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## Evaluation of Support to Injured CF Members and their Families

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1258-165 (CRS)



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## Table of Contents

|  |            |
|--|------------|
| <b>Acronyms and Abbreviations .....</b>  | <b>i</b>   |
| <b>Results in Brief.....</b>   | <b>v</b>   |
| <b>Introduction .....</b>  | <b>1</b>   |
| Background .....   | 1          |
| Aim .....  | 1          |
| Objectives .....   | 1          |
| Scope .....  | 1          |
| Methodology.....   | 1          |
| Description of Program.....  | 2          |
| <b>Physical Care .....</b>   | <b>5</b>   |
| <b>Mental Health Care.....</b>   | <b>13</b>  |
| <b>Administration for the Injured CF Member .....</b>                                  | <b>35</b>  |
| <b>Support to Families of Ill and Injured CF Members .....</b>                         | <b>51</b>  |
| <b>Benchmarking CF and Allied Forces Care of the Injured.....</b>                      | <b>58</b>  |
| <b>Summary .....</b>   | <b>60</b>  |
| <b>Findings and Recommendations.....</b>   | <b>63</b>  |
| <b>Annex A — Management Action Plan .....</b>  | <b>A-1</b> |
| <b>Annex B—CF/VAC Program Relationships .....</b>                                      | <b>B-1</b> |
| <b>Annex C—CMP Care of the Injured Campaign Plan .....</b>                             | <b>C-1</b> |
| <b>Annex D—OTSSC Mental Health Assessment Process .....</b>                            | <b>D-1</b> |
| <b>Annex E—Operational Stress Injury Social Support Program<br/>Organization .....</b> | <b>E-1</b> |



## Acronyms and Abbreviations

|             |  |
|-------------|--|
| AAG         | Arrival Assistance Group   |
| ABCA        | America, Britain, Canada and Australia (standardization program) |
| ADF         | Australian Defence Force   |
| ADIP        | Accidental Dismemberment Insurance Plan                          |
| ADM(HR-Civ) | Assistant Deputy Minister (Human Resources – Civilian)           |
| ADM(HR-Mil) | Assistant Deputy Minister (Human Resources – Military)           |
| ADM(IM)     | Assistant Deputy Minister (Information Management)               |
| ADM(Mat)    | Assistant Deputy Minister (Materiel)                             |
| AFC         | Armed Forces Council   |
| AO          | Assisting Officer  |
| Canada COM  | Canada Command   |
| CANFORGEN   | Canadian Forces General Message                                  |
| CANOSCOM    | Canadian Operational Support Command                             |
| CANSOFCOM   | Canadian Special Operations Forces Command                       |
| CAS         | Chief of the Air Staff   |
| CDS         | Chief of the Defence Staff                                       |
| CDU         | Care Delivery Unit   |
| CEFCOM      | Canadian Expeditionary Force Command                             |
| CF          | Canadian Forces  |
| CFAO        | Canadian Forces Administrative Order                             |
| CFB         | Canadian Forces Base   |
| CFD         | Chief of Force Development                                       |
| CFHIS       | Canadian Forces Health Information System                        |
| CFHS        | Canadian Forces Health Services                                  |
| CFPSA       | Canadian Forces Personnel Support Agency                         |
| CIMIC       | Civil-Military Cooperation                                       |
| CLS         | Chief of the Land Staff  |
| CMP         | Chief Military Personnel   |
| CMS         | Chief of the Maritime Staff                                      |
| CO          | Commanding Officer   |
| COAD        | Continuance on Active Duty                                       |
| CRS         | Chief Review Services  |

|           |  |
|-----------|--|
| CSC       | Correctional Services Canada                                   |
| DAG       | Departure Assistance Group                                     |
| DAOD      | Defence Administrative Orders and Directives                   |
| DASA      | Defence Analytical Services and Advice                         |
| DCCO      | Director Civilian Classification and Organization              |
| DCDS      | Deputy Chief of the Defence Staff                              |
| DCSM      | Director Casualty Support Management                           |
| DDIO      | DCDS Direction for International Operations                    |
| DGCB      | Director General Compensation and Benefits                     |
| DGCESP    | Director General Civilian Employment Strategies and Programmes |
| DGHS      | Director General Health Services                               |
| DGMP      | Director General Military Personnel                            |
| DGPFSS    | Director General Personnel and Family Support Services         |
| DMFS      | Director Military Family Services                              |
| DMH       | Director of Mental Health                                      |
| DND       | Department of National Defence                                 |
| DOS SJS   | Director of Staff, Strategic Joint Staff                       |
| DQA       | Director Quality Assurance                                     |
| DQOL      | Director Quality of Life                                       |
| DSG       | Deployment Support Group                                       |
| ECS       | Environmental Chief of Staff                                   |
| EHR       | Electronic Health Record                                       |
| FHP       | Federal Health Partnership                                     |
| FPSC      | Family Peer Support Coordinator                                |
| GDMO      | General Duties Medical Officer                                 |
| HC        | Health Canada  |
| HLTA      | Home Leave Travel Assistance                                   |
| HR        | Human Resources  |
| HRMS      | Human Resources Management System                              |
| H Svcs Gp | Health Services Group  |
| IM        | Information Management   |
| IPSU      | Integrated Personnel Support Unit                              |
| IT        | Information Technology   |



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|             |  |
|-------------|--|
| JAG         | Judge Advocate General                             |
| JPSU        | Joint Personnel Support Unit                       |
| LO          | Liaison Officer                                    |
| MEL         | Medical Employment Limitations                     |
| MFRC        | Military Family Resource Centre                    |
| MH          | Mental Health                                      |
| MOC         | Military Occupation                                |
| MOF         | Medical Officer                                    |
| MOSID       | Military Occupation Structure Identification       |
| MSP         | Medical Specialist                                 |
| NATO        | North Atlantic Treaty Organisation                 |
| NES         | Non-effective Strength                             |
| NOK         | Next of Kin  |
| OCI         | Office of Collateral Interest                      |
| OPI         | Office of Primary Interest                         |
| OSI         | Operational Stress Injury                          |
| OSISS       | Operational Stress Injury Social Support           |
| OTSSC       | Operational Trauma and Stress Support Centre       |
| PA          | Physician Assistant                                |
| PCAT        | Permanent Category                                 |
| PCRI        | Primary Care Renewal Initiative                    |
| PEN         | Primary Emergency Notification                     |
| PHAC        | Public Health Agency of Canada                     |
| PhD         | Doctor of Philosophy                               |
| PIE         | Proximity, Immediacy, Expectancy                   |
| PM          | Performance Management                             |
| P Res       | Primary Reserve                                    |
| PSC         | Peer Support Coordinator                           |
| PSEL        | Personnel Selection Officer                        |
| PTSD        | Post-Traumatic Stress Disorder                     |
| QI          | Quality Improvement                                |
| QOL         | Quality of Life                                    |
| QR&O        | Queen’s Regulations and Orders                     |
| RCMI SITREP | Royal Canadian Military Institute Situation Report |

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|----------|--|
| RCMP     | Royal Canadian Mounted Police  |
| Roto     | Rotation   |
| S&T      | Science and Technology   |
| SA       | Special Advisor  |
| SCONDVA  | Standing Committee on National Defence and Veterans Affairs          |
| SISIP    | Service Income Security Insurance Plan                               |
| SISIP FS | SISIP Financial Services   |
| SME      | Subject Matter Expert  |
| SoC      | Spectrum of Care   |
| SPHL     | Service Personnel Holding List                                       |
| Surg Gen | Surgeon General  |
| TBS      | Treasury Board Secretariat   |
| TFA      | Task Force Afghanistan   |
| TLD      | Third Location Decompression   |
| TRAC2ES  | Transportation Command Medical Evacuation Command and Control System |
| UK       | United Kingdom   |
| US       | United States  |
| USD      | US Dollar  |
| VAC      | Veterans Affairs Canada  |
| VCDS     | Vice Chief of the Defence Staff                                      |
| WHO      | World Health Organization  |
| WW2      | World War 2  |
| YOE      | Years of Experience  |



## Results in Brief

Chief Review Services (CRS) conducted an evaluation of the support to injured and seriously ill Canadian Forces (CF) members, both Regular Force and Reservists, and their families. This issue is considered a top priority of the CF leadership.

The purpose of this evaluation is to confirm whether policies, programs and activities being undertaken to improve care of the injured and support to their families, including administrative issues, were appropriate and were accomplishing their objectives.

The scope of the evaluation included both on-duty and off-duty physical and mental injuries, and considered care at the point of injury, continuity of care, and associated administrative issues.

CRS assessed the current situation against a number of criteria, including the following dimensions:

- **clinical** (i.e., effectiveness of health care delivery), and
- **administrative** (i.e., efficiency of health care management at the tactical, operational and strategic levels).

The focus of this evaluation is on clinical and administrative issues in recognition of the dynamic situation presented in reacting to Afghanistan-related requirements.

Additionally, CRS sought to understand how injured CF members themselves and their families perceived the care and information they were receiving or had received. Also, although the evaluation did not assess post-release programs available to injured CF veterans through VAC, it did consider the effectiveness of transition management from DND to VAC for those members being released for medical reasons.

The evaluation noted the complexity of total care and support, which calls for intradepartmental, interdepartmental, member and family involvement and coordination. Gaps and opportunities for improvement were identified in a number of areas.

### Overall Assessment

- CF leaders have expressed firm commitment to the delivery of high-quality care for injured and seriously ill members, and support to their families.
- While care for physical injuries is generally of a high standard, challenges remain with the delivery of mental health care due to a lack of service delivery capacity and infrastructure deficiencies in some locations.
- Continuity of care for Reservists also remains a challenge.
- A broad range of administrative policies and programs exist for injured members, although greater effort is required to communicate them to all concerned.
- For medically releasing members, transition issues from the Department of National Defence (DND) to Veterans Affairs Canada (VAC) administration continue to exist.
- While support to families has improved significantly in recent years, family policies require renewed attention to confirm the appropriate level of support and to make adjustments accordingly.

## Key Recommendations

### Medical Care

Conduct a comprehensive field force review of Canadian Forces Health Services (CFHS) that reflects its critical role in the force generation of medical personnel for operations, including a review of the Primary Care Renewal Initiative (PCRI) establishment model. Based on review findings, align the required CFHS capacity to ensure conditions for success are set for medical and dental support as outlined in the force development models.

Normalize the command and control relationship of Operational Stress Injury Social Support (OSISS) to ensure the responsible director—Director Casualty Support Management (DCSM)—has total visibility and responsibility for all of the activities associated with DND’s Operational Stress Injury (OSI) program, including acting as Chief of Military Personnel (CMP)’s subject matter expert (SME) and special advisor (SA) in order to facilitate greater universal acceptance and integration, and build on the strengths of the OSISS Program.

Direct the introduction of a clinical psychologist Military Occupation Structure Identification (MOSID) into both the Regular and Reserve Force and establish new positions as required rather than seeking offsets from within current CFHS resources.

Develop policies and programs for an internship/apprenticeship program for civilian health care practitioners.

### Administration of the Ill or Injured CF Member

Maintain an administrative linkage with those CF members, both Regular Force and Reserve Force, who have been identified as requiring exceptional attention during and after the release process, until VAC and DND have concluded that the transition has been successfully completed.

Direct a complete review of civilian health care pay and staffing including the Public Service health care classification process to address challenges relating to the recruitment and retention of health care professionals within DND.

Ensure DND and VAC spectra of care continue to be harmonized.

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**Note:** For a complete list of CRS recommendations and management response, please refer to [Annex A](#).

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## Introduction

### Background

In accordance with the CRS 2007/08 Work Plan, an evaluation was conducted on support to injured Canadian Forces members and their families. The evaluation focused on support to include those mandated activities under the *National Defence Act* for injured CF members plus those activities which have been undertaken in fulfillment of the “Social Contract” between the Government of Canada and the CF members and their families.

### Aim

The aim of this evaluation was to assess the effectiveness of the support provided to injured CF members and their families.

### Objectives

The following objectives for this evaluation were considered:

- Are the CF/DND support programs presently in place for injured members and their families sufficiently comprehensive and do they meet program objectives?
- Are the roles of, and interrelationships between, the CF/DND, VAC, and other government departments and institutions at all levels clear and well understood by all parties?
- Have the CF/DND leadership efforts at all levels set the conditions for success for support programs aimed at injured members and their families?

### Scope

This evaluation focused principally on the treatment of those ill and injured CF members being treated for medical conditions through the CFHS. It also evaluated the effectiveness of those initiatives undertaken as part of the January 2008 CMP Campaign Plan for the Injured,<sup>1</sup> and those initiatives affecting serving/transitioning members and their families under the VAC New Veterans Charter.

### Methodology

This evaluation followed accepted evaluation practices, including the following:

- Review of available literature, internal documentation, applicable policies or agreements;
- Examination of the issues from the perspective of internal and external stakeholders;
- Comparison of CF/DND practices with those of our major military allies and alliance partners;

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<sup>1</sup> Chief Military Personnel Campaign Plan for the Injured, November 2008 (see [Annex C](#)).

- Benchmarking of CF/DND practices with selected Canadian domestic agencies and institutions; and
- Leading focus groups and conducting numerous and extensive interviews at all levels with key stakeholders.

## Description of Program

The medical care and administrative actions taken by the CF and the federal and provincial governments to support injured/ill CF members and their families are extremely complex, numerous, and quite daunting to those attempting to either access the system at its various entry points, or to simply try and understand how all the processes function together. There is no single program which applies to the numerous interactive medical and administrative processes involved in care and support of the injured/ill CF members and their families from point of injury/illness through to either return to work, or release from the CF. There are numerous medical and administrative staffs, located nationally and internationally who are involved in the provision of the complete range of services to the injured CF member. There is, however, one constant in this complex system—the injured/ill CF members.<sup>2</sup>

The chart at [Annex B](#), prepared by a former CF liaison officer (LO) to VAC, illustrates the complexity of the processes that affect just VAC and DND. The chart outlines those medical and administrative processes involved in dealing with the injured/ill CF members and their families, strictly from a VAC/DND point of view. This chart does not include the front end of the complex medical and administrative support provided in garrison and on operational deployments, return of the injured/ill from a deployment to either a Canadian tertiary health care facility, or to the CF member's original unit.

CRS has completed a number of evaluations and audits relating to medical and administrative aspects of the care of the CF ill and injured over the past decade<sup>3 4 5 6 7</sup>. The CRS 1999 evaluation of CF Medical Services provided the principal initiating force behind the revamping of CF garrison medical care, delivered through what is called the "Rx2000" program. Since the inception of Rx2000, and its component parts, significant change has been under way for care of the ill and injured both on operational deployments and in garrison.

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<sup>2</sup> For the purposes of this evaluation, the following DCSM definition of casualty has been used: "A member of the Regular Force (serving or on non-effective strength (NES)), a member of the Primary Reserve (P Res) on Class "A", "B" or "C" Reserve Service, or a member of foreign military service on training, operations or exchange duty who:

- a. becomes seriously injured/ill or very seriously injured/ill;
- b. is reported missing; or
- c. dies or is killed. (Casualty Administration Manual, DCSM, December 2008).

<sup>3</sup> 7055-42-2 (CRS) Review of the CF Medical Services, October 1999.

<sup>4</sup> 5000-6 (CRS) DND/VAC Evaluation of the DND/VAC Centre for the Support of Injured and Retired Members and Their Families, March 2002.

<sup>5</sup> 7045-71 (CRS) Audit of the CF Health Information System Project, October 2004.

<sup>6</sup> 1258-136 (CRS) DND/VAC Interdepartmental Evaluation of the OSISS Peer Support Network, January 2005.

<sup>7</sup> 1258-140 (CRS) Evaluation of CF Medical Support to Deployed Operations, June 2006.

The Rx2000 mandate was to initiate corrective action to ensure a high standard of health care for all CF members—anywhere, anytime. It is a reform project aimed at repositioning the CF health care system to be patient-focused, accessible and capable of meeting the needs of CF members, at home and abroad. To achieve this mandate the Rx2000 project developed four health care reform objectives:

1. to build a health care delivery structure that will ensure continuity of healthcare to CF members and other entitled personnel;
2. to implement a national accountability framework for the renewed CF health care system under the leadership of the Director General Health Services;
3. to establish programs designed to prevent injuries and illnesses, thereby protecting CF members while meeting requirements of DND/CF operations; and
4. to develop a human resources framework to attract and retain skilled health care professionals ensuring sustainability of the CFHS.

Administrative support and benefits for the ill and injured CF members, and their families, have also undergone significant change within the last decade, mirroring that experienced by CFHS. As a result of the Standing Committee on National Defence and Veterans Affairs (SCONDVA) report in 1998, a joint DND/VAC office (the Centre) was established to provide improved administrative support to ill and injured CF members and their families. This, combined with the passage by Parliament of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* (commonly referred to as the New Veterans Charter) in 2005, has contributed to enhanced interdepartmental assistance, compensation and benefits. In 2008, CMP commenced the introduction of Integrated Personnel Support Units (IPSU) whose function will be to integrate the administration of the ill and the injured.

With the increased level of operations in the Afghanistan deployment, and resultant casualties since late 2005, there has been a necessary increase in the pace of change in both medical and administrative efforts to support the CF ill and injured and their families. Not all of these efforts have achieved their desired levels of effectiveness and have provided a focus for this evaluation.

This evaluation will provide an overarching view of the successes or weaknesses of the complete process undergone by injured/ill CF members and their families.

The CF descriptions of medical “Roles” in the treatment of the ill and the injured are as follows:

## **Canadian Forces Definitions of “Role/Echelon” of Medical/Dental Care**

### **Medical Support—Land/Air Medical Treatment Facilities**

**Role 1.** This Role entails providing primary health care, locating casualties, providing first aid and emergency medical care, evacuating casualties from the point of injury/illness to a safer location, sorting patients according to treatment precedence, and stabilizing them in preparation for evacuation to another Role of care, as required.

**Role 2.** This Role emphasizes efficient and rapid evacuation of stabilized patients from supported elements, and en route staging and sustaining care. Emergency life-saving procedures may be performed. Depending on the evacuation policy, patients who require minor care may be held for short periods and returned to duty. Medical re-supply may be provided to supported Role 1 facilities.

**Role 3.** This Role provides resuscitation, initial surgery, post-operative care, and short-term medical and surgical in-patient care. Diagnostic services such as x-ray and laboratory, and limited scope internal medicine and psychiatric services are available. Reception and storage of medical supplies and blood, and distribution to supported units is provided, as well as repair of medical equipment within the area of operations. Other ancillary capabilities include national medical liaison teams for tracking Canadian patients in allied or host-nation facilities, intra-theatre evacuation and air medical evacuation staging.

**Role 4.** This Role includes definitive care, re-constructive surgery, rehabilitation, storage and distribution of national medical stocks, and major repair or procurement of medical and dental equipment.

### **Medical Support—Maritime Medical Treatment Facilities**

**Echelon 1.** This Echelon provides basic integral primary health care in support of individual units. Capabilities are limited to resuscitation, stabilization and those described in Role 1. Where no medical staff are part of the unit, care is limited to self and buddy care, through to ships with medical personnel but no physician, to ships with medical officers and staff.

**Echelon 2.** This Echelon provides emergency surgery. There is limited post-operative holding capacity and therefore evacuation is essential to sustain the recovery of patients.

**Echelon 3.** This Echelon provides specialist surgical teams and more advanced medical support. Essentially, this Echelon is the equivalent of the Land Role 3.

**Echelon 4.** This Echelon provides full and definitive medical treatment and is the same as the Land Role 4.

Deployed medical support for individual naval warships and a naval task group is normally limited to a Physician Assistant (PA) aboard the City-class frigates and Upholder-class submarines, a medical staff with a General Duties Medical Officer (GDMO) on board the Tribal-class destroyers, and a GDMO with PA on board the Auxiliary Oil Replenishment Ships. Care is limited to Role 1 and minimal Role 2. Allied/coalition resources provide any treatment beyond these levels either ashore or on other nations vessels.

Deployed medical support for air force deployed contingents consists only of Role 1, including the presence of a flight surgeon (a GDMO with specialized air-related Occupation Specialty Specification, not a “surgeon” in the specialist sense).

The most complex and resource-consuming effort required from CFHS is the provision of medical support to the land forces, which is the principal focus of this evaluation. Depending on location, task and troop numbers, land forces, and potentially a Canadian Joint Task Force, the full spectrum of medical care from Role 1 through to Role 3 in theatre, with Role 4 provided in Canada or at an allied medical facility, is required.

## Physical Care

### General

This section of the report will cover the physical care of the ill and injured CF members from point of injury to either return to work or release from the CF as a result of those injuries. In the case of Afghanistan operational injuries, it will cover the movement of casualties through Roles 1 to 3 in theatre, evacuation to Role 4 in Landstuhl, Germany (if needed) and return for further treatment in tertiary care facilities in Canada. This evaluation has also included a study of in-garrison care of the injured and ill.

### Rx2000, PCRI and the Development of the CF Health Care Model

The October 1999 CRS report on the CF medical services resulted in the implementation of the Rx2000 project which, from 2001 to the present, is producing a series of notable changes to the delivery of CF health care.

“The CF health care mandate is to provide the health care support necessary to sustain a multi-purpose, deployable, combat capable force across the full spectrum of military scenarios. The CRS report confirmed that the CF has the responsibility to provide medical services to its members as a result of the exclusion of CF members from coverage under provincial health care plans as specified in the *Canada Health Act* of 1984. Therefore, DND is legally bound to provide for the health care needs of CF members, at home or abroad, in a universal, portable, comprehensive, accessible and publicly administered way.”<sup>8</sup>

Another outfall of the Rx2000 project was the development of the in-garrison PCRI.<sup>9</sup> This initiative provided direction for the new CF health care clinical model.<sup>10</sup>

The new garrison clinical model was designed to reflect the following:

“The CF Medical Clinic is patient-centered and focuses on the long-term health of the CF member and the CF community, using an interdisciplinary team of health care providers working together to improve patient care and support to CF operations. The CF Medical Clinic promotes an environment that understands and respects the professional skills, knowledge and responsibilities of CFHS clinical providers. The CF Medical Clinic will promote standardization while meeting the unique local needs of the CF.”<sup>11</sup>

The clinical model outlines a professional medical team approach for each Care Delivery Unit (CDU), with dedicated medical officers, nurses, medical technicians, nurse practitioners, PAs and support staff. Each CDU in a base/wing clinic will be responsible for the care of a defined number of units/squadrons located on that base/wing. This was

<sup>8</sup> Rx2000 Project Charter, DSP Project 00000297, 19 October 2000.

<sup>9</sup> PCRI Implementation Strategy.

<sup>10</sup> The CF Medical Clinic.

<sup>11</sup> PCRI Implementation Strategy.

designed to allow for better continuity of care of individual CF members, as they could usually be guaranteed to see the same team of health care providers on a routine basis in garrison.

The management of the base clinics was also altered, with a clinic manager appointed to oversee the operations and business lines of the clinic. There is also a dedicated base surgeon, a uniformed CF medical practitioner, appointed to be the senior medical officer on the base and as the key principal medical advisor to both the base commander and to the formation commander in location if applicable.

Included in the reorganization of the base clinics was a reorganization of the associated mental health clinics into two mental health teams: Psychosocial and General Mental Health.

Despite acknowledged shortfalls in uniformed medical personnel to fill the expanded clinical model, the changes have proceeded and a certain degree of the directed reorganization has taken place across the CF.

### **Professional Technical Networks—CF Physician/Nursing National Practice Leadership**

The professional-technical network, formalized under Rx2000, is designed to provide a top-down/bottom-up avenue for expert clinical advice and guidance on technical matters and best practices outside of the formal chain of command. At the top of each of these professional networks is a designated “national practice leader.”

Within the CF/DND medical clinical professions, such as the physicians, nurses, surgeons, anesthetists, etc., their respective professional networks existed long before the Rx2000 initiatives, principally through guidance from their respective colleges. The CF/DND general medicine clinicians and surgical specialists have in the main been able to integrate internal technical guidance and best practices into their professional lives, while respecting their operational chains of command.

National practice leadership is a relatively straightforward task within the physician and nursing communities—the senior representative of each profession is known to all concerned with that discipline, and communication flows well within the technical chains that exist between practitioners in that discipline. Rx2000 has had little impact on these relationships.

### **Deployed Operational Medical Care—Roles One to Three**

While not excluding illness or injury sustained in a domestic setting or training accident, this section of the report will focus on the care and treatment of those injuries sustained by CF members on active operations. Treatment of these injuries is one of the principal foci of the CF medical services and will represent most worst case scenarios from a medical perspective.

This evaluation has found that, in the case of Afghanistan, from point of injury through medical evacuation from the Canadian-led Role 3 facility in the operational theatre, CF members receive medical care from CFHS health care providers that is equal to any in the North Atlantic Treaty Organization (NATO) alliance. There is substantive evidence that injured members who have experienced significant trauma injury and have survived transport to the Role 3 can expect to survive if evacuated in a timely fashion from the point of injury.

There is also significant anecdotal evidence to suggest that improvements over time in the training of both medical and non-medical personnel in emergency tactical combat casualty care have proven to be effective in saving the lives of personnel with significant injuries in the field. This has contributed to a qualitative and quantitative advance in care for CF members.

The CF “walking wounded” normally return through regularly scheduled flights from theatre back to either their home base for recovery, or to a Canadian civilian treatment facility if required.

For the more seriously wounded individuals, transition from the Role 3 facility in Kandahar through the Bagram Air Base to the Role 4 facility in Landstuhl, Germany, via the United States (US) medical evacuation system has worked effectively. Patient tracking in transit has been aided by CF access to the US Transportation Command TRAC2ES automated tracking system. The support of our US allies in this area has helped the CF organization, members and their families.

Care delivered by US physicians and surgeons in the Role 4 facility in Landstuhl has also been noted by interviewees as exemplary, with CF patients treated as well as any US military member passing through this hospital. In 2008, CANOSCOM assumed command of the CF casualty support team in Landstuhl. CF patients credit the employment of CF medical staff and chaplains in Landstuhl as a positive element in their evacuation experience.

The CF has also invested in several US/coalition casualty tracking and identification projects and databases, which allows input and access into wound trends information. This has included partnering with the US in the Joint Trauma Tracking System in order to track wound trends. This investment has assisted in the increased monitoring of multivariate treatment results through improved visibility of multiple criteria software systems. Included in this analytical approach is increased attention recently being paid to CF members exposed to concussive explosions with a view to longer-term monitoring of the effects of these incidents on long-term health.<sup>12</sup>

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<sup>12</sup> CANFORGEN 192/08 CMP 082/08 211739Z OCT 08 – REPORT OF CANADIAN FORCES HEALTH SERVICES ADVISORY PANEL ON MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY IN MILITARY OPERATIONAL SETTINGS.

## Selection of Canadian Treatment Facility

If an injured CF member will be returning to Canada and will need further institutional medical care, a decision is made in theatre as to which civilian tertiary care facility the member will be sent. This decision is made by the theatre surgeon and medical staff in consultation with the injured member (if possible and advisable, given the condition of the individual).

The decision to place a CF member in a certain civilian care facility has not been without problems. Several of the CF base surgeons consulted during this evaluation have expressed concern about a number of attendant issues with this process. One principal concern is the capability of the requested facility to support the injured adequately. Not every Canadian hospital has the capabilities needed for advanced trauma care, or other specialties such as neurosurgery. The CRS evaluation team has been told by CF health care providers that most often the choice of facility is made based on the injured member's next of kin (NOK) being nearby for moral support.

This has resulted in some injured individuals being sent to a civilian hospital outside the reach of the force generating unit/base, with less than ideal medical capabilities, and thereby significantly increasing administrative requirements, including the ad hoc creation of link nurses and the assignment of case managers, which only adds to the existing CF health care burden.

**Finding.** CF medical staff have noted that at least for initial treatment on arrival in Canada, a seriously or very seriously injured individual will be better off at a location selected in consultation with the force generating base surgeon and member's unit. If continued care is required in a medical facility, once the most serious injuries have been addressed, then the injured member could be moved to a facility closer to NOK.

### Recommendation

Consult with the force generating base surgeon, member's unit and NOK in order to select a location in which to hospitalize a seriously or very seriously injured individual. If continued care is required in a medical facility, once the most serious injuries have been addressed, then the injured member could be moved to a facility closer to NOK.

**OPI:** CMP

## Care of Injured CF Members in Canadian Health Facilities

With the withdrawal of the CFHS in the late 1990s from providing either Role 3 or Role 4 medical facilities for CF members in Canada, the CF now sends its ill and injured members to Canadian provincially run health care facilities for treatment.



This is somewhat similar to the approach taken by the United Kingdom (UK) armed forces, with the exception of military wards that are kept in specialized UK facilities with expertise in advanced trauma care.<sup>13</sup>

The US armed forces have an extensive health care system (TRICARE) which provides complete health care, principally in their own facilities, for serving members, some reserve force personnel, families of serving members and eligible veterans.

Previous studies by independent sources such as the Standing Senate Committee on National Security and Defence have noted that treatment of CF members has varied from province to province, and location to location within each province.<sup>14</sup> The evaluation team has determined that there can be significant differences in civilian medical care facilities that are accessible or near to CF force generating bases.

A number of CF bases are located in medically underserved areas of their provinces. This is specifically the case with Canadian Forces Base (CFB) Petawawa and CFB Gagetown, both force generating locations for the Afghanistan deployment and both with significant draws on all levels of medical resources. Lacking comprehensive medical facilities particularly with respect to treatment of severe traumatic injuries, CF members from both those locations must travel significant distances for specialist treatment of illnesses and injuries. This will also mean that the seriously injured members will inevitably be placed in facilities out of easy reach of their principal supporting units/bases.

The Director General Health Services (DGHS) has recently established Civil-Military Cooperation (CIMIC) cells (Health Support CIMIC—not to be confused with the Joint CIMIC function performed as part of ongoing operations in Afghanistan) on a Canadian Regional/Joint Task Force basis to try to address some of the civilian medical facility capability assessments. Most of these cells consist of one civilian and, in some cases, are joined voluntarily by the CF Joint Task Force Surgeon. This CFHS CIMIC functions as both an assessment mechanism and liaison office for the potential placement of CF injured and ill members. According to the Joint Task Force Atlantic CIMIC team, every Atlantic Area medical facility approached has been an enthusiastic and willing participant in this program.

Once a CF member is placed in a civilian health facility, much of the CF direct oversight and control over the individual's medical care is lost. Interviews with a number of CF medical staff concerning access to patient records, assessment of the adequacy of treatment in these facilities, and general passage of information on the patients have shown that there is little qualitative assessment of the adequacy of care of CF members in

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<sup>13</sup> Principally at the University Hospital Birmingham Foundation Trust, Selly Oak. The Royal Centre for Defence Medicine is also co-located with this facility. The principal UK orthopedic rehabilitation facility is the Defence Medical Rehabilitation Centre Headley Court.

<sup>14</sup> Bringing Our Wounded Home Safely, Report of the Standing Senate Committee on National Security and Defence, Second Session, Thirty-ninth Parliament, 2008.

these facilities undertaken by CF medical professionals. Most CF clinicians will accept the patient transfer records, plus the records of billable items as sufficient for their use. This is contrary to CFHS Group Instruction 7000-73.<sup>15</sup>

CRS found that CF members are seldom given the opportunity to provide timely feedback on the care received as there has been inconsistent assessment of the injured or ill members' experiences within civilian health care facilities. It is important that the CF, as a learning organization, offers the injured or ill the opportunity to provide feedback on their experience, including their preparation, the care they received and ongoing contact with DND/CF staff, such as case managers.

The open acceptance that the care provided to the civilian community by Canadian medical facilities is, by extension, appropriate for injured CF members does not account for significant differences between the two populations. For example, most Canadian hospitals have had little opportunity to treat unusual traumatic combat injuries and the often damaging psychological injuries which may accompany them. As well, it does not assure the CF chain of command that the member's unique cultural needs associated with being a military member are properly accounted for in treatment regimes.

**Finding.** Although the CF has contracted out domestic Role 3 and Role 4 responsibilities to civilian tertiary care facilities in Canada, there is a lack of consultation with the ill and injured members on the quality of care received in these facilities. As a result, those members who have observations or suggestions to improve the care received or administrative processes have no formal mechanism to do so.

### Recommendation

Implement a patient satisfaction survey system for all contracted-out medical services for ill and injured CF members.

**OPI:** CMP

**OCI:** ADM(Mat)/DQA

### Medical Records

CF medical records management policies and procedures are detailed in CFHS Group Instruction 7000-34.<sup>16</sup> When a CF member deploys on operations, a copy or shadow file of the CF 2034, the member's main medical record, accompanies him or her. If a member is injured or becomes ill, various documents relating to the injury will be placed on this shadow file, which is then sent back with the member to his/her force generating base/unit to be added to the main file. This process has not been without problems.

When asked whether all documentation relating to an injury is placed on the member's main file, it was unclear to some interviewees whether this was taking place or even should be done. Particular concern arises when medical information is being sought for

<sup>15</sup> CFHS Group Instruction 7000-73, Retention and Disposal of Personal Health Information, revision dated 9 May 2006.

<sup>16</sup> CFHS Group Instruction 7000-34, General Overview: Health Information/Records Management, revision dated 9 May 2006.

VAC claims, with the potential for missing documents that might affect that individual's case under review. The consequences of not doing this well can have a major impact on a CF member, particularly after retirement when dealing with VAC and the Veterans Review and Appeal Board.

Mixed views were heard across the CF concerning the transfer of a CF member's medical records from civilian treatment facilities. Some base surgeons interviewed for this evaluation have stated that they receive adequate information, while other base surgeons have indicated that they would prefer to receive all copies of treatment records of their patients as part of the total treatment record. The latter individuals have noted that they would prefer to screen out unnecessary documents themselves, rather than simply be given a treatment summary as the only official record.

A detailed discussion of the CF Health Information System (CFHIS) and the proposed way ahead for electronic medical records can be found in the Administrative section of this evaluation.

**Finding.** Execution of medical record keeping has been uneven.

#### **Recommendation**

Clarify and promulgate medical record keeping policies, roles and responsibilities.

**OPI:** CMP

#### **Garrison Health Care for Injured/Ill CF Members**

Ongoing operations, medical staffing shortages, force generation requirements and significantly increased numbers of injured and ill members have put an unforecasted burden on a number of CF base clinics, most notably at the principal force generating bases.

The PCRI model is still in its implementation stages and is not scheduled to transition to baseline until 2010. Most clinics have undergone a partial implementation of the model, with two clinics that the evaluation team visited, Halifax and Edmonton, having undergone almost full implementation. Given the asynchronous implementation of the new model across the CF, it was possible to look at the functionality of the CDU model in its various stages.

While Halifax and Edmonton have to all intents implemented the model, functionality varied between these two clinics. Efficacy of service delivery was dependent on adequate staffing of the clinics, and almost as critically, having adequate infrastructure to support the new CDU concept.

Reporting relationships vary between the medical clinics and the chain of command across the CF. In Halifax and Esquimalt, the Base Medical Clinics are under operational control of the respective Base Commanders. There is a similar relationship at the air force bases across the country with operational roles.

In Edmonton, as on all principal force generating army bases (Valcartier, Gagetown and Petawawa), the Base Medical Clinic is a sub-unit of the resident Field Ambulance. Military personnel can be, and are, rotated through the medical clinic from other sub-units of its parent Field Ambulance.

Most base clinical care across the CF is currently being delivered by a mixture of Public Service and contracted civilian health professionals. It was the intent of the PCRI model that the civilian component would assist the military members in the provision of continuity of care of the ill and injured, a feature that previously had been identified as missing. However, there are often few or no uniformed health care providers available for routine work in the base clinics. This problem arises regardless of whether or not a particular clinic is currently appropriately staffed with military members under the new PCRI model. With increased operational tempo and the deployment of the uniformed CF health team members, most CF base clinics will be without uniformed personnel for extended periods of time.

It was observed that one of the larger gaps in the garrison health care system for the injured CF member is the lack of appropriate physiotherapy and rehabilitation programs for the extensive physically traumatic injuries now being experienced in operations. Most of the advanced trauma rehabilitation work was being contracted out to civilian institutions and facilities due to a lack of CF resources.

However, research for this evaluation has indicated that most civilian physical rehabilitation and physiotherapy facilities are aimed principally at an aged population who are not necessarily focused on a return to work program, but simply rehabilitated to improve their mobility. The CF requires more than simple mobility improvements if the CF member is to return to full employment. This issue was recognized by CFHS and this gap in service is being addressed by the new CFHS rehabilitation improvement program.<sup>17</sup>

**Finding.** The PCRI model has not catered to necessary force generation of medical personnel across the CF. There are not enough military medical personnel in all military occupations (MOC) in the CDU establishments to allow for both garrison care and to support continuous deployed operations.

### Recommendation

Conduct a comprehensive field force review of CFHS that reflects its critical role in the force generation of medical personnel for operations, including a review of the PCRI establishment model. Based on review findings, align the required CFHS capacity to ensure conditions for success are set for medical and dental support as outlined in the force development models.

**OPI:** CFD

**OCI:** CMP

<sup>17</sup> CANFORGEN 179/08 CMP 077/08 301704Z SEP 08 NEW PHYSICAL REHABILITATION PROGRAM INITIATIVE FOR CF PERSONNEL.

## Mental Health Care

### General

This section will cover the mental health care of ill and injured members from onset of illness or injury to either return to work or release from the CF as a result of the illness or injury. In recent years there has been an increasing focus on the mental health issues of military personnel, primarily those associated with military operations. In December 2008, the DND/CF Ombudsman released a major report<sup>18</sup> that chronicles the health care and administrative experiences of CF members suffering from OSIs, and noting systemic issues that require remediation.

The CF defines mental health broadly as “that subset (of health) which pertains to cognitive, emotional, organizational and spiritual matters. Accordingly, it pertains to more than psychiatric illness. It involves intrapsychic, interpersonal, social and occupational functioning. Factors affecting mental fitness or mental health of a member can be social, individual, biologic or family.”<sup>19</sup>

Mental health conditions may often exist with multiple disorders (described as “co-morbid”) or with non-diagnostic behaviors (such as addictions) that must also be addressed. Recuperation and rehabilitation from severe physical injuries are often intertwined with mental health or emotional issues (depression, anxiety, fear, anger).

### 2002 Measurement of CF Mental Health

The CF undertook a joint project with Statistics Canada in 2002 to determine the prevalence of common mental health problems and the extent of unmet mental health care need. Known as the CF Mental Health Survey, this study provided baseline data intended to inform decision-makers about the nature and scope of the mental health problems within the Canadian military population. The Mental Health Survey report<sup>20</sup> compared mental health disorders prevalent in the CF population (Regular and Reserve Forces) to those of the general Canadian population.

The results revealed that members of the CF do suffer mental health problems at similar rates as their civilian counterparts, although depression was significantly more prevalent in Regular Force members compared to age- and sex-matched Reserve Force members or civilians. The reason for this excess of depression was not clear, though various studies have suggested that deployments *per se* are at most a minor contributor. The study looked at anxiety disorders (such as General Anxiety Disorder, Panic Disorder, Post-Traumatic Stress Disorder (PTSD), and Social Phobia), mood disorders (such as depression), and non-diagnostic disorders (such as suicidal thoughts and disordered

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<sup>18</sup> DND/CF Ombudsman report, *A Long Road to Recovery: Battling Operational Stress Injuries: Second Review of the Department of National Defence and Canadian Forces' Action on Operational Stress Injuries*, December 2008.

<sup>19</sup> Mental Health Concept Paper, para 8, p. vi.

<sup>20</sup> Mental Health Survey.

eating).<sup>21</sup> Similar results have also been recorded via the Mental Health component of the CF Health and Lifestyle Survey,<sup>22</sup> an instrument that has been used every four years since 2000.

### **CF Mental Health Initiative**

Supported by the results of the 2002 Study, CF leadership and the CF operational community sensed the impact that ten years of high operational tempo was having on the health and effectiveness of its members. It was determined that the CF had insufficient capacity to deal with the mental health needs as the awareness and demand for mental health care services rose to levels not seen since post-World War 2 (WW2). The CFHS Group undertook to assess the mental health services then available and committed to develop a system that better met the needs of all CF members.

Concurrent with this work was an internal effort by DGHS undertaken by the Standing Committee on Operational Medicine Review Working Group on Mental Health as part of the background work for Rx2000. Their detailed report from 2000 was a follow-on from several DND Ombudsman and independent Boards of Inquiry relating to care being delivered in the 1990s following the Somalia, Bosnia, Croatia, East Timor and Kosovo commitments. This Working Group prepared a set of detailed recommendations in February 2001 to improve mental health care within the CF.<sup>23</sup>

The DND/CF product derived from this background of mental health work within the Rx2000 program was known as the Mental Health Initiative which was endorsed by DGHS in September 2003, as the new Concept for CF Mental Health Care.<sup>24</sup> This Concept had been developed with extensive consultation between internal mental health care providers, the wider CFHS community, operational clients and external specialists. The Concept outlined how mental health resources were to be employed, and provided an outline plan to standardize mental health care. DGHS directed the cooperation of all care providers (not just those specialized in mental health care) to adopt and implement the mental health model.

“We will be looking for additional mental health care providers in everything from more psychiatrists and psychologists to social workers and nurses. We are also stressing the link between primary health care providers and mental health care providers. The primary care providers play a significant role in the identification and management of individual members who are suffering from mental health illnesses. We call it shared care.”

CF Mental Health Concept Paper 2003<sup>25</sup>

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<sup>21</sup> AMD015FHPAF001, 2005-09-01, p. 42.

<sup>22</sup> CF Health and Lifestyle Survey (for results); CANFORGEN 2008/210-08 for 2008 survey year.

<sup>23</sup> Annex A to CF Health Initiative 23 September 2003, “Concept for Canadian Forces Mental Health Care.”

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

Although a small portion of the CF Mental Health Strategy was to be focused in health promotion, the bulk of the Mental Health Strategy was to be directed at care post-onset of illness/injury utilizing evidence-based practices.

### The CF Model for Mental Health

The CF mental health care model is based on a multi-disciplinary approach to assessment and treatment as outlined in the Concept for CF Mental Health Care. Mental health teams were to be formed comprising psychiatrists, psychologists, social workers, mental health nurses, addictions counselors and mental health chaplains.<sup>26</sup>

This multi-disciplinary clinical approach is one that is being used in Canadian civilian mental health facilities, and is also seen in use across NATO/America, Britain, Canada and Australia (ABCA) nations for their military health care models. Integrating mental health with primary care is consistent with civilian best practice and is endorsed by the World Health Organization (WHO).<sup>27</sup>

Within the CF, at the mental health delivery/tactical level, this multi-disciplinary model was further defined to include a division within the mental health clinics located at CF garrisons into two distinct functional teams: General Mental Health and Psychosocial Mental Health. Mental health care was to be integrated with the general health services delivery system and delivered under the supervision of the CF member's assigned general-duty medical officer.

It was intended that this mental health delivery model would achieve the following:

“The proposed Mental Health concept represents the most cost-effective option to correct the operational and human shortfalls identified in recent reviews and reports. It establishes a minimum essential core military component for the effective support of operations while providing for a stable in-garrison care provision capability which optimizes the continuity of care. The structure and processes put in place enhance the co-ordination, teamwork and synergy of effort, not only of the interdisciplinary Mental Health team, but also among mental health, primary care, health protection and the operational chain of command. This conserves scarce resources while allowing enhancement of the capability to safeguard the mental health of CF members and treat injuries effectively when they occur.”<sup>28</sup>

The CRS evaluation team proceeded to seek evidence that this mental health model has produced the results expected above.

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<sup>26</sup> Appendix 2 to Annex D to CF Health Initiative 23 September 2003, “Concept for Canadian Forces Mental Health Care.”

<sup>27</sup> WHO Report “Integrating mental health into primary care—A global perspective”  
[http://www.who.int/mental\\_health/policy/Integrating%20MH%20into%20primary%20care-%20final%20low-res%20140908.pdf](http://www.who.int/mental_health/policy/Integrating%20MH%20into%20primary%20care-%20final%20low-res%20140908.pdf).

<sup>28</sup> Annex A to CF Health Initiative 23 September 2003, “Concept for Canadian Forces Mental Health Care.”

## Mental Health Care Support to Deployed Operations

Pre-deployment medical and psychosocial screening is part of the general process of screening for deployed operations. Once deployed, the CF mental health concept of operations is to embed a tailored mental health team. For example, the Afghanistan commitment features a psychiatrist, two mental health nurses, and a social worker who are deployed with the NATO Role 3 hospital at Kandahar Airfield. Their principal role is to provide mental health care as soon as practicable after onset of a critical stress reaction to combat incidents.

Medical research has shown that the likelihood of positive long-term mental health outcomes is greatly improved if the care needed is available as far forward as practicable in an operational theatre, and received as soon as possible after an incident, while at the same time the member can draw from the comradeship and trust of his/her military “family.” This military mental health concept has been described as the PIE model (“proximity, immediacy, expectancy”).<sup>29</sup>

It has been noted by most of the mental health clinical leadership consulted for this evaluation that force-generating mental health specialists from the limited number available for this task has placed a strain on the domestic mental health clinics. Despite these constraints and resource pressures, the CRS evaluation team has confirmed that clinicians, commanders and members are satisfied with deployed mental health service.

Mental health screening for smaller deployments and ship deployments includes sign-off by a mental health social worker and the member’s physician to avert mid-tour repatriations of members with unsupportable mental health issues. However, screening may not take place on return. Commanding officers (CO) interviewed for this evaluation have commented on problems associated with a small number of no-notice arrivals to their home units of well, injured and ill members from operations who have not been seen by medical personnel. There is an elevated risk that members, particularly individual augmentees, may not be screened for health issues.

The CRS team heard from administrators, family support and health care providers that the air force implementation of more frequent, but shorter, 56-day deployments has resulted in unexpected mental health consequences for the CF members and their families. CFHS has adjusted local health surveillance screening standards, and the air force is reviewing its deployment tour length policy.

Most formed units, upon redeployment, will participate in a third location decompression (TLD).<sup>30</sup> At this TLD, mental health personnel provide compulsory mental health education complemented with voluntary counseling services. CANOSCOM now conducts this program in Cyprus.

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<sup>29</sup> <http://www.rcmi.org/archives/SITREP/08/08-3%20Sitrep.pdf> “Partnership in Performance: Leaders and Mental Health Care Providers,” RCMi SITREP, May-June 2008, Vol 68, No 3, pp. 9.

<sup>30</sup> DCDS Direction for International Operations, Chapter 12, Section 6. The CF screening and reintegration policy requires that all members returning from an international operation of 60 or more days’ duration undergo the Enhanced Post-deployment Screening Process between 90 and 180 days after return to Canada.



At the Arrival Assistance Group (AAG), unit members are informed about the required mental health screening process. Formed groups redeploying to Canada are given compulsory mental health assessments by CF/DND domestic mental health practitioners three to six months following deployment.

A post-deployment screening gap may exist for members repatriated early, and members transferred mid-rotation—the screening for these individuals is due earlier than for the bulk of those in their unit. As well, the completion rate for the mandatory post-deployment mental health screening is 72 percent.<sup>31</sup> As with all post-deployment activities, it is the responsibility of the member's current commanding officer to assure that all items on the post-deployment checklist are completed in a timely manner. The leading reason for members failing to get the post-deployment screening is the failure of some (but certainly not all) COs to assure that everyone gets screened, presumably due to competing demands.

Despite requirements for submission of a detailed screening and reintegration plan three months prior to the end of each rotation, the screenings are often not built into the unit training schedule well in advance. The current screening and reintegration policy (DDIO Chapter 12, Section 6) requires that COs report back “periodically” to the force generators as to the progress of screening activities, but this is inconsistent. Weaknesses in the Human Resource Management System (HRMS) make tracking the progress of screening a manual one that varies from base to base, from rotation to rotation, and from unit to unit. HRMS cannot be relied upon to develop timely, accurate deployment nominal rolls—without these, local *ad hoc* data sources need to be used, precluding any higher-level visibility as to the progress of screening and risking the possibility that some people will be missed due to imperfect data sources. Accurate departure and return dates are particularly important because the need for screening is determined by the duration of the deployment and the timing of the screening is determined by the timing of return. The CF's inability to develop timely and accurate deployment nominal rolls has been identified as an important deficiency by a number of reports and Boards of Inquiry over the past 10 years, but little progress has been made.

The completion of the lengthy post-deployment checklist is recorded in HRMS only as a single check-box rather than a detailed list of specific activities (as is used for pre-deployment screening/personal readiness verification). This severely limits the utility of the tool for monitoring the progress of screening and reintegration activities. Finally, monitoring and researching the health effects of previously deployed CF members is impossible without accurate nominal rolls.

The improvements announced<sup>32</sup> to make pre- and post-deployment screening more effective and efficient for the member have not yet been felt in the field. The evaluation team noted that mental health questions are now part of routine medical exams and the periodic health assessment process.<sup>33</sup> Despite the uneven compliance with post-deployment screening, there is evidence that this and other mechanisms are working to

<sup>31</sup> Briefing Note Dr. Mark Zamorski, noting an improvement over prior completion rates of 41 percent and 56 percent.

<sup>32</sup> Department of National Defence Report on Plans and Priorities 2008-2009, pp. 44.

<sup>33</sup> CF2033 (02-2007) MEDICAL EXAMINATION RECORD (PERIODIC HEALTH ASSESSMENT).

get individuals in care much earlier than in the past. For example, about half of those who reported symptoms of PTSD during their post-deployment screening were already in care at the time of their screening, which took place on average about five months after return. In 2002, the Statistics Canada Mental Health Survey showed that the typical delay to care for those with service-related PTSD was more than five years.

In addition, an audit performed at CFB Edmonton after Task Force Afghanistan (TFA) Roto 1 showed that about one-third of Edmonton-based personnel had sought mental health care in the first year after their return.

The major force generation bases have permanent Deployment Support Groups (DSG) with solid processes, including mental health screening. However, spouses/families are accommodated to different degrees by the DSGs/bases; hence, mental health psychosocial spousal participation rates vary. AAGs have also been standardized by DSGs/bases, and screening at this point is particularly focused on reservists (a lesson learned about the difficulty finding them later).

The Reserve Force members are delayed the longest following a deployment in order to provide what assessment and care can be provided in the normally short period of time remaining in their contracts. Follow-up on reserve health care post-deployment is recognized by CFHS staff and the chain of command as a gap to which the CF expends considerable energy attempting to reach as many reservists as possible given the constraints.

### **Measuring Deployment-related Mental Health**

CF mental health practitioners are generally in favour of TLD and TLD mental health education to enhance participation in the follow-on mental health screening process in garrison; however, they stress the need to recognize the incremental unfunded workload Departure Assistance Groups (DAG), AAGs and TLDs have imposed on CF/DND mental health providers which further reduces capacity in CF mental health clinics.

The bulk of the mental health enhanced post-deployment screening data is collected three to six months post-deployment. CFHS analysis of the available data provides prevalence rates for symptoms suggestive of post-traumatic stress disorder, depression, suicidal thoughts, panic disorder, generalized anxiety disorder, and behaviors such as high-risk drinking (including co-morbid conditions).<sup>34 35</sup> The results of this analysis suggest a continuing demand for general mental health services, particularly as more Afghanistan veterans begin filtering through the mental health system.

CF and other comparative studies reviewed by the evaluation team suggest that the selection, training and screening processes contribute positively to the general mental fitness of the CF population and accounts for the reported rates of mental health disorders

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<sup>34</sup> At this point in time, accurate diagnostic data is not available, hence the qualification “suggestive.”

<sup>35</sup> BRIEFING NOTE ON THE PRELIMINARY FINDINGS OF THE ENHANCED POST-DEPLOYMENT SCREENING OF THOSE RETURNING FROM OP ARCHER/TASK FORCE AFGHANISTAN AS OF 28 APRIL 2008, prepared by Dr. Mark Zamorski, Head, Deployment Health Section, 26 May 2008 (see Annex D Excerpt 2).

which are commensurate with the nature of the operations. Notwithstanding the measures in place, CF/DND mental health professionals accept that deployed operations will put some CF members at increased risk of mental health issues. There is ongoing professional debate about whether mental health issues rise with frequency and intensity of deployments.

**Finding.** The prevalence of symptoms reported at the time of post-deployment screening has been stable. CF deployment health and mental health experts judge that the apparent prevalence of mental health problems is commensurate with the nature of the operation.

### **Mental Health Clinics and the Delivery of Domestic Mental Health Care**

The CF primary care setting within Canada is the local base health care clinic. Patient care within the clinic is led by the CF member's assigned GDMO (either military or civilian). When required, it is the GDMO's responsibility to refer patients to local mental health resources. Of the 51 geographically distinct medical clinics that the CF operates in Canada, 10 are large enough to support mental health clinics, and five of these have both mental health clinics and Operational Trauma and Stress Support Centres (OTSSC). The remaining clinics employ a partial team of mental health specialists.

Mental health services within the mental health clinics are organized into two areas: General Mental Health (specializing in the long-term treatment of patients) and Psychosocial Services (for assessments and short-term interventions). The major distinction between the two areas is that access to General Mental Health is via physician referral only. Psychosocial Services, however, accepts self-referrals and maintains segregated records.<sup>36</sup>

Given the duration of Rx2000 implementation, the evaluation team expected that significant progress would have been made in delivery of the mental health initiative, and that results could be shown regarding the successful and effective integration of the mental health disciplines. However, a significant challenge remains for some mental health clinic managers and the mental health national practice leads in achieving appropriate integration of the disciplines associated with mental health care.

Prior to 2003, most mental health disciplines were not functioning as multidisciplinary mental health teams. Most of the mental health professionals had some experience in team work in larger civilian hospitals and mental health care facilities. However, with few exceptions, the mental health team approach has not been common practice in the CF/DND since the dissolution of the Role 3/Role 4 domestic capability in the 1990s. The implementation of the interdisciplinary mental health teams outlined in the Mental Health Initiative Implementation Plan has changed the delivery dynamic and the balance of disciplines assigned to clinics across the CF. To provide the coordination and leadership required, CFHS introduced a Director of Mental Health in January 2009.

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<sup>36</sup> Psychosocial records are a sub-folder of the member's medical record CF2034. They are problematic because they may contain information about the member's relationships/other people and are retained indefinitely.

**Finding.** Despite the lengthy implementation of Rx2000, significant challenge remains for some mental health clinic managers and the mental health national practice leads in achieving appropriate integration of the disciplines associated with mental health care. The new Director of Mental Health has been directed to ensure that this necessary integration will be effectively accomplished in the near term.

### Co-morbidity and Physical Injuries

Interviews with mental health providers across the CF/DND have indicated that there is very often at least initial mental health problems associated with injury, whether from a combat injury or a severe training accident, or even a domestic motor vehicle accident. Mental health practitioners interviewed for this study, and background research done by the evaluation team, have also indicated that significant mental health issues may often feature increased levels of addictions and other destructive behaviours.

The CF is wholly dependent on civilian tertiary care facilities for the most seriously ill and injured, to address severe life-threatening physical injuries as a first priority. The CF is also dependent on civilian treatment centres for many severe mental health disorders. Several cases were presented to the evaluation team wherein these civilian institutions did not actively address co-morbid mental health issues. This has been attributed by health care providers to the specialized single-focused nature of the institutions themselves. In several of these cases, the evaluation team noted that CF/DND health care providers were either not made aware of potential co-morbid issues, or did not follow up on suspected problems. This has had consequences for the affected CF member, principally due to less than ideal coordination amongst the case management teams.

**Finding.** Best practices indicate that better coordination and engagement of CF Mental Health and Rehabilitation teams in a multidisciplinary approach is needed in complex cases involving severe physical injuries where long hospital stays are needed.

### Operational Trauma and Stress Support Centres

Five CF bases have OTSSCs that offer an enhanced level of support “for those psychological, emotional, spiritual and social problems that arise from military operations.”<sup>37</sup> The mental health concept held that mental health resources were to be “geographically distributed in close proximity to the client.”<sup>38</sup>

The OTSSCs were created in 1999 and had been evolving independently of each other until 2007. In 2007, the Deputy Surgeon General directed that OTSSC staff take a common approach to their assessment and treatment protocols across the CF. Recent progress to achieve treatment consistency and to address continuity of care that

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<sup>37</sup> The OTSSC mandate is to develop and maintain a body of expertise and experience on the management of the types of mental health problems associated with military operations; to share this expertise and experience with care providers at base level through constant liaison and through outreach educational activities; and to apply this expertise and experience in the management of individual cases referred to them.

<sup>38</sup> MH Concept para 58c, p. 21/37. The OTSSC as of January 2009 are located at Esquimalt, Edmonton, Ottawa, Valcartier and Halifax.

patients receive when they are transferred between facilities is evident in interviews with key leadership in these clinics; yet, there remain areas of contention and professional disagreement that require further work and standardization efforts.<sup>39</sup>

A serious issue exists in the resource distribution and workload between bases with OTSSCs and other high-need army bases (e.g., Petawawa, Gagetown) that remain configured as mental health clinics. OTSSCs by their nature are full-service facilities with sufficient staff to provide the full range of assessment and treatment of CF members. As noted by the CF Ombudsman report, the consequence of not placing adequate numbers of mental health professionals in certain locations, in particular high-need army deployment bases, is that they remain underserved by mental health services, such that members and families must travel long distances to attend regular appointments and suffer longer wait times to access services.<sup>40</sup>

In Gagetown, by early 2008, the backlog of CF members waiting for their necessary mental health assessments before treatment had climbed into the hundreds. At the time there were delays of several months in scheduling mental health assessments, with a psychiatrist available only 2.5 days per week for the clinic. Gagetown does not have an OTSSC structure and has encountered problems with outsourced mental health providers. There was also a lack of a clinical lead for each of the disciplines, which an OTSSC has. There were unclear guidelines between the mental health disciplines, accompanied by a high and growing demand for services. This finally reached a point where the Base Commander became involved in dealing with parliamentarians and the media who were asking questions about this specific clinic.

The mental health model, as envisaged in 2003, was simply not working effectively in high-demand locations without an OTSSC structure, lacking adequate numbers of qualified staff, and without adequate clinical and professional guidance and standards. The evaluation team spoke at length with a number of the mental health professionals affected. It was clear that these mental health care providers were extremely dedicated to what they were doing. They said that they were also frustrated by the pattern of internal conflict, professional disagreements over treatment issues, caregiver stress and burnout, and a lack of higher-level clinical and professional guidance.

In military terms, these organizations lack adequate “doctrine” which would provide a standardized, replicable direction on how to act as members of the mental health teams. Some of these mental health professionals, such as psychiatrists and nurses, have a self-regulating college, while others have an association or professional organization which provides for professional accreditation and standards to be followed in their own individual line of mental health care. What is missing from the mental health model is how to operate together—who does what, to whom, and when? However, concrete actions have been taken to remedy some of these issues, particularly, as noted earlier, with the appointment of a Director of Mental Health.

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<sup>39</sup> The process for an OTSSC assessment is explained in the flowchart at Annex D, taken from recent standardization efforts.

<sup>40</sup> DND/CF Ombudsman report, *A Long Road to Recovery: Battling Operational Stress Injuries*, December 2008 <http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/osi-tso-3/doc/osi-tso-3-eng.pdf>.

## Mental Health Leadership and Professional Technical Networks

It was envisaged under the 2003 mental health concept that a national practice leader for each of the disciplines would be involved directly in the building of their respective communities of practice within DND and to provide professional technical guidance and training development. What the evaluation team has seen is something other than this desired outcome.

The mental health model did not set itself up for success in the original concept. It was envisaged that all that would be required at the national/strategic level was a mental health coordinator to ensure that all the pieces were working together. However, the evaluation team noted that the concept only saw the need to put a lieutenant-colonel health services officer in the coordinator position, and not necessarily a mental health professional. This did not ensure that a qualified professional would oversee the development of what was then a new approach for the mental health community at the national level.

Within the mental health disciplines, the evaluation team noted that virtually all of the mental health national practice leads were working in isolation from each other. Significant professional disagreements were noted between several of the disciplines on treatment protocols and initial mental health assessments. Some of the leads had not routinely provided any technical or professional guidance for their disciplines since the professional-technical system had been set up. Interviews conducted at the tactical/base level confirmed that many mental health professionals were less than satisfied with the direction being provided to them from their national level practice leadership.

Issues surrounding continuation training of the mental health disciplines surfaced at every base the evaluation team visited. There was great concern expressed amongst certain disciplines that professional continuation training was being insufficiently funded. While the evaluation team did not pursue detailed investigation of this claim, it was noted that this was expressed almost universally across the CF/DND from the mental health professionals at the base level. Anecdotal information indicated that many were taking leave days and paying out of their own pockets to take required training necessary to maintain professional accreditation. There was frustration expressed by many of these same interviewees on what they saw as a lack of involvement from their leaders in this area.

In the CF/DND mental health community as a whole, processes and standards within each discipline are not mature, and credentialing standards and standards enforcement in the field are inconsistent (for example, there are ongoing efforts to standardize credentialing issues relating to psychologists and addictions counselors). DGHS has also instituted a credentialing cell which will track all health care providers' credentials with the exception of the contracted Calian employees. It was also noted that military cultural training or acculturation of the mostly civilian mental health providers is minimal or lacking in virtually all locations. The CRS team noted that mental health case management reviews were being conducted in most locations; however, although there was consistent agreement as to the benefit of these interdisciplinary reviews, the clinicians interviewed stressed that this represented a significant workload on mental

health staffs that further reduces clinic capacity to see patients. Despite the positive support expressed by the CF/DND mental health community, those outsourced mental health clinicians interviewed by the evaluation team confirmed that they are not included in case reviews, often due to funding and scheduling difficulties.

**Finding.** The principal issue facing the CF/DND mental health community is one of a lack of national leadership and governance. There is currently no single individual to whom those within the community can turn to for strategic guidance, policy setting, doctrine production and overall professional leadership.

**Finding.** The mental health clinical team concept has been weakened by a lack of mental health team doctrine, guidance on boundaries between practicing mental health professions similar to what exists in the physical medicine professions, and coherent training and professional development regimes. As a result, the national practice leadership concept has not been effectively implemented. It will be critical for the new Director of Mental Health to address these issues.

### Care for the Caregiver

The mental health concept included a comprehensive Care for the Caregiver program. The CRS evaluation team saw little evidence that elements of that program have been implemented. Most clinics did not have organized caregiver programs; it was often left to individuals to arrange this amongst themselves. Although some practice leads include elements of such programs into their national conferences if held, not all personnel get the opportunity to attend. Interviews with health care professionals and research done for this evaluation have noted the need for a caregiver program. Both medical and mental health practitioners have observed that there is burnout and compassion fatigue amongst the providers.

**Finding.** The morale and welfare of mental health caregivers is at risk.

### Recommendation

Meet with appropriate SMEs, such as the Canadian Caregiver Association, and seek advice that would assist at-risk mental health caregivers who provide care for CF members.

**OPI:** CMP

### Availability of Mental Health Services in French

Concern was expressed by clinicians about the lack of mental health services available to francophones in their mother tongue. Mental health professionals interviewed for this study noted that it is rare that a clinician is able to perform patient counseling to professional standards in their second language.

**Finding.** CF mental health services lack the capability to meet the demand for services in French to francophone members in most clinic settings.

### Recommendation

Meet with the Canadian Psychological Association/Société canadienne de Psychologie and seek advice that could assist in developing a framework for care for French-speaking CF members who require mental health services in their own language. Specific advice from l'Ordre des psychologues du Québec and other associations with French membership should be sought. Further work of this nature should be undertaken with the respective health care providers' Colleges and Associations.

**OPI:** CMP

### Operational Stress Injury Social Support Program

In addition to clinical treatment, CF members who suffer OSIs typically receive social support from their families, units and peers. To formalize peer support, DND and VAC jointly established the OSISS program utilizing a network of peer support coordinators (PSC) and local volunteers. The PSCs are all veterans of CF operations who have suffered an OSI as a result of service, and who have recovered to a point where they are able to fulfill the coordination role.

The mission of the OSISS program is to establish, develop and improve social support programs for CF members, veterans and their families affected by operational stress, as well as bereaved families of military members and veterans, and provide education and training in the CF community to create an understanding and acceptance of operational stress injuries.<sup>41</sup> More recently, family peer support coordinators (FPSC) have been hired to assist family members who are supporting a CF member with an OSI. The number of PSCs and FPSCs now totals about 40, all of whom are Public Service employees. Allied to the OSISS program is the Mental Health and Operational Stress Injury Joint Speakers Bureau, created to build awareness of mental illness and OSIs and to increase understanding and acceptance of these conditions.

In terms of governance within DND, in that the OSISS program is non-clinical, it is outside the Rx2000 mental health model and is administered nationally by a program manager within DCSM. Policy statements issued by DCSM and published on the OSISS website provide the necessary direction and protocols respecting program implementation. Program oversight and guidance are provided through the OSI Steering Committee and the Mental Health/OSI Working Group. The position of SA for OSIs has recently been established and reports directly to CMP on relevant issues.

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<sup>41</sup> *Operational Stress Injury Social Support (OSISS) Program Policy Statements*, DCSM, revision dated 26 May 2006 [http://osiss.ca/PDFS/ENGLISH/OSISS\\_Policies\\_En\\_July\\_08.pdf](http://osiss.ca/PDFS/ENGLISH/OSISS_Policies_En_July_08.pdf).



A joint DND/VAC evaluation of the OSISS peer support network was conducted in 2005 and concluded that “the Peer Support Network is a key element of the social support structure for CF/Veterans affected by OSI” and is “contributing effectively” to meeting their needs.<sup>42</sup> Notwithstanding these positive results, the DND/VAC evaluation did identify a number of issues requiring attention to reduce risk and improve program effectiveness.

The OSISS program was not evaluated, but research and interviewees noted that it is a positive adjunct to clinical treatment of OSIs. Nonetheless, despite consistent support at the strategic level, CRS observed that boundary concerns and inconsistency still exist with respect to program execution at the tactical level in some locations. On some bases a productive synergy exists among OSISS PSCs, the mental health clinical team and the local chain of command, characterized by mutual trust and effective communications. On other bases, local PSCs are seen by health services staff and the chain of command as sometimes working at cross-purposes to their efforts. This has contributed to a degree of mistrust and has the potential to undermine the clinical treatment being provided. In that regard, OSISS Policy Statements advise PSCs that boundary conflicts can be avoided by, *inter alia*, “developing strong positive working relationships with a range of CF and VAC staff/care providers” and “respecting the mandate and dedication of all other professionals who work with Peers.” Some work is still required to build that mutual respect and understanding.

In some locations, there is also concern by the local chain of command that those PSCs and volunteers who continue to publically exhibit symptoms of their own OSI are unsuited to the task of providing effective peer support. As the OSISS peer support network continues to evolve and expand, selection of suitable PSCs will become even more critical.

**Finding.** OSISS is a non-clinical social support program that is outside the DND/CF mental health model. Boundary concerns exist at the tactical/base level. Improved integration of OSISS with clinical mental health care is required.

### Recommendation

Normalize the command and control relationship of OSISS to ensure the responsible director (DCSM) has total visibility and responsibility for all of the activities associated with DND’s OSI program including acting as CMP’s SME and SA in order to facilitate greater universal acceptance and integration, and build on the strengths of the OSISS Program.

**OPI:** CMP

### Medical/Clinical Infrastructure

It was noted by DGHS staff that the successful implementation of the new CF clinical model hinged very much on timely delivery of the new infrastructure associated with the model:

<sup>42</sup> DND/VAC Interdepartmental Evaluation of the OSISS Peer Support Network, 1258-138 (CRS), January 2005.

“The successful implementation and operation of the clinic model is significantly dependent upon two other major CFHS projects:

- **The CFHS Infrastructure Recapitalization Project.** This project involves recapitalization of all CF clinics to ensure they meet health care standards and to ensure they provide the appropriate layout and sufficient space to allow staff to operate effectively. The current funding envelope for the recapitalization initiative is spread out over a period of approximately 20 years; and
- **The CF Health Information Systems Project.** This project provides an electronic health record (EHR), as well as patient scheduling, and other capabilities.

The clinic model and its associated processes were designed based on the assumption that the infrastructure and electronic health information system would be in place prior to full implementation of the new model.

Anything that jeopardizes either of these two projects has the potential to jeopardize the successful implementation of the clinic model.”<sup>43</sup>

This infrastructure delivery across the CF has been uneven at best, despite risk mitigation efforts. Most of the clinics visited by the evaluation team feature temporary accommodations for the new CDUs. It is only the established clinical facilities in locations such as Halifax that have had little problem implementing the new clinical model. For the rest, there are nests of rented trailers, which provide little or no privacy for clinicians and patients alike, do not allow for emergency evacuation by stretcher because of hallway width issues, and feature some access and transport problems for the mobility-impaired.

In some locations, base commanders will no longer allow any further temporary structural development of existing base clinics, with the result that some clinical capabilities that should be co-located are now off the base. In places such as Gagetown and Edmonton, the lack of timely delivery of needed infrastructure has meant that the mental health clinics, which should have been located with the rest of the medical facilities, have been or will shortly be forced off the base due to lack of space, to the detriment of treatment and care. This has had the expected results, such as loss or delay of medical documents, including clinical referrals and requests for tests. It has certainly inhibited collegiality between the various clinicians and their support staffs.

**Finding.** On those bases with adequate medical infrastructure that enables co-located clinical facilities, noticeably streamlined care for the ill and the injured has been observed. On those bases lacking this clinical co-location, noticeably inhibited treatment of the ill and injured has been noted.

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<sup>43</sup> CF PCRI Clinical Model Implementation Strategy, November 2004.

## **Communications with the Chain of Command and Medical Employment Limitations (MEL) Interpretation**

Successful care of injured and ill CF members is strongly predicated on numerous factors, one of which is a good working relationship between the medical practitioners and the individual's chain of command. The chain of command is that supportive link in a CF member's military life that is quite distinctive from that which is normally found in the civilian community at large.

The evaluation team interviewed individuals at all rank levels on both sides of this relationship during the conduct of this project. All interviewees from the chain of command have firmly expressed their views that one of the most critical pieces in this equation is the role of base surgeon on the operational CF bases. With the centralization of all health care resources under DGHS, and the need to establish effective command and control relationships between the CF medical services and the chain of command, dealing with the local military leadership is one of the base surgeon's most critical functions. It has been noted in the conduct of this evaluation that the success or failure of this relationship is very much personality-dependent, and its degree of success or failure has varied widely from location to location.

This problem has often been exacerbated by the extremes in experience levels of the various base surgeons. On two bases visited by the evaluation team, the base surgeon was a Calian-employed contractor. On several other bases, we found only recently qualified, quite inexperienced medical officers as the substantive base surgeon. There are very few experienced medical officers employed in this function. One of the consequences of having inexperienced base surgeons, combined with a medical staff composed principally of civilian Public Service or contracted personnel, is a reduced level of communications and levels of trust with the chain of command on those bases.

The overwhelming number of civilian health care workers on CF bases have had little or no cultural training or familiarization with how the CF functions, and what their patients undergo in their day-to-day occupations. This has meant that much of the health care workers' decisions on sharing of information will be made based solely on their civilian experience and training. Very few of them understand, to any great degree, the role which both the commissioned and non-commissioned officers play in a CF member's life. Once again, this can also compound the issues surrounding records provided to CF members for dealing with VAC upon retirement.

There has been one controversial thread present in all discussions with the CF chain of command at the tactical level, and it involves the interpretation of MEL. This is one of the most omnipresent dissatisfiers encountered during this evaluation. The problem revolves around patient privacy concerns versus the chain of command's need/right to know issues involving CF members under their command.

The medical practitioners interviewed by the evaluation team have been universally quite firm in their views that they have shared all information that is appropriate concerning the ill and injured with the various chains of command. The overwhelming majority of those in the chain of command have been just as firm in their views that they have not been provided with enough information to adequately care for the CF members in their charge.

Increased efforts at identifying and quantifying risks associated with MELs are ongoing, with the latest direction initiated by the Director Medical Policy and approved by CMP providing a risk management matrix for use by medical officers and career management staffs.<sup>44</sup>

The chain of command must also adapt to the new reality of Access to Information and Privacy legislation to become better acquainted with the regulatory framework and determine what the chain of command truly needs.

**Finding.** There remains a lack of focused guidance or standardized direction, such as a jointly written aide-mémoire that would inform clinicians, practitioners and the chain of command the information that can and must be passed on to the operational chain of command. There is still too much latitude for individual interpretation.

## Performance Measurement

Within the CF medical system, one of the most significant issues in performance reporting has been the lack of useful performance measurement metrics and processes. Throughout this evaluation, all of the component parts of the CFHS related to care of the wounded and injured have been queried about their performance measurement strategies and systems. Few useable methodologies or systems were observed by the evaluation team.

Most of the extant CFHS performance measurement systems the evaluation team observed either aggregate information at too low a level to be of any management use, or are simply not being systematically collected on a routine basis. The evaluation team was told in numerous interviews with health care providers that data that used to be collected in the former CF health care clinics for trend analyses has ceased to be a reporting requirement, and is not being used even if collected unofficially. Outside of tracking of the ideations of the wounded in Afghanistan, it is usually by exception that any sort of performance measurement data related to the care of the injured is collected.

This has made areas such as injury trend analysis, patient flow, and most other quantitative analytical efforts difficult to undertake. This is particularly evident at the strategic level within CFHS, where staff lack coherent data sets which can be analyzed by national practice leaders, and which can be shared with the CF strategic leadership. Most performance measurement data collection appears to be either unfocused or the initiative of individuals throughout the CFHS who have a personal interest in a particular data subset.

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<sup>44</sup> CANFORGEN 187/08 CMP 080/08 141648Z OCT 08 - USE OF MEDICAL RISK MATRIX FOR AR/MELS.

**Finding.** A continuing lack of performance measurement at virtually all levels hinders effective and efficient control of CFHS resources, and ultimately contributes to a lack of knowledge of best shared practices and procedures throughout the CFHS.

#### **Recommendation**

Commit to a performance measurement regime, and develop in all levels of CFHS a performance measurement culture.

**OPI:** CMP

### **Human Resources – Staffing of Military Clinical Positions**

**Military.** The CFHS currently has significant shortfalls, or forecasted shortfalls, in many of the clinical MOCs. Although civilian clinicians can fulfill many of the healthcare needs of CF members, the lack of uniformed clinicians is having a significant adverse effect on meeting the in-garrison occupational health and operational support components of the clinic mandate. The CF Clinic Model will be difficult to implement and, once implemented, will function far less effectively as a result of the current shortfall of uniformed clinicians.<sup>45</sup>

Rx2000 identified a number of understrength/stressed MOSIDs and Public Service health care professional occupations which required remedial attention if the program was to succeed. Included was a severe shortage of GDMOs, medical technicians, pharmacists, physician assistants and biomedical technicians, and a significant number of mental health professionals—both civilian and military—necessary for the new PCRI program clinical model. CRS has been informed that CFHS will achieve its goal of recruiting GDMOs in early 2009, and is well under way to recruiting the more than 400 mental health professionals required under the Rx2000 Mental Health Model. Attainment of these goals, while a progressive step for CFHS, has not been without significant challenges.

Although some clinics have attained the Rx2000 preferred manning level and PCRI model manning levels, evidence indicates that there is not enough flexibility built into the current CFHS field force model, let alone the PCRI clinical model, to account for the military component on extended deployed operations.

There is an almost universal lack of leadership experience amongst uniformed clinical professionals, particularly in military leadership positions such as base surgeon, in many CF health care clinics across Canada. Ongoing operations outside of Canada have stripped virtually all of the base clinics of their uniformed health care professionals for extended periods of time over the last three years. This includes full six-month deployments for nurses, medical technicians and GDMOs, plus extended staff and technical assistance visits between other medical professionals such as surgeons, anesthesiologists and psychiatrists.

The difficulty in finding uniformed medical and mental health professionals for international deployments, while retaining sufficient numbers at the base clinics, has been exacerbated by historical CF MOSID structures which have not allowed a number of

<sup>45</sup> CF PCRI Clinical Model Implementation Plan, November 2004.

trained medical or mental health professionals to be employed effectively in the Reserve Forces, principally in the Reserve Force Field Ambulances. This has been alleviated somewhat by the inclusion of nurses as a MOSID within the Reserves, but has not really progressed beyond this point. Some use is also made of the Health Services Primary Reserve List which provides some flexibility in obtaining a broader range of health care professionals. Every NATO/ABCA country, except Canada, has the full range of both medical and mental health professionals included in the Reserve Forces.

Also, filling the established positions of uniformed personnel for the CF/DND health community has been problematic at best. There is a country-wide shortage of trained health professionals, which has compounded the problems in recruiting and retaining appropriate numbers of physician assistants, medical technicians, psychiatrists, mental health nurses and social workers.

The current multidisciplinary mental health care model requires both psychiatrists and psychologists to be employed in the CF mental health clinics in order to maintain effective clinical practice. There is also the additional requirement to employ mental health teams on deployed operations, which must ultimately draw on the limited pool of uniformed psychiatrists, social workers and mental health nurses.

This is particularly relevant in the case of the uniformed CF mental health community, where Canada stands out as being the only NATO/ABCA nation that does not have military clinical psychologists in either the Regular or Reserve Forces. What this has meant is that all psychologist positions must be either public servants or contracted civilian practitioners, which has added to the operational deployment burden for the remaining uniformed mental health professionals.

There have been attempts at resolving this issue through the creation of a Reserve Force MOSID for clinical psychologists; however, this has not progressed beyond a Statement of Requirements prepared for CFHS leadership review in 2007.<sup>46</sup> The current Regular Force Personnel Selection Officer (PSEL) classification already has a mobilization specification prepared (occupation code M72E – Combat Psychology) which provides for a military clinical psychology capability within its MOSID.<sup>47</sup>

However, anecdotal interview evidence indicated that Corps and “hat badge” issues had been seen to be hampering progress toward the introduction of a CF clinical psychologist specialty.

CFHS was also directed by a previous Vice Chief of the Defence Staff (VCDS) to hold the line at the current establishment numbers for medical practitioners, and therefore no additions to these numbers will be considered.

**Finding.** The existing Rx2000 PCRI CDU concept does not have enough military personnel flexibility built into the model to allow for continued garrison care and for undertaking extended military deployments.

<sup>46</sup> Statement of Requirements – Reserve Clinical Psychology Positions, Final Revisions, 8 January 2007.

<sup>47</sup> A-PD-055-002/P-001, CF Manual of Occupational Structure Volume 2 Part 1– Occupational Specification for the Personnel Selection Occupation MOC 72, 18 January 2005.

**Finding.** Only Canada amongst all ABCA and major NATO countries lacks uniformed clinical psychologists.

**Finding.** The CF has a clinical psychologist occupation mobilization specification already prepared which is suitable for use in both the Regular Force and Reserve Force now.

### Recommendation

Conduct an analysis and provide costing options for the introduction of a clinical psychologist occupation into both the Regular and Reserve Force.

**OPI:** CMP

## Human Resources – Staffing of Civilian Clinical Positions

**Civilian.** A core cadre of civilian clinicians is considered essential to succeed at one of the most important recommendations stemming from previous CRS reviews—improved continuity of care. However, civilian clinicians, particularly physicians and pharmacists, are in high demand in Canada and the CF remains at risk for being unable to attract these professionals into their clinics.

**Mitigation Strategy.** Similar to the strategy used to address the shortfall of uniformed clinicians, the CFHS must strive to become an employer of choice for these highly sought-after professionals. More specifically, the CFHS believes that the clinic model will be seen by clinicians, both civilian and military, as a good environment in which to practice their profession.<sup>48</sup>

The Rx2000 PCRI plan to complement military positions with civilian Public Service and contracted personnel has fallen short of its objectives, particularly in medically underserved areas of the country such as Gagetown and Petawawa. Neither the contractor, Calian, nor DND have been able to attract or retain enough civilian medical professionals to provide the backfill to the deployed military medical staff, let alone reach the overall PCRI staffing objectives.

Examples were provided to the evaluation team of trained civilian medical and mental health practitioners wanting to join the Public Service in these underserved areas, but who were rapidly disillusioned by the lengthy Public Service civilian staffing and hiring processes. Several clinical staff members interviewed by the CRS team noted that contrary to some professionals who were unhappy with current pay scales, these individuals under consideration were more than willing to take reductions in salary, often from stable private practices or civilian medical facilities, in order to work with the CF medical and mental health professional community as public servants.

<sup>48</sup> CF PCRI Clinical Model Implementation Strategy, November 2004.

A principal issue directly associated with the staffing problem is the current Public Service practice of directly associating job classification levels with supervisory responsibilities. This particularly affects medical and mental health specialists, who in the civilian world, are paid for their education, expertise and experience, not necessarily their supervisory responsibilities.

A number of interviewees across most CF bases visited and in other clinical settings expressed concern that DND/CF does not have appropriate internship/apprenticeship programs in place to grow the stressed occupations. It is DND/CF current policy, particularly for public servants and contracted employees, to be fully qualified for the positions that they will occupy. This does not permit the growing of a trained body of accultured civilian physical and mental health professionals. There is currently no higher-level human resources (HR) policy governing internship/apprenticeship which covers compensation and liability matters.

**Finding.** Current federal Public Service staffing policies and practices have continued to hinder what should be a responsive and effective hiring process for DND medical and mental health professionals, particularly in underserved areas of Canada.

**Finding.** There are no higher-level HR policies governing internship/apprenticeship programs for civilian health care practitioners.

### Recommendation

Examine the feasibility of introducing internship/apprenticeship programs for civilian health care practitioners, and develop supporting policies and procedures as appropriate.

**OPI:** CMP

**OCI:** ADM(HR-Civ)

### Civilian Health Care Provider Pay

Pay is a significant factor in the recruiting of civilian health care professionals. This evaluation has examined the issues surrounding the pay for Public Service and contracted medical professionals. In addition to the Public Service staffing procedures being an extreme dissatisfier to many willing practitioners, the lower level of pay offered by the Public Service for several medical professions was the deciding factor for many considering a career in DND.

One of the principal examples brought forward was that of the DND psychologists, all of whom are either Public Service or contracted personnel. Regardless of the area of the country where DND psychologists are employed, the overwhelming majority of practitioners interviewed for this evaluation noted that they could earn substantially more money in a private practice than what the Public Service has to offer for comparable work. Virtually all clinical psychologist positions within DND have been established as PS 02s.<sup>49</sup> The Public Service currently pays the majority of the clinical psychologists as PS 02s between \$47,000 and \$65,000 a year, depending on education, experience and

<sup>49</sup> Appendix 1 to Annex C to 300000297-7 DGHS Mental Health Implementation Plan, 2003.



supervisory responsibilities.<sup>50</sup> All psychologists are currently required to have a Doctor of Philosophy (PhD) in clinical psychology in order to practice in either DND or VAC positions.

This does not compare well to equivalent civilian doctoral level clinical psychologists who make \$65,000 to \$100,000 a year based on figures provided by the American Psychological Association (for Canadian psychologists) as noted in Table 1.

| Percentile         | YOE<br>2 – 4 | YOE<br>5 – 9 | YOE<br>10 – 14 | YOE<br>15 – 19 | YOE<br>20 – 24 | YOE<br>25 – 29 | YOE<br>30+ |
|--------------------|--------------|--------------|----------------|----------------|----------------|----------------|------------|
| 90 <sup>th</sup>   | 90,000       | 120,000      | 120,000        | 148,500        | 160,000        | 184,100        | 197,000    |
| 75 <sup>th</sup>   | 79,000       | 89,250       | 105,000        | 105,000        | 110,000        | 124,000        | 125,000    |
| Median             | 65,000       | 75,000       | 83,000         | 87,000         | 85,000         | 95,000         | 100,000    |
| 25 <sup>th</sup>   | 53,000       | 60,000       | 68,500         | 68,500         | 68,000         | 73,000         | 75,000     |
| 10 <sup>th</sup>   | 49,100       | 50,000       | 55,000         | 56,300         | 55,400         | 55,000         | 58,600     |
| Mean               | 68,625       | 80,242       | 89,354         | 95,279         | 99,635         | 109,197        | 114,176    |
| Standard Deviation | 22,987       | 32,613       | 33,639         | 43,400         | 55,774         | 63,621         | 68,978     |

**Table 1. 2007 Salaries for Doctoral Level Clinical Psychologists Years of Experience (YOE), in USD.**<sup>51</sup>

In interviews with ADM(HR-Civ) staff, the evaluation team was informed that DGHS has the lead in dealing with Treasury Board, through the Federal Health Partnership (FHP), with regards to compensation for all civilian health care workers. The FHP is a forum that brings together all the federal government departments involved in health care. It should be noted that the state of human resources for health care in the Public Service remains one of the key concerns of the FHP. There have been attempts by DGHS in negotiating special exceptions for DND with Treasury Board in order to meet DND’s needs to fill positions, especially in medically underserved areas of the country. This has met with some resistance by both Treasury Board and with some labour representatives for various bargaining units. Existing ways of doing business are not accomplishing the Rx2000 aims and goals in recruiting civilian staff for certain areas of the country.

**Finding.** Current Public Service pay scales and occupation classifications for a number of medical and mental health professions have not been sufficient to attract appropriate numbers of suitable persons to meet CF/DND needs in medically underserved areas of the country.

<sup>50</sup> Dentistry Group Annual Rates of Pay [http://www.tbs-sct.gc.ca/pubs\\_pol/hrpubs/coll\\_agre/sh/sh07-eng.asp#Toc105550752](http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/coll_agre/sh/sh07-eng.asp#Toc105550752).

<sup>51</sup> 2007 Salaries in Psychology. Center for Workforce Studies, American Psychological Association, 2008.

**Recommendation**

Participate in a collaborative examination by the Federal Health Partnership, the Public Service Commission and Treasury Board of classification and remuneration for all health care occupations within the public sector.

**OPI:** CMP

**OCI:** ADM(HR-Civ)



## Administration for the Injured CF Member

### General

As is shown in the DND/VAC chart at [Annex B](#), administration for the injured CF member is an extremely complex undertaking. The CRS team conducted an extensive literature review, interviews and benchmarking against similar systems in the ABCA countries, and looked within a number of Canadian provincial systems for the administration of injured civilian workers.

The three principal tracks shown at [Annex B](#) were followed:

- Care of the wounded until the member returns to work in his/her original MOSID;
- Care of those who are wounded and must change MOSIDs to remain in the CF; and
- Care of those who must be released from the CF as they breach universality of service rules or request release.

In all cases, the evaluation team also looked at the processes that are in place to ensure an effective transition to VAC care following release for those CF members qualifying for their services.

### Notification of Injuries

When a CF member has been injured, the process of notification of the various chains of command and staff organizations, NOK, and other concerned organizations commences. This process is extremely complex, with a necessity of both speed of passage of information and a sensitivity to the privacy issues required.

On an operational deployment, notification of injuries or death has been shown to be done effectively and efficiently from within the theatre of operations, through the Joint Task Force Headquarters, to Canadian Expeditionary Force Command (CEFCOM) and National Defence Headquarters, and then out to the affected formations and units within Canada that require this information. The communications lockdown procedures now in place within the theatres of operation have been proven relatively effective in controlling the flow of information surrounding injuries and death in theatre.

As well, the Guidebook on casualty notification prepared under the auspices of DCSM<sup>52</sup> had contained errors in formal message addresses. This Guide is not as complete in details on standard operating procedures for both assisting officers (AO) and the chain of command as the evaluation team has noted in other ABCA nations' publications, most notably the UK Casualty Notification Guide.<sup>53</sup>

Particular difficulties have been noted by participants in this process in passage of information to NOK. Despite continuing efforts to ensure the correctness of information on a CF member's NOK forms, a number of problems have arisen in attempting to have NOK informed of injuries to those CF members. It was explained to the evaluation team

<sup>52</sup> Casualty Admin Manual, DCSA, December 2008.

<sup>53</sup> UK JSP 751 Joint Casualty and Compassionate Policy and Procedures, 2007.

by a number of interviewees that some CF members continue to fill in incorrect data on their NOK forms in order to have other individuals on these forms that the members wish to accompany them on Home Leave Travel Assistance (HLTA) visits. HLTA allows a CF member to take leave from an operational theatre and have their NOK meet them in a third-party location to take that leave.

Also, numerous interviewees within the CF/DND and VAC staff systems have indicated that information on injuries within Canada seldom moves quickly enough to those who must know about these injuries. This has become particularly noticeable within the joint DND/VAC Centre for the Injured in Ottawa, where staff action on receiving notification of injuries can have a significant impact on the speed and efficiency of delivery of benefits to the injured CF members.

Much of the delay experienced by these staff teams can be attributed to a lack of action within the CF chain of command in message delivery to all concerned staffs. There is little sense of urgency that has been noted in passing domestic injury information outside of routine CF personnel chains. This has had an impact on the processing of claims and determination of benefits that might have been available on notification to the proper staff organizations, such as the Centre in Ottawa. VAC must be included in any resolution of this issue.

**Finding.** The linkage of HLTA benefits to NOK has caused issues particularly when actual NOK are unknown to the CF and thereby cannot easily be located when that CF member is injured or dies on duty.

#### **Recommendation**

Delink HLTA benefits from NOK forms.

**OPI:** CMP

**Finding.** Lack of proper message handling/passage of information concerning CF domestic injuries to members has inhibited appropriate staff actions.

#### **Recommendation**

Reinforce through the chain of command that proper procedures for both domestic and operational injuries must be followed, and introduce specific performance measures to track compliance.

**OPI:** CMP

**OCI:** CMS, CLS, CAS, Comd Canada COM, Comd CEFCOM, Comd CANSOFCOM, Comd CANOSCOM, DOS SJS)

### **Return to Work Programs/Vocational Rehabilitation**

Most injured personnel are assigned a temporary medical category from the CF medical system that outlines the restrictions on their employment for a given period of time. Once an individual has been declared by the CF medical system as fit to return to some form of viable employment, injured CF members have a variety of programs available to them, dependent on the severity of their injuries.

Those personnel with relatively minor injuries, and whose prognosis indicates that they will return to duty full time in their original MOSID, are normally sent back to their unit on a part-time basis, gradually increasing their duties until they are restored to full employment as their need for rehabilitation diminishes. This program is one with which the CF has had great familiarity over the years, and is effective. Participants in this program and those interviewed working within the CF chain of command have expressed their satisfaction with this program.

Those personnel with more severe injuries, but who are judged to still be potentially employable within the CF but by necessity in a different MOSID as a result of their injuries, will be presented with a number of options for their future. Most of the injured in this category have received traumatic physical or mental injuries and are generally required to maintain a physical or mental rehabilitation regime strictly controlled by the CF medical system. Since 2007, the Canadian Forces Personnel Support Agency (CFPSA)—now Director General Personnel and Family Support Services (DGPFSS)—Soldier On program has also promoted an adjunct approach to the rehabilitation of injured members by supporting their active and full participation in physical activity, recreation and sport.

While policies governing the retention of those who are seriously injured or ill due to CF operations continue to be refined, the situation is also bringing about changes to retention policies and rehabilitation practices respecting members suffering from serious off-duty injuries or medical conditions (e.g., kidney stones). In the past, many of those with serious non-operational injuries and illnesses had little opportunity to remain in the CF, and in some cases may have had less access to rehabilitation services that would facilitate their return to service than those returning from operations. However, regardless of how or where serious injuries or illnesses were acquired, any inequities in policy or practice have been or are being addressed. CDU nurses, case managers or link nurses are assigned proactively to all, and the treatment received is to a common standard.

Once rehabilitation has been adjudged to have been successful to the point where the member can be re-employed, there will be an offer made to proceed to reclassification training and employment in the new MOSID. If the rehabilitation efforts have not been successful over a period of three years or reclassification training has been unsuccessful, in most cases the individual must then be prepared for release from the CF.

This combination of rehabilitation, reclassification training and re-education has been viewed by participants and CF leaders and staffs as a generally successful program, and is in keeping with the philosophy of “continuance on active duty” (COAD) in order to preserve valuable military skills and expertise. The recently created Injured Soldier Network, coordinated by the SA to CMP for issues relating to injured and ill CF members,<sup>54</sup> provides relevant COAD information, resources, guidance, links with other stakeholders and peer support. The SA also plays an important role in enhancing senior leadership situational awareness of relevant issues, as well as policy development and interdepartmental liaison.

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<sup>54</sup> CANFORGEN 202/08 CMP 086/08 301335Z OCT 08, SPECIAL ADVISOR FOR THE ILL AND INJURED.

For those individuals with the most severe injuries, either physical or mental, and who cannot be advantageously employed within the CF, a somewhat different set of processes take place. The rehabilitation efforts will still be undertaken, but instead of reclassification training for future employment within the CF, if they are physically or mentally capable, free vocational retraining will be offered for those fit enough to take it. This can be for up to a six-month period and generally consists of taking courses in civilian institutions or training facilities to prepare the individual for a civilian career. Again, this program has been deemed by participants and CF staffs to be both effective and efficient.

For those who are physically and/or mentally unfit for reclassification or vocational retraining, they will be released from the CF once their CF medical treatment has either run its course, or the individuals seek a more immediate release from the CF in order to transition to the civilian world, usually also transitioning to VAC care for their existing service-related conditions once released. This particular process has not been without its problems.

### **Integrated Personnel Support Units**

IPSUs were new organizations created by, and reporting to, CMP to replace the former Casualty Support Detachments located on most major CF bases.<sup>55</sup> The IPSUs are subordinate to the Joint Personnel Support Unit (JPSU), headquartered in Ottawa under DCSM command. The IPSUs will assume much of the responsibilities that used to reside within the CF operational chain of command at the bases in caring for the more seriously injured CF member.

It is envisaged that the IPSU will include both military and civilian staff members from the CF/DND and will also include a liaison presence with a VAC representative, similar to what exists at the Centre in Ottawa. The IPSU will assume career management and administrative responsibility for those individuals placed on the Service Personnel Holding List (SPHL). A medical case manager will be provided in a liaison capacity to the IPSU for individual care requirements. It will include compensation and benefits specialists, case managers from the CF medical community, VAC case managers to ensure an easier transition, and other functional staff members. It should be noted that most of the individuals on SPHL who are moved under control of the IPSU are destined for release from the CF.

Extensive interviews with CF leadership at the tactical level across the CF have revealed a dichotomy of views on how the IPSUs will conduct their business. The navy and air force tactical level leadership was generally in agreement that centralized control of SPHL individuals who were headed towards release from the CF could easily be accommodated on their bases, usually as long as there were appropriate CF personnel included in the IPSU chains of command to provide feedback and liaison to the operational chain of command.

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<sup>55</sup> CANFORGEN 104/08 CDS 013/08 051327Z JUN 08, STAND-UP OF UNITS FOR THE CARE OF INJURED AND ILL CANADIAN FORCES PERSONNEL.

The army tactical leadership, however, generally views the IPSU in an entirely different light. A very different cultural set of values is imbued in the army, and is especially evident in views on the control of army personnel. There is an exceptionally strong feeling of family in most combat arms and combat support arms units in the CF. This extends throughout the army combat formations in the CF. Virtually every army commanding officer/regimental sergeant major interviewed for this evaluation expressed not only reluctance to hand over their personnel to a CMP-controlled entity, but a willingness to go to almost any measure to protect what they see as personnel for which they are ultimately responsible. This loyalty and responsibility to the soldiers under their command is seen by this group as one of those factors that can never be delegated to others.

The method of introducing the IPSU concept did little to assuage the concerns of the army tactical level leadership. There was little consultation done with the units and formations at the tactical level that would have to enact this new way of doing business. There remain many questions on roles and responsibilities that have yet to be satisfactorily answered by CMP staff. The evaluation team attended the latest CMP-led Casualty Support and Administration Symposium (24-26 September 2008), and noted that there was a continuous string of penetrating and insightful questions raised by participants who were unsure of exactly how these units were to operate, even as they were being declared operational on some CF bases.

**Finding.** The JPSU/IPSU concept of assuming control of the administration for the severely injured is an appropriate measure that will lead to much improved efficiency and effectiveness in the care of the injured; however, much better communication must be undertaken to explain exactly how they will function, and how communication with the losing unit will be maintained.

### **Appointment of an Assisting Officer**

In all cases of serious injury, illness or death of a CF member, an AO will be appointed through the CF chain of command. Most often a commissioned officer is chosen from the member's home unit. The AO is responsible from the very beginning of the process to be involved either with the notification team or available to the member's family immediately following notification of injury or death. The AO responsibilities are contained in the DCSM Guide for Assisting Officers.<sup>56</sup>

Most AOs have been chosen before a unit will depart for operations, and will have been given the appropriate training outlined in the AO Guide. In circumstances of serious domestic injuries, illnesses or death, most CF units now have a number of available personnel who have received the appropriate training and will be appointed to assist the NOK. In the case of a member's death, the AO will assist the NOK through the process of interment and initial administrative dealings with estates and other financial matters. The AO will remain the NOK point of contact until replaced. Under the new JPSU/IPSU system, the AO will hand over point of contact responsibilities to an assigned individual within the IPSU, as appropriate.

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<sup>56</sup> Assisting Officer Guide – Casualty Support and Administration, the Centre.

In cases of serious injuries or illness, the AO will be the principal point of contact between the CF and the CF member and his/her immediate family or designated NOK, again remaining with them until relieved of this responsibility by an appointed IPSU staff member.

This transition through the IPSU, once all staff have been hired and trained, will be of benefit to the CF as it will relieve the AO of what has become an extremely burdensome task for junior officers or non-commissioned members who are not trained as either financial or welfare counselors. However, it is important that an AO remain available to CF members or NOK as that social link to their former unit.

**Finding.** The present regime of training and utilization of AOs has proven to be an effective approach in dealing with the NOK of the injured and deceased CF members.

### Spectrum of Care

Serving CF members and spouses of injured CF members raised concerns about the responsiveness of the Spectrum of Care (SoC) Committee, and the adequacy of coverage of the Spectrum. A number of these interviewees/correspondents noted the divergence, in some cases, between what CF/DND will cover and what VAC will cover. Most of the issues noted by these individuals surround what the SoC Committee considers to be unproven treatments or therapies, such as massage therapy.

The CF SoC issued under the authority of the Assistant Deputy Minister (Human Resources – Military (ADM(HR-Mil))) in 2004, was intended to accomplish the following:<sup>57</sup>

“CF members and certain other persons are entitled to receive health benefits and services through CF Health Services Group (H Svcs GP) in accordance with Queen’s Regulations and Orders (QR&O) Chapters 34 and 35 comparable to those provided to other Canadians through their respective provincial health care plans. The CF SoC provides direction to CF health care providers, Base/Wing Surgeons, Clinic Managers and Dental Detachment Commanders. QR&O 34.07 *Entitlement to Medical Care* and 35.04 *Entitlement to Dental Care* are the authority for utilization of public funds to ensure CF members have access to a range of medical benefits and services similar to those Canadians receive through provincial health care plans, as well as comprehensive dental treatments in accordance with Defence Administrative Orders and Directives (DAOD) 5010-0 *Dental Services* and DAOD 5010-1 *Dental Examinations and Treatment*.”

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<sup>57</sup> ADM(HR-Mil) INSTRUCTION 03/04 - THE CANADIAN FORCES SPECTRUM OF CARE, 23 April 2004.



This directive was further amplified in a Director Health Services Delivery instruction in the “Management of the Spectrum of Care” instruction, last reviewed in 2006.<sup>58</sup> In late 2007, the Chief of the Defence Staff (CDS) directed a change in composition of membership of the SoC Committee to better reflect involvement of the environmental chiefs of staff (ECS). The CDS stated:

“..(The CDS) made it clear at the Armed Forces Council (AFC) meeting in December 2007 that the SoC Committee is not to focus on equity with the provinces, but that the goal should be operational effect – having the right person available for operations with the right level of fitness.”<sup>59</sup>

This change is reflected in the minutes of the SoC Committee of 4 February 2008 chaired by the Assistant CMP. The revised Committee members included ECS staff and the Deputy Surgeon General. In addition there is a VAC representative, Judge Advocate General (JAG) and CFHS legal officers, and CFHS advisors and policy staff as ex-officio Committee members.

The various minutes of the latest SoC Committee meetings demonstrate a concerted effort by appropriate staff officers and advisors to execute the direction provided by the CDS. Discussions about various treatments, such as massage therapy, are conducted with due consideration to both operational effectiveness and efficient use of public funds.

**Finding.** The revised structure of the SoC Committee provides a suitable forum for addressing issues surrounding changes in health care coverage and attendant benefits. Representation from VAC at these meetings will raise awareness between both Departments on SoC harmonization efforts.

### Recommendation

Ensure DND and VAC SoC continue to be harmonized.

**OPI:** CMP

**OCI:** VAC LO

### Transition to Veterans Affairs Canada

When a CF member is injured, either physically or mentally, and the injury is attributed to service in the CF, VAC will become involved in addressing a number of medical, and compensation and benefits issues. As noted in the DND/VAC chart at [Annex B](#), a significant amount of activity VAC undertakes runs in parallel to actions taken within the CF/DND.

The New Veterans Charter, introduced in 2006, has caused a shift in emphasis within VAC from that of taking care of aging WW2 and Korean Conflict veterans, to also having more responsibilities for the new younger CF veterans, who often have significant

<sup>58</sup> 5000-01 (D H Svcs Delivery) Management of the Canadian Forces Spectrum of Care, effective 1 June 2002, last reviewed 9 May 2006.

<sup>59</sup> MINUTES OF SPECTRUM OF CARE REVIEW COMMITTEE MEETING HELD AT MGEN PEARKES BUILDING, OTTAWA ON 4 FEBRUARY 2008.

traumatic physical or mental injuries. This shift to include the new veteran has not been without challenge, as experienced by CF members attempting to deal with the changing VAC system. This has exacerbated an already overloaded VAC case management system once the CF member becomes a VAC client.

VAC may only take early action based on information of a CF member’s injury received through the CF/DND chain of command. The joint Centre in Ottawa is regarded as the focal point for this early entry of VAC into the process, and is reliant at this point in time on hand delivered, paper copies of notification of injuries provided to the DND portion of the Centre. It has also been noted by both DND and VAC staffs at the Centre that other than injuries from Special Duty Areas, message traffic is often not forthcoming concerning injuries to CF members. This includes most domestic injuries, and injuries resulting from routine training accidents while a CF member is deployed.

Once VAC is informed by DND of an injury, and treatment or rehabilitation regimes have been established, VAC can begin providing benefits to both the CF member and to his or her families while still serving in the CF (see [Annex B](#)). This includes participation in vocational retraining, career counseling, job placement/job search assistance, and detailed involvement with the CF medical case managers and rehabilitation specialists in treatment programs. Assistance with VAC procedures for obtaining monetary awards through the New Veterans Charter procedures can also be obtained, either through VAC directly, or through inquiries to the Bureau of Pension Advocates, funded by VAC.

There has also been a change in responsibilities for long-term disability treatment and compensation. Formerly, if a CF member was injured in an accident not attributable to service, the Service Income Security Insurance Plan (SISIP) would provide a monetary “insurance” type award to the member, and would be involved in rehabilitation and vocational retraining if required. ....

VAC staff want to become involved as early as possible in a CF member’s case. Earlier intervention by VAC is particularly important with complex cases. With a VAC legacy system undergoing rapid and significant change, VAC involvement early in a CF member’s future is essential. Until recently, VAC staff would only become involved once a CF member was assigned a permanent category (PCAT) and the Director Military Career Administration renders its career decision. Once a member is assigned a PCAT, and is unable or unwilling to change MOSIDs, the member will normally be released from the CF within six months.

**Finding.** VAC involvement before the six-month period prior to release from the CF is advantageous to CF members and their families.

One weakness in the current system in the transition of injured CF members to VAC care is related to the transition of the member from the CF medical system to the civilian health care system on release. This area has been shown to be problematic in a number of cases brought forward to the evaluation team. Physically or mentally injured CF

members have no more leverage in gaining access to either family physicians or medical specialists than do civilians in the area the CF member and family selects as their designated place of residence.

Cases have been noted by the evaluation team where injured and ill individuals within several months of release from the CF have indicated they have not been able to find health care specialists in the area they are moving to, but are still being released. In all of these cases, VAC and the CF have little or no influence on the current provincial health care systems regarding higher priority access to medical assistance. It is unfortunate that injured CF members are being released without assured medical care on release.

DGHS staff have noted that it can be difficult to track persons on release, particularly when individuals choose to move into locations away from CF resources. While this concern is understood, there are still individuals who are being released who have not been able to be guaranteed medical care appropriate to their condition(s). In addition, many of these extremely vulnerable individuals have been unable to claim support from either DND or VAC during the transition. This is a very distressing period for these individuals, particularly when there is such uncertainty over their medical care.

**Finding.** Some injured CF members are being released without guaranteed medical support in the civilian community on release.

### **Recommendation**

Maintain an administrative linkage with those CF members, both Regular Force and Reserve Force, who have been identified as requiring exceptional attention during and after the release process, until VAC and DND have concluded that the transition has been successfully completed.

**OPI:** CMP

**OCI:** VAC LO

## **Compensation and Benefits for the Injured and their Families**

### **General**

As part of the mandate of this evaluation, investigation was undertaken on whether injured members and their families received timely, fair, equitable, and comparable compensation for injuries suffered as a result of military service. The focus for this part of the evaluation was principally on those outstanding issues noted from previous Senate and House of Commons Committees, and those arising from a number of DND Ombudsman Reports.

## Definition of Family

One of the problems is the long-standing issue of the definition of “family.” There have been extensive discussions held over the past decade, with a number of quasi-legal documents reviewed by the evaluation team, all circling around the issue and never properly addressing the fact that there is no authorized definition for “family” that has been accepted across the CF/DND. This has an ongoing impact on compensation and benefits awarded to families of injured CF members.

The evaluation team has found that other ABCA countries have provided definitions of “family” which are used by their armed forces and VAC equivalents. The UK definition is similar to a number of CF variants seen by the evaluation team and is provided as an example only:

“(Family) is determined in the following order:

1. Surviving spouse (even if separated);
2. Issue ad infinitum—children, grandchildren, great grandchildren;
3. Parents;
4. Brothers and sisters of whole blood;
5. Issue of brothers and sisters of whole blood;
6. Brothers and sisters of half blood;
7. Issue of brothers and sisters of half blood;
8. Grandparents;
9. Uncles and aunts of whole blood;
10. Issue of uncles and aunts of whole blood;
11. Uncles and aunts of half blood; and
12. Issue of uncles and aunts of half blood.”<sup>60</sup>

**Finding.** There is no commonly accepted definition of “family” used throughout CF/DND.

## Recommendation

Choose an acceptable definition of “family” and ensure this definition is promulgated across the CF/DND.

**OPI:** CMP

<sup>60</sup> UK Joint Service Publication 751, Annex A to Chapter 1, dated September 2007.

### New Veterans Charter and Families

The introduction of the New Veterans Charter established many needed programs to support the new generation of young disabled veterans of current conflicts and their families.<sup>61</sup> The new charter replaced *Pension Act* monthly pensions with a lump sum disability award valued up to approximately \$260,000, depending on the degree of disability.<sup>62</sup> The disability award is meant to recognize the member’s pain and suffering and compensate him/her for the certain impacts of a service-related disability.

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..... It should be noted that the UK .....  
..... now have a graduated disability/  
pension award scheme. There will be an initial lump sum award, but if the individual will require longer-term care, or the members’ condition worsens, a monthly pension will also be provided to supplement the initial award.<sup>63</sup> .....

.....

### Compensation for Disabilities Process

VAC adjudicates pension awards and disability awards for serving and retired CF members. In addition SISIP Financial Services (SISIP FS) Accidental Dismemberment Insurance Plan (ADIP) provides an insurance payment in accordance with a schedule of indemnities for such things as an accidental dismemberment or the loss of sight, speech or hearing if attributable to military service. It is limited to injuries that have occurred by way of accidental, external and violent means.

Reserve Force members on class A or B service have an ADIP coverage limit of \$100,000, whereas Regular Force members and class C reserve service are covered to \$250,000. The differences in payments and awards under ADIP are historically based on legislation and Treasury Board assessments. Treasury Board noted that full-time employees are entitled to disability awards at a different rate based on units of work. Class A Reserve Force employees were deemed to work less than 20 hours per week, and thus awarded four “units” of credit, each unit being worth up to \$25,000. Full-time employees could be credited with up to ten units, therefore worth \$250,000.

SISIP FS and VAC’s benefits assessment processes for various physical impairments were compared to those of Canadian provincial workers’ compensation organizations, and it was found that similar assessment schemes were being used, generally based on

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<sup>61</sup> <http://www.vac-acc.gc.ca/clients/sub.cfm?source=forces>.  
<sup>62</sup> <http://www.vac-acc.gc.ca/clients/sub.cfm?source=forces/nvc/programs/da>.  
<sup>63</sup> Armed Forces Compensation Scheme Statistics, 30 September 2008, K. Cook, J. Edgell, A. Byers Defence Analytical Services and Advice (DASA).

American Medical Association Guides.<sup>64</sup> The evaluation team noted that the awards granted to CF members compare favourably with those available to like civilian occupations (police, firefighters) for physical disability.

The situation is more complex with mental health disabilities but equally comparable. The evaluation team noted that the VAC policy to reassess mental health disability every five years is consistent with civilian practice.<sup>65</sup>

### **SISIP Long Term Disability**

Considerable media attention has been focused on an issue raised by the CF Ombudsman respecting the SISIP FS Long-Term Disability Program. The CRS team acknowledges that the official departmental position on this matter is to wait until the judicial proceedings have been completed.

### **DND/Royal Canadian Mounted Police (RCMP) Comparability—Medical Treatment Entitlements and Survivor Income Plan**

The evaluation team compared the RCMP Medical Treatment Entitlements, Life and Disability Insurance Programs and Services to those available to CF members. For the most part, CF member treatment is comparable. RCMP policy pertaining to medical treatments or therapies are based on the same principles as DND's SoC in that non-controversial, scientifically evidence-based or proven, medically beneficial, and non-cosmetic treatments are approved.<sup>66</sup> Two principal differences were noted.

There is a funded entitlement for family counseling for any number of service-related factors for the RCMP. This is not the case in DND, with certain specific exceptions related strictly to treatment of the injured CF member. Current DND social work policy permits brief interventions and couples counseling. Family members can be included in some counseling, with the CF member's permission; however, further service is dependent on the availability and caseload of local CF/DND health care providers.<sup>67</sup>

RCMP spouses and NOK have better income protection than do their CF equivalents when the CF member has a service-related death. The RCMP Survivor Income Plan is designed to supplement other monthly benefits payable (*RCMP Superannuation Act* survivor benefit, Canada Pension Plan survivor benefit, *Pension Act* survivor benefit) with an amount that tops up income to what would have been earned had the member lived and served a full career to age 60. CF members have no equivalent benefit.

**Finding.** Discrepancies exist between publicly funded survivor benefits programs in the RCMP and DND.

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<sup>64</sup> American Medical Association Guides (4<sup>th</sup> or 5<sup>th</sup> Ed) contains a standard process to evaluate, measure, and report impairment.

<sup>65</sup>

<http://www.wsib.on.ca/en/community/WSIB/230/OPMDetail/24347?vnextoid=d85ac0d9ca3d7210VgnVCM10000449c710aRCRD> WSIB Ontario Policy wrt Assessing Permanent Impairment due to Mental and Behavioural Disorders.

<sup>66</sup> RCMP Administrative Manual, Vol II, Chapter 18 Medical Treatment Entitlements Para D Policy.

<sup>67</sup> Ibid para S.2.

### Recommendation

Review the RCMP programs and services related to survivor benefits for spouses and NOK to determine whether the same effect can be obtained for military spouses/NOK.

**OPI:** CMP

### Administration for Deceased CF Members and their Families

With the increase in operational casualties as a result of operations in Afghanistan, processes for the care of the deceased CF members and their families have been exercised more often than for previous CF operations. The evaluation team has noted that once notification of NOK has occurred, there is a relatively comprehensive system in place to ensure a respectful reception and burial of the deceased.

Persons interviewed for this evaluation have noted that the reception of the deceased in Trenton, and its surrounding activities, have been handled professionally and with great respect. Administrative procedures surrounding the movement of the NOK to Trenton, then onwards through the coroner's office in Toronto, then burial, have evolved over the past three years to become a relatively seamless system.

Some minor financial issues that still surround the payment of certain expenses associated with the burial ceremonies and some of the AO's duties with regards to expenses related to the NOK were brought to the attention of the evaluation team. Compliance with financial regulations will need to be confirmed once more comprehensive administrative direction has been issued concerning payable expenses allowed during this period.

**Finding.** Care and administration for the deceased member's NOK during the reception and burial processes operates efficiently and effectively with few observed systemic problems.

**Finding.** Explanation of financial benefits and provision of documentation to the NOK has generally been seen as appropriately handled.

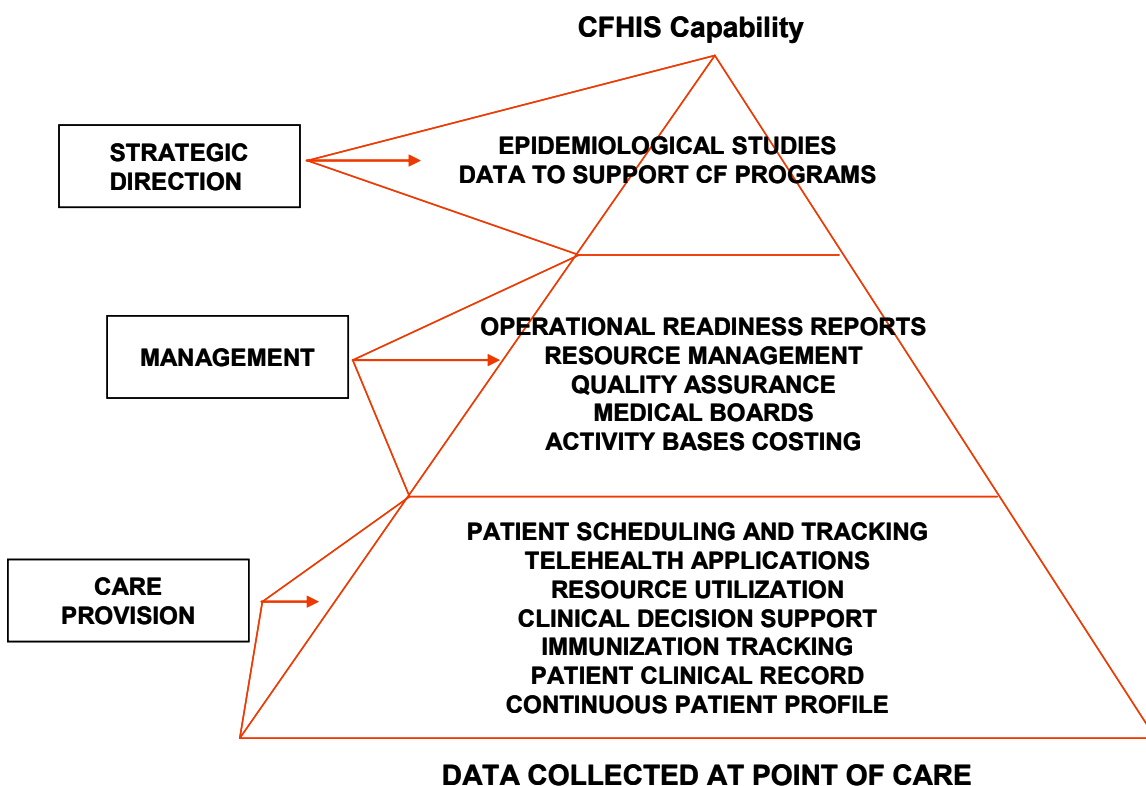
### CF Informatics Support affecting the Ill and Injured and their Families

#### Health Information Systems

Implementation of the CFHIS was deemed to be critical to the success of Rx2000. Basic medical appointment scheduling and EHR subsystems are presently being introduced, and are at various implementation stages. The CF health care clinics across the country are experiencing some difficulties changing and obtaining resources to operate both the new and old systems during transition. Problems identified to the evaluation team include medical records scanning, scheduling, training for the new system, audit/error checking, and login times.

CF/DND health care workers provided examples of system failures that had direct impacts on patient care because of lost lab results, mishandled referrals, etc. The efficiency gains that these systems were intended to deliver have taken years to put into operation at the pilot sites, and are unlikely to produce the immediate benefits expected for the majority of clinics just coming on-line now.

Much of the advanced, higher-tier functionality of CFHIS (for example, epidemiological data mining) (see Figure 1) and medical information support to deployed operations (deployed CFHIS, patient evacuation tracking) has been pushed into Phase 3 of the project, and has yet to be well defined. Health Policy, Deployment Health and Force Health Protection staffs said they have little confidence that their inputs and concerns at the top tier will be addressed by the project. Non-information technology (IT) work to re-engineer the health business processes has yet to begin, and many working groups are in abeyance. CFHIS is not yet configured to take full advantage of the CFHIS technology injection.



**Figure 1. Hierarchy of CFHIS Functionality.** The first two phases of the CFHIS project have focused on the bottom tier functions. CFHIS leadership underscores the importance of attaining the strategic functionality as well (Phase 3).

Medical policy practitioners and national practice leaders expressed an inability to gauge the impact of current operations on issues such as hearing loss, vision, skin, traumatic brain injuries and mental health, without measurement tools and IT support. This has a direct impact on the quality and continuity of care for injured CF members.



**Finding.** Confidence is generally low that the CFHIS project has the resources or the scope to address needed higher-level health functions.

**Finding.** The performance of CFHIS is unknown.

### Recommendation

Ensure that Phase 3 of the CFHIS program includes the required higher-level functionality originally specified and remains within the scope of the CFHIS program, and establishes a performance measurement framework.

**OPI:** CMP

**OCI:** ADM(IM)

## Personnel (HR) and Administrative Information Systems

CMP has implemented links between CFHIS and the HRMS – PeopleSoft. This has meant, for example, that the eligibility of injured reserve members to access health services no longer has to be questioned with each visit. Despite this improvement, there is still a lack of integration between HRMS, CFHIS and various other health and administrative information systems with significant impact particularly on the Reserve Force community.

CF/DND clinicians have advised the evaluation team that more areas of cooperation are needed between health and personnel information systems. Currently, there is no mechanism to relate who was deployed to a particular location over a particular time with accurate health information on service utilization, the process of care, diagnosis, and ultimate health outcomes. The various case management systems that have emerged to support the ill and injured are not integrated, making it more difficult to coordinate efforts that impact ill and injured members.

HRMS is the system of record for NOK and Primary Emergency Notification (PEN) data that supports notification of families in the event of a member's death or serious injury. Numerous interviewees have indicated that CF members must resubmit NOK/PEN forms with every movement, such that they and the chain of command are universally frustrated by the existing processes, and are unclear as to which are the officially recognized NOK/PEN forms of record. As well, the DCSM data custodian has identified the need to record more comprehensive information (e.g., complex family relationships, maps to rural locations). This has had a direct impact on injured CF members and their families.

**Finding.** The lack of information system functionality, which permits access to internal personnel data, processes and services, is hindering the integrated management of CFHIS and CF personnel information systems, with consequent implications for injured and ill CF members.

## Information Exchange with VAC and Civilian Institutions

The FHP is a federal government initiative aimed at standardization and implementation of, amongst other things, electronic health care records across Canada. It initially was limited to provincial health bodies, but was expanded to include all federal departments

involved in health care. Interviewees noted that, although DND is participating in the FHP and other interoperability/standardization programs, no electronic links to civilian health care systems exist as of yet.

DND medical records do not include all records pertaining to a CF member's treatment in the civilian health care system as there is no automatic exchange of all treatment information. This situation can also delay provision to VAC of the injury documentation that they need before an injured member and/or family can access care and benefits.

Other than Blue Cross billing summary information, electronic information exchange with VAC has also not been implemented. The CRS team noted that, although CFHIS and HRMS have dramatically improved the CF's ability to locate a member or former member's medical/service record, no interface has yet been enabled with VAC.

Much of the discussion surrounding this issue is related to perceptions by both Departments of the individual member's information privacy. Since the injured CF member will in most cases become a VAC client, certain privacy issues should not be a barrier to electronic communication between the two Departments to help those injured members.

**Finding.** There is no electronic information sharing between DND and VAC regarding documentation of injured CF members.

### **Recommendation**

In collaboration with VAC, address current IM/IT system interoperability limitations and deficiencies that impede effective information sharing.

**OPI:** CMP/Surg Gen

**OCI:** ADM(IM)



## Support to Families of Ill and Injured CF Members

### General

The support provided to the families of injured and deceased CF members was included in the terms of reference for this evaluation.

A number of interviewees stated that, while this area is undergoing significant change, almost on a daily basis, most of the changes in organization and administration have been viewed in a very positive light by the affected CF members and their families. In that regard, the CF Family Covenant<sup>68</sup> officially signed by the CDS on 22 September 2008, has signaled a commitment to recognize, honour and partner with families to enhance the family life of CF personnel. One of the stated key family policy areas is Mental Health Services and Social Support.

### Canadian Forces Family Covenant

We recognize the important role families play in enabling the operational effectiveness of the Canadian Forces and we acknowledge the unique nature of military life. We honour the inherent resilience of families and we pay tribute to the sacrifices of families made in support of Canada. We pledge to work in partnership with the families and the communities in which they live. We commit to enhancing military life.

CMP has placed the highest emphasis on all phases of care and employment of the injured and their families. It is within the CMP organization that most responsibility rests for policies and activities related to CF members' families.

DEPARTMENT OF NATIONAL DEFENCE: 2008-2009 REPORT ON PLANS AND PRIORITIES Section II: Analysis of Program Activities by Strategic Outcomes, page 47

**Care and Employment of the Injured, the Fallen and their Families.** Care and Employment of the Injured, the Fallen and their Families is the highest priority within Chief Military Personnel. Canadians have witnessed, over the past year, the professionalism of the CF not only as a fighting force, but also in caring for its fallen and their families. A number of activities, including casualty and family support in all phases—pre-, during and post-deployment—in order to alleviate deployment-related stress for service personnel and families, are being progressed in fiscal year 2008-2009. As risks continue to exist for our men and women serving in hostile regions of the world, it is crucial to ensure the mechanisms for repatriation, support for members and families and recovery function effectively.

<sup>68</sup> Canadian Forces Family Covenant, 22 September 2008.

## CMP Family Support Initiatives

Family support initiatives within the CF/DND had, historically, been undertaken as tactical-level responses to perceived needs at the CF base level, often outside the CF chain of command. There are some mentions of family-related policies in QR&Os, but they focus principally on when dependants fall under the Code of Service Discipline. The exceptions are described in the following Article, where, in certain situations, the Surgeon General (Surg Gen) or Minister of National Defence can direct support to dependants when certain conditions have been met as outlined in QR&Os, Volume 1, Article 34.23:

### **34.23 – PROVISION OF MEDICAL CARE GENERALLY – DEPENDANTS**

1. A dependant of a member of the Regular Force, of the Reserve Force on Class “C” Reserve Service or of a force of a North Atlantic Treaty Organization State may be provided with medical care by the medical services of the Canadian Forces:
  - a. in an emergency;
  - b. where, in the opinion of the Surgeon General, no adequate civilian medical facilities exist;
  - c. at the request of an appropriate civilian medical authority, where it is necessary to supplement civilian medical services; or
  - d. in any other circumstances prescribed by the Minister.

Most policies and instructions dealing with families/dependants are found in DAODs and are administrative in nature. They deal in large part with financial matters surrounding military directed cost moves or administrative procedures to be taken when a CF member dies. In addition, under the mandate of the Personnel Support Program, various benefits accrue to families of CF members in areas such as sports and recreation.

A most significant change in the status quo is related to the control and direction of support to family members. An organizational change made within the CMP group in early 2008 saw the integration of several disparate organizations into one group under a chief executive officer. This group, designated as DGPFSS, includes a civilian Director of Military Family Services (DMFS).

DMFS, with a small central staff in Ottawa, is responsible for the effective coordination of all DND military family support programs, including control and policy oversight of the Military Family Resource Centres (MFRC) located across Canada and in certain overseas locations.

## **MFRCs and the Families of Injured CF Members**

The CRS team visited MFRCs affiliated with a number of navy, army and air force bases across Canada. All MFRCs located in Canada are provincially registered, not-for-profit organizations with executive directors paid through non-public funds, and an additional number of paid staff, plus a fluctuating number of volunteers working at or out of the Centres. MFRCs are seen as the centre of gravity for all programs and initiatives associated with CF dependants.

Most of the Canadian MFRCs either provide the infrastructure occupied by the local CF-staffed DSG, or have a close affiliation with this organization on the local base. The DSG is a recent development in the CF wherein a small number of CF members, both Regular Force and Reserve Force, are appointed to provide a 24-hour/7 days a week coordination capability between the CF chain of command and the families of deployed CF members. In several locations, the DSG has injured CF personnel employed as part of their Return to Work program during their recuperation.

The interrelationships between the MFRCs and DSGs were examined to see if the dynamics between a basically all-volunteer spouse-based organization and a CF directed coordination group added value in support of the families of the injured CF members. It was stated by some interviewees that regardless of service affiliation, at the bases where there were strong interpersonal contacts between the MFRC leadership and the DSG, services to families of the injured were noticeably enhanced. The DSGs were functioning successfully on the bases examined by the CRS evaluation team, and their input is much appreciated by the MFRC staffs.

The MFRCs have grown from their initial role in the late 1980s to early 1990s from providing minor coordinating services such as child care, to becoming an extremely important piece in the military family support structure in areas where bases are the focal point for CF family activities, or where most families are within an easy commute of the MFRC.

The MFRC's role in support to the families of the injured is multi-faceted. Many of the MFRCs provide psychological support to family members in the form of contracted social workers or psychologists. These specialists are available to all family members, including the CF members, for initial counseling and referrals, but not treatment. Finding mental health support outside the medical community for this sort of general mental health assessment capability has generally been successful across the CF. In common with local full-time residents, military families do have a difficult time in finding and accessing timely or comprehensive mental health services from their local communities.

Most MFRCs provide daycare services, including up to 72 hours of funded emergency daycare, which is especially helpful in times of crisis. MFRCs give appropriate preferential access to the families of the injured to resources and assistance, as should be expected.

### **MFRCs and Family Health Care**

While extending a broad range of social services to family members, there still remains one overriding dissatisfier related to family support, and that is the provision of adequate health care to the families of CF members. While this evaluation is limited to examining only those factors relating to the care of the ill and injured CF members and their families, the area of family health support overarches the whole family picture, whether for the families of the injured or not.

Much discussion within the CF/DND strategic levels has been ongoing in the family health care area over the last several years as part of the bigger picture on recruiting, retention and maintaining job satisfaction for the CF member. The military Family Covenant was but one output of this discussion process, but the family health care issue has proven to be problematic.

One of the principal issues is that several of the main CF force-generating bases are in underserved areas for provincial medical and social support. These bases and the local civilian communities have not been able to attract suitable numbers of civilian health care providers to move to these areas to set up family practices. This problem is reflective of the greater problem within Canada of finding family physicians; however, the isolation or semi-isolation of these bases only exacerbates the problems.

A variety of initiatives have been undertaken by CF, DND and MFRC staffs across the country to alleviate this situation, from base commanders seeking the support of local Members of Parliament or Members of the Legislative Assemblies at the provincial levels where actual responsibility resides for health care, to providing some health support services through the MFRC itself. It is this last solution—provision of family health care through the MFRC—that has caused the evaluation team concern over potential liability issues.

The evaluation team has been provided with extensive background documentation on the recent developments towards a DND position on the provision of health care to the CF members' families. There have been working groups comprised of military and civilian lawyers who provided a series of alternatives.<sup>69</sup> Following this was a set of explanatory briefing notes through the CF chain of command to CMP,<sup>70</sup> and for the Deputy Minister's consideration.<sup>71</sup>

Further recent documentation has also been reviewed; however, indications are that the CF/DND is no closer to an agreeable solution to the provision of health care for families, including families of the injured and ill, who carry an additional burden. Some staff members have looked at providing added health care coverage only to the families of the ill and injured where family caregiver burnout is becoming more common.

Efforts made in providing, through non-public funds, office and clinical facilities, which can then be leased to family physicians, have not been successful at 8 Wing Trenton. In that case, a Concession Agreement was initiated in 2006, a clinic was built with non-public funds, and family physicians as concessionaires were invited to occupy the clinic offices. There was no viable response for two years, and the offer has now been withdrawn as the Base seeks alternative solutions. Another initiative at 8 Wing Trenton that has shown initial promise is an arrangement to link CF families with family physicians from the neighbouring Prince Edward County which has available patient capacity. However, this is a special case that applies solely in the 8 Wing area and is not a solution that can be extended to other military bases.

<sup>69</sup> Dependant Health Care Working Group – Legal, 4900-19-5 (LAS), 8 July 2005.

<sup>70</sup> DQOL Briefing Note to CMP, 22 November 2007.

<sup>71</sup> DQOL/CMP Briefing Note to Deputy Minister, CF and VAC Casualty and Family Support, 31 January 2008.

In CFB Kingston, the MFRC on their own initiative, with non-public funds, set aside a portion of their MFRC infrastructure and funds, built a walk-in clinic, and now employs several family physicians. This effort, while admirable in seizing this opportunity when other options to attract family physicians had failed, may entail unnecessary liability risks for the Executive Director and Board of that MFRC. One of the guiding principles set down in the background documentation studied for this evaluation decreed “A health care clinic cannot be located under the management of the local MFRC.”<sup>72</sup> The Dependant Health Care Legal Working Group had stressed the advisability of not incurring risk or legal liabilities to the Crown when considering health care options for dependants.

CF bases located in medically underserved areas of the country are disadvantaged in terms of access to basic family medical care. Attracting family physicians to those areas has posed a difficult challenge for provincial authorities, and will remain even more problematic for the families of CF members who are obliged to move for operational and career reasons. Current efforts by the CF/DND have met with limited or no success. Future efforts proposed by CF/DND staffs will remain constrained by the *Canada Health Act*, provincial responsibilities for health care, and legal considerations by CF and DND legal advisors and noted in the guiding documentation examined by the evaluation team.

Similar efforts undertaken by our closest allies as to how they have dealt with the issue of family health care were examined. The UK government, experiencing similar problems to Canada’s, and following extensive parliamentary committee involvement, has issued a defining paper on support to military families. It is similar to what would be a combination of the Canadian New Veterans Charter, plus a significant amount of detail on support to military families, both while the member is in service, and upon retirement. In a policy paper on the subject, the government directs, *inter alia*, that the families of UK service members will retain their “place in line” for access to the National Health Service family physician client lists wherever they are posted within the UK.<sup>73</sup> They do not discriminate between the families of the injured and the family members of the rest of their forces as there are no inter-jurisdictional issues such as experienced in Canada with the provinces.

The Australians, who do not have a publicly funded health care system but with similar problems of finding medical support for families in isolated areas, have taken a quite different approach from past practices. As the Australian government has noted:

“The Government is committed to recognizing the service and sacrifices of Australian Defence Force (ADF) personnel and the important and valuable role their families play in the achievement of the Defence mission. The families of those serving Australia deserve full support and this trial is aimed at evaluating a model of healthcare that will benefit our ADF families.”<sup>74</sup>

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<sup>72</sup> Draft DQOL Family Health Care - Discussion Paper, 2005.

<sup>73</sup> The Nation’s Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans, Secretary of State for Defence and Minister of State for the Armed Forces, July 2008.

<sup>74</sup> [http://www.defence.gov.au/health/Dependant\\_Healthcare/i-healthcare.htm](http://www.defence.gov.au/health/Dependant_Healthcare/i-healthcare.htm) October 2008.

Australia will be starting a trial project in May 2009 that will provide for the establishment of 12 government-funded Defence Family Health Care Clinics to provide free health care for ADF dependants (i.e., spouses and children). This trial covers a significant number of ADF bases in isolated locations.

The US, which does not have a national socialized medical system per se, has an entirely different health care model for dependants. Under their TRICARE health services plan, the US Department of Defense and US Department of Veterans Affairs operate a joint health care system which provides medical support for serving armed forces members, their dependants and qualified veterans.

“Today, with an all-volunteer force, shrinking infrastructure of bases, increasing reliance on reserves, and perhaps more importantly, wartime mission demands, the assurance to military families that the Department is prepared to underwrite family support is of primary importance.”<sup>75</sup>

The US government prepared this quoted social compact for their armed forces and veterans in 2004. It contains a commitment to deliver world-class health care to all its client groups. With minor exceptions, and even with expected bureaucratic lapses, their system delivers on this commitment. The Department of Defense sponsored TRICARE system provides what the Canadian socialized medical system should provide, but especially includes care for eligible veterans and families of military members at US bases and facilities worldwide.

### **CF Health Care Clinics and Family Medical Support**

In past years, CF GDMOs were empowered to see CF dependants as clients on bases across Canada, using CF facilities. In locations such as Cold Lake, CF physicians provided all family medical care until the late 1980s. In Petawawa during the 1970s, CF GDMOs did likewise. Overseas, CFB Lahr provided full medical services to all CF dependants until its closure in 1994.

The Canadian model has a geographically dispersed Canadian Forces, with a number of bases located in either isolated or medically underserved areas. Since the cutbacks in CF medical personnel and infrastructure in the 1990s, most CF bases have barely enough CF/DND uniformed or civilian medical staff to provide health care for their local CF members on a day-clinic basis five days a week, let alone be available for family medical support, even if it was within their mandate. No CF health care clinic is available to CF members during silent hours (usually after 1530 hours until 0730 hours local time the following day) or on weekends. Most civilian health care providers in the CF/DND system are not authorized for, and do not work, overtime outside of exceptional emergency situations.

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<sup>75</sup> A New Social Compact, Deputy Assistant Secretary of Defence (Military Community and Family Policy) 2004.



It therefore cannot be expected that the existing CF health care clinics, staffed at current levels, and with current infrastructure shortfalls, could be involved in providing health care to CF dependants other than in an emergency, which is permissible and required under law. This is the current situation, despite the desire expressed by virtually all uniformed and civilian medical providers interviewed on the bases that they be allowed to see dependants on a routine basis, if they had the time.

Many provincial health authorities have been unable to solve the problem of providing medical support to the civilian communities at large and particularly in the rural areas of their provinces. The MFRCs cannot be expected to shoulder the legal risk and the burden of acquiring medical support for CF dependants on their own. They cannot be expected to undertake the added logistical burden of attracting prospective family physicians into their existing facilities to help with dependant family health care. Several of the executive directors of MFRCs interviewed for this evaluation have categorically stated that they will not involve themselves or their organizations directly in the provision of family medical care.

DGHS staff have expressed their concerns about moving into additional treatment of dependants, let alone qualified veterans, principally based on funding and the lack of qualified medical professionals nationally. However, if the CF/DND believes that military families should not be disadvantaged through postings or life-changing injuries of CF members over which they have no control, added risk may have to be assumed by the Crown as part of the solution. Depending on options chosen, other than the status quo, potentially significant resources and interdepartmental and interprovincial cooperation will be needed to enable a coherent plan.

**Finding.** For much of what the CRS team has seen related to family health care, there is a demonstrated lack of policy and legal authority.

**Finding.** Initiatives under way under CDS direction and CMP authority that would try to improve health care provided to families of CF members through MFRCs, particularly in medically underserved areas of the country, will founder under legal impediments and bureaucratic staffing processes, unless significantly different approaches than those now being considered are taken. Federal and provincial ministerial-led action will be needed if these new approaches are to be successful.

## Benchmarking CF and Allied Forces Care of the Injured

Throughout this evaluation, comparisons have been made between the delivery of care of the injured by the CF and allied nations, principally the US, UK and Australian forces. These benchmarking citations have included both physical and mental health care of the ill and injured, with occasional reference to care for the families of the ill and injured.

**Physical Care.** The CF has provided operational (Role 1 to 3 inclusive) physical care comparable to that of our closest allies. Survival rates of those CF members injured on operations in Afghanistan, and evacuated to the CF-led Role 3 facility in Kandahar, are comparable to allied survival rates for similar injuries. These survival rates for all Allied forces are marked improvements compared to even relatively recent conflicts such as the Viet Nam war or Gulf War 1991.

**Tertiary Care.** Comparisons of care of injured CF members on return to a Canadian tertiary care facility are somewhat more difficult to discern. The US, with their comprehensive DoD TRICARE system, has complete control over their injured personnel from wounding to discharge from their facilities. The CF and the UK armed forces are similar in that with the closures of their respective military hospitals, injured members are sent to civilian-controlled tertiary care facilities. Evidence has shown similarities in the CF/UK experience with injured military members having, at times, significant issues with the perceived level of care provided to them in these facilities.

**Mental Health Care.** In the area of mental health care, the US forces, with significantly more dedicated mental health resources, are acknowledged leaders in military mental health care. As an example, their ongoing “Millennium Cohort” mental health study has already become a benchmark to which the CF has been contributing data in order to be able to access longer-term data on mental health issues for service members. The UK has experienced similar issues to the CF in dealing with mental health care, and in dealing with contracted mental health care services. The evaluation team noted also that overall mental health injury rates for benchmarked allied forces are quite similar—including areas such as OSI’s and attendant co-morbidity issues.

**Casualty Administration Support.** The issue of casualty administrative support is handled quite differently by the CF and allied countries. The UK has a very comprehensive formal casualty administration manual which the CF does not have. Both the UK and US forces have more mature casualty notification and casualty reception processes than does the CF. Most documents seen by the evaluation team revealed that, cultural and procedural differences aside, compensation and benefits processing are handled similarly amongst all allied forces.

**Compensation.** There is one compensation area where Canada has diverged somewhat from its allies, and that is in the area of compensation “awards” for disabilities. Under the New Veterans Charter, disability compensation for injured CF members is in the form of a one-time, lump sum payment. Canada’s allies have all retained a mix of one-time “awards” and longer-term pensions for comparable injuries. ....  
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**Support to Families.** In the area of support to families of the ill and injured, allied efforts in this area are more diverse and more mature in comparison to the CF. Both the US and UK have engaged charitable organizations as part of the “family compact” effort to a significantly higher degree than has the CF. Once again, the US with their TRICARE system, can provide the full spectrum of health care to families, which no other ally can match. However, the UK does make provisions to keep military families in a priority list for family health care, and the Australians, as this report notes, are conducting a trial of federally sponsored health care clinics for dependants and veterans.

To summarize, the CF effort in caring for their ill and injured and their families is generally consistent with similar efforts being taken by our closest allies.



## Summary

This evaluation focused on the effectiveness of health care service delivery and related administration (including compensation and benefits) for injured CF members and their families, and not on the associated financial costs. In adopting this focus, CRS approached the evaluation from the perspective of what senior policy-makers, CF leaders and members themselves would expect as an appropriate standard of support to injured members and their families.

CRS thus took into consideration SCONDVA's 1998 position<sup>76</sup> that Canada has a moral commitment to the care and compensation of injured CF members, based on the guiding principle of compassion. Much more recently, in response to a December 2008 DND/CF Ombudsman's report related to CF health care,<sup>77</sup> the Minister of National Defence stated that "One of my priorities is to ensure that our Canadian Forces members receive the best care possible."<sup>78</sup> And, in his Guidance to Commanding Officers,<sup>79</sup> the CDS noted that "Our CF health care system is fundamental to the maintenance of morale and effectiveness of the CF as a fighting force." This and related evidence demonstrated to the CRS team that senior government officials and CF leaders are committed to duty of care in supporting injured CF members and their families.

As for what standard CF members (as well as DND/CF caregivers and administrators) would expect, those interviewed expressed the need for a consistently high standard of support and administration, characterized by effective coordination within and external to DND and sustainability in terms of available health care capacity.

Considerable progress has been made through Rx2000 and other initiatives in re-establishing an effective health care system following budget cuts in the 1990s. Those receiving physical injuries in particular as a result of deployed operations generally receive a high level of care through in-house and contracted resources. The range of compensation and benefit programs for injured members has also been expanded, and, where appropriate, VAC staff engage earlier in the process than in the past for those members being medically released. Allied to those improvements is a growing recognition that military families make sacrifices in support of Canada and assume a significant burden of care in the case of seriously injured CF members.

However, despite all the positive improvements and the dedication of health care staff at every level, this report notes that significant challenges remain. The fact that health care systems must be agile and require ongoing attention is recognized in complex adaptive systems theory,<sup>80</sup> which views health care systems as dynamic, flexible networks that are

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<sup>76</sup> Standing Committee on National Defence and Veterans Affairs report, *Moving Forward: A Strategic Plan for Quality of Life Improvements in the Canadian Forces*, Chapter 1, October 1998.

<sup>77</sup> DND/CF Ombudsman report, *Assessing the State of Mental Health Services at CFB Petawawa*, December 2008 <http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/asm-ees/doc/petawawa-eng.pdf>.

<sup>78</sup> Minister of National Defence, *Letter of Response to the Ombudsman*, 19 December 2008 <http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2831>.

<sup>79</sup> *CDS Guidance to Commanding Officers*, section 1903.8, version dated 14 October 2008.

<sup>80</sup> John Norris, *Healthcare Systems not as Machines but Living Organisms*, 28 July 2008, [john-norris.net](http://john-norris.net), <http://john-norris.net/2008/07/28/healthcare-systems-not-as-machines-but-living-organisms>.

difficult to optimize. This is especially so where roles, responsibilities and accountabilities in some areas (e.g., mental health) remain unclear. The CF health services system is even more interdependent than civilian systems, given the reliance on a multitude of individual external health care providers and provincial systems, the interface with VAC, as well as the competing resource demands of satisfying both in-garrison and force generation responsibilities. As a result of constraints, many beyond the control of CFHS, local solutions sometimes are developed that can lead to a lack of standardization and consistency in approaches to health care delivery at some bases across Canada.

With respect to Rx2000, there is the need to complete the implementation of CFHIS, which is seen as critical to the success of the Rx2000 program, and to address health care infrastructure deficiencies on a number of major bases. The growing need for mental health resources in underserved locations is a recognized problem that does not appear to have a viable short-term solution, given the limitations of the current paradigm and despite the best efforts of all. As for the management of mental health service delivery, there is a pressing requirement to clarify roles, responsibilities and assigned resources within the mental health professional technical network, particularly with respect to leadership, technical guidance and control. As well, a number of key health policy and guidance documents that have been in draft for a number of years should be finalized as an important component of effective governance.

Another critical element of the health care control framework is effective performance measurement, including the identification and tracking of key performance indicators to ensure that the health care system, both at the local base/wing level and nationally, is attuned to changing circumstances and developing trends. Unfortunately, the extent to which statistics are kept is uneven at best, is not driven by national reporting requirements, and is largely a local decision. Additionally, in cases where the health of CF members is entrusted to third-party providers, there is a lack of consistency in terms of the availability of feedback mechanisms for those receiving the care, as well as institutional monitoring and quality assurance of the outside care being provided.

For those injured members being released, transition to VAC administration, while improved, is still not seamless, and some injured members report facing perplexing bureaucratic hurdles at a time when they are mentally and emotionally vulnerable.

DND administration for injured and seriously ill CF members is generally meeting the need, and the broad range of programs in place contributes to positive outcomes. The stand-up of IPSUs should facilitate a “one-stop shopping” approach to care, and ensure effective coordination and integration. The role of all stakeholders in that model, including former units of CF members being medically released, requires clear definition to ensure full comprehension and trust.

There is also a need to improve communications regarding available compensation and benefit programs to alleviate confusion. CF members and the chain of command repeatedly told CRS of difficulties in becoming informed regarding the array of programs and help which could be made available, as websites are often not linked and some are harder to navigate than others. There is also a need to better educate all stakeholders as

to policies and programs available to injured reservists, and to improve tracking mechanisms and access to DND/CF health care for those reservists who do not live near CF bases/wings.

Regarding support to the families of injured members, despite the breadth and scope of tailored support programs available through MFRCs, more is needed with respect to health care for families who may themselves be at risk from the burden of caring for an injured member or veteran. This may require considering ways of addressing the current policy and legal impediments that would be a significant departure from the status quo and are currently beyond the authority of DND/CF policy-makers to effect. Family support models to be investigated further include those of the US, UK and Australia.

CRS offers findings and recommendations to address the current challenges associated with support to the injured and their families. In some cases resolution will require innovative approaches (e.g., introducing military clinical psychologists to increase CF mental health capacity; retaining case management responsibility for CF members being medically released until they have successfully established themselves within a provincial medical system; and seeking a new health care model for families of seriously injured members).

## Findings and Recommendations

### Medical Care

1. CF medical staff have noted that at least for initial treatment on arrival in Canada, a seriously or very seriously injured individual will be better off at a location selected in consultation with the force generating base surgeon and member's unit. If continued care is required in a medical facility, once the most serious injuries have been addressed, then the injured member could be moved to a facility closer to NOK.

#### Recommendation

Consult with the force generating base surgeon, member's unit and NOK in order to select a location in which to hospitalize a seriously or very seriously injured individual. If continued care is required in a medical facility, once the most serious injuries have been addressed, then the injured member could be moved to a facility closer to NOK.

**OPI:** CMP

2. Although the CF has contracted out domestic Role 3 and Role 4 responsibilities to civilian tertiary care facilities in Canada, there is a lack of consultation with the ill and injured members on the quality of care received in these facilities. As a result, those members who have observations or suggestions to improve the care received or administrative processes have no formal mechanism to do so.

#### Recommendation

Implement a patient satisfaction survey system for all contracted-out medical services for ill and injured CF members.

**OPI:** CMP

**OCI:** ADM(Mat)/DQA

3. Execution of medical record keeping has been uneven.

#### Recommendation

Clarify and promulgate medical record keeping policies, roles and responsibilities.

**OPI:** CMP

4. The PCRI model has not catered to necessary force generation of medical personnel across the CF. There are not enough military medical personnel in all MOCs in the CDU establishments to allow for both garrison care and to support continuous deployed operations.

### Recommendation

Conduct a comprehensive field force review of CFHS that reflects its critical role in the force generation of medical personnel for operations, including a review of the PCRI establishment model. Based on review findings, align the required CFHS capacity to ensure conditions for success are set for medical and dental support as outlined in the force development models.

**OPI:** CFD

**OCI:** CMP

5. The prevalence of symptoms reported at the time of post-deployment screening has been stable. CF deployment health and mental health experts judge that the apparent prevalence of mental health problems is commensurate with the nature of the operations.
6. Despite the lengthy implementation of Rx2000, significant challenge remains for some mental health clinic managers and the mental health national practice leads in achieving appropriate integration of the disciplines associated with mental health care. The new Director of Mental Health has been directed to ensure that this necessary integration will be done effectively in the near term.
7. Best practices indicate that better coordination and engagement of CF Mental Health and Rehabilitation teams in a multidisciplinary approach is needed in complex cases involving severe physical injuries where long hospital stays are needed.
8. The principal issue facing the CF/DND mental health community is one of a lack of national leadership and governance. There is currently no single individual whom those within the community can turn to for strategic guidance, policy setting, doctrine production and overall professional leadership.
9. The mental health clinical team concept has been weakened by a lack of mental health team doctrine, guidance on boundaries between practicing mental health professions similar to what exists in the physical medicine professions, and coherent training and professional development regimes. As a result, the national practice leadership concept has not been effectively implemented. It will be critical for the new Director of Mental Health to address these issues.
10. The morale and welfare of mental health caregivers is at risk.

### Recommendation

Meet with appropriate SMEs, such as the Canadian Caregiver Association, and seek advice that would assist at-risk mental health caregivers who provide care for CF members.

**OPI:** CMP

11. CF mental health services lack the capability to meet the demand for services in French to francophone members in most clinic settings.



### Recommendation

Meet with the Canadian Psychological Association/Société canadienne de psychologie and seek advice that could assist in developing a framework for care for French-speaking CF members who require mental health services in their own language. Specific advice from l'Ordre des psychologues du Québec and other associations with French membership should be sought. Further work of this nature should be undertaken with the respective health care providers' Colleges and Associations.

**OPI:** CMP

12. OSISS is a non-clinical social support program that is outside the DND/CF mental health model. Boundary concerns exist at the tactical/base level. Improved integration of OSISS with clinical mental health care is required.

### Recommendation

Normalize the command and control relationship of OSISS to ensure the responsible director (DCSM) has total visibility and responsibility for all of the activities associated with DND's OSI program including acting as CMP's SME and SA in order to facilitate greater universal acceptance and integration, and build on the strengths of the OSISS program.

**OPI:** CMP

13. On those bases with adequate medical infrastructure that enables co-located clinical facilities, noticeably streamlined care for the ill and the injured has been observed. On those bases lacking this clinical co-location, noticeably inhibited treatment of the ill and injured has been noted.
14. There remains a lack of focused guidance or standardized direction, such as a jointly written aide-mémoire that would inform clinicians, practitioners and the chain of command the information that can and must be passed on to the operational chain of command. There is still too much latitude for individual interpretation.
15. A continuing lack of performance measurement at virtually all levels hinders effective and efficient control of CFHS resources, and ultimately contributes to a lack of knowledge of best shared practices and procedures throughout the CFHS.

### Recommendation

Commit to a performance measurement regime, and develop in all levels of CFHS a performance measurement culture.

**OPI:** CMP

16. The existing Rx2000 PCRI CDU concept does not have enough military personnel flexibility built into the model to allow for continued garrison care and for undertaking extended military deployments.
17. Only Canada amongst all ABCA and major NATO countries lacks uniformed clinical psychologists.

18. The CF has a clinical psychologist occupation mobilization specification already prepared which is suitable for use in both the Regular Force and Reserve Force now.

**Recommendation**

Conduct an analysis and provide costing options for the introduction of a clinical psychologist occupation into both the Regular and Reserve Force.

**OPI:** CMP

19. Current federal Public Service staffing policies and practices have continued to hinder what should be a responsive and effective hiring process for DND medical and mental health professionals, particularly in underserved areas of Canada.

20. There are no higher-level HR policies governing internship/apprenticeship programs for civilian health care practitioners.

**Recommendation**

Examine the feasibility of introducing internship/apprenticeship programs for civilian health care practitioners, and develop supporting policies and procedures as appropriate.

**OPI:** CMP

**OCI:** ADM(HR-Civ)

21. Current Public Service pay scales and occupation classifications for a number of medical and mental health professions have not been sufficient to attract appropriate numbers of suitable persons to meet CF/DND needs in medically underserved areas of the country.

**Recommendation**

Participate in a collaborative examination by the Federal Health Partnership, the Public Service Commission and Treasury Board of classification and remuneration for all health care occupations within the public sector.

**OPI:** CMP

**OCI:** ADM(HR-Civ)

**Administration for the Ill/Injured CF Member**

22. The linkage of HLTA benefits to NOK has caused issues particularly when actual NOK are unknown to the CF and thereby cannot easily be located when that CF member is injured or dies on duty.

**Recommendation**

Delink HLTA benefits from NOK forms.

**OPI:** CMP

23. Lack of proper message handling/passage of information concerning CF domestic injuries to members has inhibited appropriate staff actions.

### Recommendation

Reinforce through the chain of command that proper procedures for both domestic and operational injuries must be followed, and introduce specific performance measures to track compliance.

**OPI:** CMP

**OCI:** CMS, CLS, CAS, Comd Canada COM, Comd CEFCOM, Comd CANSOFCOM, Comd CANOSCOM, DOS SJS

24. The JPSU/IPSU concept of assuming control of the administration for the severely injured is an appropriate measure that will lead to much improved efficiency and effectiveness in the care of the injured; however, much better communication must be undertaken to explain exactly how they will function, and how communication with the losing unit will be maintained.
25. The present regime of training and utilization of AOs has proven to be an effective approach in dealing with the NOK of the injured and deceased CF members.
26. The revised structure of the SoC Committee provides a suitable forum for addressing issues surrounding changes in health care coverage and attendant benefits. Representation from VAC at these meetings will raise awareness between both Departments on SoC harmonization efforts.

### Recommendation

Ensure DND and VAC SoC continue to be harmonized.

**OPI:** CMP

**OCI:** VAC LO

27. VAC involvement before the six-month period prior to release from the CF is advantageous to CF members and their families.
28. Some injured CF members are being released without guaranteed medical support in the civilian community on release.

### Recommendation

Maintain an administrative linkage with those CF members, both Regular Force and Reserve Force, who have been identified as requiring exceptional attention during and after the release process, until VAC and DND have concluded that the transition has been successfully completed.

**OPI:** CMP

**OCI:** VAC LO

29. There is no commonly accepted definition of “family” used throughout CF/DND.

**Recommendation**

Choose an acceptable definition of “family” and ensure this definition is promulgated across the CF/DND.

**OPI:** CMP

30. Discrepancies exist between publicly funded survivor benefits programs in the RCMP and DND.

**Recommendation**

Review the RCMP programs and services related to survivor benefits for spouses and NOK to determine whether the same effect can be obtained for military spouses/NOK.

**OPI:** CMP

31. Care and administration for the deceased member’s NOK during the reception and burial processes operates efficiently and effectively with few observed systemic problems.
32. Explanation of financial benefits and provision of documentation to the NOK has generally been seen as appropriately handled.
33. Confidence is generally low that the CFHIS project has the resources or the scope to address needed higher-level health functions.
34. The performance of CFHIS is unknown.

**Recommendation**

Ensure that Phase 3 of the CFHIS program includes the required higher- level functionality originally specified and remains within the scope of the CFHIS program, and establishes a performance measurement framework.

**OPI:** CMP

**OCI:** ADM(IM)

35. The lack of information system functionality, which permits access to internal personnel data, processes and services, is hindering the integrated management of CFHS and CF personnel information systems, with consequent implications for injured and ill CF members.
36. There is no electronic information sharing between DND and VAC regarding documentation of injured CF members.

**Recommendation**

In collaboration with VAC, address current IM/IT system interoperability limitations and deficiencies that impede effective information sharing.

**OPI:** CMP/Surg Gen

**OCI:** ADM(IM)

## Family Support

37. For much of what the CRS team has seen related to family health care, there is a demonstrated lack of policy and legal authority.
38. Initiatives under way under CDS direction and CMP authority that would try to improve health care provided to families of CF members through MFRCs, particularly in medically underserved areas of the country, will founder under legal impediments and bureaucratic staffing processes, unless significantly different approaches than those now being considered are taken. Federal and provincial ministerial-led action will be needed if these new approaches are to be successful.



## Annex A — Management Action Plan

### Medical Care

#### CRS Recommendation

1. Consult with the force generating base surgeon, member's unit and NOK in order to select a location in which to hospitalize a seriously or very seriously injured individual. If continued care is required in a medical facility, once the most serious injuries have been addressed, then the injured member could be moved to a facility closer to NOK.

#### Management Action

Agree. Since this CRS evaluation was undertaken the CFHS has stood up a physical rehabilitation cell that is developing policy on the treatment of seriously injured and very seriously injured soldiers. This includes ensuring that members receive the most appropriate care in the most appropriate locations. The method of selecting a location for care in Canada is currently very similar to that outlined in the CRS review recommendation, with the exception that when required, the specialist in charge of the rehabilitation program will also provide advice. (CF H Svcs Gp)

**OPI:** CMP

**Target Date:** December 2009 Policy completed;  
consultation will occur on an ongoing  
basis as injuries occur.

#### CRS Recommendation

2. Implement a patient satisfaction survey system for all contracted-out medical services for ill and injured CF members.

#### Management Action

Agree. CFHS commits to survey and gauge our clients' treatment experiences for all contracted-out medical services. Although the establishment of a full quality assessment process would be the ideal situation, the CFHS has no direct ability or authority to assess the quality of care delivered by outside facilities. However, case managers and primary care physicians follow the care the patients are receiving from civilian providers and change providers if there is a concern regarding the care being received. This is further bolstered by the use of civilian accreditation and credentialing standards as proxies for quality care assurance, and accredited care delivery facilities and duly credentialed providers are used whenever possible. Regarding the delivery of mental health services, the Mental Health Directorate monitors all services that are contracted out to community providers on a regular basis through wellness checks with the member and through case reviews with the external providers. (CF H Svcs Gp)

**OPI:** CMP

**Target Date:** December 2009 Survey Implemented.

**OCI:** ADM(Mat)/DQA

### CRS Recommendation

3. Clarify and promulgate medical record keeping policies, roles and responsibilities.

### Management Action

Agree. With the implementation of CFHIS, CF Health Records Management will evolve towards a true electronic health record. As a result of CFHIS implementation, there will be a corresponding overhaul of the entire health records charting system. CF H Svcs Gp has promulgated an interim update regarding the movement from paper to electronic health records as CFHIS is phased in at each CF Health Care Clinic. Once CFHIS is rolled out in its entirety, a new policy regarding the storage and access to all health records will be promulgated. With respect to documentation pertaining to care delivered in civilian facilities, civilian standards for care summaries and referral reports are already followed. As well, interim guidance has been sent to the clinics regarding mental health records that govern the handling of the mental health and psychosocial files. (CF H Svcs Gp)

**OPI:** CMP

**Target Date:** December 2010

### CRS Recommendation

4. Conduct a comprehensive field force review of CFHS that reflects its critical role in the force generation of medical personnel for operations, including a review of the PCRI establishment model. Based on review findings, align the required CFHS capacity to ensure conditions for success are set for medical and dental support as outlined in the force development models.

### Management Action

**OPI Comments.** Agree. We acknowledge the ambiguous status of reviews and studies, for CMP consideration. This recommendation on CFHS capacity will be incorporated in the analyses and design of changes to the Defence Force Structure. These analyses and structural changes will recognize that health services care is vital to operational fitness, readiness and morale. The solution space is expected to recognize the realistic capability-generating capacity of the nation to provide personnel in this occupational field. (CFD)

**OCI Comments.** While a comprehensive review of direct and indirect Health Services operational support requirements is long overdue, initial work on the development of a field force review was placed on hold pending the completion of the Defence Force Structure Review. With respect to in-garrison delivery of health care, there has been an ongoing evolution of the Position Charters for all CF Health Care Centres as PCRI has matured over the course of the Rx2000 project. (CF H Svcs Gp)

**OPI:** CFD

**Target Date:** October 2011

**OCI:** CMP

### CRS Recommendation

5. Meet with appropriate SMEs, such as the Canadian Caregiver Association, and seek advice that would assist at-risk mental health caregivers who provide care for CF members.

### Management Action

Agree. This initiative is supported but should be expanded to include all health service provider occupations. The Rx2000 project has institutionalized the expectation that all clinicians have access to clinical supervision and support mechanisms. This support can be contracted locally from the community or academic settings. Additionally we have included this support at workshops and conferences. The potential for the Canadian Caregiver Association and similar organizations to contribute to this activity will be investigated. (CF H Svcs Gp)

OPI: CMP

Target Date: June 2009

### CRS Recommendation

6. Meet with the Canadian Psychological Association/Société canadienne de psychologie and seek advice that could assist in developing a framework for care for French-speaking CF members who require mental health services in their own language. Specific advice from l'Ordre des psychologues du Québec and other associations with French membership should be sought. Further work of this nature should be undertaken with the respective health care providers' Colleges and Associations.

### Management Action

Agree. The CF H Svcs Gp is committed to delivering health care to CF members in their language of choice. All CF clinics seek out community providers who can provide services for French speaking CF members if the service cannot be provided within the clinic itself. Members who require extensive care that cannot be provided on site are referred to the closest facility that can offer the service in their preferred language. The Canadian Psychological Association will also be consulted to obtain care provider lists. (CF H Svcs Gp)

OPI: CMP

Target Date: September 2009

### CRS Recommendation

7. Normalize the command and control relationship of OSISS to ensure the responsible director (DCSM) has total visibility and responsibility for all of the activities associated with DND's OSI program including acting as CMP's SME and SA in order to facilitate greater universal acceptance and integration, and build on the strengths of the OSISS Program.

### Management Action

Agree. This will include establishing closer director-to-director ties DCSM to the newly established Director of Mental Health (DMH) and issue joint communication and problem resolution policies for both the OSI social support and Mental-Health (MH) clinical practitioner communities. (DCSM/DMH)

OPI: CMP

Target Date: April 2010



### CRS Recommendation

8. Commit to a performance measurement regime, and develop in all levels of CFHS a performance measurement culture.

### Management Action

Agree. CF H Svcs Gp is currently undergoing the accreditation process with Accreditation Canada. Accreditation Canada is a national, non-profit, non-government independent body that offers health organizations an external peer review process to assess quality by developing national standards of excellence, assessing compliance with those standards, and sharing information from accreditation reviews and decisions. The accreditation framework allows organizations across the continuum of care to share the same focus, underpinned by a common methodology and reporting system. Included in the accreditation process is the validation of continuous quality improvement (QI) and the associated adoption of a standards for health care risk management. These two processes are supported and validated via a verifiable performance management (PM) measurement system. Currently CF H Svcs Gp is in the process of formalizing the first series of PM indicators that will be used to validate the current delivery of care to CF members. The national CF H Svcs Gp QI Committee has been established to ensure that PM standards are set and promulgated to the clinic managers and COs. There has also been collaboration with VAC on this topic and research materials and tools are being shared amongst all players. (CF H Svcs Gp)

OPI: CMP

Target Date: October 2011

### CRS Recommendation

9. Conduct an analysis and provide costing options for the introduction of a clinical psychologist occupation into both the Regular and Reserve Force.

### Management Action

Agree.

OPI: CMP

Target Date: December 2010

### CRS Recommendation

10. Examine the feasibility of introducing internship/apprenticeship programs for civilian health care practitioners, and develop supporting policies and procedures as appropriate.

### Management Action

Agree. Under the auspices of the FHP there are a number of collective initiatives under way to address common issues, including the following two that relate directly to this recommendation:

- Federal clinical placement program—to provide clinical experience for students enrolled in health sciences training programs. The development of residency and clinical placement programs for health care learners may result in new hires having had clinical experience within the CF environment prior to employment. The intent is to have 15-20 learners per discipline (medicine, nursing and psychology) placed within VAC, Public Health Agency of Canada (PHAC), CSC, HC and DND.

### Management Action (cont'd)

- Physician Professional Development Program—to meet physicians' requirements for licensure, while ensuring that physicians also have the opportunity to enhance their expertise in their field of practice as well as gain management and leadership development required for positions in the federal milieu. Work is under way with the Treasury Board Secretariat (TBS), physician community and the Science and Technology (S&T) community to develop a framework for this program, which will provide a model for similar programs in other health disciplines.

CFHS and ADM(HR-Civ) will consult on an ongoing basis to further these initiatives. (CF H Svcs Gp, DGCESP)

OPI: CMP

Target Date: December 2010

OCI: ADM(HR-Civ)

### CRS Recommendation

11. Participate in a collaborative examination by the Federal Health Partnership, the Public Service Commission and Treasury Board of classification and remuneration for all health care occupations within the public sector.

### Management Action

Agree. This significant issue needs to be addressed by the Government of Canada collectively. The FHP has identified wage parity as a key factor that influences the recruitment and retention of health care professional within the Public Service. The FHP needs to work collaboratively with the Public Service Commission/Treasury Board in order to examine the classification and remuneration of all health care occupations within the public sector, thereby making them an employer of choice and more competitive within the health care sector. Under the auspices of the FHP there are a number of collective initiatives under way to address common challenges, including the following ones that relate directly to this recommendation:

- Health Education Training program—to fund post-secondary education for students participating in health education programs. Due to the *Public Sector Equitable Compensation Act* increases in public service wages will be limited to 1.5% for the next two fiscal years. Federal organizations cannot consider developing or implementing any new initiatives that involve allowances, bonuses or incentives. However, existing federal legislation and collective agreements provide the framework for federal organizations to fund post-secondary education. This FHP initiative is being pursued across the partners with the intent of funding and sponsoring a number of students by disciplines. Where possible the student would participate in clinical experiences in the federal milieu. Professional development opportunities would also be provided for health care providers already employed as indeterminate public servants, e.g., Occupational Health and Safety, Epidemiology, Nurse Practitioner Masters, PhD for Psychological Associates.
- Classification—in collaboration with TBS and through the FHP, over the next 18-24 months, priorities have been set to collectively address issues related to classification standards, occupational group structure and specific classification requirements, e.g., restructuring of the Medical Officer/Medical Specialist (MOF/MSP) classification, reclassification of Nurse Practitioners and Pharmacists. DND/DCCO is a key participant in the classification working group established under FHP to analyze the issues and work with TBS on implementing the appropriate solutions. DND/DCCO is also concluding several years of work in clinic organization design and collective work description classification.



### Management Action (cont'd)

- Recruitment—FHP is committed to collective recruitment activities where feasible. Further, DND has undertaken the following initiatives:
  - Integrated Service delivery—ADM(HR-Civ) has implemented an integrated unit to provide civilian HR services to all levels of the CMP organization. This new structure is resulting in more precise and timely recruitment and staffing strategies. For example, through this unit and in advance of standing up the JPSU in the eight regions across Canada, the Civilian HR Service Centres planned for and were ready to hire several groups and levels through a range of externally and internally advertised processes, including 17 AS 04 and four CR 04 positions.
  - Reduce the staffing burden initiative will streamline processes and reduce the time to hire—collective processes have been implemented with CFHS and DGPFSS (JPSUs) for both classification and staffing.
  - DND will be taking the lead to initiate a job fair at the University of Toronto in fall 2009. This fair will involve other departments, specifically those who are part of the FHP. (CF H Svcs Gp, DGCESP)

OPI: CMP  
OCI: ADM(HR-Civ)

Target Date: December 2010

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### Administration for the Ill/Injured CF Member

#### CRS Recommendation

12. Delink HLTA benefits from NOK forms.

#### Management Action

Agree. A new PEN will be released soon (approx Jun 09) which includes a statement that the PEN form is to be used for notification purposes only (DGPFSS).

The HLTA benefits are delinked from NOK forms. (DGCB)

OPI: CMP

Target Date: Completed.

#### CRS Recommendation

13. Reinforce through the chain of command that proper procedures for proper message handling/passage of information for both domestic and operational injuries must be followed, and introduce specific performance measures to track compliance.

#### Management Action

Agree. A new DAOD on Casualty Administration is currently being drafted which will re-emphasize the proper message handling procedures. This draft DAOD is in the early stages of development and will replace the current CFAO 24-1 and CFAO 24-6. Target date is to be determined given the lengthy process for DAOD processing and approval.

### Management Action (cont'd)

DCSM will track compliance of these procedures as part of its performance measurement framework. However, Commands have a major role to play to enforce compliance within their Units as there is still an issue. (DGFPS)

**OPI:** CMP

**Target Date:** April 2010

**OCI:** CMS, CLS, CAS, Comd Canada COM,  
Comd CEFCOM, Comd CANSOFCOM,  
Comd CANOSCOM, DOS SJS

### CRS Recommendation

14. Ensure DND and VAC SoC continue to be harmonized.

### Management Action

Agree. The harmonization of the VAC and DND SoC is ongoing. The CF H Svcs Gp Directorate of Health Services Delivery is engaged with VAC to bring the two SoC into alignment. It must be noted that harmonization cannot be translated into equality. There will always be some differences between the two SoC. (CF H Svcs Gp)

**OPI:** CMP

**Target Date:** Process in place

**OCI:** VAC LO

### CRS Recommendation

15. Maintain an administrative linkage with those CF members, both Regular Force and Reserve Force, who have been identified as requiring exceptional attention during and after the release process, until VAC and DND have concluded that the transition has been successfully completed.

### Management Action

Agree. This process will be undertaken through the JPSU construct and in close consultation with Veterans Affairs Canada.

**OPI:** CMP

**Target Date:** April 2010

**OCI:** VAC LO

### CRS Recommendation

16. Choose an acceptable definition of “family” and ensure this definition is promulgated across the CF/DND.

### Management Action

Agree. A definition of “family” shall be created and promulgated. It shall be used to determine eligibility for services by the Military Family Services Program.

**OPI:** CMP

**Target Date:** September 2009



### CRS Recommendation

17. Review the RCMP programs and services related to survivor benefits for spouses and NOK to determine whether the same effect can be obtained for military spouses/NOK.

### Management Action

Agree. This review is in progress. (DGCB)

**OPI:** CMP

**Target Date:** June 2011

### CRS Recommendation

18. Ensure that Phase 3 of the CFHIS program includes the required higher-level functionality originally specified and remains within the scope of the CFHIS program, and establishes a performance measurement framework.

### Management Action

Agree. At this time the CFHIS project is going through an exercise to scope Phase 3 requirements in order to complete the CFHIS by March 2010. We will be able to meet some of the higher functionality requirements but not all of the original scope. The performance measurement framework for CFHIS was not identified as a requirement in the original project SOR and as such will not be part of CFHIS project. We are now in the process of developing follow-up projects which will include a performance measurement system, some of the de-scoped requirements in the present CFHIS project and any new requirements. (CF H Svcs Gp)

**OPI:** CMP

**Target Date:** Post-2010

**OCI:** ADM(IM)

### CRS Recommendation

19. In collaboration with VAC, address current IM/IT system interoperability limitations and deficiencies that impede effective information sharing.

### Management Action

Agree.

Information sharing with VAC has been ongoing since the beginning of the Rx2000 initiative in 1999. However, this information sharing remains an issue, given that both departments have IM/IT systems that are not interoperable. Currently exchanging information is largely a manual labour-intensive process. The Joint VAC DND Steering Committee has made information exchange improvements a priority for the next year, with a view to modernising both IM/IT systems to facilitate the timely passage of information electronically. A full analysis and costing of several initiatives is under way. (CF H Svcs Gp)

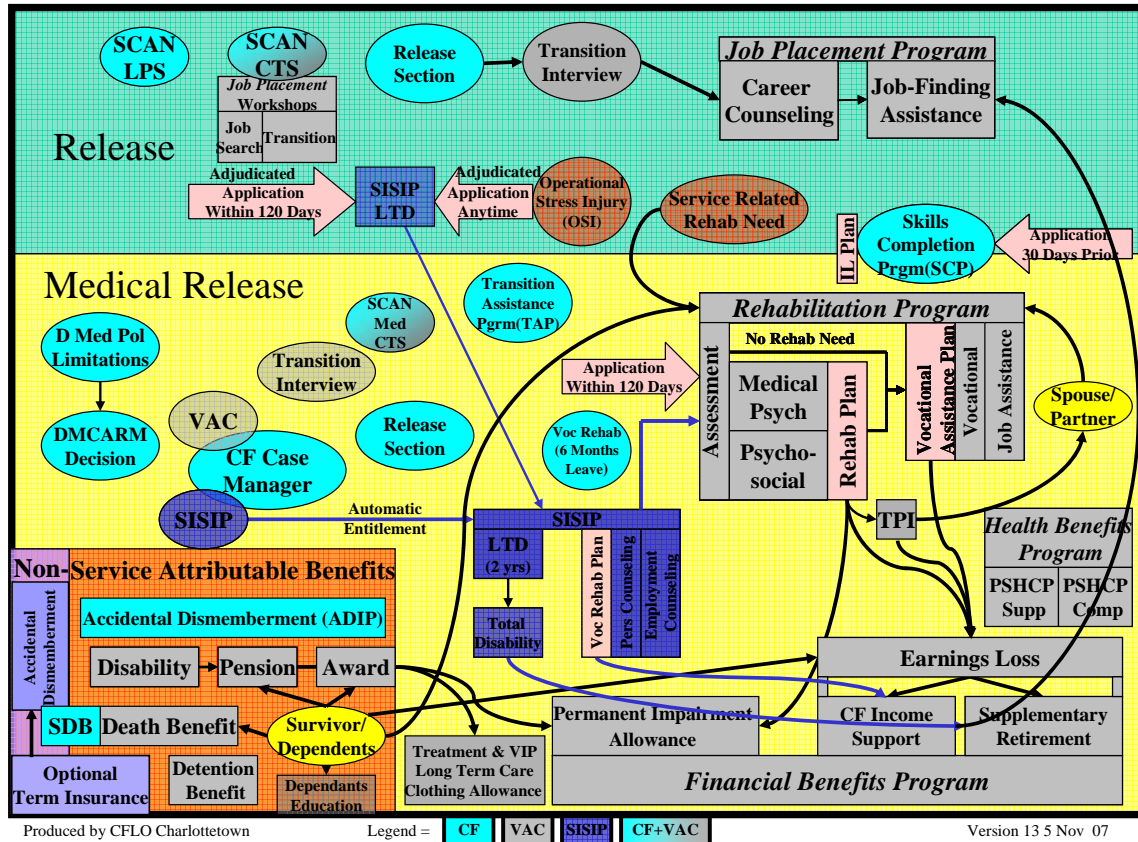
The Joint Network of Clinics MOU, signed in October 2006 with VAC and the RCMP, has set up a series of committees and sub-working groups to address this matter. These committees meet regularly and progress is reported quarterly to the Joint VAC/DND Steering Committee. (CF H Svcs Gp)

**OPI:** CMP/Surg Gen

**Target Date:** Proof of Concept for VAC/DND  
IT Interoperability and Records  
Scanning – December 2010

**OCI:** ADM(IM)

### Annex B—CF/VAC Program Relationships



**Figure 2. Current CF/VAC Program Relationships.** This flowchart highlights the complex inter-relationships of existing programs available to ill and injured CF members and their families, or the CF members’ survivors.

Starting with voluntary release, a member has a number of available programs, including Second Career Assistance Network, Transition Interviews, Job Placement including career counseling and job finding assistance. As well the chart shows that, should a former member discover after release that he or she has a service-related medical condition, the member may be eligible for the same VAC rehabilitation programs provided to those medically releasing. SISIP is also available for those who become totally disabled in specific circumstances.

When a member is being medically released from the CF, there is a process in place to determine medical limitations, and when necessary, compulsory release. VAC becomes involved in this phase in certain areas including transition interviews and consultation with CF case managers. During the medical release process, as applicable, there are a number of rehabilitation programs and associated assessments for both physical and psycho-social issues.

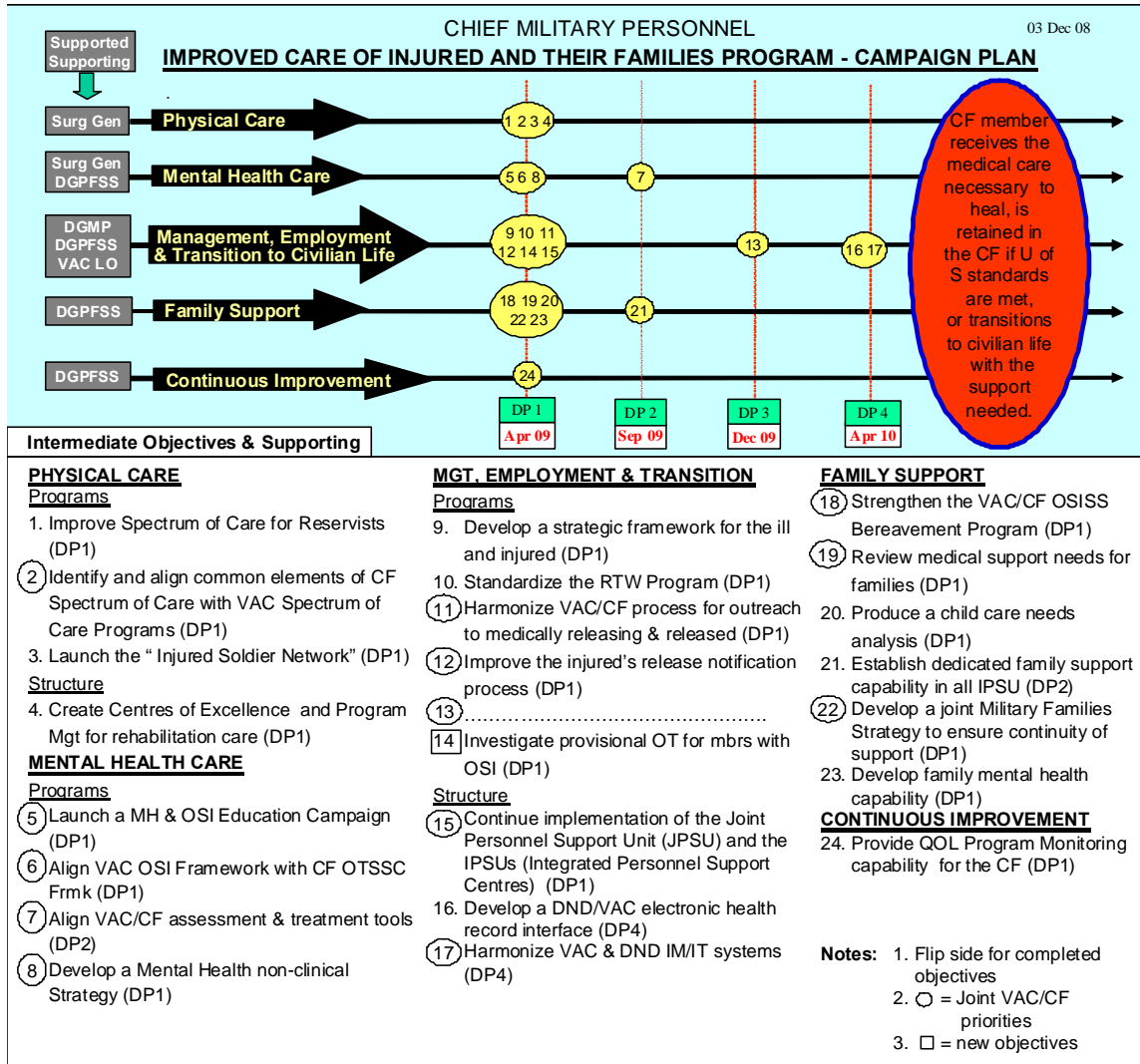
**Annex B**

A medical release, which also includes the death of a CF member, triggers a number of benefit and allowance programs managed by VAC including the Veterans Independence Program, Income Support and Earnings Loss programs.

In addition, for certain non-service injuries, there are benefits provided to program subscribers to include Accidental Dismemberment awards, and further disability and pension awards and benefits.



### Annex C—CMP Care of the Injured Campaign Plan



**Figure 3. CMP Care of the Injured Campaign Plan.** CMP launched a campaign to improve care and treatment of injured CF members and their families. The ongoing campaign plan is based on five pillars: physical care; mental health care; management, employment and transition to civilian life; family support; and continuous improvement. This plan contains intermediate objectives for all pillars starting from April 2009 and progressing to April 2010.

As shown below, the current version of this plan lists a number of completed intermediate objectives for each of the five pillars.



**Annex C**

**Physical Care**

Programs

1. Develop a Physical Rehab Program

Structure

2. Appoint a Special Care of Injured Advisor to CMP
3. Install additional case managers in Edmonton, Gagetown and Petawawa
4. Develop Rx2000 infrastructure
5. Establish an inter-departmental Prosthesis Review Committee
6. Establish Reserve Medical Link Teams throughout Canada (addition since last edition)

Awareness

7. Brief AFC on Spectrum of Care
8. Brief AFC on Rx2000
9. Brief AFC on new Veterans Charter

**Mental Health Care**

Structure

10. Integrate all non-clinical mental health and OSI education across the CF
11. Augment mental health capability in Petawawa and Gagetown
12. Establish an OSI Advisor to CMP
13. Establish CF/VAC Mental Health Oversight Committee
14. Re-establish a CF-OSI Steering Committee
15. Appoint a Head of Mental Health for CF (addition since last edition)

Awareness

16. Brief AFC on mental health
17. Launch a Mental Health Education Campaign

**Management, Employment and Transition**

Programs

18. Place injured reservists on full-time service
19. Conduct Transition Process Mapping Exercise

20. Provide VAC transition interviews to Reservists returning from operations
21. Promulgate the CO's Guide to Casualty Support
22. Examine and augment where needed VAC on-site requirement for all navy and air force bases
23. Improved injury notification process
24. Develop a robust tracking system for wounded

Structure

25. Develop career management capability for the injured (addition since last edition)

Awareness

26. Increase awareness of VAC Transition Interview Process
27. Increase awareness of VAC's Job Placement Program to serving members

**Family Support**

28. Establish DG Personnel and Family Support Services capability
29. Establish a CF Directorate of Family Support Service
30. Develop Military Family ID cards
31. Enhance post deployment mental health and OSI education for families (addition since last edition)

**Continuous Improvement**

32. Conduct a National Lessons Learned Symposium
33. Conduct a National Prosthesis forum
34. Develop follow-up and feedback procedure for NOK and families of deceased members

**Physical Care.** Completed objectives related to development of a physical rehabilitation program, appointment of a Special Care of the Injured Advisor to CMP, installation of additional case managers in Edmonton, Gagetown and Petawawa, and the establishment of Reserve Medical Link Teams throughout Canada.

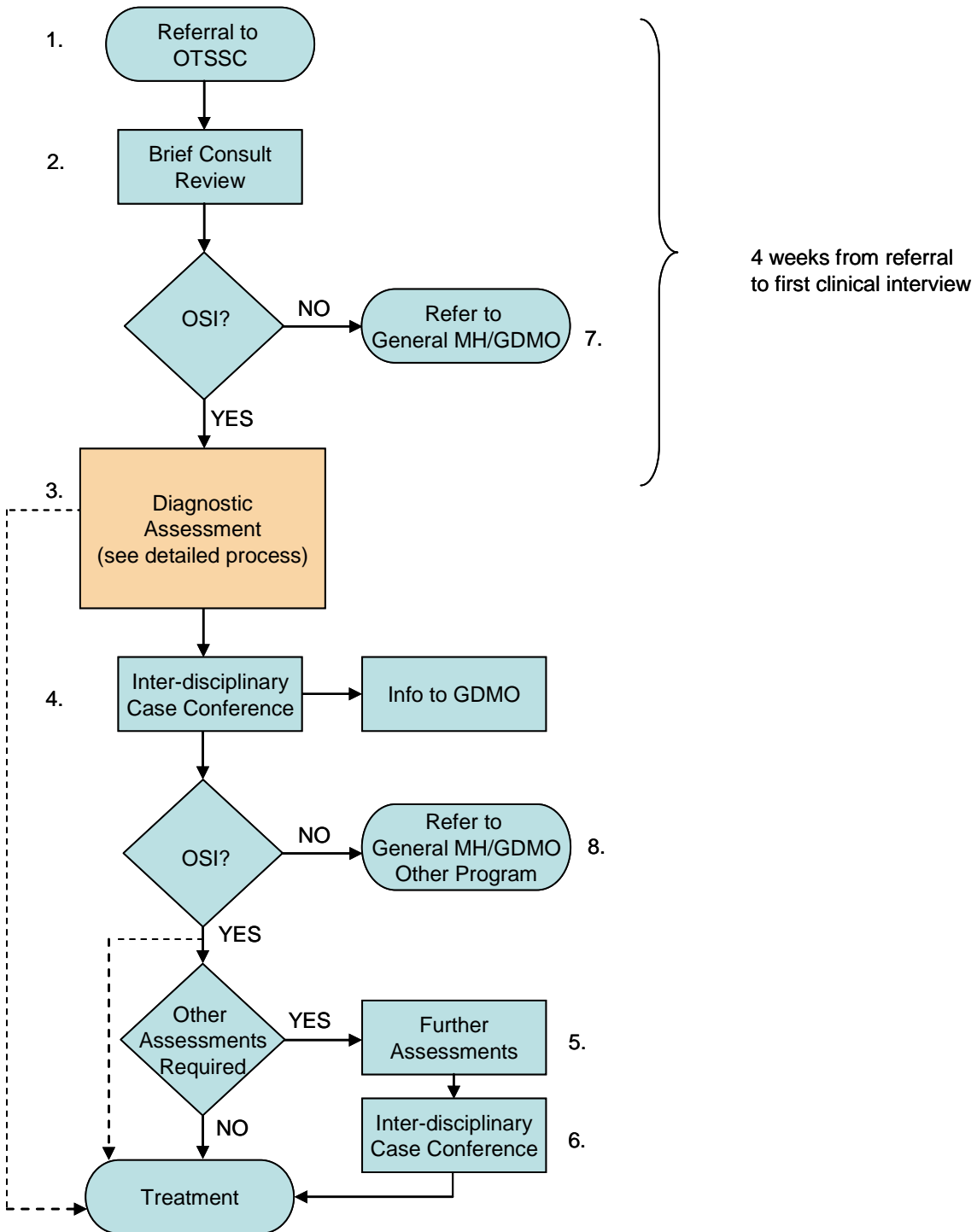
**Mental Health Care.** Completed objectives include the integration of all non-clinical mental health and OSI education across the CF, augmentation of the mental health capability in Petawawa and Gagetown, establishment of an OSI Advisor to CMP, establishment of a CF/VAC Mental Health Oversight Committee, and appointment of a Head of Mental Health for the CF.

**Management Employment and Transition.** Completed objectives include the placement of injured Reservists on full-time service, Transition Process Mapping Exercise, provision of VAC Transition Interview to Reservists returning from operations, promulgation of a CO's Guide to Casualty Support, examination of Navy and Air Force needs for VAC augmentation, improved injury notification process and development of a robust tracking system for the wounded.

**Family Support.** Completed objectives include establishment of DG Personnel and Family Support Services capability, established a CF Directorate of Family Support Service, developed military family identification cards, and enhanced post-deployment mental health and OSI education for families.

**Continuous Improvement.** Completed objectives include the conduct of a National Lessons Learned Symposium, conduct of a national prosthesis forum, and development of a follow-up and feedback procedure for NOK and families of deceased members.

### Annex D—OTSSC Mental Health Assessment Process



**Figure 4. CF OTSSC Assessment Process (Minimum Requirements).** This flowchart explains what takes place when a CF member is referred for a mental health assessment at an OTSSC.

Annex D

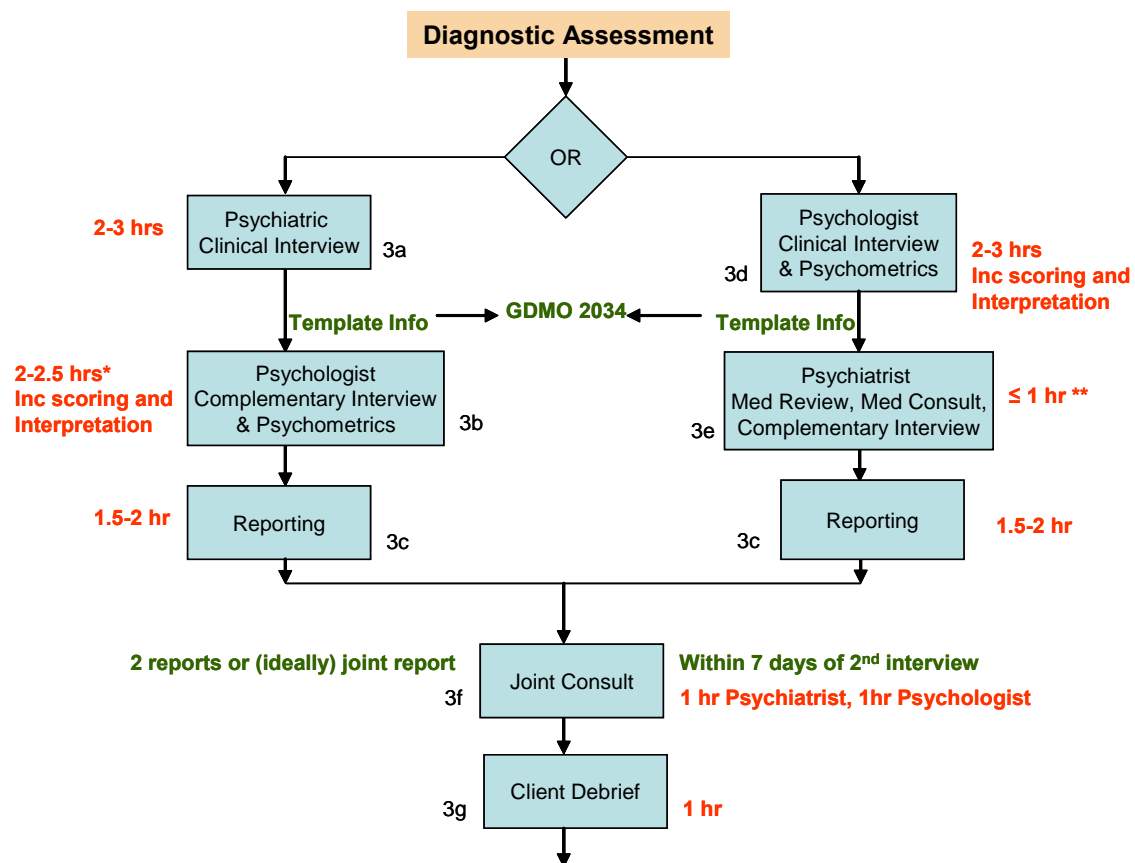
The process starts with the CF member being referred to an OTSSC (Step 1). Step 2 is a process entitled “Brief Consult Review.” For the first two steps, it could take four weeks from referral to the first clinical interview.

A quick determination is made as to whether or not the client is suffering an OSI. If “No”, the process branches to Step 7 “Refer to General MH/GDMO” and terminates. If “Yes”, the process proceeds to Step 3 “Diagnostic Assessment” (see detailed process in the second figure to this Annex). Note that treatment can begin prior to full assessment.

At Step 4 “Interdisciplinary Case Conference,” the OTSSC Mental Health team provides information back to the CF member’s GDMO/family doctor. If the client is not suffering an OSI, the process branches to “Refer to General Mental Health/GDMO or other program” and terminates.

If the client does have an OSI, treatment can begin before a full diagnosis has been made. However, if other assessments are required, the process proceeds through Step 5 “Further Assessments” and Step 6 “Inter-disciplinary Case Conference” before arriving at the process box labeled “Treatment.”

The end result for the client is access to treatment.



\* Mandatory unless indication that it would be harmful. This must be documented. Other instruments at discretion of the clinicians.  
 \*\* If template from first interview is available.

**Figure 5. CF OTSSC Assessment Process, Diagnostic Assessment (Minimum Requirements).** This flowchart explains how CF mental health clients are assessed by clinician disciplines serving within the OTSSC Unit. Note that this flowchart was representative of the OTSSC MH standard practice at the time of collection, and that these standards continued to evolve over the period of observation and since the report was drafted.

CF clients enter the OTSSC for diagnostic assessment. The process begins by indicating that any client may follow one of two possible paths through the assessment processes.

The first path is as follows:

- Psychiatric Clinical Interview (2-3 hours). A template form is completed at this stage that goes through the client’s GDMO (family doctor) and military medical record/chart (DND 2034);

- Psychologist Complementary Interview and Psychometrics (2-2.5 hours, including scoring and interpretation)—note that this assessment is mandatory unless indication that it would be harmful. This must be documented. Other instruments at discretion of the clinicians; and
- Reporting (1.5-2 hours).

The second path is as follows:

- Psychologist Clinical Interview and Psychometrics (2-3 hours including scoring and interpretation);
- Psychiatrist Medical Review, Medical Consult, Complementary Interview (less than one hour if the template from the first interview is available on the 2034); and
- Reporting (1.5-2 hours).

Both paths lead to a joint consult between the attending Psychiatrist (1 hour) and Psychologist (1 hour) with a note indicating that this consult occurs within seven days of the second interview. This consult leads to the production of two reports or (ideally) a joint report.

The last step is a client debrief (1 hour).

## Annex E—Operational Stress Injury Social Support Program Organization

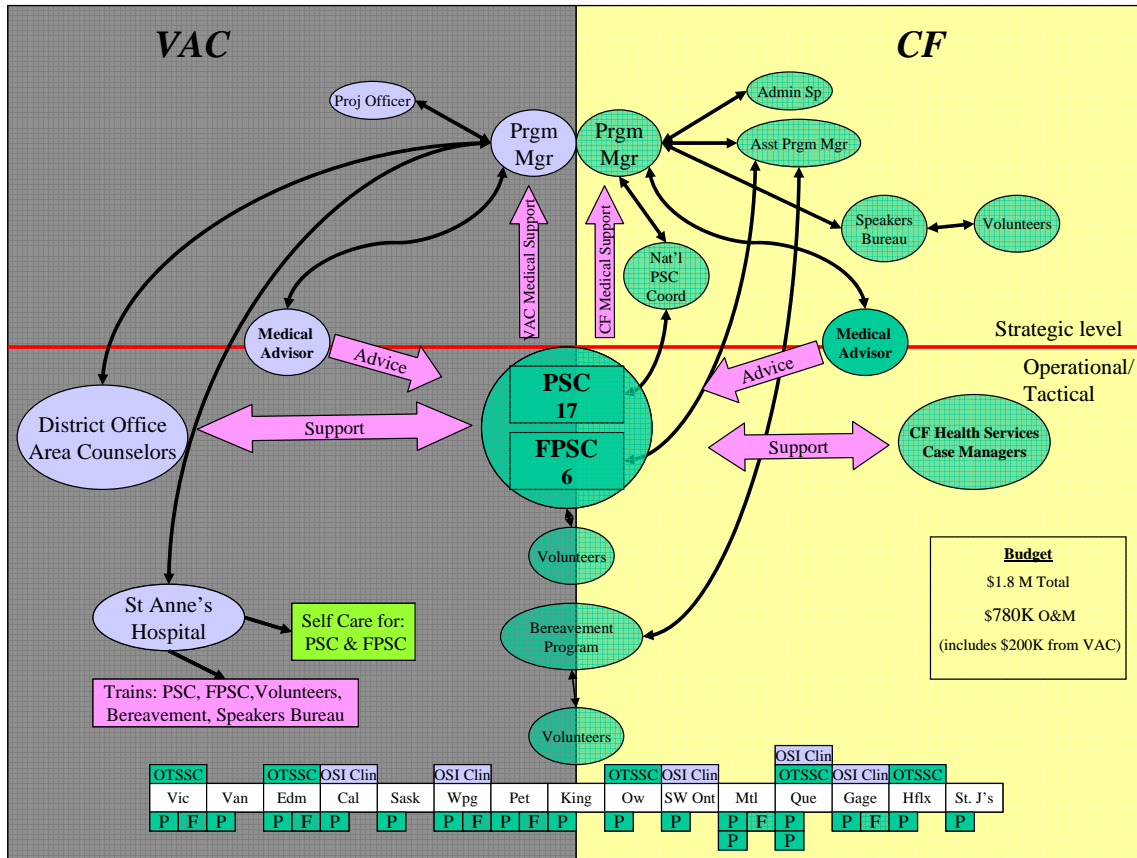


Figure 6. OSISS Structure. This chart describes the July 2007 OSISS Program.

The program has both a CF and VAC component, including a Program Manager for each organization and a number of shared sites. Both CF and VAC provide co-located and interoperable services for operational stress and bereavement through full-time and volunteer staff members in the program which is seamless from the strategic through operational and tactical levels across the country.

On the VAC side of the program, assisting the Program Manager is a medical advisor who also provides advice to the various support centres across the country.

VAC also has District Office Area Counselors who provide support to the Joint OSI clinics and the OTSSC's integral to the program.

VAC also provides the training for the OSI full-time and volunteer counselors through their OSI centre at St-Anne's Hospital and tracks self-care programs for the Peer Support Centres.

St-Anne's also trains the bereavement counselors and those persons selected to be part of the OSI Speakers Bureau.

**Annex E**

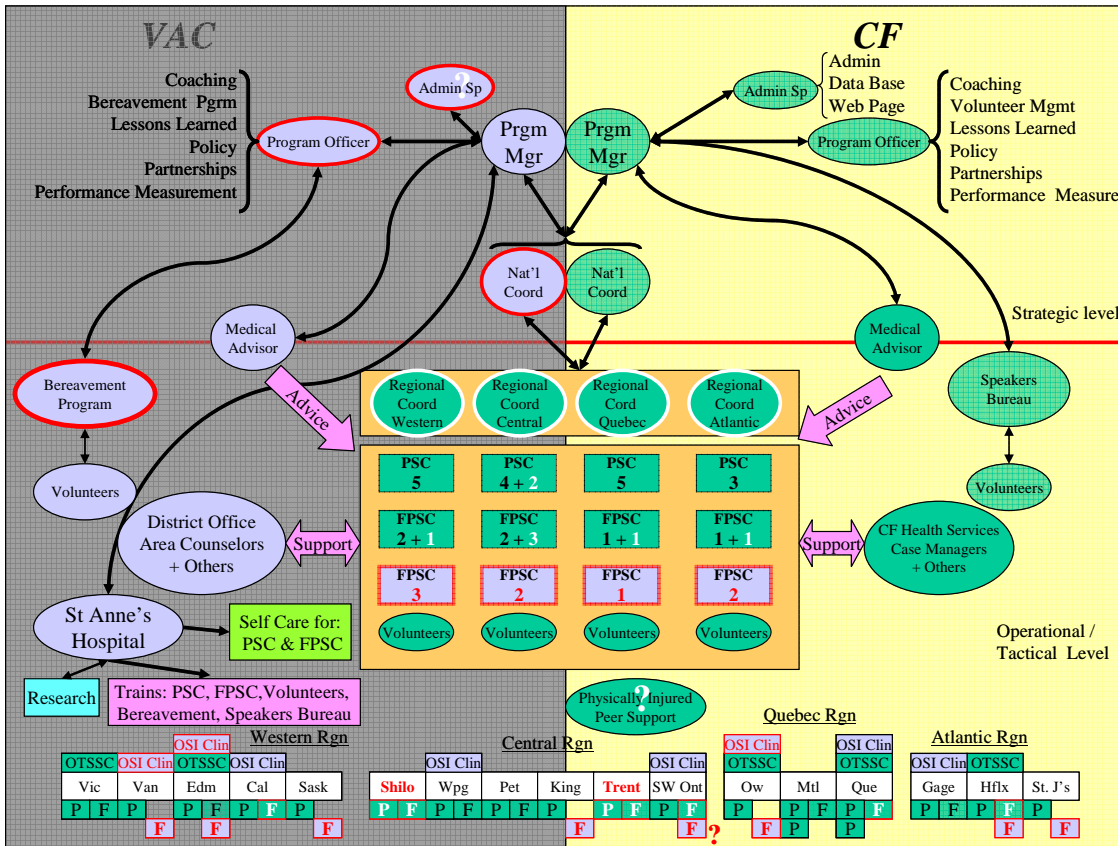
On the CF program side, there is a Program Manager and a national Peer Support Centre coordinator who monitors the full-time and volunteer members of the Peer Support Centres across the CF and provides a coordinating function with their VAC counterparts.

The CF also provides a Medical Advisor to give advice to the Peer Support Centres, and CFHS ensures interoperability with the CF Health Services Case Managers.

The 2007 budget for the CF OSISS program was \$1.8 million including \$780,000 for operations and maintenance costs, and a \$200,000 input from VAC.







**Figure 7. OSISS Structure (Proposed).** This chart describes the proposed restructuring of the current Joint VAC/DND OSISS program. It includes all of the functions of the July 2007 OSISS structure and adds a new layer of Joint DND/VAC Regional Coordinators—one each for the Western, Central, Quebec and Atlantic regions. Note that Administrative Support, Physically Injured Peer Support and staffing at the Southwestern Ontario OSI Clinic are to be determined.

The Regional Coordinators will supervise the execution of the OSISS program through their Support Centre networks already established in all four Regions, and staffed with both full-time and volunteer personnel. These Centres will work in close coordination with the Joint DND/VAC OSI clinics established in each region.

The new OSISS structure adds a Program Officer at the strategic level of both VAC and the CF. Working for the Program Manager through National Coordinators, the Program Officer will coordinate the coaching, bereavement program, lessons learned, policy, partnerships, volunteer management and performance measurement.

In the Western Region, there are OTSSCs in Victoria and Edmonton, an OSI clinic in Calgary and a new OSI clinic in Vancouver, plus part-time and full-time Support Centres in Victoria, Vancouver, Edmonton, Calgary and Saskatchewan.

In the Central Region there is an OSI clinic in Winnipeg and a proposed clinic for Southwestern Ontario, with a network of full-time and part-time Support Centres in Shilo, Winnipeg, Petawawa, Kingston, and Trenton.

**Annex E**

In the Quebec Region there is an OTSSC and OSI clinic in Ottawa and Quebec City, with Support Centres in Ottawa, Montreal and Quebec City.

In the Atlantic Region, there is an OTSSC in Halifax, an OSI clinic in Fredericton supporting Gagetown, and Support Centres in Gagetown, Halifax and St. John's.

Physically injured peer support may be integrated into this program.

