expenses. CANFORGEN 100/00 states that the decision to place a member on the SPHL should be based primarily on the member's best interests. This policy was in effect when the original investigation was under way and did not appear to be effective in ensuring the best interests of the member were being served in all situations.

236 In both the existing policy and the proposed changes to the policy in the draft DAOD referred to earlier in this report, the CO must initiate the process to place a member on the SPHL and forward the application to the appropriate Career Manager, including the move to the SPHL to accommodate vocational rehabilitation training. If the CO wishes to post the member to the SPHL at a

location other than the home unit, the CO must provide the Career Manager with reasons. The Career Manager retains the responsibility for posting the member to the SPHL and to another location if requested.

Conclusion

237 Ultimately, the decision to transfer a member to the SPHL should be approved at a level as close as possible to the member. A centralized bureaucratic process at a headquarters several levels removed from the member will frequently result in decisions that do not reflect the desires of the CO or the Medical Officer or, indeed, the best interests of the member. We expect the final DAOD will address this issue, but at this point there is no evidence that the problem identified in the first investigation has been rectified.

Recommendation 22

238 Units maintain contact with members on the SPHL bi-weekly, subject to any restrictions imposed by the member's treating caregiver, or any desire expressed by the member.

CF response

239 This recommendation is supported in full. It is recognized that local follow-up, contact and support are integral to the PTSD treatment process. SPHL information obtained from Peoplesoft will be recorded in the Career Manager Information System (CMIS). Career Managers, as part of their duties to monitor the establishment of a unit, will track members on the SPHL and assist units in following up.

240 The authority to place a member on SPHL rests with DGMC and the Career Managers make decisions in accordance with CANFORGEN 100/00. It therefore becomes the responsibility of the Career Manager to monitor the status of that member for the duration of the SPHL period. DGMC will investigate by 30 Jun 02 the feasibility of having the SPHL process controlled and administered entirely within DGMC.

241 Modifications to CMIS will allow Career Managers to track SPHL members. Maintaining personal contact remains unit responsibility with assistance from DCSA. The new version of CMIS is in place and ready to roll out once other IT issues are ironed out. It is expected in September or October of 2002.

Analysis

242 CANFORGEN 100/00 requires a unit to maintain contact with a member and if the member is posted to the SPHL at another location, to appoint an appropriate sponsor to maintain contact. We were told repeatedly during the original investigation that members on the SPHL rarely heard from their own units. Cpl McEachern himself stated that no one from his unit contacted him in the two years he was on the SPHL, other than a Master Corporal who called him informally to see how he was doing.

Consequently, many members on the SPHL feel betrayed and abandoned by their units, interpreting the lack of contact as a sign that they are no longer useful and have effectively been disposed of. There are, of course, members on the SPHL who do not want regular contact with units for a variety of reasons. However, we found a significant majority would welcome the opportunity to feel they were still a part of their unit.

243 There have been positive developments. Some units have introduced their own program whereby personnel of equal or higher rank are appointed as sponsors. They contact personnel on the SPHL to provide unit liaison and/or encourage them to return to work. Most personnel interviewed appreciated this initiative; some complained, however, that in cases where the sponsor was of higher rank, they felt harassed and intimidated by the process. Another unit introduced a 'buddy system' program appointing members of equal rank to maintain contact with SPHL/OSI personnel. One SPHL co-ordinator has developed, on his own initiative, a process of maintaining weekly contacts with the members on the SPHL. This person feels that "one of my responsibilities is to make sure the member's ok." In cases where a member doesn't want to be contacted, it is agreed that it becomes the member's responsibility to contact the co-ordinator regularly. There was clearly a genuine concern for the welfare of members.

244 A work reintegration program has been introduced in some units. It consists of unit representatives facilitating the return to the workplace, or to another unit if the workplace poses a problem for the individual.

245 The Navy has had a centralized SPHL on both coasts since 1990. Without a rear party, once a ship goes to sea it becomes difficult to contact a member bi-weekly, thus the centralized approach was established. Approximately 95 percent of naval personnel posted to the SPHL are assigned to the centralized unit. It is then the responsibility of the SPHL unit to stay in contact with the member, track their medical requirements, and handle any administrative matters. The SPHL unit staff also tries to find suitable employment for members on the SPHL, which accommodates their medical limitations.

246 A common observation was that units simply do not have the resources to keep in regular contact with members who are on the SPHL. A CO of a recently returned Battle Group presented to the OSI Steering Committee on 1 October 2002. He advised that one of the main OSI issues from his perspective, as an operational commander was "the lack of personnel resources to maintain

contact with members on the SPHL due to the focus on operational training and deployment."

Conclusion

247 Unfortunately, in general, we found units are still not contacting members on the SPHL on a regular basis, regardless of the provisions of CANFORGEN 100/00. In essence, this amounts to no less than ignoring an order of the CDS. The primary reason given for flouting the General Order was the press of other responsibilities, which gave little time for units to make regular contact. I find this difficult to accept — surely it is not too onerous to require units to find the time to make a phone call? Ultimately, the question remains: what is the point of issuing an order from the top if it is routinely ignored?

248 There have been some instances where units and SPHLs have shown excellent initiative, as outlined above. Unfortunately these appear to be the exceptions rather than the rule. A standardized approach is needed. Overall, based on the anecdotal evidence we heard, there has been little discernible improvement in units contacting their members who are on SPHLs.

Recommendation 23

249 The Canadian Forces address resource issues that are preventing units from properly looking after members diagnosed with PTSD within their units.

CF response

250 This recommendation is supported in full.

251 DCSA will investigate the issue of resource allocation and report to COS (HR-Mil) on deficiencies by 30 Jun 02.

Analysis

252 This recommendation was made because many units have neither the personnel nor positions available to take proper care of the members who are diagnosed with an OSI and able to remain within the unit. Implementation of this recommendation is not within the purview of DCSA. During the severe personnel downsizing efforts that began in earnest in the early 1990s, many unit positions disappeared that allowed for temporary rest and respite within the units. At the same time, workloads for those remaining increased dramatically, and many of the 'softer' responsibilities, such as maintaining contact with sick members, were dropped. While the responsibility for taking care of all their members, including the injured, has not been removed from the chain of command, there is no evidence that resources are being allocated at the unit level to allow this responsibility to be fulfilled. Even COs we talked to who were very sympathetic to the plight of their injured members were not able to consistently muster the resources to take care of this responsibility.

253 The Navy has unique difficulties employing a member who is "unfit sea" (unable to sail) in their home unit, if that unit is a ship. However, there are shore units that will maintain responsibility and employ personnel from sea-going units even after they have been assigned to the SPHL.

Conclusion

254 The intent of this recommendation was to suggest specific personnel resources be provided to line units to allow the effective performance of this function. The CF response undertook an investigation and report at the NDHQ level. Implementation of this recommendation in the commands and at the base and unit level has clearly not taken place and, in the current personnel resource shortage situation, does not appear to be about to happen. This is unfortunate, as a small expenditure of resources could result in significant savings in the long term through the retention of valuable trained and experienced members. As I have noted before, it costs approximately $315,000 to recruit and train a member to a level where he or she is operationally deployable. As a consequence of the failure to implement this recommendation, the CF will lose trained members who may have been rehabilitated.

Recommendation 24

255 The Canadian Forces prioritize and accelerate the efforts toward standardizing treatment of members diagnosed with PTSD among OTSSCs.

CF response

256 This recommendation is fully supported and has been addressed in part.

257 A national psychology meeting was held 29 April 02 and the standardization of assessment tools completed.

258 OTSSC standardization is ongoing; staff assistance visits (SAVs) at the OTSSCs by the Rx 2000 Mental Health Team to verify implementation are to be completed by the end of November 2002. Initial indications of the SAVs conducted indicate that the standardization of clinical processes is in progress and much further developed than one year ago; however, there is still room to improve.

259 A Treatment Standardization Committee was created and held its first meeting in May 2002. A consolidated document is currently being prepared that will bring together all of the policies, guidelines and assessment tools developed through the series of working groups held over the past 18 months.

Analysis

260 During the original investigation it was evident that lack of co-ordination and standardization among the OTSSCs was the norm. The potential negative impact on CF members of varying standards of care and treatment across the country was the rationale for this recommendation. The CF has made considerable progress since that time in co-ordinating the activities of OTSSCs.

261 Staff assistance visits (SAVs), which are designed in part to ensure units are following appropriate procedures and adhering to best practices, are proceeding on schedule, and guidelines have been

published and distributed by the Treatment Standardization Committee (TSC). The TSC is a standing committee, with multidisciplinary representation from each OTSSC and Ste-Anne-de-Bellevue's VAC hospital mental health department, and is responsible for the promotion of standardized evidence-based treatment of deployment-related mental health illnesses and injuries. This committee meets quarterly and reviews and disseminates the latest information on dealing with OSIs.

Conclusion

262 The response to this recommendation has been positive and co-ordinated. Significant efforts are under way to implement this recommendation, and the standardization of clinical processes is well under way.

Recommendation 25

263 OTSSCs be resourced on a priority basis, and to a level sufficient to perform all of their designated functions.

CF response

264 This recommendation is supported and has already been addressed in full.

265 OTSSC Directors, in concert with their chain of command, are currently reviewing the additional staff they require to meet the guidelines developed during the OTSSC Directors/Rx 2000 MH Team meeting held on 28 Nov 01. In order to determine additional funding and support required from Canadian Forces Medical Group Headquarters (CFMGHQ), it was requested that each of the OTSSCs provide DGHS with a reasonable estimate of the additional staffing required. The requirements will then be addressed with the DGHS and Surg Gen. The funding commitment by DGHS has always been evident; however, despite the availability of adequate funding, there are still problems in finding additional staff for the OTSSCs because of shortages in mental health care providers in Canada. Recruiting is ongoing by the third-party contractor and innovative hiring practices are being explored.

266 ADM (HR-Mil) provided additional funding to support OTSSCs to DGHS through a reprofiling of QOL funds deemed surplus by VAC. This funding is being made available to enhance the programs and services provided through the OTSSCs.

Analysis

267 In late 2001, the CF identified a number of issues relating to the operation of OTSSCs, including the need to standardize treatment, as noted above. Other issues included staff burnout, staff and funding shortages, problems with civilian staffing, and a lack of time, money and direction to implement recommendations from focus groups.

268 Additional resources are being made available. The additional funding of $400,000 added to the initial operating budget ($2.4 million) this year for service enhancements at the OTSSCs was re-allocated from existing budgets. This is clearly a positive indication of the priority of these clinics. However, an assurance that funding will continue to remain available in the longer term would be even more positive.

269 The allocation of dedicated funding for research activities is also a positive step. In the end, funded research will not only help advance treatment and prevention but will also draw talented professionals to the organization.

270 According to DGHS staff, the availability of qualified mental health professionals continues to be a major problem. This shortage is felt across Canada and incentives have been put into place to try to address these issues. However, even incentives such as higher salaries, continuing education and the possibility of working in a civilian emergency unit are not sufficient to attract personnel like psychiatrists who are already "at a premium."

Conclusion

271 The CF has recognized the essential nature of OTSSCs and is addressing priority funding. Long-term commitment of funding still remains to be confirmed. The CF also continues to experience significant challenges in recruiting and retaining experienced and skilled human resources to meet OTSSC needs.

Recommendation 26

272 The DGHS initiate a pilot project that locates one OTSSC off-base, to ascertain whether such an arrangement is better suited to the objectives of the OTSSC.

CF response

273 This recommendation will be subject to a detailed examination.

274 Locating an OTSSC off-base, as a means of addressing this recommendation would only serve to increase the perception that stress-related injuries are in some way "dishonourable." In addition, medical experts recommend that optimal treatment of CF members with PTSD includes (to the greatest extent possible) maintenance of contact with the unit and the military. Moving an OTSSC off site could actually create a barrier to recovery. Locating an OTSSC off site would also increase the administrative and logistic difficulties of CF members in accessing care. OTSSCs, however, will conduct on a case-by-case basis, off-site support for individuals incapable of attending base facilities.

275 Nonetheless, DGHS will examine the ramifications of this proposal and develop a plan in detail recognizing that the recommendation has merit as long as it does not create more turmoil for CF members. The ongoing DND/VAC collaborative effort at VAC's Ste-Anne-de-Bellevue hospital (in Montreal) in the areas of in-patient and out-patient treatment for PTSD; joint research projects; pain management clinic and continuing professional support to the OTSSC will be used as a model. DGHS is to advise ADM (HR-Mil) of the feasibility of the Ombudsman's proposal by 30 Jun 02.

Analysis

276 The rationale behind this recommendation was that many CF members were not coming forward to seek treatment because they did not want their colleagues to know they were attending an

OTSSC. To a significant numbers of injured personnel, who were concerned about being discovered by their peers or superiors, a visit to the OTSSC located in a well-trafficked and highly visible location on the base was just too difficult. Even entering a CFB is very difficult for some of the patients who do attend the OTSSC for treatment.

277 My investigators found very little had changed since the release of the first report. All OTSSCs are still located on base, often sharing premises with other health care providers. For example, one OTSSC is located on the second floor of the base hospital. According to staff that works there, the stairs to the second floor OTSSC are known colloquially as the "stairway of shame." Another OTSSC is located on the fifth floor of the base hospital, accessible through the elevator bank facing the main waiting room. A number of patients at this OTSSC to whom we spoke found it extraordinarily difficult to have to walk through the waiting area of the Medical Inspection Room to take the elevator to the OTSSC. One stated that "everybody knows there is something mentally wrong with you when they see the elevator go to the fifth floor." As another CF member being treated at the same OTSSC said, "You feel like walking in with a paper bag on your head." At another OTSSC, the waiting room is visible to passers-by; as one staff member put it, "It is as if the clients are on display."

278 A vast majority of the patients we talked to in the course of preparing this report said they would rather go to an off-base location. We heard from caregivers who had been contacted by several CF members who had recently returned from Afghanistan. These members are simply refusing to come into the OTSSC because, in part, it is in such a public location (the other concern is confidentiality of their medical records). One caregiver told us "they don't want to be seen at the OTSSC; they don't want to be identified."

279 The majority of OTSSC and mental health caregivers we spoke to supported locating an OTSSC off-base as a pilot project. However, a significant minority of OTSSC caregivers supported the status quo, for the reasons advanced in the CF response detailed above. One OTSSC clinician stated that the "cornerstone of treatment is desensitization, and coming to base is just that." He added that members are often anxious at first to come to the hospital, but "in time become accustomed to it."

280 Other caregivers we spoke to argued there were no significant administrative or logistical difficulties to piloting an OTSSC off-base, and we heard no compelling arguments from any source that

supported this objection in the CF response. No concrete evidence has been produced to support the notion that an off-base OTSSC would be a "barrier to recovery." A number of caregivers and patients suggested a hybrid solution, with an on-base OTSSC supplemented by an off-base satellite to accommodate those who were not yet ready to seek help in a more visible area.

281 I understand the DGHS is still examining whether to fully implement this recommendation. A senior DGHS officer advised us that the analysis is under way and the viability of partnerships with VAC and/or the private sector is being considered. The analysis will not be complete until March 2003, which is, in his words, "far longer than anticipated." An OTSSC has commissioned a consultant to conduct a survey of patients to determine their views on having an OTSSC off-base. This survey is expected to be completed soon.

282 On 3 July 2002, DND and VAC officially opened the Ste. Anne's Centre for serving and retired CF members. The Centre is located at the Ste-Anne-de-Bellevue hospital near Montreal and has been treating current and former CF members since July 2001. It provides specialized services for trauma resulting from military service and offers assessment and treatment for psychological injuries. Ste. Anne's Centre works with treatment clinics that are being established by VAC in selected long-term care facilities that are currently contracted by VAC. It will become involved in outreach and education, as well as engaging in research on OSIs. It has a small in-patient facility. Ste. Anne's Centre will be affiliated with OTSSCs and will work closely with them. It employs a multidisciplinary approach and has similar evaluation, treatment and follow-up processes to those used by OTSSCs. Although the creation of Ste. Anne's Centre is a very welcome and positive development, it clearly does not qualify as a pilot project for an off-base OTSSC, primarily because of its geographic location. Ste. Anne's Centre is not within reasonable travelling distance from a major CFB with large numbers of CF members who have been operationally deployed.

Conclusion

283 I disagree with the CF response that creating an off-base OTSSC capability feeds into the perception that stress-related illness is "dishonourable." That perception is already widespread within the CF. Being off-base does not preclude close contact with the unit, nor does it create an impression of being dishonourable — that is

well in hand already. It certainly does not significantly increase the difficulty of providing administrative and logistical support. Until the CF creates a culture where those seeking treatment have confidence their illness will be understood and accepted by their comrades, the CF has, in my view, an obligation to provide treatment in an environment that encourages all members to come forward.

284 There appears to be some confusion as to exactly why this recommendation was made. It was not designed as the 'thin end of the wedge' to 'civilianize' OSI treatment. I anticipate an off-base OTSSC will be staffed exactly as the ones on-base are currently, with a blend of military and civilian staff. The reasoning behind creating an off-base OTSSC does not relate primarily to treatment; rather, it is a privacy and confidentiality issue. We were told that a significant number of CF members are not coming forward to get the treatment they need because they do not want their peers to know that they may need psychological help. This is quite understandable given the stigma attached to OSIs. The main purpose of an off-base OTSSC is to create an environment where members will access the help they need more quickly, thereby increasing their chances of remaining productive CF members. In that scenario, everybody wins.

285 I have some concerns that the current survey commissioned by one of the OTSSCs to determine members' views about having an OTSSC off-base is being done only with current OTSSC patients. While I am sure they will provide valuable input, the primary goal is to encourage members who have not yet come forward to get treatment. This survey does not assist in quantifying the number of members who fall into that category. To get a more thorough picture, the CF should also conduct a survey of members returning from Afghanistan to determine what their preferences would be in the event that they wanted to get help for a possible OSI.

286 DGHS has asked for a grace period to complete the analysis. I agree that if the CF does begin a pilot project it should be done based on thorough and objective research, and I look forward to the analysis. I will be keeping a very close eye on how DGHS continues to deal with this recommendation.

287 I also encourage the Health Services branch to listen to members and the individual caregivers in the field on this issue and give the recommended pilot project a fair chance.

Recommendation 27

288 The Canadian Forces take steps to deal with the issues of stress and burnout created by lack of resources and high caseloads among Canadian Forces caregivers.

CF response

289 This recommendation is fully supported and has already been addressed in part.

290 A series of recommendations to ensure adequate "care for the caregiver" were developed and supported by the DGHS. Of note were the requirement for a formalized clinical supervision program (one hour per week per clinician), the need for an external counsellor to be available to support OTSSC clinicians, and the need for regular team-building exercises.

291 There was also a commitment to immediately address staffing issues to reflect reasonable caseloads. Mental Health Care Manager positions will also be created at each of the clinics that have an OTSSC to remove some of the administrative burden from the clinical staff.

292 In order to better comprehend the scope of provider burnout in the CF, the DGHS is currently conducting an analysis of the number of health care providers who are away from their place of employment because of stress and burnout. The Chap Gen staff maintains a database monitoring the well-being and functioning of all Reg Force Chaplains relative to a number of criteria including stress/burnout. CFPSA will survey MFRC counsellors involved with PTSD issues and determine the extent of stress and burnout in their staff. Additionally CFPSA staff will examine the acquiring of the DGHS clinical supervision program for their counsellors.

Analysis

293 This recommendation was intended to raise awareness about the plight of the many dedicated military and civilian personnel who are trying to improve the quality of life of CF members, often with insufficient resources and in stressful working conditions. In the words of one social worker describing what would happen if outreach were added to the task load, "If you want to put something else on my plate, you'll find me in the hole."

294 Mental Health Manager positions have been created at the OTSSCs we visited. It is too early to determine with any certainty to what extent these positions have alleviated the administrative burden on front-line workers. We were advised that there is still insufficient administrative and clerical support for caregivers in at least one OTSSC, which has just one administrative clerk for 21 active clinicians.

295 As pointed out in Recommendation 1, it is difficult to obtain meaningful statistics about the numbers of OSI patients CF-wide. However, there is some evidence that patient numbers are increasing significantly. For example, one OTSSC saw 113 new OSI cases between January and July of this year, compared with 120 cases in total in 2001, and 105 cases in total for 2000. VAC reported that PTSD cases had increased from 30 to 120 for the area between Saskatoon and Thunder Bay in an 18-month period ending in June 2002. One CF social work office reported that it had 37 PTSD cases currently open in December 2001, of which 21 were opened in the previous six months.

296 There is evidence in some centres that workloads are becoming manageable, although this conclusion is by no means based on any scientific analysis. In at least one OTSSC we visited, the numbers of cases that are being outsourced are being reduced.

297 My investigators found that there is still a disturbingly high incidence of stress and burnout among the caregivers they interviewed for this investigation. Equally as worrying is the existence in some locations of intense workplace conflict — in some cases we heard of workplaces being referred to as poisoned environments. The CF has lost very experienced and dedicated caregivers as a result. It can ill afford to do so. Many with intimate knowledge of the CF blame friction between military and civilian cultures, with confusion over who was actually in charge. Others blame conflicts between physicians and other health care professionals that exist even in civilian environments. The use of a

third-party contractor to provide staff was generally seen in a negative light from a military culture perspective, creating uncertainty over job security and a further layer of bureaucracy that made reporting chains unclear and exacerbated friction within the organizations. At the very least, the use of yet another category of staff member in the workplace, with different entitlements and exclusions, exacerbates the challenge of effective team building. It is of tremendous credit to all concerned that the tension within certain workplaces has not had a widespread impact on the excellent quality of care given to patients. However, there can be no doubt that a price is being exacted, not only on the caregivers, but also ultimately on the patients and the CF.

Conclusion

298 The CF continues to lose excellent caregivers through overwork and, on occasion, through poor workplace management. Job stress, workplace tensions and team-building issues have persisted and have been exacerbated by the high reliance on third-party contractor staff. This creates additional challenges. All efforts must continue to be taken to resolve this situation.

Recommendation 28

299 The Canadian Forces take steps to improve support programs designed for the families of members diagnosed with PTSD, at all elements and locations.

CF response

300 This recommendation is fully supported and has been addressed in part. Family support programs are being considered as Part 4 of the OSISS program. Furthermore, there are currently a number of individual initiatives that are going on at Military Family Resource Centres across the country where the Prevention and Intervention Counsellors are very involved with this issue — particularly as it relates to families. MFRCs are also standing members of Base Crisis Intervention and CISD [critical incident stress debriefing] teams, have a referral function, and are involved with all pre- and post-deployment briefings, etc. The Web site "PTSD and The Family" is currently undergoing revision with the intent to post on the CFPSA Web site. The details of how best to implement this recommendation will be undertaken in 2002 for implementation in 2003/2004.

Analysis

301 My first report included this recommendation to highlight the scarcity of resources provided to help families of members suffering from PTSD and other OSIs. Children of all ages, spouses, partners and even parents of members suffering from an OSI are affected, and the CF must do more to help them.

302 OSISS peer support is an excellent first step, but OSISS is currently not able to take on the full range of problems affecting families. OSISS has a well-developed expansion plan that will allow the focus to include support to families affected by issues associated with stress-related injuries in the next several years. Unfortunately, this concept must be allowed to evolve slowly to allow for the build-up of expertise before it can take on all the OSI issues. Response to the ever-increasing demands on OSISS services is limited by the existing budget. This has not stopped OSISS peer

co-ordinators from becoming involved in helping families in some situations, but their numbers are simply too limited to expand this service in the short term.

303 MFRCs are an excellent tool to help support CF families. My investigators were very impressed by the dedication and effort put forth by the MFRCs across the CF and the many fine personnel who staff them (both professionally and voluntarily). However, they too are often faced with many challenges in fully meeting the family requirements.

304 As for all caregivers, confidentiality of information is a major issue for MFRCs and they were not created with the idea of handling highly sensitive information. For example, MFRCs do not have access to Protected "B" documents, such as lists of deployed personnel, owing to the sensitivity of the information. This restricts their ability to intervene in some circumstances. The MFRCs have a unique communication challenge as well, in that they do not report through the normal medical or operational chain of command. This often leaves them out of the information loop. They are also sometimes hampered by a lack of resources.

305 The Royal Canadian Legion is a valuable resource that is not yet being fully used. The Legion offers a wide variety of services to veterans and their families to ensure they are aware of and have access to the benefits and programs that are available to them. The Legion is working with OSISS, MFRCs and with VAC on OSI issues.

Conclusion

306 More work needs to be done in this area. Although there are good intentions and plans to expand services to families through the OSISS project, it currently does not have the capacity or budget to meet the full needs of families in the short or medium term. Similarly, MFRCs require more resources and better communication links if they are to pick up a greater share of responsibility in providing services to family members. Excellent initiatives were noted at the MFRCs we visited and they will help to make a difference for the members. I look forward to increased co-operation between DND/CF and the Royal Canadian Legion.

Recommendation 29

307 The Canadian Forces continue support for the Operational Stress Injury Social Support initiative and provide resources as required to extend this or similar programs across the Canadian Forces.

CF response

308 This recommendation is fully supported and has already been addressed. DCSA has dedicated resources to OSISS and has hired Peer Co-ordinators for the Peer Support Network Pilot that commences in Feb 02. Additionally, DGHS has hired a civilian Social Worker (former CF) to be a dedicated resource for OSISS; this mental health expert will be available to provide clinical PTSD input to all phases of the OSISS project.

Analysis

309 OSISS has made tremendous strides since it became operational in March 2002. Currently it has four peer co-ordinators, based in Edmonton, Winnipeg, Petawawa and St. John's. Four more peer co-ordinators will complete their training by November 2002. As of 7 October 2002, OSISS was dealing or had dealt with 215 cases. OSISS has a full-time staff member seconded from VAC to assist the peer co-ordinators.

310 According to Maj Stéphane Grenier, the OSISS project manager, the CF has been supportive in providing resources. However, demands for service have been higher than anticipated and opportunities have also arisen that require flexibility in allocating available assets. For example, visits to Edmonton by staff from Ste-Anne-de-Bellevue and, separately, a visit from a Vietnam veteran to help the peer co-ordinator set up a support group were not originally foreseen and have to be accommodated within the budget. OSISS also intends to begin a family support program, but "funding remains a concern," according to the minutes of OSI Steering Committee meeting held on 1 October 2002.

311 My investigators heard widespread praise for OSISS throughout the CF community and VAC. The comments of one MFRC worker were typical of the reaction: "It's an awesome idea." OSISS has

made the health of its staff a priority to address concerns that the workload may have an adverse effect on their members.

312 My Office has also seen first-hand the success of the OSISS project in action in individual cases and has been witness to the dedication and commitment of OSISS peer co-ordinators. Subsequent to the release of the original report, my Office received and continues to receive calls from CF members suffering from OSIs who have fallen through the cracks in the system and who often need immediate help. In some circumstances, we have been able to work directly with OSISS peer co-ordinators to facilitate referrals and have seen immediate results, with support being provided to the member and co-ordination being put in place to get the member in touch with treatment and resources. For example, my Office was recently contacted by a Crown attorney about a PTSD sufferer who had encountered the criminal justice system partly as a result of an OSI. The Crown attorney contacted us out of concern that this person had become disconnected from the CF care system and might not be receiving the necessary treatment and follow-up. My Office was able to facilitate the involvement of OSISS, which had had previous contact with the member. An OSISS peer co-ordinator immediately attended where the member was being detained, provided support to the member and his family, and ultimately facilitated the person's release into a treatment centre.

313 My investigators also attended parts of the inaugural and subsequent OSISS training courses, and were present when OSISS peer co-ordinators spoke to CF groups. They saw that peer co-ordinators, because of their backgrounds, were very effective and credible educators. As noted under Recommendation 11, OSISS intends to create a database of members and former members with experience of operational stress who are not peer co-ordinators but who are prepared to present on OSI issues. This is an excellent idea.

314 I am also encouraged that OSISS has a 'seat at the table' at the OSI Steering Committee, albeit in an advisory capacity, not as a full member. OSISS also presented to the committee on its activities at the meeting on 1 October 2002.

Conclusion

315 I congratulate the CF for championing this initiative, and urge that it continue this support. Resources should be allocated as the project expands, according to its growing needs. I believe OSISS

has proven itself to be a very valuable tool in dealing with the OSI issues that face the CF and threaten its operational effectiveness. OSISS will be a key contributor to the culture change required to combat the stigma associated with OSIs and to ensure that CF members who may have an OSI are not too frightened to come forward to get the help they need as soon as possible. My staff has kept in close contact with OSISS staff members throughout this investigation and will continue to do so. It is clear that the success of this project is largely because of the determination and leadership of Maj Stéphane Grenier, the ongoing support of the chain of command, including LCol Dave Wrather and LGen Christian Couture and the commitment and dedication of the OSISS peer co-ordinators. They deserve credit for their excellent work.

Recommendation 30

316 The Canadian Forces initiate an end-to-end review of the rules dealing with confidentiality of medical information. In the short term, breaches of confidentiality must be dealt with quickly and visibly to re-establish confidence in the Canadian Forces' commitment to protect personal information.

CF response

317 This recommendation is fully supported and has already been addressed in part. CANFORGEN 026/00 ADM (HR-MIL) 181430Z FEB 00 "Disclosure of Medical/Social Work Information to Commanding Officers" was promulgated stating that medical information was not to be disclosed to Commanding Officers without the member's consent. This message covered the basics of bringing the CF's policy in this area in line with policy in the civilian world. Its contents have been reinforced to Canadian Forces health care providers. While it is hoped that all Canadian Forces health care providers are acting in accordance with this communication, cases where they are not, will be dealt with appropriately.

318 The Canadian Forces Health Service has already undertaken a comprehensive review of CF policies on the privacy and confidentiality of medical information. This review included extensive consultation with military and civilian experts. This has resulted in the production of a draft Defence Administrative Order and Directive (DAOD) on this subject. The DAOD brings CF policies in this area in line with those in place in the civilian world in Canada. The DAOD must now receive full review, and then be promulgated across the CF.

319 In conjunction with the DAOD, a draft Health Services Instruction for the Canadian Forces (HSICF) has also been produced. This document gives detailed guidance to health care providers covering some of the more complex areas concerning the privacy of health care information. This instruction will be promulgated to

CF health care providers once the DAOD on which it is based receives final approval.

Analysis

320 A delicate balance is required between confidentiality and the need to communicate information required by commanders and decision makers to do their jobs. My investigators were rightly concerned about instances of medical confidentiality being breached that they heard about during the original investigation into Cpl McEachern's complaint. When a patient's private medical information is shared inappropriately with others, the violation of privacy must be dealt with. However, it is clear that there is another half to the confidentiality equation, and that is the necessity to communicate between the caregiving community and the operational chain of command. To focus only on the problem of disclosing too much dismisses the potential damage to the health and welfare of CF members, their families and possibly others, if too little is communicated. It is evident that the CFHS are striving to find the proper balance between saying too little and saying too much. This problem is clearly not yet resolved. One Base Commander told us he "couldn't imagine that the communication gap between the operational chain and the medical professionals could get worse."

321 The issue of confidentiality of personal information is clearly a central concern of the CF health care community, but it is even more of a concern to CF members who are or may be suffering from an OSI. We have heard from reliable sources that several members who have recently returned from Afghanistan refuse to seek help for potential OSI issues because, in part, they have no confidence that their medical records will be kept confidential. One of the most alarming comments we heard during this investigation came from a senior, experienced and very dedicated OTSSC staff member who told us, "If I were a soldier, I wouldn't come here. There's no real confidentiality. Everyone knows you're here. We can't protect your records. If I were them, I'd get private treatment."

322 CANFORGEN 100/00 section 5.B. (2) states that "The Health Care Co-ordinator (HCC) will inform the CO of the member's employment limitations, including information on when or if the member is likely to be returned to full duty without limitations." It was reported to my investigators that strong educational efforts are being made across the CF. During a 'blitz' in the spring of 2002, caregivers were given a briefing about what information could be

provided to the chain of command and under what circumstances. Each region was asked to review the awareness level in this area. However, the fundamental issue is communication of information. In the words of a senior CF Medical Group (CFMG) member, "It is increasingly difficult to help soldiers when you can't discuss specifics."

323 In every instance when the issue of confidentiality of information was raised with caregivers during this investigation, there was a high level of awareness of the rules. Similarly, most caregivers immediately acknowledged the challenge of providing enough information to the operational chain of command to allow them to do their job. The other challenge lies in explaining the confidentiality rules to members and to restoring trust and confidence in the system. In the end, the most effective way to reduce the members' concern about the privacy of information may be to change the stigma associated with mental health issues. Another way is to facilitate administrative changes mentioned elsewhere in this report, changes that are intended to retain as valuable contributing members of the CF those members who suffer from an OSI. Too frequently members fear coming forward with their OSI issues because they believe this may be their "ticket out of the Canadian Forces."

324 An area of concern during the earlier investigation was the sharing of information between VAC and DND medical authorities. CF members and some VAC employees had expressed very real concerns that this would lead to violations of confidentiality. My investigators did not find that fear realized. In fact, they found that the concern surrounding this issue had virtually disappeared. While a few people still expressed reservations, no evidence of breaches in confidentiality were found. What is causing considerable concern are confidentiality issues raised by the Primary Care Renewal Initiative (PCRI) currently being undertaken by DGHS. The PCRI process requires that notes taken by mental health caregivers (including social workers) become part of a member's general medical file, and therefore accessible to non-mental health professionals. These notes often contain very sensitive and personal information. This initiative, in its current form, is seen by many of the mental health caregivers we spoke to as an unnecessary and retrogressive step that will further erode members' faith in the confidentiality of their records. There have been instances where CF members, having been advised of the policy, have refused treatment. Apparently, the rationale for appending clinician notes to a member's general medical file is that there was poor communication between mental health caregivers

and Medical Officers. The Medical Officers stated that they needed some details of the patient's mental health to ensure they gave appropriate treatment.

Conclusion

325 Confidentiality of personal medical information is an important issue; however, in an organization such as the CF, the ability to communicate effectively between the caregiver community and the operational chain of command for the protection of members and society in general is equally important. The CF medical community is striving to protect privacy and confidentiality of medical information to the best of its ability and the level of awareness of the rules surrounding confidentiality of medical information is very high within the medical community. The level of concern about the privacy of OSI information remains high and continues to prevent some members who may need help from coming forward. I do not think it should be difficult to reach a compromise on information sharing between Medical Officers and mental health professionals. Surely it is possible to provide sufficient information for a Medical Officer's needs without divulging detailed case notes.

326 The bottom line, from our perspective, is that CF members are refusing to come forward and get help because they are concerned about who will have access to their health care records. In many cases, these concerns about confidentiality are directly related to the stigma associated with OSIs, which still persists, and fears that members who suffer from OSIs will not be well treated by the system and will ultimately be released from duty.

Recommendation 31

327 The Canadian Forces create the position of PTSD co-ordinator, reporting directly to the CDS and responsible for co-ordinating issues related to PTSD across the Canadian Forces.

CF response

328 It is acknowledged that the CF must take a holistic approach to the issue of Operational Stress Injuries, of which PTSD is the best known. All of the core activities identified by the CF Ombudsman (mental health, family support, spiritual well-being, compensation and benefits, policy development, education and training (and their delivery in CF institutions)) are the responsibility of ADM (HR-Mil) who reports directly to the CDS. It is therefore obvious that ADM (HR-Mil) is already the *de facto* CF OSI Co-ordinator. To assist ADM (HR-Mil) in the fulfilment of this responsibility and to ensure that the chain of command is actively engaged, a steering committee will be organized consisting of all principal stakeholders including the EC [Environmental Chiefs] Deputy Commanders. The steering committee will create a formal means for the review of all OSI matters. The mandate of this steering committee will be to co-ordinate, where necessary, OSI-related issues and its terms of reference will be issued in due course.

329 The Steering Committee has been formed and held several meetings. The CDS has appointed a special advisor on PTSD, Capt (N) Judy Harper, assisted by the CF CWO [Chief Warrant Officer], to provide direct input on the issue.

330 The OSI Steering Committee, with membership at the Asst ECS [Assistant Environmental Chiefs of Staff] level and representatives from the operational, medical, social, career, family, education and policy domains met 21 May 02. The confirmed goal of the SC [Steering Committee] is to advance the awareness and acceptance of OSI issues by all CF members and to harmonize CF policies to support these initiatives. It was also reiterated that the SC will examine the full

spectrum of stress-related issues and will not be limited to those arising from operational deployments.

Analysis

331 A large number of disparate authorities within the CF, often reporting through different chains of command, each have an impact on how the CF deals with OSIs. Indeed, in some instances, the ADM (HR-Mil) cannot control how the CF deals with OSIs. For example, the Environmental Commands play a crucial role, as do the Military Police, but neither report to ADM (HR-Mil). In short, it was anything but obvious that the ADM (HR-Mil) was the *de facto* CF OSI Co-ordinator.

332 It did seem obvious to me that a holistic approach was needed to ensure the CF tackled OSI issues effectively. To achieve this goal, I recommended that the CF create the position of a PTSD co-ordinator whose responsibility included all of the various stakeholders, of which ADM (HR-Mil) was the major but not the only one. This person, who would report directly to the CDS, would be responsible for ensuring ongoing co-ordination among all CF stakeholders.

333 I had numerous discussions with the CDS over the implementation of this recommendation. Ultimately we agreed the model that has been put in place, with a special advisor reporting directly to him and a steering committee composed of key decision makers from stakeholders across the CF, met the intent of the recommendation. I indicated that I would monitor its effectiveness.

334 Captain (Navy) [Capt (N)] Judy Harper was appointed Special Advisor to the CDS for OSI. Her terms of reference were issued by the CDS on 12 July 2002. The terms provide that "The Special Advisor to the CDS for Operational Stress Injuries is a secondary duty." She has access to the CDS "on a regular basis" but reports to ADM (HR-Mil) on a day-to-day basis. The terms require that she "take the lead in representing the CDS' interests in implementing the solutions, working closely with the Committee and Environmental Chiefs of Staff." She is also mandated to establish "a working relationship with the ECS at all levels from strategic to local/tactical in order to determine and report on the requirement for compliance with OSI policies and procedures." She is required to "report regularly to the CDS and OSI Steering Committee on program adequacy and compliance." Capt (N) Harper is also DTEP. Chief Petty Officer, 1st Class, Richard Lupien, who is the CF Chief Warrant Officer (CFCWO), assists her in her OSI duties.

335 The OSI Steering Committee is made up of senior CF stakeholders, including the Assistant Chiefs of Land, Air and Maritime staffs, the DGHS, the Director General Military Careers, a senior DCDS representative, the Chaplain General and the Surgeon General. The OSI Steering Committee has a number of advisors who attended the first meeting, which was held on 21 May 2002, including the DCSA, the Chief CF Social Worker and the head of the CFMG Mental Health Team. It includes an observer from VAC. The OSI Steering Committee has a very broad mandate, including, according to its terms of reference "addressing the concerns" that I raised in my original report. One of its primary goals is to

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> ensure the chain of command is actively engaged at all times and in all situations to effect a cultural change within the CF that will develop a supportive environment, develop better understanding of issues at all levels and ensure co-operation and focused work to get service members healthy and back to work.

337 The OSI Steering Committee is chaired by the ADM (HR-Mil), LGen Couture, and according to the terms of reference, is scheduled to meet quarterly unless the need arises to meet more often. As noted in the minutes of its first meeting in May 2002, LGen Couture "stressed that this was not another committee but an attempt to establish a process to ensure that corresponding issues both from the [original] report and other initiatives were dealt with without duplication of effort and inconsistencies."

338 The OSI Steering Committee met for the second time on 1 October 2002. I am pleased to note that there was no significant dilution in the decision-making authority of members who attended. In his opening remarks, LGen Couture emphasized the "importance of the Steering Committee as a forum to provide the leadership, guidance and direction to address the entire spectrum of OSI issues." The meeting covered a variety of issues, and the deliberations are included where appropriate in the analysis of individual recommendations. The Director of Professional Services at Ste-Anne-de-Bellevue presented on VAC OSI initiatives and Maj Grenier presented on developments in the OSISS project. I was also pleased that a CO from a recently deployed Battle Group also presented on OSI issues from the operational perspective.

339 The level of co-operation between the Special Advisor to the CDS for OSI and the Ombudsman's investigators was very good during this investigation. The OSI situation within the CF is a multifaceted, complex series of interconnected issues and it will take time for any individual, however dedicated, to master them. It

was apparent during an interview on 18 July 2002 with Capt (N) Harper and the CFCWO that they were not aware of the Department's progress in a number of key areas, but this is quite understandable since their terms of reference had been issued six days previously. I understand that the Special Advisors attended a number of information sessions on OSI issues subsequent to that meeting. My investigators met with them for a second time on 23 September 2002 and although there is much yet for them to master and field trips had not yet been taken, it was clear their level of awareness had markedly improved. I understand they intend to visit Edmonton in late October to gather information in the field. It will be important for the Special Advisors for OSI to concentrate on talking with caregivers and members of the operational community at the working level during their travels to ensure they reflect the results in the field as opposed to the plans on paper.

Conclusion

340 During the field visits by my investigators, it was evident that co-ordination and co-operation must still be improved in several areas. Examples have already been provided under specific recommendations. In general, we observed that the level of co-ordination and co-operation at the field level has not improved. In this regard, I am particularly concerned that units do not appear to be receiving OSI training to any great degree. I believe co-ordination between the Environmental Commands and the health care chain of command could relatively easily rectify this problem, in broad accordance with the DTEP review recommendations. This is a prime example of a case where responsibilities for implementation of OSI supportive activities are split between the operational chain of command (which ultimately reports through the Environmental chain of command) and the medical chain of command (which reports through the ADM (HR-Mil) chain).

341 In the case of unit continuation training, the onus is on the unit to request training and the OTSSC is responsible, along with OSISS and other resources as necessary, to deliver it. If continuation training is not improving, it may be due to the units not requesting it — as was the case in one large base we visited — or it may be due to the inability of the OTSSC or OSISS to free up the resources to develop or deliver it. In either case, responsibility is difficult to assign, but it is clear that co-ordination has not yet been successful.

342 As another example, MFRCs are not fully included in the network of care, and consequently opportunities are lost for sharing of information. Indeed, even within the MFRC organization, we were told that most OSI information for distribution is dug up and/or developed locally. The specific example provided was when the local MFRC wanted critical incident stress (CIS) training, the MFRC found and funded a local municipality-based organization to do it. The MFRC worker also described duplication of services and a lack of clearly defined lines of responsibility. Another social worker told us "There is a high level of territoriality being borne out of the inability to communicate between various helping bodies." Conversely, we heard that some MFRCs relied on OTSSCs for their OSI activities. Clearly there is room for more co-ordination between MFRCs and other organizations.

343 It is too early to determine whether or not the Special Advisor to the CDS for OSI system as it currently stands works in practice. The creation of a Special Advisor position is an excellent step, but I have some lingering concerns that it has been designated a part-time position. The incumbent has many other onerous duties including that of DTEP and it is difficult to see how she will be able to devote the time and effort required to this task, even with the assistance of the CFCWO, who himself also has numerous other responsibilities. That said, my investigators were impressed by their willingness to tackle the issues and I look forward to concrete results in the near future.

344 As an initial step, the CDS has made the right decision in appointing an OSI Special Advisor who is not part of the medical community. This reinforces the very important message that PTSD and other stress-related injuries are a direct responsibility of the chain of command, as opposed to being simply a medical problem. Dealing effectively with OSIs has an obvious and very important medical component, but the leadership element must be provided by the chain of command.

345 The creation of the OSI Steering Committee is also a very positive development. The establishment of the goal to advance the awareness and acceptance of OSI issues by all CF members and to harmonize CF policies to support these initiatives is encouraging. However, a key difficulty with the committee approach is the lack of specific accountability. In addition, the workload for already heavily tasked individuals, especially the Environmental Command Deputy Commanders, may preclude the attention this subject deserves, despite the best of intentions. With respect to responsibility, ADM (HR-Mil) is clearly the organization most heavily involved with responding to the challenge of dealing with

OSIs, but the majority of my recommendations will require the active involvement of organizations and individuals not directly under the control of this personnel organization.

346 The activity of the OSI Steering Committee will need to be monitored to ensure that attendance does not end up being delegated to environmental staff members with less authority. The effectiveness of the committee approach will need to be monitored to ensure the lack of a single point of responsibility does not dilute the committee's efforts. Lastly, very aggressive efforts are needed to connect this high-level committee with the reality of what is transpiring in the field.

Challenges

347 During the course of this follow-up investigation, we identified key issues that present significant challenges to the care of CF members with OSIs: resources, a growing gap between the operational chain of command and fairness.

Resources

348 Resource shortages have become a fact of life for the CF and frequently come to the foreground during discussions about the ability of the organization to put combatant forces in the field or to replace aging equipment. It is now abundantly clear, however, that resource limitations are seriously affecting how the organization deals with stress-related injuries in almost every area. One Deputy CO described his conundrum this way: "I need to balance the need to be compassionate and provide treatment for the soldier with the need to meet incredible task burdens."

349 Chronic personnel shortages are affecting the way military members view those around them who are suffering from stress-related injuries. The level of resentment that develops toward injured members when they are unable to carry their full load cannot be overstated. In my opinion, this is a major contributor to the very complex peer attitude toward those who suffer from stress-related injuries.

350 At a very fundamental level, the unrelenting shortages of people, time and financial resources are creating a dangerous level of background stress within the CF. This problem is particularly severe within the organizations that support the combat units.

351 One of the most critical shortages is time. Over and over again, my investigators heard that life in the CF is simply "no fun anymore." The time to build relationships and develop healthy *esprit de corps* is just not there in an organization that is constantly on the go. In one instance, we heard of a unit that had to order members to attend a family day. The CO was trying to build unit spirit and include the families, but the members were just tired and wanted to spend the little time off they had at home. The words of one Deputy CO of an Infantry battalion sum it up well: "Taskings are the number-one killer in the Army."

352 The ability to take time to introduce new training and/or education efforts to help change the culture within the CF to be more understanding and accepting of stress-related injuries is not

there either. As a result, even if the direction exists to improve the level of awareness about stress and stress-related injuries, and the honest desire is there, the actual ability to do it is seriously impeded by the lack of time — both on the part of the operational chain of command and on the part of those able to deliver the training.

353 The level of awareness within the medical community about the role and functions of the operational elements they serve is severely limited by the available time they have to pursue familiarization efforts.

354 In the opinion of my investigative team, the vast majority of the members of the chain of command are committed to improving awareness about stress-related injuries and changing the culture. However, the lack of time and resources precludes much improvement.

355 Resource shortages are also increasing the severity of the workload within the caregiver community. In many cases, my investigators were assured at the national level that sufficient resources are available. While we did note improvement in some areas, shortages at the unit level were severe and hampering the delivery of the service. The dedication is obvious, but the workload is so high that, combined with the impact of organizational change, normal workplace team-building efforts are not pursued. This leads to deteriorating working environments, creating yet more stress on the caregivers. Padres, social workers, doctors, nurses, psychiatrists and psychologists are equally affected. One padre indicated to my investigators that he was looking forward to a deployment to finally get a rest. Within the chain of command, similar levels of stress exist and are getting worse. Many times, the interaction between the chain of command and the caregiver community suffers badly as a result. The simple lack of time is certainly the largest contributing factor to the increasing communications gap and growing alienation between these two communities.

Cost of recruitment

356 The human cost of not dealing with OSIs is considerable. Additionally, there are huge financial costs involved in replacing members who leave the CF because of an OSI. It takes approximately $315,000 to recruit and train a member to a level where he or she is considered combat-ready and deployable as an infantry soldier.

357 The cost in terms of lost experience, poor morale and damage to perceptions of the CF as a desirable place to pursue one's career are impossible to measure. No doubt these factors have cost the CF and continue to contribute to its poor performance in the areas of recruitment and retention. According to the April 2002 Report of the Auditor General of Canada,

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> despite efforts, the Canadian Forces' current push to recruit has not attracted enough new regular force members to meet its target of 7000 […] The Canadian Forces needs its skilled and experienced people to stay in the military and so is looking at retention options.

359 This poor performance in turn contributes to personnel shortages. The result is a vicious circle where personnel shortages continue to exacerbate members' stress and pose an obstacle to resolving problems associated with OSIs.

Cost of litigation

360 There is another potential financial cost that I touched on in my first report — litigation. Currently, the United Kingdom Ministry of Defence (MOD) is dealing with claims from approximately 2,000 former military members who have or may have PTSD. The majority of these claims (1,700) are joined in a group action suit that is currently before the Courts. The total value of the claim in this action is about C$675 million. The case, which is scheduled to conclude in 2003, has already cost the MOD approximately C$30 million in legal fees alone. Interestingly, according to the MOD Chief Claims Officer, one of the major issues at trial is whether the MOD created a culture where individuals were too afraid to come forward to receive treatment in a timely manner. Other issues that will likely arise during the trial include what duty of care the MOD had to military members, both during a member's service, at the time of discharge and subsequently; predeployment briefing, screening and preparation; post-deployment debriefing; cumulative exposure; treatment; and resources. These are similar issues to those discussed in my original report. The CF and the Canadian government are now facing a $6-million lawsuit filed by two CF members. They claim they are suffering from PTSD that they allege was brought on by a variety of factors including inappropriate care during and after overseas deployments, as well as by increased workloads and responsibilities.

Growing gap between the operational chain and caregivers

361 This is a serious situation, deteriorating as time passes. Exacerbated by the shortages of people and time, it will not cure itself, despite the best efforts of some very dedicated members of both communities. What my investigators found as they visited the bases and units across the country was that members of the chain of command were becoming increasingly distrustful of the caregivers. Now that Medical Officers can grant sick leave directly, many in the chain of command believe these caregivers hand out stress leave on a whim. For example, my investigators were told 'second hand' of a Medical Officer who allegedly granted stress leave to an individual who found his house-hunting trip stressful. Supervisors reported to us that the medical chits are "useless," in many cases simply stating the member is unfit for military duties. The individual's supervisory chain cannot get any details about what they can do to help.

362 The medical personnel, many with little or no military experience, are increasingly relying on the perception of the chain of command they develop by listening to their patients. This one-dimensional view frequently paints the supervisory chain as insensitive, uncaring and focused on getting rid of the problem rather than helping the individual return to work.

363 These two perceptions — the frivolous medical professional handing out sick chits and stress leave without justification, and the unfeeling and uncaring chain of command — are clearly so far off the mark as to deserve ridicule. But they exist. A very small amount of time spent with either group is enough to convince anyone that just the opposite is true. Both of these groups are clearly dedicated, professional and absolutely committed to doing the right thing for the welfare of the members of the CF, for whom they share responsibility. We did come across some local initiatives where the chain of command was making efforts to bring operational commanders and caregivers together to discuss these issues on a regular and informal basis. The recent initiative of the Commander of the Brigade Group in Edmonton to have a breakfast at which caregivers and local commanders were present is an excellent example. Unfortunately, both groups are so busy, and getting busier, that they cannot spend sufficient time in each other's areas to dispel the false impressions.

Fairness

364 A constant theme detected by my investigators throughout this investigation was the question of fairness. Simply stated, in the effort to treat stress-injured members properly, the system cannot afford to create situations where those who are not injured seem to be treated unfairly.

365 First, inequity of any kind is a source of discontent and can lead to morale problems. Second, it increases the stigma already associated with members suffering from stress-related injuries. In many of the complaints my investigators handled, the resentment about perceived advantages received by those who were diagnosed with serious stress injuries was at the heart of the issue. These benefits also tended to create a perception that there were people out there who would attempt to gain them dishonestly, because they were so attractive. We heard of one case where a soldier approached a padre to say, "I have a lot of stresses, being a single parent with stresses. I was with them, lived through the same things and I don't have PTSD but I could go see the social worker and get it [PTSD diagnosis] like that. I won't do it but it's tempting."

366 For all of these reasons, valid inequities must be removed wherever they exist and ignorance about the so-called benefits of being injured must be dispelled. For example, being able to earn a second salary "especially as a bouncer downtown," as one CO referred to it, while still earning the CF salary was a source of great resentment. The additional right to receive a VAC disability pension while still serving created even more inequity in the eyes of many soldiers. A Medical Officer in the field referring to this said, "I question the award of a VAC pension while so-called ill members are still earning their military pay."

367 In reality, not a single patient we have talked to or any member of their family would ever choose to live the life of a PTSD victim. The quality and indeed the quantity of life are much reduced, and the price paid for the service-induced injury far exceeds any potential compensation. Nevertheless, the perception of unfairness must be dealt with and inequities with respect to leave, salary and pension benefits must be minimized or removed.

Conclusion

368 The purpose of this report is to provide a snapshot of the progress the CF has achieved in implementing the recommendations in the nine months since my first report on this issue was released. As I noted at the beginning of this report, very significant things can happen in nine months. That said, I am fully aware that it takes time for an organization as large as DND/CF to make fundamental changes. In particular, changing any culture to become more understanding of stress-related illnesses will not be accomplished overnight, and DND/CF is no exception.

369 Overall, I am pleased to see there is much happening that is positive. DND/CF senior leadership has acknowledged that OSIs have a huge impact on operational effectiveness. It has approved a program that will hopefully improve education and training about OSIs for all CF members, while at the same time targeting CF leaders in particular. DND/CF has created and supported the OSISS project. Further, all indications to date are that the in-theatre mental health care resources and reintegration programs put in place for the Battle Group that went to Afghanistan were successful.

370 Senior CF leadership has demonstrated a commitment to tackle the issues raised in my original report, and to redouble the efforts that were ongoing prior to its release. However, I am concerned that this sense of urgency is not always reflected further down the chain of command. For example, in some of the areas we visited during this investigation, field units were still not requesting training about OSIs, citing other more pressing priorities. In my view, this training is crucial in helping to destigmatize OSIs among peers. In another example, little has been done to implement a pilot project to locate an OTSSC off-base. We believe putting an OTSSC in an anonymous location will encourage CF members who may not be coming forward, because the current OTSSCs are in highly visible locations on base, to seek the help they need earlier than they otherwise might have. From my perspective, one of the most worrying findings of this investigation is that there are several members who served on OP APOLLO who recognize that they need assistance with a potential OSI, but refuse to access that help because they do not have faith the system will protect them.

371 I am particularly concerned that, in an era where recruitment and retention is an issue, valuable and productive CF members are still being unnecessarily lost. Many see OSI as a one-way ticket out of the CF. Heavy operational and training commitments, combined with limited resources, not only create stress, but further alienate peers from members who are perceived not to be pulling their

weight. The Minister of National Defence recently commented on the risks of overtasking military personnel and their families. He noted that some members will simply quit if this issue is not addressed.

372 In my view, DND/CF must be as proactive and dynamic as possible in dealing with OSIs, and I am pleased to note that DND/CF is far more progressive in its approach to OSI issues than some of the other military organizations I have contacted. Nevertheless, I am somewhat concerned that unless we tackle OSIs aggressively on all fronts, there is the potential that DND/CF, and individual CF members, will become immersed in very expensive and time-consuming litigation, as we have seen in the United Kingdom.

373 The onerous demands we make on our soldiers, sailors, airmen and airwomen became even clearer to me during my visit in July to CF members deployed on OP APOLLO. I met with CF soldiers in Kandahar, and Air Force and Navy personnel in the Gulf. We ask these members to make extraordinary sacrifices on our behalf. Tragically, four soldiers made the ultimate sacrifice.

374 DND/CF health care professionals tell us that incidents of OSI will arise from OP APOLLO. How many remains to be seen. DND/CF owes these members, and all other members who have sustained an OSI, the best care that can be provided, in a culture that is supportive and accepting. I believe this report shows that DND/CF is making considerable strides in several important areas to achieve that goal. Progress in other areas has been slow. There is still much to be done.

375 On a final note, I want to reassure members of the DND/CF community that I have not closed the book on the way in which OSIs are treated by our military. On the contrary, I believe that my Office's work on PTSD has resulted in important momentum that needs to be sustained and built on. Our work, coupled with the fact that DND/CF has maintained that more time is necessary to properly assess the CF's renewed undertakings in regard to OSIs, dictates a more lasting scrutiny from the Office of the Ombudsman. As a result, BGen (Retired) Joe Sharpe has kindly agreed to continue to serve as Special Advisor to the Ombudsman on OSI. BGen Sharpe is a well-respected retired officer who has acquired much expertise in this area and has been very helpful in our investigations of these issues. Accordingly, he has agreed to provide me with regular updates and his assessment of the situation. I intend to report at least annually on the continuing commitment of DND/CF to improve the way it treats its members who suffer from OSIs.

Appendix: List of abbreviations and acronyms

ADM (HR-Mil)	Assistant Deputy Minister (Human Resources — Military)
Asst ECS	Assistant Environmental Chiefs of Staffs
BGen	Brigadier-General
CANFORGEN	Canadian Forces General Message
CDS	Chief of the Defence Staff
CF	Canadian Forces
CFB	Canadian Forces Base
CFCWO	Canadian Forces Chief Warrant Officer
CFHIS	Canadian Forces Health Information System
CFMG	Canadian Forces Medical Group
CFMGHQ	Canadian Forces Medical Group Headquarters
CFPSA	Canadian Forces Personnel Support Agency
CFRETS	Canadian Forces Recruiting, Education and Training System
Chap Gen	Chaplain General
CIS	Critical Incident Stress
CISD	Critical Incident Stress Debriefing
CMIS	Career Manager Information System
CO	Commanding Officer
COS (HR-Mil)	Chief of Staff (Human Resources — Military)
COT	Compulsory Occupational Transfer
Cpl	Corporal
D Med Pol	Director Medical Policy
DAG	Departure Assistance Group
DAOD	Defence Administrative Orders and Directives
DCDS	Deputy Chief of the Defence Staff
DCSA	Director Casualty Support and Administration
DGMHRPP	Director General Military Human Resources Policy and Planning
DGHS	Director General Health Services
DGMC	Director General Military Careers
DMCARM	Director Military Careers Administration and Resource Management

DND	Department of National Defence
DQOL	Director, Quality of Life
DTEP	Director Training and Education Policy
ECS	Environmental Chiefs of Staff
HCC	Health Care Co-ordinator
HSICF	Health Services Instruction for the Canadian Forces
LTD	Long Term Disability
LCol	Lieutenant-Colonel
LGen	Lieutenant-General
MFRC	Military Family Resource Centre
MOC	Military Occupation Code
MOD	Ministry of Defence
NCM	Non-Commissioned Member
NCO	Non-Commissioned Officer (now NCM)
NDHQ	National Defence Headquarters
NRD	Naval Reserve Division
OP APOLLO	Operation Apollo
OP PALLADIUM	Operation Palladium
OSI	Operational Stress Injuries
OSISS	Operational Stress Injury Social Support
OT	Occupational Transfer
OTSSC	Operational Trauma and Stress Support Centre
PCRI	Primary Care Renewal Initiative
PERSTEMPO	Personnel Tempo
PSO	Personnel Selection Officer
PTSD	post traumatic stress disorder
QOL	Quality of Life
SAV	Staff Assistance Visits
SC	Steering Committee
SORT	Special Ombudsman Response Team
SPHL	Service Personnel Holding List
Surg Gen	Surgeon General
TSC	Treatment Standardization Committee
VAC	Veterans Affairs Canada
VOT	Voluntary Occupational Transfer