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MASTERS OF DEFENCE STUDY

RETURNING FROM A STRESSFUL OPERATIONAL ENVIRONMENT

Is the Canadian Forces decompression process adequate?

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La présente étude a été rédigée par un stagiaire du Collège des Forces canadiennes pour satisfaire à l'une des exigences du cours. L'étude est un document qui se rapporte au cours et contient donc des faits et des opinions que seul l'auteur considère appropriés et convenables au sujet. Elle ne reflète pas nécessairement la politique ou l'opinion d'un organisme quelconque, y compris le gouvernement du Canada et le ministère de la Défense nationale du Canada. Il est défendu de diffuser, de citer ou de reproduire cette étude sans la permission expresse du ministère de la Défense nationale.

ABSTRACT

Canadian soldiers going on a deployed operation are exposed to a wide variety of stressors, which may cause Post Traumatic Stress Disorder or Operational Stress Injuries in some. Mental health issues related to deployed operations became the object of recommendations by the DND and CF Ombudsman. One of those recommendations called for a pilot project, to determine effective ways of helping soldiers reintegrate into family life upon their return from a deployed operation. The CF answered it with the development of the CF TLD concept. A TLD offers the opportunity for soldiers to relieve pressure caused by the operation, before they go home. They decompress in a safe and relaxing environment, away from the theatre of operation and side by side with those who lived similar experiences. There also is an education aspect, where they learn how their family may react to their return and how they may themselves react to their family. This is meant to make their return back to a normal life easier. They are also informed that it would be normal to experience stress or psychological troubles, in which case there is a whole support infrastructure available to help them pull through. This paper demonstrates that soldiers returning from an extended deployment into a highly stressful environment may greatly benefit from a decompression period, to better prepare them for their return back to a more regular life. It also demonstrates that such a process is a leadership responsibility that has to be championed at the highest level in the CF, in order to ensure uniformity, continuity and success of the approach. It finally demonstrates that, although decompression will neither prevent nor cure PTSD and OSIs, it may enable detection of such psychological problems, by raising awareness and reducing the stigma often associated with mental health concerns.

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INTRODUCTION

"Most people are exposed to at least one violent or life-threatening situation during the course of their lives."[1] People react to such traumatic events and their resulting stress in many different ways. There are those responding to a traumatic event with resilience, maintaining "relatively stable, healthy levels of psychological and physical functioning"[2]. Others however, will experience various degrees of distress or grief. Some will recover quickly, while others will be affected for a long period of time. Some will recover completely, while others will experience minor or major setbacks.[3]

How people react to traumatic and stressful events is influenced by "a variety of factors, such as temperament, learned coping strategies, the presence and intensity of past psychological trauma, and the extent to which the individual has been directly affected by the event".[4] In the absence of resilience, typical responses to a traumatic event can be a varying level of fear, loss of control, flashbacks, trouble concentrating, guilty feelings negative self-image, depression or disrupted relationships. Although these responses are

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[1] George T. Bonanno. "Loss, Trauma and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events?" *American Psychologist,* 2004, Vol 59, No. 1, 20.

[2] *Ibid*., 20.

[3] *Ibid.*

[4] National Institute of Mental Health, "Post-Traumatic Stress Disorder." http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-easy-to-read/index.shtml; Internet; accessed 17 February 2009.

a normal part of the recovery process, they can cause a significant loss of quality of life and productivity.[5]

In the military, risk is such that soldiers are much more likely to be exposed to traumatic and stressful situations than most people. "Current military soldiers are constantly required to operate in complex, stressful, and ambiguous environments."[6] Military training is therefore designed to enable "the systematic acquisition of the knowledge … skills … and attitudes …, with the goal being to develop the competencies necessary for effective performance in work environments."[7] Military training is in fact designed to develop automatisms or reflexes through repetitive training, in order to ensure soldiers' tasks will be performed as expected, regardless of the stress caused by the environment.[8]

The training program leading to an operational deployment into a theatre of war is progressive and highly intensive. Before they deploy, Canadian soldiers are exposed to

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[5] Medical University of South Carolina, "Victim Reactions to Traumatic Events Handout." http://colleges.musc.edu/ncvc/resources_public/victim_reactions_general_trauma.pdf; Internet, accessed 17 February 2009.

[6] C. Shawn Burke, Heather A. Priest, Eduardo Salas and Katherine A. Wilson. "Scenario-Based Training: Improving Military Mission Performance and Adaptability," in *Military Life: The Psychology of Serving in Peace and Combat, Vol.2 – Operational Stress*, edited by Adler, Amy B., Carl Andrew Castro and Thomas W. Britt, 32-53. (Westport, Connecticut: Praeger Security International, 2006), 32.

[7] *Ibid*., 33.

[8] Donald R. McCreary and Megan M. Thompson. "Enhancing Mental Readiness in Military Personnel", in *Military Life: The Psychology of Serving in Peace and Combat, Vol.2 – Operational Stress*, edited by Adler, Amy B., Carl Andrew Castro and Thomas W. Britt, 54-79. Westport, Connecticut: Praeger Security International, 2006, 57.

conditions similar to those they can expect in a theatre of war, such as Afghanistan.[9] Nevertheless, no training can perfectly compare to a tour of duty in Afghanistan. As of 14 April 2009, 117 Canadian soldiers have died in the line of duty in Afghanistan, and a few hundred more were seriously wounded in combat.[10] This means that while they prepare to go to Afghanistan, soldiers are very much aware of the risks they will face once deployed. They are consequently subject to stress related to the anticipation of such tragic events.

In fact, "deployments are a source of potential stressors for military personnel and their families. The stressors begin at the pre-deployment, continue through the deployment phase, and include the post-deployment period of adjustment."[11] Pressure is therefore present while they prepare to deploy, culminate in an all-time high once they are deployed, and typically fades away once they come back home.

Working conditions in Afghanistan are particularly austere and demanding for Canadian soldiers. They are away from their family for a very long period of time;[12] they are subject to a very high operational tempo, suffer from sleep deprivation and constantly live in a hostile environment. Canadian troops are regularly exposed to enemy threat.

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[9] Donna Miles,. "U.S. Soldiers Train Canadians for Afghanistan in Texas." *American Forces Information Services News Articles*. (27 February 2008) available from http://www.globalsecurity.org/military/library/news/2008/02/mil-080227-afps02.htm; Internet; accessed 17 February 2009.

[10] CBC News, "Canadian soldier killed, 4 wounded by roadside bomb in Afghanistan." http://www.cbc.ca/world/story/2009/04/13/afghan.html; Internet; accessed 16 April 2008.

[11] Amy B. Adler, Paul Cawkill, Coen van den Berg, Philippe Arvers, Jose Puente, Yves Cuvelier. "International Military Leaders' Survey on Operational Stress," *Military Medicine*, Vol 173 (January 2008): 10.

[12] A typical tour of duty in Afghanistan normally lasts six months.

Combat units actively engage in combat operations. Support troops are targeted, while conducting sustainment convoys. Medical personnel are exposed to a high level of war casualties. Headquarters staff is involved in complex decision making processes, which endanger other soldiers' life. Finally, camps can come under rocket attacks at any time and everyone must therefore continually have their senses on alert.

In Afghanistan, soldiers constantly remain vigilant, looking for potential threat to their health, wellbeing and even their life. Once soldiers go back home, the combat and theatre related stress they experienced should drop, sometimes suddenly. They therefore have to cope with the fading of that pressure, while they readapt to a regular life, where stimuli no longer relate to enemy threats. Returning home from such a theatre is therefore a challenging process.

Coming home after a long deployment certainly remains a happy event; however, it involves significant difficulties. Not only do soldiers have to cope with the residual stress from their deployment, but they also have to face challenges that might arise from reuniting with their families. They go back to their close ones, who have lived with their absence for a long period of time. New habits and daily routines may have formed and are now disrupted by the ones returning. It can be frustrating, not only for those coming back, but for their family also. Day-to-day life might be different from what it was before the soldiers left and everything cannot instantly go back to what it was, prior to them deploying. To make matters even more complicated, the change of pace involved in going from deployed to home life means the focus and responsiveness of those around the returning soldiers will be different. Family and friends at home have lived at a regular pace for the past few months and do not share the same level of responsiveness as

someone who was facing enemy threat for six months. Home life does not require the same attitude as deployed life and it may therefore be difficult for soldiers to adapt to that change of pace around them.

Leadership is responsible for the provision of training to their troops and to prepare them to face the operational stress related to a deployment into a theatre of war.[13] It is just as much a leadership responsibility to prepare those same troops for their return home. This is why the CF Chief of Defence Staff (CDS) made it a requirement for "Task Force Commanders (TF Comd) to assess the impact their mission has had on their personnel and develop plans to satisfy their decompression and stress mitigation requirements."[14]

The men and women of the CF are a pillar of the institution.[15] That pillar is at risk when "the CF says that one in seven soldiers arrive home [from Afghanistan] suffering from debilitating mental conditions."[16] Everything must therefore be done to help those soldiers maintain their quality of life and productivity upon their return from a stressful environment.

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[13] Allan D. English,. "Leadership and Operational Stress in the Canadian Forces." *Canadian Military Journal,* Vol. 1 No 3 (Automn 2000): 36.

[14] Special Report to the Minister of National Defence - From tents to sheets : An analysis of the CF Experience with Third Location Decompression after Deployment. André Marin, Ombudsman. (Ottawa: National Defence and Canadian Forces, 2004), 44.

[15] Canada. Department of National Defence. *Canada First Defence Strategy*; available from http://www.forces.gc.ca/site/focus/first-premier/June18_0910_CFDS_english_low-res.pdf; Internet; accessed 26 February 2009, 14.

[16] Jaqueline Chartier. "Hidden Wounds," *FrontLine Defence*, July/August 2008, 21.

As previously described, the change of pace is so dramatic for troops coming out of Afghanistan, that the CF chain of command has determined a decompression period was required before they returned home. In a military environment, decompression refers to a process that allows soldiers returning from a theatre of operation to adapt to their home environment, in a graduated way, therefore hopefully reducing potential difficulties related to psychological adjustment.[17] Such a process can contribute to the member's wellbeing, the upkeep of the institution productivity and the retention of Canadian soldiers in the CF.

The decompression process developed by the CF is called Third Location Decompression (TLD). It offers an opportunity for soldiers to relieve some of the pressure caused by the operation before they go home. They decompress in a safe and relaxing environment, away from the theatre of operation and side by side with those who lived similar experiences. Members receive information on what to expect once they get home. A mental health team informs them on how their family may react to their return, but also how they may react to their family and to their return back to a normal life. They are also informed that it would be normal to experience stress or psychological troubles, in which case there is a whole support infrastructure available to help them pull through.[18]

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[17] Jamie G.H. Hacker Hughes. "The Use of Psychological Decompression in Military Operational Environments," *Military Medicine* (June 2008). Available from http://findarticles.com/p/articles/mi_qa3912/is_200806/ai_n27995836/pg_1?tag=artBody;col1; Internet, accessed 14 January 2009.

[18] Michel Rossignol. "Afghanistan: Military personnel and operational injuries." *InfoSeries* (7 November 2007). Library of Parliament; Available from http://www.parl.gc.ca/information/library/PRBpubs/prb0720-e.pdf; Internet, accessed 14 January 2009.

The combination of all stressors related to an operational deployment as described so far, may result in soldiers developing Post Traumatic Stress Disorder (PTSD) and other Operational Stress Injuries (OSIs). PTSD and OSIs among Canadian soldiers have therefore become an important topic in the CF and they significantly contributed to the implementation of the CF TLD process. This paper will consequently demonstrate that soldiers returning from an extended deployment into a highly stressful environment may greatly benefit from a decompression period, to better prepare them for their return back to a more regular life. It will demonstrate that such a process is a leadership responsibility that has to be championed at the highest level in the CF, in order to ensure uniformity, continuity and success of the approach. It will finally demonstrate that although decompression will neither prevent nor cure PTSD and OSIs, it may enable early detection of such psychological problems, by raising awareness and reducing the stigma often associated with mental health concerns. Decompression can therefore be a force multiplier, which can significantly contribute to the reintegration and reconstitution phase of troops returning back from a deployed operation.

Following the introduction, this paper will first show how important and relevant its topic is, by presenting the wide variety of sources that have discussed and studied it in the recent past. It will then offer some historical background behind the TLD process in the CF, followed by detailed procedures implemented to ensure its success. It will also present what is done by other nations in terms of TLD, in order to offer a comparison point. It will finally present and evaluate some of the arguments that could be made against the CF TLD process and go into what could be done differently in order to improve it and therefore potentially improve its results.

CHAPTER 1 - LITERATURE REVIEW

The literature review section of this paper reinforces the importance and relevance of TLD and mental health in the CF, by presenting summaries of the wide variety of material recently written about them. Decompression, and more specifically the CF TLD, is not a common topic in the military or scientific literature; however, mental health, PTSD and OSIs are common themes in both. The CF TLD process is a response to the stress caused by military deployments, and the resulting potential for PTSD and OSIs emergence in the military, which are significant mental health issues; those topics are therefore closely related. This section will thus not specifically concentrate on what has been written about the CF TLD as such, but rather on what has been written about mental health, PTSD and OSIs, as they relate to the Canadian military. Consequently, the CF TLD will become a by-product of great significance.

LITERATURE ON MENTAL HEALTH, PTSD, OSIs AND MILITARY SERVICE

The variety and the quantity of documents written about mental health, PTSD and OSIs in the military are noteworthy. There are military publications, specialized books and articles, research papers, mainstream newspaper articles and news network reports, government publications and various Web sites all devoted to this topic. Put together, these are a testimony to the growing significance of mental health issues as they relate to the stress experienced by soldiers coming back from various military operations.

“Five years ago, the term PTSD was perhaps familiar only to mental experts and researchers. Today however, it has entered our nation’s lexicon as an alarming

percentage of soldiers return from Iraq and Afghanistan showing symptoms of PTSD."[19] This comment refers to the U.S. military, but it could just as well be about Canadian soldiers.

IDENTIFICATION OF PTSD IN THE CF - BOARD OF INQUIRY CROATIA

Mental health concerns such as PTSD first surfaced as a formal concern in the CF with the Board of Inquiry (BOI) Croatia, held in 1999 and 2000. The BOI Croatia was "called to investigate whether Canadian soldiers who served as peacekeepers in Croatia … were exposed to environmental toxins."[20] The BOI Croatia was not limited to this specific issue however, and found that there was a high probability that at least some of the symptoms experienced by Canadian soldiers returning from Croatia resulted "from the very high level of chronic stress experienced during the operation."[21] The BOI Croatia therefore recommended "a change of attitude and improved procedures across the CF on mental and physical health issues and programs"[22], and the improvement of "CF and Veterans Affairs Canada (VAC) medical staffs' education and awareness regarding mental health issues."[23] PTSD and OSIs have since become a recurring theme in the CF, similar to what has happened in the U.S. military.

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[19] Schwartz, Brett. "A Different Kind of Enemy: American Soldiers Face Mental Health Challenges After Returning Home." *The Defense Monitor*, July/August 2008, 8.

[20] *Board of Inquiry Croatia – Final Report.* Ottawa: DND, 26 January 2000, 1.

[21] *Ibid*., 53.

[22] *Ibid*., 46.

[23] *Ibid.*

U.S. MILITARY PUBLICATIONS

The U.S. military has developed formal procedures and published official documents aimed at enabling its soldiers to effectively operate in stressful environments. For example, the U.S. Army has a publication specifically dealing with Combat and Operational Stress Control (COSC).[24] It "outlines the functions and operations of each COSC element within an area of operation. It is a field manual that establishes Army doctrine and guidance for COSC …"[25] Although PTSD is not part of that publication's terminology, COSC is clearly an initiative which addresses problems caused by combat and operational stressors. The book provides detailed procedures to follow in order to mitigate the impact of operational stress. It is aimed at both leaders and health care personnel involved in combat and other operational environments. More specifically:

> *This manual provides doctrinal guidance for controlling excessive stress in combat and other operational environments. It identifies command and leadership responsibilities for COSC. This manual provides definitive guidance to behavioural health (BH) personnel and combat stress control units for their COSC mission and for management of combat stress control restoration (COSR) and other behavioural disorders patients (BDPs). It identifies the requirements for COSC consultation, planning, coordination, rehearsal, and implementation of the COSC plan contained in the force health protection (FHP) annex of the operation order (OPORD).*[26]

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[24] United States. Department of the Army. FM 4-02.51(FM 8-51) *Combat and Operational Stress Control*, Washington: Headquarters Department of the Army, 2006.

[25] *Ibid*., vi.

[26] *Ibid*., viii.

The mere existence of such a publication is an acknowledgement by the U.S. Army of the mental health challenges caused military operations. It shows their active involvement in the development of doctrine and guidance, in order to establish formal procedures for the handling of combat stress and behavioural disorder patients, which would compare to those suffering from PTSD and OSIs in Canada.

The U.S. Marine Corps (USMC) has a similar publication, entitled *Combat Stress*.[27] That manual "provides techniques to prevent, identify, and treat harmful combat stress reactions at the lowest level or until professional medical assistance is available."[28] More specifically:

> *This publication is written to inform small-unit leaders of stress characteristics and management techniques in order to prevent, reduce, identify and treat combat stress reactions in the Service member's own unit to the maximum extent possible. A significant part of training is learning to control and cope with stress. Leaders must learn to cope with their own stress and then assist junior personnel in managing their stress. The application of combat stress management techniques helps conserve fighting strength and provides one more step toward achieving success.*[29]

The U.S. Army publication presented first is more reactive in nature. It provides doctrine and guidance on how to handle stress related injuries. The U.S. Marine publication on the other hand, is aimed at leaders of small-units and is more preventive.

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[27] United States. Department of the Navy. FM 90-44/6-22.5 *Combat Stress – U.S. Marine Corps*, Washington, DC: Headquarters United States Marine Corps, 23 June 2000.

[28] *Ibid*., Forward.

[29] *Ibid*., Preface.

It teaches readers how to cope with stress rather than how to handle those injured by stress.

Although the two aforementioned publications address the same topic with a different focus, they are a clear indication of the high importance granted by the U.S. military to mental health and stress management in an operational environment. The Americans have formally structured the handling of combat stress, to help soldiers react better to it and to maintain their performance level, even when subjected to such stress.

SPECIALIZED ARTICLES

Soldiers' mental health is also addressed in publications such as the *British Journal of Psychiatry*, *Canadian Military Journal, FrontLine Defence*, *Health Affairs, Military Psychology*, *Military Medicine* and *The Defense Monitor*. A wide variety of specialized articles have been written about the effect of combat stress on mental health, PTSD and OSIs.

Some of the articles examine resilience, hardiness and coping, and how these facets of the individual are related to the ways people experience traumatic events. One article explains that PTSD, OSIs and their resulting recovery process are not the absolute norm in terms of reaction to a traumatic event. In fact, resilience is common among those who experience a traumatic event.[30] Furthermore, another article argues "that leaders in military units may well be able to foster increases in the kinds of cognitions and

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[30] George T. Bonanno. "Loss, Trauma and Human Resilience…, 22.

behaviours that typify the high-hardy person's response to stressful circumstances."[31] This is consistent with the U.S. Marine publication previously presented. The article identifies the possibility for leaders to develop psychological hardiness in their subordinates, by challenging them and presenting them with opportunities to learn and grow, while ensuring their tasks are interesting and worthwhile. The article also indicates that developing hardiness requires leaders to show their subordinates they can exert influence and even control over their tasks.[32]

These articles do not address the consequences of PTSD and OSIs. In fact, they are doing quite the opposite, by presenting cases where individuals have gone through traumatic events without experiencing PTSD or OSIs. They remain important to this paper because they expose the fact that although the CF TLD initiative is important to mitigate the impact of PTSD and OSIs, many going through the process will not suffer from a stress related illness. The challenge of the CF TLD is therefore not to appear as forcing a treatment or a process on those who may not need it, in order to ensure everyone's receptiveness.

Other articles address PTSD and OSIs, as they relate to military operations in the recent years. They conclude that, although PTSD and OSIs have always existed, they are now more widely acknowledged, possibly as a consequence of the modern combat environment and the shocking contrast experienced by soldiers going from theatre to

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[31] Paul T. Bartone. "Resilience Under Military Operational Stress: Can Leaders Influence Hardiness?" *Military Psychology*, July 2006, S132.

[32] *Ibid*., S138.

home in a matter of hours. For instance, the recent emergence of stress related injuries is highlighted in a "Canadian Military Journal" article, which says:

> *The increasing incidence of military members suffering from debilitating stress-related injuries as a result of their tour of duty became more widely known to Canadians and within the Canadian military community during and after the Croatia BOI conducted in 1999-2000.*[33]

Furthermore, another article published in "FrontLine Defence" identifies air travel as a potential cause for such an emergence:

> *Technically modern air travel allows troops returning to Canada to set foot on Canadian soil within hours of being in a theatre of war. The human brain was never designed to make such a rapid adjustment, and that is why returning soldiers are required to experience a five-day decompression stop on the way home.*[34]

Other articles identify stigma as a compounding factor in the emergence of PTSD and OSIs, because those suffering from them hesitate to seek help. "Stigma" refers to "associating negative qualities with having a mental illness. For example, a person with a mental illness may be wrongly viewed (or even view themselves) as being weak or "damaged", leading to feelings of shame and/or embarrassment."[35] In such a context, injured soldiers hesitate to come forward for fear that a mental illness might have a negative impact on their career and on their relationship with others. For instance, Time

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[33] Don Richardson , Kathy Darte, Stéphane Grenier, Allan English and Joe Sharpe. "Operational Stress Injury Social Support: A Canadian Innovation in Professional Peer Support," *Canadian Military Journal* Vol. 9, No. 1 (Spring 2008): 57.

[34] Jaqueline Chartier. "Hidden Wounds,"…, 22.

[35] Tull, Matthew. "PTSD and Stigma." About.com: Post Traumatic Stress (PTSD) (29 October 2008) available from http://ptsd.about.com/od/treatment/a/Stigma.htm; Internet; accessed 18 March 2009.

Magazine published an article entitled "Stigma Keeps Troops from PTSD Help".[36] The article basically explains that soldiers are afraid that "others would think less of them if they sought out counselling."[37]

RESEARCH PAPERS

Aside from those specialized articles, other studies and research papers have been written on soldiers' post-deployment mental health, PTSD and OSIs. For instance, the Walter Reed Army Institute of Research has published a report on behaviours and emotions that keep soldiers alive on the battlefield, but which are not appropriate at home and with family. The report indicates that soldiers who experienced more than twenty combat experiences and "received Battlemind Training reported fewer mental health problems and less stigma compared to Soldiers who received the Standard Stress Education Training."[38] Battlemind Training is a U.S. Army initiative designed to help soldiers deal with those behaviours acquired while in theatre, and which are not appropriate in day-to-day home life. It is a clear indication that the U.S. Army is developing mental health programs to help its soldiers when they return from deployed operations. Battlemind Training will be further explained later in this paper.

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[36] Kathleen Kingsburry. "Stigma Keeps Troops from PTSD Help". *Time Magazine (01May 2008)*; http://www.time.com/time/health/article/0,8599,1736618,00.html; Internet; accessed 20 mars 2009.

[37] *Ibid*.

[38] Carl Andrew Castro, Charles W. Hoge, Charles W. Milliken, Denis McGurk, Amy B. Adler, Anotny Cox and Paul D. Bliese. *Battlemind Training: Transitioning Home from Combat*. Walter Reed Army Institute of Research. Silver Spring: November 2006.

Another report from the U.S. Defense Health Board Task Force on Mental Health identifies PTSD as one of two "signature injuries" of modern conflicts, the other one being traumatic brain injury.[39] In fact, many research papers consulted for this essay identify the high cost of PTSD and OSIs for the military. They mostly emphasize the importance of taking action in order to mitigate the impact of mental health issues, be it through training, awareness campaign or better availability and quality of mental health care. The problem of mental health care availability has actually been confirmed by the CF and DND Ombudsman. In fact, the most recent Ombudsman's investigation revealed that there is a significant shortage of mental health care givers, such as chaplains, social workers, physicians, psychologists, psychiatrists and mental health nurses in the CF. Furthermore, many of them carry a heavy caseload, themselves risking a burnout.[40]

So far, the review of literature concentrated on material related to PTSD and OSIs however, the topic of this paper is more precisely military decompression and the CF TLD. Research identified a few documents specifically addressing decompression. For instance, a paper published in 2008 by the Canadian Defence & Foreign Affairs Institute applies specifically to Canadian soldiers. It addresses the mental health issues related to the redeployment of Canadian soldiers from Afghanistan, describing their return as a "rite of passage". Part of that rite is called the "Liminal Phase", which corresponds to the TLD, in the sequence of events of a soldiers' return from a deployed operation. That

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[39] *An Achievable Vision: Report of the Department of Defence Task Force on Mental Health.* Vice Admiral Donald C. Arthur, Lieutenant General Kevin C. Kiley and Shelley MacDermid, Co-Chairs (Falls Church, Virginia: Defence Health Board, 2007.

[40] *Special Report to the Minister of National Defence – A Long Road to Recovery: Battling Operational Stress Injuries*. Mary MaFadyen, Ombudsman. Ottawa: National Defence and Canadian Forces, 2008, 27-28.

paper identifies strengths and weaknesses of the current CF TLD process. In a nutshell, the author considers the opportunity to relax as the most positive component of that process. She also identified the fact that soldiers did not decompress with their primary group as the most significant weakness.[41] That issue will be discussed later in this paper.

Finally, British, Canadian and Dutch reports have presented studies showing that soldiers having gone through a TLD were generally satisfied with their experience and thought it to be useful. CF TLD statistics are provided in some details later in this paper.

MEDIA

The military procedures, research papers and studies mentioned so far are an indication that soldiers' mental health, PTSD and OSIs are being addressed by the military and academic domains. The topic has also attracted the general public's attention, through mainstream newspaper articles and other news network reports that have identified and presented the issue. They brought forward stories of soldiers suffering from PTSD and made it a public issue. A search of the Toronto Star, La Presse and CBC Web sites returned more than 200 hits on a search with the keywords *PTSD and military*, showing this topic has been discussed frequently in daily news over the last few years. Furthermore, specialized Web sites are also available to inform about PTSD and OSIs. Web sites such as *Veterans Affairs Canada*[42] and the *Operational Stress Injury*

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[41] Irwin, Anne. *Redeployment as a Rite of Passage*. Calgary: Canadian Defence and Foreign Institute, 2008, 12.

[42] Veterans Affairs Canada, "Mental Health," http://www.vac-acc.gc.ca/clients/sub.cfm?source=mhealth; Internet; accessed 14 January 2009.

Social Support (OSISS)[43] offer detailed information about PTSD, OSIs and peer support networks, while many other sites such as *PTSD Blog*[44] and *PTSD Combat: Winning the War Within*[45], present more general blogs on the subject.

SUMMARY

A review of literature has shown that the issue of soldiers' mental health, PTSD and OSIs is an important and relevant topic. It is addressed within military organizations, studied by specialists outside of the military, reported in the media, existing as a public concern and thoroughly followed-up by the DND and CF Ombudsman. Research has identified and recognized the problems related to PTSD and OSIs in the military and it has identified many of its negative consequences.

Widespread coverage of these topics may contribute to the reduction of the stigma surrounding mental health issues, by bringing them forward for discussion and normalization, in order to mitigate taboos around them. For this to work however, it will require success stories involving credible individuals, who have dealt with PTSD or OSIs and kept living a productive life. A good example is the story of MGen (Ret'd) Roméo Dallaire. He was a very well respected member of the CF, who was diagnosed with PTSD following a United Nations (UN) mission in Rwanda. The severity of his mental

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[43] Operational Stress Injury Social Support, "The Invisible Wound," http://www.OSIsss.ca/engraph/index_e.asp; Internet; accessed 14 January 2009.

[44] About.Com: Post Traumatic Stress Disorder (PTSD). "PTSD Blog." http://ptsd.about.com/b/; Internet; accessed 31 March 09.

[45] PTSD Combat: Winning the War Within. http://ptsdcombat.blogspot.com/; Internet; accessed 31 March 2009.

illness caused him to be released from the military;[46] however, he sought treatment, got better, wrote a book about his life-changing experience in Rwanda and became a Canadian Senator. Although this is clearly not a typical case, it contributed to the reduction of the stigma around mental health, by showing a successful high-ranking member of the military going through the full range of the PTSD experience. It normalized the issue to a certain extent; if a general officer can be affected and then get better, so can anyone else.

Finally, as previously mentioned, the literature proposed solutions such as TLD, in order to help reducing the impact of PTSD and OSIs on soldiers returning from deployed operations. The next section will therefore present the evolution of the CF TLD concept over the last few years, the reasons why that initiative was developed and its expected results.

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[46] CBC News, "Dallaire says PTSD seared genocide in his memory." http://www.cbc.ca/canada/montreal/story/2007/10/03/qc-dallaire1003.html; Internet; accessed 20 March 2008.

CHAPTER 2 - CF TLD HISTORICAL BACKGROUND

A review of the literature showed PTSD and OSIs are highly relevant and important in terms of the attention they get from military leadership, specialized publications, researchers, government authorities, media and public in general. Beyond soldiers' mental health however, this paper is more precisely about the CF TLD initiative, which has been implemented in due diligence by the CDS, to "minimize family reintegration stress and ensure early identification of any potential health problem …"[47] This includes mental health concerns. A review of how the CF TLD concept emerged and evolved in the recent years will help better understand why it came about, what the intent of it is, and what exactly has been done so far in that regard.

IMPACT OF DEPLOYMENT – RELATED STRESS

"Since the Vietnam War, decompression has become an increasingly accepted part of the U.S. post deployment personnel policy and there is a general agreement that decompression leave following combat is essential."[48] This quote from a British author relates yet again to the U.S. military; however, decompression has also come up as a process to address the challenges related to Canadian soldiers suffering from deployment-related stress, following an operational tour. Research for this paper has identified the BOI Croatia

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[47] *Special Report to the Minister of National Defence - From tents to sheets…*44.

[48] Jamie G.H. Hacker Hughes. "The Use of Psychological Decompression…

final report as the starting point to determine the origin of the CF TLD process and this is where the historical background starts.[49]

The BOI Croatia identified a range of symptoms that resulted from service in Sector South, during Op HARMONY in Croatia, from 1993 to 1995. As mentioned in the previous chapter, when the BOI Croatia expanded its research to address stress related injuries, it discovered it was highly probable that at least some of the symptoms experienced by Op HARMONY veterans resulted from a very high level of chronic stress experienced during the operation. It also concluded that care provided to those suffering from stress-related injuries was insufficient.[50] "Medical assessments administered to CF members prior and subsequent to their deployment were inadequate."[51] Assessments were not designed to detect psychological injuries that might have been present prior or after a deployment. The development of more detailed psychological assessments was therefore recommended, to help identify injuries at an earlier stage and consequently decrease their severity.[52]

From then on, the origin of the CF TLD can be linked to a series of reports published by the DND and CF Ombudsman. Those were released between 2001 and 2008. Shortly after the BOI Croatia report was published, the Ombudsman got involved in an investigation related to PTSD. In 2001, his office published a very comprehensive

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[49] *Board of Inquiry Croatia – Final Report…*, 3.

[50] *Ibid.*, 53.

[51] *Ibid.*, 40.

[52] *Ibid.*, 41.

report entitled *Systemic Treatment of CF members with PTSD*. It used Cpl Christian McEachern's case as a foundation leading to the identification of systemic deficiencies in how the CF dealt with soldiers suffering from PTSD.

> *On 15 March 2001, Cpl McEachern allegedly drove his vehicle into the Garrison Headquarters at Canadian Forces Base (CFB) Edmonton for which he is facing criminal charges. … Cpl McEachern's primary concern was the way the CF deals with issues related to PTSD. He stated that there is insufficient understanding about, and awareness of, PTSD in the CF, that he and other received little or no training and education about PTSD, and that members diagnosed with PTSD are often ostracized, stigmatized and abandoned by their units.*[53]

While investigating this case, the Ombudsman identified a number of deficiencies in the way the CF handled soldiers suffering from PTSD. One major problem identified was the reluctance of CF members suffering from PTSD to come forward. In Edmonton alone, a CF psychiatrist thought only about 30% of members suffering from PTSD were being treated, the others not coming forward for fear of being stigmatized. The report also found overwhelming evidence that many within the CF were sceptical about PTSD as a legitimate illness. Additionally, the report identified that there were inadequate contacts between members diagnosed with PTSD and their units, to the point where members with PTSD felt abandoned. Other findings were related to the lack of proper training and education on mental health and PTSD, for both for military members and

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[53] *Report to the Minister of National Defence – Systemic Treatment of CF Member with PTSD*. André Marin, Ombudsman. Ottawa : National Defence and Canadian Forces, 2001, v.

caregivers.[54] At the end of that report, thirty one (31) recommendations were made by the Ombudsman, of which one related directly to TLD.

THE ORIGIN OF THE CF TLD

Recommendation number 15 of that report was: "The CF set up a pilot project to determine the most effective ways of allowing members returning from deployment to be reintegrated into family and garrison life."[55] The recommendation did not call for a TLD as such but gave the CF an opportunity to develop its own approach to the reintegration of soldiers returning home after a deployed operation. The reintegration process could have been implemented in theatre, just prior to soldiers' departure, or at home, once they got back. The process could have been one hour, one day or one week; whatever leadership deemed necessary. This is when the TLD concept first emerged.

The CF answered the Ombudsman who then analysed the response in a Follow-up Report published in December 2002. In his analysis, the Ombudsman congratulated the CF on the initiative of a decompression process that had been carried out by the 3rd Battalion of the Princess Patricia Canadian Light Infantry (3 PPCLI), after a tour of duty in Afghanistan.[56]

After a six-month tour served on Op APOLLO in Kandahar, soldiers from 3 PPCLI spent three to five days on the Pacific Island of Guam, where they were given a

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[54] *Ibid*., vi-vii.

[55] *Ibid*., 135.

[56] *Follow-up Report – Review of DND/CF Actions on Operational Stress Injuries*. André Marin, Ombudsman, Ottawa: National Defence and Canadian Forces, 2002, 44.

decompression program. It included mental health briefings, recreational activities and rest time. This was an initiative of the deployed chain of command and the decision to implement it was made in January 2002, prior to the troops deploying.[57] Soldiers deployed to Afghanistan from February to July 2002, they lived in austere conditions, were actively engaged in battle for the duration of their tour and suffered some casualties.

After they returned home, an Ombudsman team interviewed forty (40) of those who had deployed on Op APOLLO and "virtually without exception, those interviewed felt that the decompression activity had value and was beneficial."[58] This was the first TLD ever to be conducted by the CF and it was considered a success. Some improvements would still be required to make the process better; lessons learned helped shaping TLDs that were conducted later and which will be discussed in the next chapter.

STIGMA STILL EXISTS

Regardless of the focus brought on mental health issues by the Ombudsman in 2001 and 2002, the stigma associated with PTSD and OSIs remained strong in the CF. The Ombudsman published another report in March 2003, entitled *Off the Rails*. That report dealt with an incident that involved the 2 PPCLI in Edmonton. In summary, while soldiers were having a pre-Grey Cup celebration, they built a parade float that portrayed a mythical Crazy Train, which was locally known as a derogatory reference to members suffering from OSIs. The incident was disgraceful and poorly handled by the chain of

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[57] *Special Report to the Minister of National Defence - From tents to sheets: An analysis of the CF Experience with Third Location Decompression after Deployment.* André Marin, Ombudsman. Ottawa: National Defence and Canadian Forces, 2004, 13.

[58] *Ibid.*

command, yet showing that mental health issues were not well understood at many levels within the military.[59]

The only recommendation coming out of that report was the implementation of a unit level training program to educate CF personnel on OSIs. That recommendation was considered a complement to the thirty one (31) recommendations made in the previous report. The objective was to "close the gap between the commitment of senior leadership and the lack of progress at the unit level in changing the culture and stigma associated with OSIs."[60] In short, the report put the onus on senior CF leadership to properly shape the military institution, in order to enable suitable handling of PTSD and OSIs victims.

CF TLD – RUN IT OR NOT

The next Ombudsman report came out in July 2004. Entitled "From Tents to Sheets: An Analysis of the CF Experience with Third Location Decompression after Deployment", the report explained the concept of TLD, described the current CF policy on Decompression and Redeployment and described the recent DND and CF experience with TLD. It analyzed the decompression process that took place in Guam and concluded that while it was most likely a beneficial initiative, it was "not easy to quantify the impact it would have on stress reduction or its potential long-term effect on reducing OSIs among those deployed."[61]

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[59] Report to the Minister of National Defence – Off the Rails – Crazy Train Float Mocks Operational Stress Injury Sufferers. André Marin, Ombudsman. Ottawa: National Defence and Canadian Forces, 6 March 2006, 1.

[60] *Ibid*.

That same report also analysed the reasons why no decompression was conducted for Op ATHENA in 2004. This was another mission that took place in Afghanistan, but in Kabul rather than in Kandahar. In that case, the deployed chain of command deemed it unnecessary to run a TLD, based on the better living conditions offered in Kabul, a fairly stable threat environment throughout the mission and the substantial block of leave every member was able to take while on tour.[62]

That report also presented other militaries' practices. Those will be covered later in this paper.

It finally recommended some guiding principles to consider, in determining whether TLD is required after an operational deployment. Those guiding principles are:

1. *Level of threat and danger experienced on the mission;*
2. *Casualties and major incidents experienced during the mission;*
3. *Mission mandate and it extent and clarity;*
4. *Public awareness and support for the mission*
5. *Tour length;*
6. *Number of tours and operational tempo;*
7. *Tempo of the mission;*
8. *Living and working conditions during the tour;*
9. *Ability to communicate with family and loved ones;*
10. *Opportunities for leave during the tour;*
11. *Training and education to assist in reintegration;*

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[61] *Report to the Minister of National Defence - From tents to sheets…*, 16.

[62] *Ibid*., 18.

12. *Input from professional community;*
13. *Input and feedback from members; and*
14. *Recognition for member's participation in the mission*.[63]

The latest Ombudsman report applicable to TLD was published in December 2008 and is entitled "A Long Road to Recovery: Battling Operational Stress Injuries". That report considered the TLD process as an implementation of Recommendation 15 from the 2004 report.[64] When the 2008 report came out, the CF TLD had been conducted since July 2006, when the CF moved its base of operations from Kabul to Kandahar and began a more combat-oriented mission in Afghanistan. That CF TLD was, and still is, held in Cyprus, with a program structured similarly to what was offered in Guam. That Ombudsman report is very recent; therefore its content will be further addressed in the next section, dealing with current CF TLD, rather than in this more historical section.

WHY THE CF TLD IS IMPORTANT

This paper has linked the CF TLD's origin to the BOI Croatia report and many of the Ombudsman's reports dealing with PTSD and OSIs. Those reports support the conclusion that deployment-related PTSD and OSIs are an unavoidable occupational risk for soldiers going on deployed operations such as the Canadian mission in Afghanistan. The BOI Croatia and Ombudsman's investigations have determined there is a strong

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[63] *Ibid*., 41.

[64] *Special Report to the Minister of National Defence – A Long Road to Recovery…*, 41.

stigma associated to those suffering from PTSD and OSIs. The result is that ill soldiers tend not to come forward, making it a great challenge for the CF to treat PTSD and OSIs properly.

In fact, a mental illness is often considered to be a weakness within the individual and it conflicts with the military culture of the warrior, instilled in soldiers who train so hard to deploy to active theatres of operation, such as Afghanistan. In that context, PTSD and OSIs can be perceived as an indication that the affected individual is a failure as a soldier. Because of this, affected soldiers will hesitate to come forward, for fear of being identified as weak. This is a hard problem to solve because PTSD and OSIs are difficult to detect and easy to hide, with no clear physical evidence of injury.

The CF has had to eliminate the obstacles preventing victims from coming forward and to ensure treatment is accessible. "There are programs in place to enhance the self-help skills of CF personnel. These initiatives cover healthy living, stress management, anger management, addiction awareness and family violence prevention."[65] Unit level mental health training and awareness campaigns have been conducted. Furthermore, "the Military Family Resource Centres located at all major CF bases can make information available on … mental health;"[66] however, the crazy train incident has shown that the stigma is not easy to eradicate. Stigma might partly be the result of the weakness factor discussed in the previous paragraph. It can also be caused by people thinking that PTSD can easily be faked. There is no evidence however, that faking is

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[65] National Defence and the Canadian Forces. "Backgrounder: Operational Stress." http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2871; Internet; accessed on 31 March 2009.

anymore prevalent in the CF than in the general population. The Ombudsman has in fact found overwhelming evidence that "milking the system" is not a serious issue in the CF. His findings are based on information obtained from the Statistics Branch of the Workplace Safety and Insurance Board (WSIB), which indicates that fraudulent claims for compensation are negligible.[67]

In no case should PTSD and OSIs be stigmatized to the point where someone will refuse to seek help for fear of what others may think. The Ombudsman's reports were aimed at ensuring members would not be afraid of any repercussions, be it from peers, subordinates or superiors, if they came forward with PTSD or OSIs. These are medical conditions and only medical personnel (including mental health staff, such as psychologists and social workers) should be allowed to pose a judgement in that regard. Medical staff, however, has to be appropriately trained in order to properly evaluate PTSD and OSIs in soldiers. Their credibility relies essentially on their ability to accurately diagnose victims and to offer adequate treatment.

The CF TLD has now become part of that process. It is where individuals get their first exposure to the mental health team, once they come out of theatre. It is also where they are told it would be normal for some people to suffer from PTSD and OSIs and that in such a case, they cannot hesitate to seek help. In fact, the earlier they consult, the better the chances of speedy recovery.

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[66] *Ibid*.

[67] *Report to the Minister of National Defence – Systemic Treatment…*,73.

The historical background has shown that the origin and the evolution of the CF TLD are linked to attempts to mitigate the impact of PTSD and OSIs on soldiers returning from deployed operations. Part of the reason why PTSD and OSIs are such a big concern is the negative consequences they generate on quality of life, productivity and retention in the CF.

Once the CF leadership decided to implement the TLD concept, it became a no-fail task for whoever would develop it. Delivering that service to soldiers returning from Afghanistan would involve significant challenges.

When soldiers come out of a deployed theatre of operation such as Afghanistan, they are tired from a long and demanding mission, they are eager to get home and air travel can literally get them there within twenty-four (24) hours of leaving the mission. Only a critical requirement will make a delay in that return home tolerable. The CF TLD represents such a delay and the challenge is therefore to deliver it in a way that will foster soldiers' positive attitude and receptiveness, rather than their impatience and bitterness. How that process is delivered is what is covered in the next chapter.

CHAPTER 3 - CF TLD PROCEDURES

Operating in Afghanistan has triggered many innovations in how the CF train its soldiers and operate. The military had to adapt to the context of counterinsurgency (COIN), which introduced new deadly threats to Canadian soldiers, such as Improvised Explosive Devices (IED) and suicide bombers. Canadian soldiers were unfamiliar with those until recently. The consequence was that new equipment was acquired, such as Unmanned Aerial Vehicles (UAV), Armoured Patrol Vehicles (APV) and Expedient Route Opening Capability (EROC).[68] Those novelties enabled Canadian troops to effectively perform their role and to be better protected against those new threats. Nonetheless, more Canadian soldiers have been killed or wounded in Afghanistan than in any other theatre of operation since the Korean War, making it a highly taxing mission.

As indicated in the historical background, PTSD and other OSIs existed in the CF before Afghanistan. It is those circumstances described above, however, that triggered the development of the CF TLD process. It came about as yet another innovation, similar to the new ways to train and operate, and the new equipment acquired by the CF. A major difference, however, is while new training and operating methods and new equipment show results almost instantly, the CF TLD does not. In fact, while a TLD may intuitively appear of some benefit for soldiers returning from a stressful theatre of operation, there is no empirical evidence to demonstrate what those benefits might be.[69]

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[68] These are only a few examples of new equipment acquired by the CF since they first deployed to Afghanistan. They simply illustrate how the CF reacted to the new threat caused by the proliferation of IEDs in Afghanistan.

[69] *Report to the Minister of National Defence - From tents to sheets…*, 7.

The only way to obtain such empirical evidence would have been to implement the TLD concept gradually, and with only a portion of the soldiers redeploying. This would have allowed a comparison between those having done TLD and those having not; however, the study would have taken months and even years. CF leadership opted for a more rapid implementation.

Despite that lack of evidence, the CF TLD was implemented, in the spirit of due diligence and in recognition of the exceptionally demanding conditions under which Canadian soldiers operate in Afghanistan. For such a concept to be effective and successful, however, soldiers had to be receptive of the idea. Furthermore, a few elements of the CF TLD are critical to its success and contribute to making it appealing to soldiers. Those elements will be analysed in this section and are: the location, the TLD team components, their roles and the programs they deliver. Some soldiers' response to CF TLD satisfaction surveys will then be presented as a measure of success for those CF TLDs that have been conducted so far. First however, some key details will be presented, on the actual conduct of the CF TLD. Detailed information on such conduct was obtained through the Canadian Operational Support Command Headquarters (CANOSCOM HQ).

CANOSCOM HQ is responsible for coordinating the delivery of the CF TLD. It has produced Standard Operating Procedures (SOPs) and Terms of Reference (TORs) and has accumulated Lessons Learned (LL) on the conduct of the TLD. All of those documents were made available to the author to ensure a proper level of detail in the production of this chapter.

CONDUCT OF THE CF TLD

In order to fully appreciate the complexity and the challenges related to the delivery of a CF TLD, it is essential to understand a few details related to how it is conducted. As mentioned previously in this paper, the CF TLD is a five-day decompression program, currently offered to Canadian soldiers returning from Op ATHENA, the CF mission in Kandahar, Afghanistan. The program is offered only to those soldiers rotating out of Afghanistan, during the deliberately planned relief in place (RiP) of the Task Force (TF), which takes place every six months.

Other soldiers returning to Canada out of the planned cycle do not go on a TLD. They may return to Canada out of cycle due to injury. They may also have gone to Afghanistan for less than a full six-month tour, on a Technical Assistance Visit team (TAV) or some other type of visit.[70] Out of cycle decompression is currently impossible, because there is no permanent CF TLD infrastructure and personnel establishment. It only sets up whenever a TF rotates out of Afghanistan.

The delivery of a CF TLD is a considerable task. During a period of approximately six weeks, more than 2000 soldiers go through the CF TLD. This is repeated twice each year (approximately every February and August) for the main deployments, with a smaller TLD for returning headquarters staff every nine months. Soldiers arrive there in groups of roughly one hundred (100). A new group arrives almost every day. Every time a new group arrives, the TLD process starts from the

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[70] TAV can last for months but they are not part of the Joint Task force establishment and do not rotate on a specific cycle.

beginning for that group. This means that at any given time, multiple groups are on location and those separate groups are at a different stage of their decompression.

A typical CF TLD would have five stages or five days. The first day is the arrival, which includes the welcome briefing and hotel check-in. This is normally the stage at which soldiers are the most affected by the drinking of alcohol. They are tired and it is their first contact with alcohol in months. The second day is devoted to Battlemind Training in the morning. This is a half day mental health session, which will be further explained later in this paper. A recreational activity can be booked for the other half of that same day. The third day is composed of the elective mental health sessions and once again, a half day recreational activity can also be booked. The fourth day is a full-day of recreational activities. The fifth day is the departure for Canada.

With many soldiers at different stages of their decompression at the same time, tight schedule coordination is required to ensure everyone receives the mandated briefings, an opportunity to meet with a counsellor if they so desire, and the possibility to fully participate in the recreational program. At the same time, soldiers are free to go as they wish. They can eat at the hotel or in local restaurants and they can drink alcohol at the hotel or in local bars. Soldiers on decompression are prohibited, however, to drive a car or ride a scooter, in order to mitigate the risk of accident or the risk of a drinking and driving incident.

The sole control measures available to the CF TLD staff to monitor decompressing soldiers' whereabouts are the attendance sheets for the mental health

sessions; those are the only mandatory activities and they take place on day two and three of the TLD. Nothing else is done to formally oversee soldiers' actions while on TLD.

Nevertheless, non-attendance or attendance while intoxicated to one of the mental health sessions could lead to the suspension of drinking privileges and recreational program for those at fault, until the mandated program is properly completed.

LOCATION

By definition, a TLD is held in a location other than the theatre of operation and the soldiers' home base. It is therefore conducted in-transit, once soldiers have left the theatre of operation and before they arrive home. The TLD location has to offer western standard living conditions, making it a significant upgrade compared to what existed in the theatre of operation. It has to be safe, relaxing and enjoyable. Soldiers who were exposed to enemy fire will therefore have the opportunity to walk down the street, without having to worry about IEDs or other threats that existed in theatre and consequently readapt to a more normal life.

The CF TLD is currently held in a hotel in Paphos, a relatively small and isolated town on Cyprus. Cyprus offers a tropical climate, which is very warm in the summer but not so warm in the spring. Those rotating in the February timeframe do not benefit from as many tourist attractions. Pools and beaches are not accessible during that timeframe; however, the location still serves the purpose. Nevertheless, surveys have shown a certain level of dissatisfaction with the location on those iterations which took place in the February timeframe. Interestingly to note also is the overall perceived value of the TLD seems to slightly go down whenever the interest for the location goes down.

Furthermore, only one out of four surveyed groups showed greater interest for the location than for the overall training. Figure 3-1 provides a summary of what soldiers thought of the location where TLD was held over the last few years.

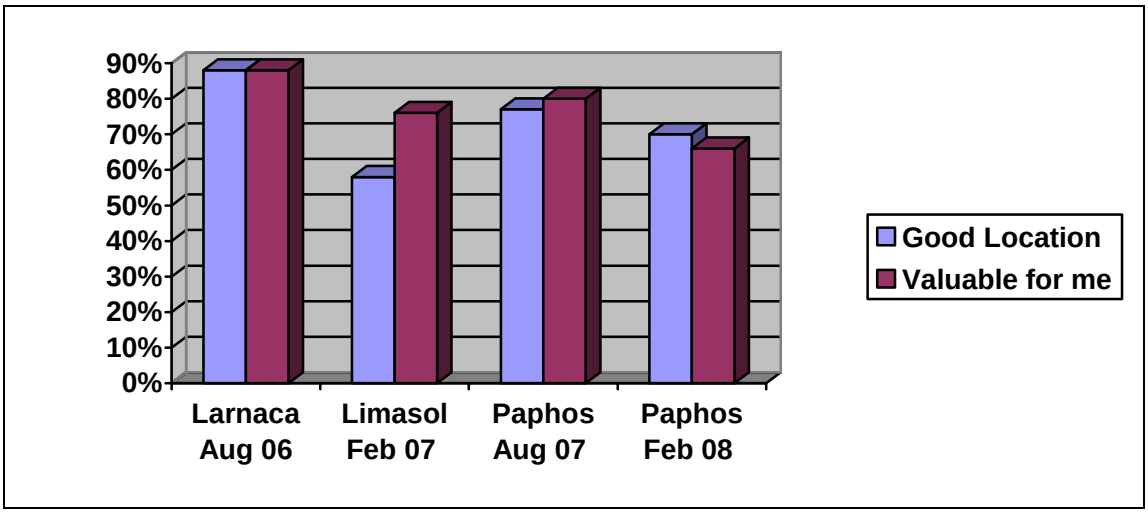

Figure 3.1 – Location vs. TLD overall value
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings* [71]

Soldiers normally arrive in Paphos less than twenty four (24) hours after leaving Kandahar. They share a room with a peer of their choosing and are mutually responsible for each others' safety and wellbeing. They are dressed in civilian clothing for the duration of their decompression and can act as tourists in the local community. Soldiers are free to go to local restaurants, bars and shops, as long as it does not interfere with the mandated mental health program.

[71] "Cyprus Third Location Decompression: *Most Recent Evaluation Findings*" is a briefing that was presented to the Comd CEFCOM by Bryan Garber MD, from the Deployment Health Section of the CF Director of Medical Policy.

The team coordinating the delivery of the CF TLD is accommodated in the same hotel as the troops on decompression, therefore providing continuous presence, be it for counselling or any other type of support the troops may require.

There is no Status of Forces Agreement (SOFA) with the Host Nation (HN), which means Canadian soldiers are subject to local laws while in Cyprus. Locals have proven to be highly receptive of the Canadian presence so far and it is up to the CF TLD team to ensure the CF remain welcome in Cyprus. The CF TLD represents a significant influx of customers for local businesses and therefore, the local community has proven to be fairly tolerant and understanding of those soldiers who may have behaved in a reprehensible manner. Every effort is made by the CF TLD team however, not to abuse local hospitality.

CF TLD TEAM COMPONENTS AND THEIR ROLES

The CF TLD team is composed of roughly fifty-five people, divided into three major roles. First, there is the command team ensuring the infrastructure and living conditions are adequate for the delivery of a fruitful TLD program. The command team is made of headquarters staff, logistics support staff, Military Police (MP) and a medical team. Second, there is the mental health team, ensuring the delivery of the mental health portion of the decompression. The mental health team is composed of mental health clinicians, Operational Stress Injury Social Support (OSISS) counsellors, a chaplain and a Personnel Selection Officer (PSO). Third, there is the CFPSA team, made of contractors specialized in organizing recreational and social events.

Command team – enabling the CF TLD

The Command team is responsible to provide a safe and favourable environment for the conduct of the TLD. They arrange transportation to and from the airport, they ensure hotel room allocation is well coordinated and they ensure classrooms and equipment are available for the delivery of the mental health sessions.

The command team also ensures adherence to the CF TLD sequence of events, which is based on the 5-day template presented before. The 5-day cycle is initiated again every day a new group arrives. Once they land in Cyprus, soldiers are immediately transported to the hotel; they are not allowed to drink alcohol until they have received the welcome briefing. They are briefed on the rules of the TLD and they are informed of the consequences of inappropriate behaviour. The briefing does not prevent alcohol related incidents from happening. Nevertheless, it ensures that soldiers understand that, while on TLD, although every effort is made to make them feel comfortable and relaxed, they remain on duty and must therefore behave accordingly. A relative level of freedom is granted to allow them to relieve stress however, some boundaries are set.

As previously mentioned, Cyprus laws are applicable to Canadian soldiers on TLD. The command team liaises with local authorities, to ensure the local population is aware of the Canadian presence in the community and in order to prevent possible friction with Cypriots. The CF TLD has Canadian MP Patrols roaming the bar district and the hotel grounds to show presence and to deescalate any incidents before they degenerate.

Soldiers are not limited in the amount of alcohol they drink; however, the Health Services Section has an isolation room, where highly intoxicated individuals can be kept under surveillance until they sober up. Furthermore, as mentioned previously, members have to be sober when they attend mental health briefings.

Finally, the medical team provides on-site care in case of minor injuries or illnesses and liaises with local hospitals to ensure ready access in case of major injuries and illnesses.

Mental health team – Delivering the mental health program

As already mentioned, the CF TLD is composed of two distinct programs: mental health and recreational. They both serve the purpose of decompression, which is to prepare soldiers to reunite with their family and to provide them with an opportunity to relax. Mental health sessions however, are the only mandatory activities offered on the CF TLD. The mental health team provides those and, furthermore, is present day and night, to offer one-on-one counselling as required.

The mental health program is dispensed in two half-days, preferably on the two days following their arrival. It is divided into two distinct parts: the Battlemind Training program and the elective sessions. The Battlemind Training program offered on the CF TLD is extracted from a U.S. military product, which focuses on the initial transition of soldiers returning home. It addresses safety and relationships, and it is aimed at normalizing common reactions and mental health symptoms resulting from combat stress. It consists of a forty (40) minute video, made of four vignettes. The vignettes show soldiers who have returned from combat and who are experiencing flashbacks,

anger and other behaviours that may arise after they have been exposed to highly stressful situations. The session is designed to stimulate a follow-on group discussion.[72]

The elective program offers five topics, out of which every soldier has to pick two, in order to fulfill their mandated requirement. Topics are healthy relationships, coping with stress and anger, leadership after the action, spirituality and operations, and OSISS. The elective concept allows for some tailoring of the products offered to soldiers, in order to better fit the best range of possible needs for everyone. Once again, those sessions are designed to stimulate discussions and the sharing of personal experiences.

CFPSA team – Delivering the recreational program

The CFPSA team is composed of contractors who have for the most part previously served with CFPSA in Afghanistan. CFPSA members have therefore been in contact with deployed soldiers and understand the dynamic of the TLD. They also understand what might be of interest to them, as part of the recreational program. CFPSA organizes a wide variety of activities, with the support of locally hired contractors. Together, they coordinate the activity schedules, enrolments, payments, and attendance. The recreational program is scheduled as a counterpart to the mental health sessions and is therefore included in the overall scheduling effort of the CF TLD.

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[72] Extracted from: "Cyprus Third Location Decompression: *Most Recent Evaluation Findings*" is a briefing that was presented to the Comd CEFCOM by Bryan Garber MD, from the Deployment Health Section of the CF Director of Medical Policy.

CFPSA ensures a wide variety of activities is made available to soldiers. They all receive money to spend on Rest and Recreation (R&R) and they can use it to book a therapeutic massage at the hotel spa, a traditional local meal with entertainment, a visit to the go kart track, a round of golf, a local cruise or a fishing or sightseeing excursion, to name only a few of the activities made available by CFPSA. Scuba diving is not allowed however, because of the short duration of stay and the risk of decompression sickness related to that activity. CFPSA finally holds portable DVD players and an extensive DVD library, for those who prefer to spend quiet time in their hotel room.

Summary

The CF TLD involves a multidisciplinary team which is dedicated to the provision of a safe and pleasant decompression to those soldiers transiting through Cyprus. There is a great number of moving parts at any given time during the process and very few control measures to ensure compliance with the program. The CF TLD team has to be highly effective, in order to maintain soldiers' interest while delivering the mandated program and keeping everybody safe and sound.

As hard as the CF TLD team may work to deliver a good process, in the short term, results can only be measured in terms of soldiers' satisfaction. The next section presents survey results, which indicate whether soldiers thought the CF TLD was a positive and valuable experience to them.

SURVEYS ON SOLDIERS' SATISFACTION

Before leaving Cyprus, soldiers on the CF TLD have to answer a questionnaire, in order to evaluate their level of satisfaction with the decompression process. Answers have been collected and computed by the Deployment Health Section of the CF Director Medical Policy. The CF TLD mental health team administers the questionnaire, upon completion of their program. Resulting statistics are presented in this paper, based on data collected over four (4) separate CF TLDs. They have taken place between August 2006 and February 2008. This accounts for more than 8000 soldiers. Those on the first two CF TLDs were administered the same questionnaire again, four to six months later, in order to determine if their answers changed over time.

Statistics are presented in a series of graphs, showing soldiers general level of satisfaction with regard to their experience on the CF TLD.[73]

Figure 3-2 presented next relates to the concept of TLD in general. It does not specifically relate to the actual TLD Canadian soldiers have just experienced. The question rather is whether they thought that some form of TLD was a good idea, regardless of its format. A vast majority of those who responded either agreed or strongly agreed that having some form of TLD is in fact a good idea.

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[73] Statistics were found in: "Cyprus Third Location Decompression: *Most Recent Evaluation Findings*" is a briefing that was presented to the Comd CEFCOM by Bryan Garber MD, from the Deployment Health Section of the CF Director of Medical Policy.

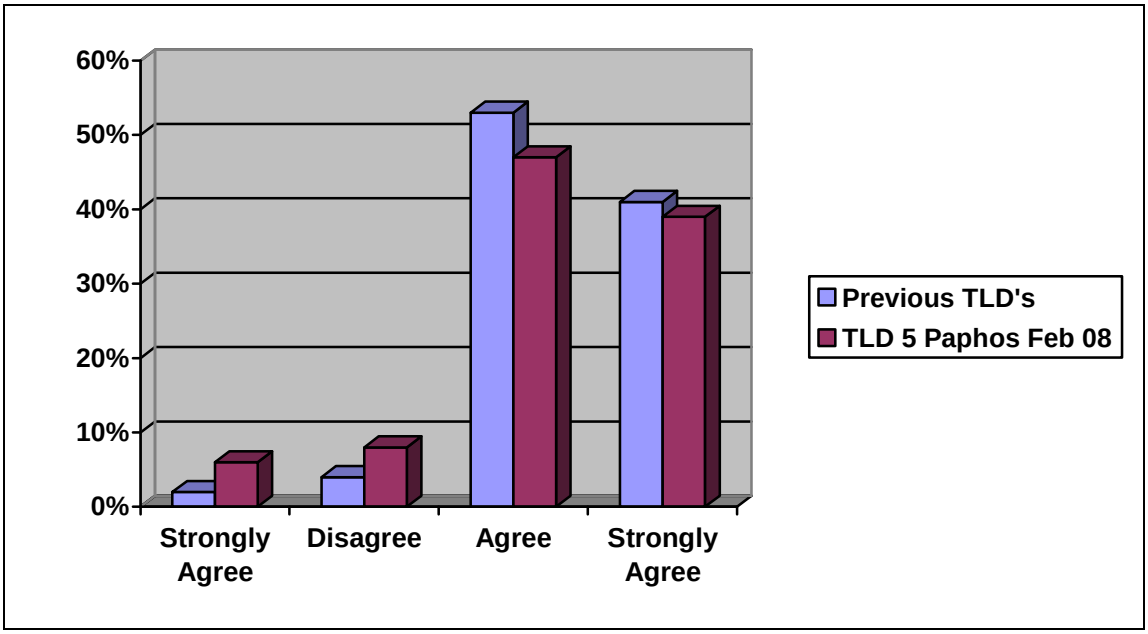

Figure 3.2 – Some Form of TLD is a Good Idea
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings*

The next two graphs are more specific. They refer to the mental health sessions provided to the soldiers during their TLD and how satisfied they were with their content and delivery.

First, as indicated at Figure 3-3, soldiers were asked about the Battlemind Training. A vast majority of them indicated they were either somewhat or very much satisfied with the Battlemind Training they received while on TLD.

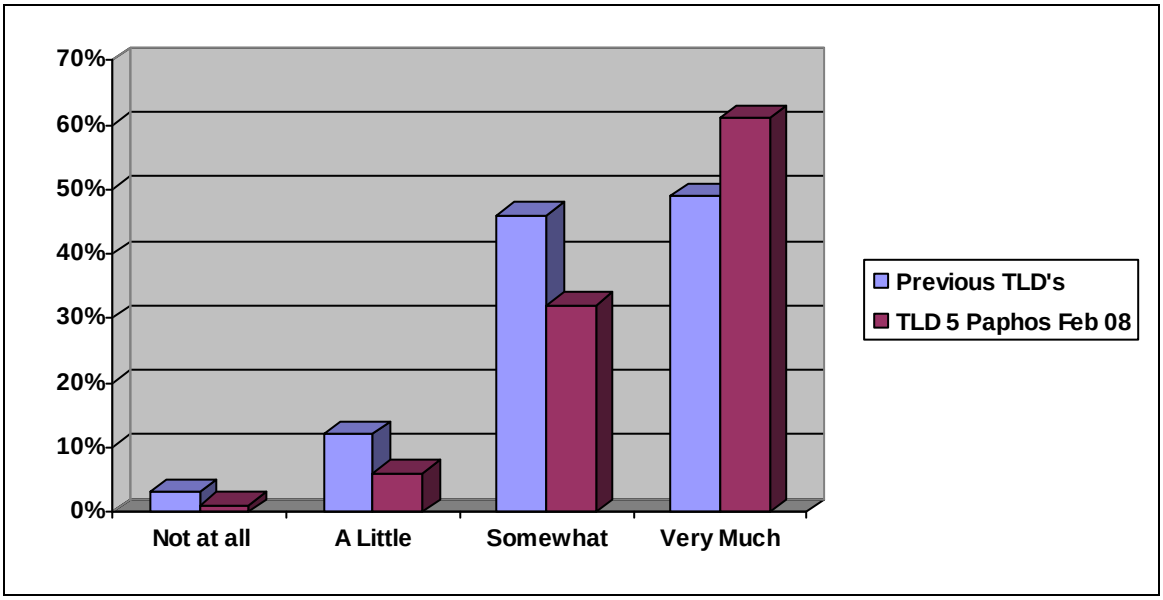

Figure 3.3 – How Satisfied were you with the Battlemind Training?
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings*

One main criticism was made by Canadian soldiers about the Battlemind Training and was also reported by the Mental Health team in their LL[74]. Battlemind is a U.S. Army product and it has a strong American flavour, with scenarios that do not exactly reflect Canadian reality. Canadian soldiers did not entirely relate to situations involving American soldiers. Furthermore, because some of them were on their second TLD, they had received that training before and deplored the redundancy.

[74] Lessons Learned documents from past CF TLD were provided by Major Peter Crow, J3 MST 3/CANOSCOM HQ for the production of this paper.

Second, as indicated in figure 3-4, soldiers were asked about the mental health elective sessions. A similar trend was noticed, while a vast majority of soldiers indicated that they agreed or strongly agreed that they were satisfied with those sessions.

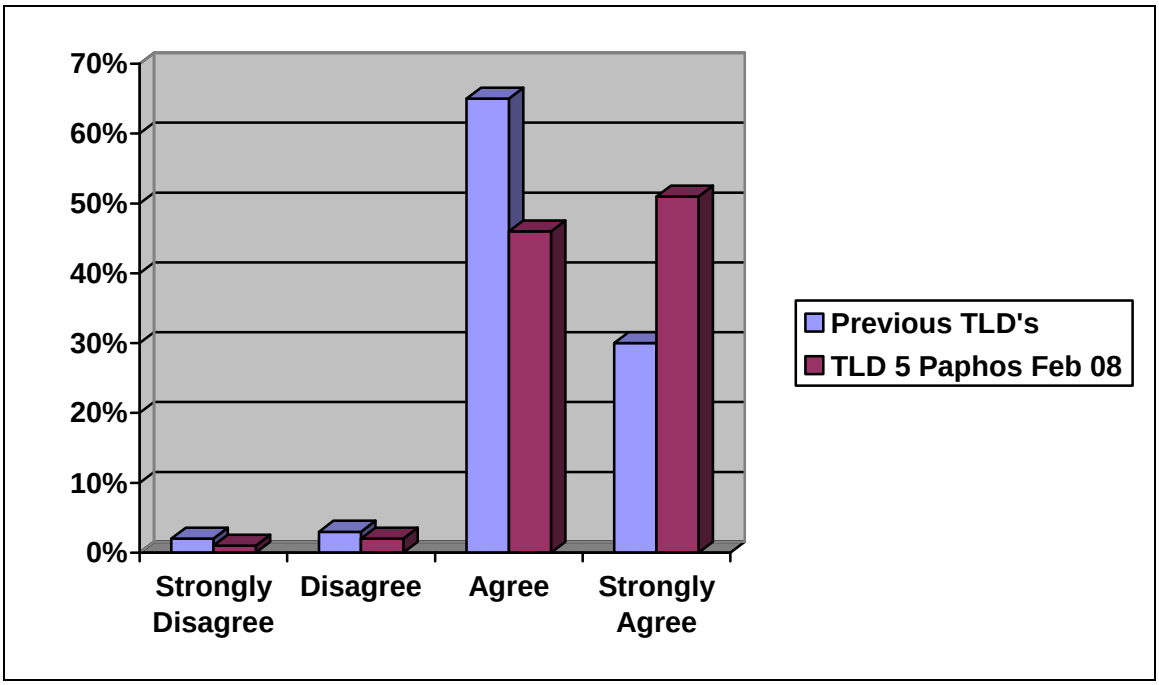

Figure 3.4 – I was satisfied with the elective training
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings*

The popularity of each session was compiled. Coping with Stress and Anger was the most popular at 36%, followed by Healthy Relationships at 34%. OSISS came in at 14%, followed by Leadership after the Action at 13%. Spirituality came in last at 4%, this topic being new, relatively more focused and therefore aimed at a smaller portion of soldiers.

The survey also asked the soldiers whether they thought the TLD was a valuable experience for them. Figure 3-5 shows a vast majority of them agreed that it was and that they were happy with their experience. This means that all of the efforts invested in the

delivery of the CF TLD are appreciated by those who benefit from it and that the process is rather successful from a recipient's perspective.

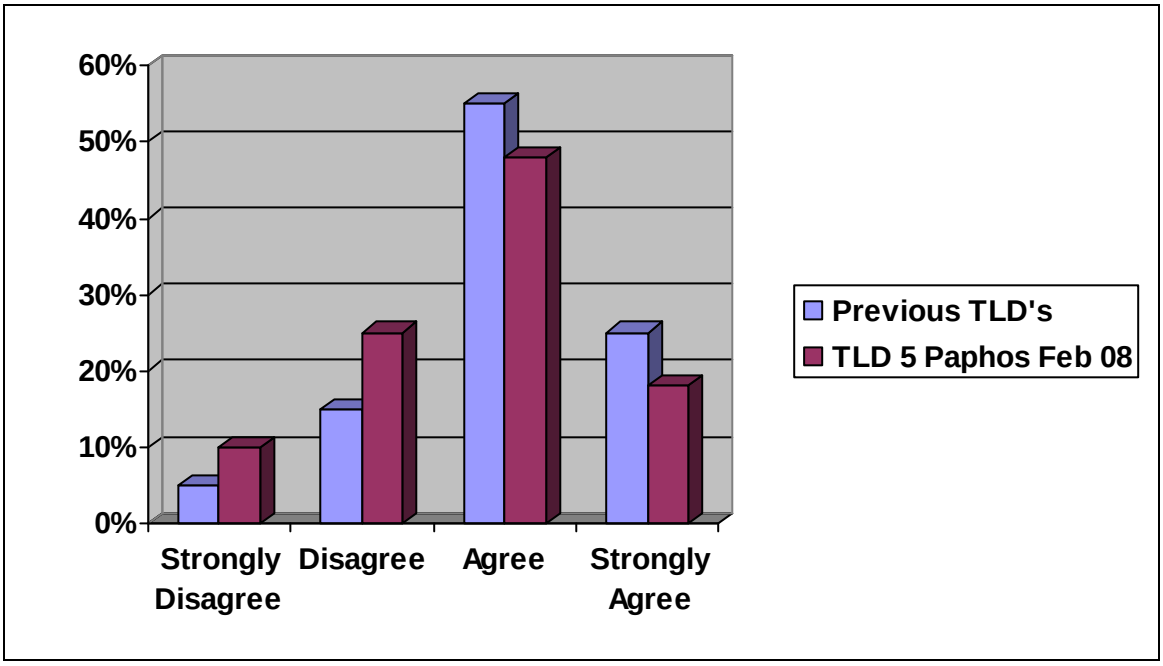

Figure 3.5 – I think the TLD was a valuable experience for me
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings*

Statistics presented so far are based on data collected from soldiers immediately after they completed their TLD. This means both the decompression process and the deployed operation were fresh to their memory. At that specific moment however, they had very little perspective on the process and were rather eager to get home. Those soldiers were asked similar questions again, four to six months after their return, to determine whether their opinion might have changed over time. The last two figures compare what soldiers thought of their overall TLD experience in general and more precisely its educational content, immediately after completion of the TLD and again four

to six months later. Only two (2) groups are represented in those graphs: August 2006 and February 2007.

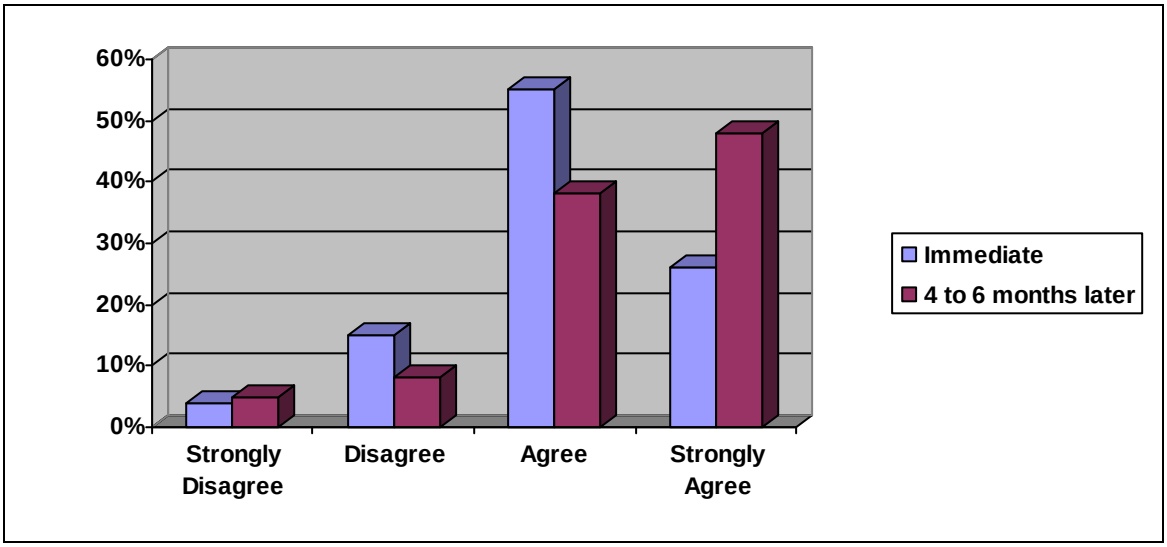

Figure 3.6 – I think the TLD was a valuable experience for me (TLD 1 and 2 only)
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings*

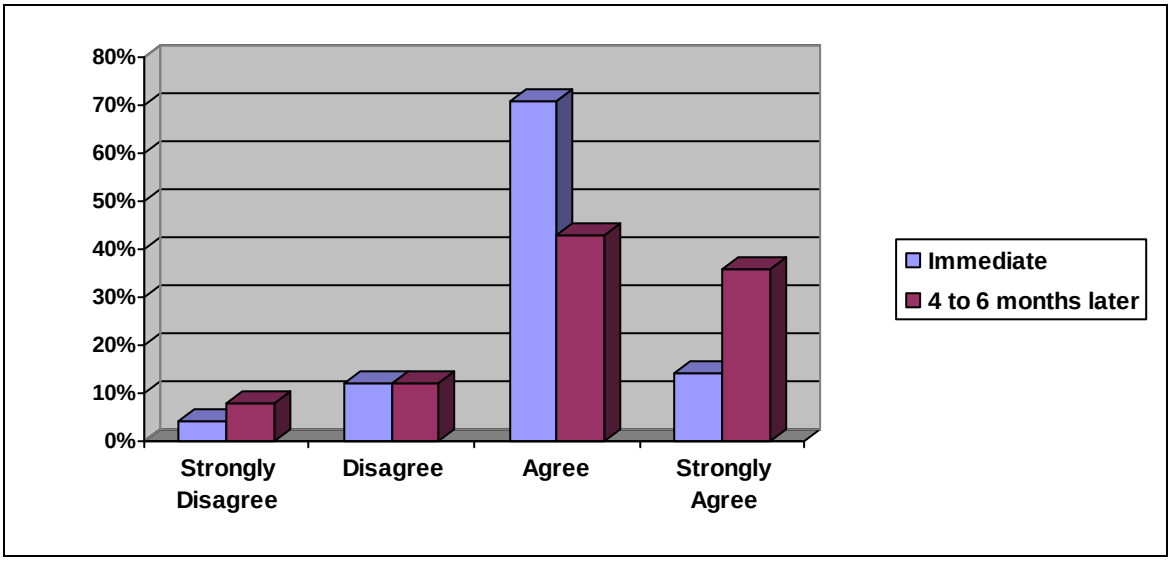

Figure 3.7 – Overall, I was satisfied with the educational component of this TLD
Source: Cyprus Third Location Decompression: *Most Recent Evaluation Findings*

The first few graphs presented in this section already showed that a vast majority of soldiers either agreed or strongly agreed with the overall value of the TLD experience and with its educational content. These last two graphs significantly reinforce this conclusion. While roughly the same proportion either agrees or strongly agrees with the statements, time has allowed a positive shift from those who agree to those who strongly agree. This may indicate that once soldiers have returned home, they have had a chance to reflect back on their experience and have been able to fully appreciate the benefits of the TLD.

In the end, the surveys answered by Canadian troops tend to confirm the validity and success of the CF TLD process, at least from a soldiers' perspective.

CF TLD SUMMARY

This section explained the level of difficulty involved in the running the CF TLD. A number of factors have to be considered in order to make it successful. The TLD team has to be properly balanced in order to provide a suitable environment and to deliver both the mandated mental health program and the recreational program.

There are a number of risks involved in running a TLD, which could lead to its failure. For example, the unrestricted consumption of alcohol could cause a significant incident or accident to happen, which could significantly negate the positive effects of the TLD. A major incident could cause Canada to be forced out of Cyprus and if the incident ended in the news, public opinion could turn against the TLD altogether. Furthermore, since the decision about whether to hold a TLD belongs to the chain of command, a poorly delivered TLD could lead to the leadership refusing to run one. Beyond

leadership, a poorly delivered TLD could finally lead to the soldiers being unresponsive to the program. It is therefore a TLD team responsibility to address those risks and to ensure the successful delivery of the process.

It is not easy however to measure the success of a TLD, because there is no benchmark data against which success can measured. Furthermore, TLD does not provide immediate visible results, but rather produces long-term intangible effects. TLDs are nevertheless conducted, to mitigate the emergence of PTSD and OSIs among soldiers returning from a combat operation. It does so by offering the soldiers an opportunity to decompress for few days, in a safe and relax environment, while they receive information on mental health issues. TLD is not a panacea to PTSD and OSIs but is rather a tool helping troops dealing with them, self detecting them and detecting them in others. It also helps soldiers develop a better understanding of the resources available to overcome PTSD and OSIs and remove the stigma associated to mental health through the normalization of mental health issues. Success in that regard can be measured, not in terms of impact on soldiers' mental health, but rather with the level of satisfaction of those soldiers toward the TLD. Surveys administered so far have confirmed a positive level of satisfaction among soldiers, which is a positive success indicator.

Soldiers' satisfaction is a good way to validate the CF TLD concept and to infer its value added. Comparison is another way to validate a process. It is therefore possible to evaluate the CF TLD process, by comparing it to what is done by other nations. The next section will present what is done in the United Kingdom, Australia, the Netherlands and the United States, in terms of helping soldiers reintegrating their home life, once they return from a combat environment.

CHAPTER 4 - DECOMPRESSION AND OTHER NATIONS

There is no agreed upon common definition or common practice to what nations call "military decompression". There are elements however, that are common to most: a process designed to help soldiers "unwind" in a safe and comfortable environment, when returning from a deployed operation and prior to their return home.[75] "Decompression typically takes place prior to personnel returning home, either in a safe area within the country of operation or a third location away from both the country of operation and home."[76] For example, until recently, the British conducted their decompression over a three to four (3 to 4) day period, in barracks, on return to base.[77] What is clear is that decompression can be performed a number of different ways. This section will examine how some like-minded nations do it in comparison to Canada.

Research for the 2004 Ombudsman report entitled "From Tents to Sheets: An Analysis of the CF Experience with Third Location Decompression after Deployment" included interviews of representatives from the Netherlands, Australia, Germany, Italy, Greece and the U.S. The intent was then to learn about other nations' decompression practices. Those interviewed all confirmed that their country provides some form of reintegration program for their troops returning from an operational deployment. The representatives from the Netherlands and Australia were to only ones however, to

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[75] Jamie G.H. Hacker Hughes. "The Use of Psychological Decompression…, 5.

[76] Catherine Field. "Ration Packs to the Sunday Roast – An Analysis of the Australian Defence Forces Experience with Post Deployment Reintegration." Research Report, Post Graduate Diploma of Psychology, Monash University, November 2005, 10.

[77] Jamie G.H. Hacker Hughes. "The Use of Psychological Decompression…, 3.

confirm the use of a decompression process as part of their national program.[78] Research for this paper confirmed that the United Kingdom has also conducted decompression for troops returning from deployed operations.

In comparison to decompression, reintegration is a more practical or administratively oriented process, making sure that those returning are well taken care of, in terms of leave entitlement, medical screening, indemnities and return to work process. Decompression on the other hand, is more about dealing with the psychological stressors related to the redeployment. It can be incorporated in the reintegration process, but ideally has to take place prior to soldiers reuniting with their families.

This section will present decompression from a United Kingdom, Dutch and Australian perspective. It will also present some U.S. military initiatives, related to decompression and reintegration of their troops returning from a deployed operation. Presenting other nations' position and initiatives with regard to decompression will help determine where Canada stands in comparison to its allies and may offer lessons to be learned from those allies.

UNITED KINGDOM

British military authorities consider it to be of great benefit, for those who have had life-changing and stressful operational experiences, to discuss the incidents among themselves. Such discussions are encouraged while soldiers go on decompression, a process that the British now call "normalization". As mentioned previously, until

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[78] *Special Report to the Minister of National Defence - From tents to sheets.*…19.

recently, British military decompression usually took place in barracks, upon return to base. They would conduct military activities in the morning, recreation in the afternoon and contact with families in the evening. This decompression preceded any type of post-deployment leave.[79]

Running decompression in the barracks however, made it difficult to incorporate reservists and augmentees in the process. Reservists and augmentees normally go home immediately upon return from deployed operations. Since they are rarely co-located with the unit they deployed with, they usually missed decompression. This is why the British military now increasingly uses TLD, for three to four (3 to 4) days. It allows for everybody, including reservists and augmentees, to be with their peers once out of theatre and before they go home. The British TLD process normally includes time for congratulations, adjustment to change of pace and management of expectations with regards to soldiers' return to base. There can be post-operational stress briefings and those psychologically vulnerable can be identified, monitored and referred to health services as necessary. There can also be religious ceremonies.

Decompression for British troops is a discretionary requirement. Nevertheless, it is mandatory for the leadership to at least consider its use. The ultimate decision to implement it is made at brigade level.[80]

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[79] G.H. Hacker Hughes. "The Use of Psychological Decompression…, 3.

[80] *Ibid.*

AUSTRALIA

In the Australian context, decompression means:

> *the practice of requiring personnel who are returning from a deployment to return to their unit for about two weeks and undertake normal work duties along with any counselling or post deployment medical tests. This process ensures that returning personnel have time to adjust before spending all of their time on recreation leave.*[81]

Australia has debated the requirement for military decompression for some time already. The Joint Standing Committee on Foreign Affairs, Defence and Trade Report no. 106, tabled on 23 September 2002, recommended the following: "the Department of Defence must ensure that the use of decompression periods for all Australian Defence Force (ADF) personnel returning from operational deployments is mandatory."[82] The Australian government responded to that recommendation, saying that "ADF personnel returning from operational deployment are best managed with a degree of flexibility that allows commanders to make decisions [regarding decompression] based on the best interests of their subordinates."[83]

In the Australian Army, decompression as defined above is considered Standard Operating Procedure (SOP). The ADF however, "orders that war service leave should be

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[81] *Ibid.*

[82] Parliament of Australia Joint Committee. "Completed Inquiry: Review of Foreign Affairs, Trade and Defence Annual Reports, 2000-2001." http://www.aph.gov.au/house/committee/jfadt/Dod2001/AnRptsIndx.htm; Internet; accessed 20 March 2009.

[83] *Ibid*.

taken immediately upon return to Australia and prior to other form of leave."[84] This in fact contradicts the requirement for decompression and that is why the Joint Standing Committee made the recommendation mentioned in the previous paragraph. Furthermore, the Committee came to conclusions similar to what the British have: decompression for Australian reservists is not SOP and those soldiers are therefore at a disadvantage, reinforcing the need for mandatory decompression for everyone.[85]

The decompression and reintegration process of the ADF is executed on an ad hoc basis. A study has been carried to determine the value of such process and whether it delivers any of the desired effects. It concluded that those organisations exposing their personnel to high stress and/or trauma must develop and implement comprehensive strategies to manage the wellbeing of these personnel. Consequently, the study concluded that military decompression becomes critical from an operational, legal, financial and moral point of view.[86]

As it stands, Australian soldiers returning from deployed operations are medically and psychologically screened. A range of support is available to them at all times, such as the Defence Community Organisation, the family breakdown support and the chaplains. Any requirement beyond what is commonly provided, such as a formal decompression, is driven by the nature of the deployment. Those returning from a highly traumatic operation will therefore be more carefully managed than others. As a result,

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[84] *Ibid.*

[85] *Ibid*.

[86] Catherine Field. "Ration Packs to the Sunday Roast…, 24.

the need for decompression may outweigh the direction to send soldiers home on their war service leave. This decision however, is left to the military leadership to make. Decompression in this case would likely be run in Australia. The reference materiel, however, did not specify whether it was run at home base or some other domestic location.

NETHERLANDS

In 2005, the Dutch State Secretary of Defence developed a policy on health care for the military, which stated that deployed soldiers should participate in redeployment activities, such as end-of-deployment closure sessions, interviews on homecoming, and health care surveillance. Those activities may vary from group sessions to individual sessions.[87]

TLD may be part of the Dutch end-of-deployment process, for high tempo missions and those that go beyond three months. The Netherlands has used TLD after missions, such as those they conducted in Ethiopia, Liberia, Iraq and Cambodia. The aim of their TLD has been to balance operational and emotional experiences under professional supervision and before returning home.[88]

Whenever they conduct a decompression process, the Royal Netherlands Armed Forces follow a number of principles. First, their decompression has to be run in a

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[87] Martin Meijer and Rodney de Vries. *Good Practices of End of Deployment Debriefing in the Royal Netherlands Navy*. NATO Researh and Technology Organization (April 2006). Available from http://www.rta.nato.int/pubs/rdp.asp?RDP=RTO-MP-HFM-134; Internet, accessed 28 January 2009.

[88] *Special Report to the Minister of National Defence - From tents to sheets.*…19.

location other than the theatre of operation and before they return home. This could be on a ship or at any other location that would allow for the segregation of the soldiers, while allowing for R&R, medical and psychological debriefings. The TLD must be formed of mental health, medical and administrative staff, with Military Police presence, very much the same as what a CF TLD would be made of.[89]

The Royal Netherlands Navy conducted a study similar to the Canadian surveys presented in the previous chapter. They surveyed 378 Navy personnel, from both seagoing (237) and marine (141) units. The respondents went to Cyprus for decompression, after a mission in Iraq. They were questioned on their level of satisfaction with regards to the quality and usefulness of the debriefings they were given. Survey results showed that a vast majority of them were satisfied or very satisfied with every aspect of the end-of-deployment process. Nevertheless, the research report recommended that some topics be given more attention in the debriefing process. Those topics are "changes at home, significant others, children, other family members, work related peers, managing the media, coping with stress symptoms and tips on what to avoid and where to go for help or support."[90]

UNITED STATES

As presented in the literature review, both the U.S. Army and USMC have formal procedures to mitigate the impact of combat related stress on soldiers and on operations. Nevertheless, a U.S. Department of Defense (DoD) Task Force on Mental Health report

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[89] *Ibid*., 20.

[90] Martin Meijer and Rodney de Vries. *Good Practices of End of Deployment…*

has identified fiscal and personnel deficiencies regarding mental health in the U.S. military. It has consequently determined the urgent need for the U.S. DoD to acknowledge the increasing demand for, and the criticality of, mental health services. Those services identified were "resilience-building, assessment, prevention, early intervention, and the provision of an easily-accessible continuum of treatment for psychological health of service members and their families in both the Active and Reserve Components."[91]

This section will present two U.S. military initiatives, which are consistent with the recommendations made by the previously mentioned Task Force on Mental Health. First there will be the U.S. Army Battlemind Training program and then the U.S. Navy Warrior Transition Program (WTP). Those programs are consistent with the military decompression concept and are used in the reintegration process of U.S. troops returning from deployed operations. Note that the Battlemind Training program used in the CF TLD process is extracted from the Battlemind Training program presented below.

Battlemind Training

"The stigma associated with mental health problems is one of the major hurdles the Army must overcome. By providing more training on mental health to soldiers, the Army hopes to mitigate the stigma and identify personnel that may need assistance."[92] The Battlemind Training program was therefore developed as a mitigation strategy to

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[91] *An Achievable Vision: Report of the Department of Defence…*, ES-2.

[92] James Williams III. "Army Expands Battlemind Training," *Army.mil/news*, available from http://www.army.mil/-news/2008/05/30/9548-army-expands-battlemind-training/net; accessed 14 January 2009.

face mental health problems in the U.S. Army. It is a comprehensive program that includes pre-deployment, deployment and post-deployment activities, for warriors, leaders and their families. The program was developed based on years of gathering data about deployment and reintegration of U.S. soldiers. "More than 80,000 troops filled out surveys since at least 2003 providing data on the typical effects of combat and the typical problems after coming home."[93]

The Army has made the Battlemind Training program an Army-wide standard training. It focuses on easing soldiers' adjustment to their family environment when they return from deployed operations. It helps soldiers who are transitioning from combat readjust to regular life. For instance, soldiers have to understand that operational secrecy learned in combat no longer applies in a family context. Likewise, combat driving or always being armed is no longer acceptable once back at home. Furthermore, while surviving is critical in combat, there are human limits to preventing death and injuries. The "survival guilt" can be destructive and therefore also has to be dealt with.[94]

Research psychologists with the Walter Reed Army Institute of Research indicate that there are fewer reported sleep problems among soldiers who returned from Iraq and participated in Battlemind training. There also were less-severe PTSD symptoms, compared with soldiers who had received either no post-deployment mental health training or a simple briefing about stress. Notwithstanding those reported results, one of

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[93] Nancy Montgomery. "Study finds Battlemind is beneficial." *Stars and Stripes*. (February 2009): http://www.army.mil/-news/2009/02/17/16986-study-finds-battlemind-is-beneficial/; Internet; accessed 20 March 2009.

[94] *Ibid.*

the researchers made it clear that although positive, Battlemind Training effects are still small and that no disorders were cured.[95]

Warrior Transition Program

While the U.S. Army Battlemind Training program offers a comprehensive coverage, with activities in pre-deployment, deployment and redeployment phases, it does not include any TLD activities. The U.S. Navy (USN) on the other hand, has developed the WTP process, which is very similar to the CF TLD concept. The USN has based the WTP in Kuwait. It provides Individual Augmentee (IA) sailors with an opportunity to reintegrate back into the Navy, after having been embedded with an Army unit for six to twelve (6 to 12) months.[96] This is where sailors begin their transition home. They receive pastoral care and counselling, for three to five days (3 to 5), in a safe environment. They can relax and reflect on their experience, while surrounded by people who have lived similar events. The WTP is designed to reduce the negative effects of deployment and combat stress, while focusing on healing the body, mind and spirit.[97]

Similar to what the Battlemind Training program offers, the WTP includes a pre-deployment briefing and a post-deployment follow-up. The main effort however, is concentrated on the decompression portion. The WTP is considered especially important for reservists, because chaplains and medical personnel are there on hand. Reserve

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[95] *Ibid.*

[96] Navy.mil. "New Warrior Transition Facility Improves Support for Redeploying Sailors." http://www.news.navy.mil/search/display.asp?story_id=34071; Internet; accessed 4 April 2009.

[97] Daryl C Smith. "Warrior Transition Program Helps Seabees Adjust to Normal Life." http://www.navy.mil/search/display.asp?story_id=27828; Internet; accessed 30 March 2009.

members may not have easy access to that kind of comprehensive support, when they return to their individual hometowns. The "Seabees"[98] are the only branch of the military to use such a transitional area for this purpose.[99]

SUMMARY

The nations presented in this chapter have all demonstrated concerns for soldiers' mental health, as it relates to combat stress. By addressing their soldiers' need for decompression, they have all acknowledged the challenges of going so rapidly from a combat environment to a normal family environment, which is a change of pace so drastic it may in fact be difficult to handle by some. The consequential need for soldiers to unwind as they redeploy is therefore handled with great similarities by those nations, with some relatively minor differences.

The UK, the Netherlands and the USN all have some type of TLD as part of their decompression process. Australia, on the other hand, has a decompression policy which does not necessarily involve a third location as such. Nevertheless, mental health support is the main focus in all cases, with some R&R as a sort of enabler to facilitate stress relief.

Some of the nations have debated the need to make decompression a universal requirement, for all soldiers coming back from a deployed operation. The consensus

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[98] Seabees is the term used to designate U.S. Navy Construction Battalion personnel.

[99] Daryl C Smith. "Warrior Transition Program Helps Seabees…

however, is that the decision to conduct a decompression process or not has to belong to the military chain of command, based on the length and intensity of the operation.

An important factor in the decision to conduct a formal TLD process is the need to provide augmentees and reservists with the same opportunity to decompress as everyone else. A TLD is the preferred solution because it is difficult to provide a decompression to those reservists and augmentees that are not co-located with their deployed unit once they come home. While the UK, the Netherlands and the USN have all chosen the TLD option to solve that issue, Australia has not formally defined its preferred course of action, simply indicating that decompression will take place in a safe staging area, which could be in theatre, in Australia or at some other location.[100]

Although there is no empirical evidence of the benefits of conducting a TLD for redeploying troops, all nations seem to intuitively understand how it may produce positive results. Furthermore, the UK and the Netherlands have conducted surveys and research, in an attempt to legitimize and possibly improve their process. Interestingly enough, they have learned that in general, soldiers respond quite positively to the initiative, which reinforces Canadian results to similar surveys.[101]

So far, Canada is doing as much as, and in some instances more than other nations for matters related to military decompression. Canada might even be considered as a leader for the concept. In fact, other nations often refer to the Canadian experience as an

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[100] *Report to the Minister of National Defence - From tents to sheets…*, 21.

[101] British survey results were reported in the paper by Jamie G.H. Hacker Hughes and Dutch survey results were reported in the paper by Marten Meijer and Rodney de Vries. Both papers are listed in the bibliography.

example to follow in terms of decompression. The Canadian approach is definitely consistent with what other nations are doing, which to a certain degree, confirms the validity of the CF TLD process.

CHAPTER 5 - COUNTERARGUMENTS AND POSSIBLE AREAS OF IMPROVEMENTS FOR THE CF TLD

COUNTERARGUMENTS

The findings contained in this paper so far indicate that the CF TLD concept seems to be a step in the right direction, in order to mitigate the impact of combat-related stress and the emergence of PTSD and OSIs in the CF. Nevertheless, there are some arguments going against such a process.

First, when the CF TLD was initially implemented, it was perceived as protracting the deployment period, therefore delaying soldiers' reunion with their family. Even the Ombudsman was not completely convinced that a TLD was a productive or practical way to proceed with the reintegration of Canadian soldiers after a deployment. He thought that "extending the tour length may increase stress levels and that the logistical and financial implications were considerable." [102] He eventually realised however, that his initial reservations were unnecessary.[103]

Secondly, only a minority of the soldiers coming out of Afghanistan (roughly 27%)[104] will have some difficulties readapting. In that context, why should everyone else have to go through the TLD process? Since it is virtually impossible to identify who those 27% are, the best way to reach them is to have everyone go through the TLD. It

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[102] *Report to the Minister of National Defence - From tents to sheets…*, 3.

[103] *Ibid.*

[104] *Special Report to the Minister of National Defence – A Long Road…*, 1.

can be beneficial, not only to those who will have difficulties readapting, but also to the others, even if only to rest and relax.

A third counterargument is about whether the CF TLD will reduce the incidence of PTSD and OSIs. The CF Health Services Branch insists on saying the TLD was not developed to decrease the level of PTSD. It is in fact simply designed to "reduce the tension that can arise when a soldier goes from a theatre of operations to his family the next day."[105] It is not a medical requirement to conduct TLD but rather a leadership initiative, since there is no proof of benefit on the incidence of PTSD or OSIs for those attending TLD vice those who don't.[106] It is for that same reason that TLD is not considered as a course of action to prepare soldiers going on their mid-tour leave. Furthermore, the logistical and operational challenges of such an approach would be overwhelming, while it is considered a fair course of action for contingent rotations.[107]

A fourth counterargument is the danger associated to alcohol consumption while soldiers are on TLD. It is virtually impossible to completely eliminate the risk of a serious incident involving alcohol, while giving the soldiers the freedom required for them to fully decompress. Such an incident could for example involve a fist fight between soldiers or with a local citizen or a soldier drinking himself into stupor. Aside

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[105] Standing Committee on National Defence, Number 011, 2nd Session, 39th Parliament. Rick Casson, Chair. Ottawa: House of Common, February 2008, 4.

[106] House of Commons Committees. "Government Response to the First Report of the Standing Committee on National Defence." http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=3077584&Language=E&Mode=1&Parl=39&Ses=1; Internet; accessed 5 April 2009.

[107] *Ibid.*

from the risk for soldiers' health and safety, such an incident could also have consequences related to the public image of the CF. It could finally have political consequences related to the embarrassment caused by an incident and ultimately negate the positive effects of the TLD. The mitigation strategy to face that counterargument is the presence of MPs on TLD staff to deescalate situations that could otherwise degenerate. The formal briefing given to the troops also clearly lay out the boundaries within which the troops can unwind, explaining them that they remain accountable for their actions, even while on decompression.

A fifth counterargument is related to the mandated requirement to run a TLD for troops coming out of Afghanistan, while others going to Haiti, Sudan, Sierra Leone and other smaller missions don't have the same option. Navy personnel coming back from six months at sea don't either. Although it is a TF Comd prerogative to decide whether a TLD is required upon completion of a deployment, those smaller missions would likely not be able to run one, due to the lack of volume and the inability of the CF to mount multiple smaller versions of the CF TLD. Legitimacy of the process however, might be related to its universality, at least in terms of accessibility for those commanders who would deem it necessary. The only solution to this counterargument would be to provide an opportunity to run a TLD to any deployed TF Comd, regardless of the size of his mission. This would require an expansion of resources dedicated to the planning and delivery of CF TLD and has yet to be considered. It would likely have to involve a fully dedicated team that could coordinate CF-wide TLD decompression process development and delivery.

Finally, the credibility of the program is directly linked to the educational material presented to the soldiers. The Battlemind Training program might have proven to be effective in the U.S., it is nevertheless an imported product, which lacks a Canadian touch to which Canadian soldiers would identify better. Furthermore, the other lectures offered on TLD will become redundant for those who will go on TLD for a second or even possibly a third time. The program simply has to be "Canadianised" and expanded, in order to maintain its relevance and credibility. Failure to do so might lead soldiers to get frustrated of going through the exact same process more than once, seeing the same presentations again and again.

POSSIBLE AREAS OF IMPROVEMENTS

Other countries' experiences and the counterarguments presented in this paper, as well as LL collected from past CF TLDs helped in identifying possible areas of improvement for the CF TLD program. Suggestions for improvements made in this document are based on the author's assessment of the current CF TLD situation, in comparison with some of the findings presented herein.

A first possible improvement would be to ensure unit integrity for troops transiting through the TLD and when forming groups for mental health sessions. This requirement has surfaced in comments made by Canadian soldiers during their TLD.[108] The CF TLD mental health team has acknowledged such requirement in their LL and made every effort to accommodate it on location; however, this should be coordinated at

[108] Item 68 of the Lessons Learned from the CF TLD held in August 2008.

a higher level. An additional effort should be made for the Relief in Place (RiP) plan to move soldiers out of theatre as formed units. There is no need for entire units to move together, all at the same time, since this would likely make proper theatre handover impossible. It should still be possible however, to move them together in formed groups derived from larger units, in order to allow for cohesion developed in theatre to positively contribute to the decompression process, without hindering the RiP.

Another possible improvement relates to the preparation of troops prior to going on TLD. The CF TLD is still a relatively new process and some soldiers have been critical of it, mostly just prior to and upon their arrival at the TLD location. This reflects negatively on their mind-set when they first arrive at the TLD; however, a positive change of attitude generally happens for the vast majority of soldiers after their first day of decompression.[109] In order to alleviate this issue, soldiers should receive information about the TLD process from their chain of command as soon as possible. In fact, information on program content and duration should be provided to soldiers before deploying, in order to manage their expectations. Furthermore, soldiers' return date to Canada should be based on completion of the TLD and not on the date they are leaving the theatre of operation. Actually, although on the periphery, the TLD location could be considered as part of the theatre of operation and the mission should therefore only be considered completed once soldiers are leaving it. Finally, leadership at every level has to present a unified front and a positive outlook on the conduct of the TLD, explaining to

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[109] This finding is not documented however, the author witnessed the phenomenon when he commanded the CF TLD Cyprus during the rotation of the Joint Task Force Afghanistan HQ Roto 4 in May 2008. Other CF TLD staff who attended different Rotos confirmed the same.

their troops that it is in deed an initiative implemented by their chain of command. Any dissension along that chain of command with regards to the value of the TLD process might very well lead to soldiers questioning it, and it may therefore undermine its success.

Chapter three of this paper demonstrated how important the location is to the successful conduct of the CF TLD. The Dutch military reported for instance that whatever the location is, it has to allow for the segregation of the soldiers.[110] In a Canadian context, this means the CF TLD should have exclusive access to the hotel selected. There should be no civilian customers in the hotel at the same time as a CF TLD is conducted. The TLD process requires a minimum of seclusion, in order to allow for soldiers to fully decompress. The presence of civilians in the same hotel may cause a feeling of being observed. It may also attract undue public attention on a process that is rather private. Furthermore, interaction with civilians and the eventual questions they might ask about the CF presence in a Hotel Resort may place soldiers in an uncomfortable position. In fact, sharing a hotel with civilian customers can only be counterproductive, in terms of the quality of life for the soldiers, the customers and also for the CF TLD team, because soldiers would have to be monitored more closely, to ensure other customers are not inconvenienced by their presence.

Additionally, figure 3-1 showed that the CF TLD current location (Cyprus) was not as popular in winter months as it is in summer months. Although this is a relatively minor irritant, every effort has to be made to ensure optimal conditions are met for the

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[110] *Report to the Minister of National Defence - From tents to sheets…*,20.

TLD and therefore, another location might prove to be better for TLDs conducted during winter months.

With regards to the mental health program offered to the troops during a CF TLD, statistical data presented in chapter three has proven it to be fairly satisfactory so far. Nevertheless, a Canadian version of the Battlemind Training program might be more reflective of the Canadian reality, which is somewhat different from the American reality. This is true from a cultural point of view as much as from a practical point of view. Furthermore, an expanded variety of mental health session topics would also be appropriate for soldiers who go on a second and a third TLD. [111] This would once again contribute to the level of receptiveness of the soldiers, who might otherwise think it futile to repeat training they have already done once in the past. Such an expansion of the mental health program might however require a larger number of mental health specialists to participate in the TLD. It might also require a TLD mental health team to be fully dedicated to the development and the delivery of the TLD program, as opposed to the ad hoc teams currently being formed for each and every CF TLD. This would not only allow for the eventual expansion of the program, but also to ensure continuity, consistency and relevance.

For example, some soldiers have identified the need for mental health information to be made available, while they are still in theatre, in order to prepare them for mid-tour leave. A TLD prior to mid-tour leave is clearly not practical or even possible; however, some soldiers have said that information about healthy relationships might have been

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[111] Item 72 of the Lessons Learned from the CF TLD held in August 2008.

useful before they went home for a few weeks in the middle of their tour.[112] A dedicated TLD mental health team could concentrate on issues such as this one and come up with possible solutions.

Finally, a standardization of the decompression program offered to Canadian soldiers is needed. Every Canadian soldier returning from a deployed operation should be entitled to the same level of care and services, regardless of the size of their mission. This does not necessarily mean every deployed soldier has to go on a TLD before he returns home. The chain of command should in fact remain responsible to make the determination of a TLD requirement, based on mission's particulars and guiding principles, such as those listed in chapter two of this paper. The current problem is the chain of command does not have that prerogative, because there is no opportunity to run TLDs, other than for troops coming out of Afghanistan.

A Canadian Expeditionary Forces Command (CEFCOM) Staff Inspection Visit (SIV) conducted in September 2008 at the CF TLD Cyprus identified the requirement for the CF TLD to handle decompression requirements for missions other than Op ATHENA.[113] The report mentioned the need to develop a list of decision criteria, for the determination of TLD requirement of other missions. Once again, those would likely have to coincide with the guiding principles presented in chapter two of this paper.

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[112] Item 7 of the Mental Health team After Action Report (AAR) dated 17 March 2008.

[113] 3350-135/A29 (OS Pers Ops) *Staff Inspection Visit Report – TLD Op ATHENA ROTO 5*, dated 1 October 2008.

Smaller missions involve significant challenges, which might be different from those experienced by Canadian soldiers in Afghanistan, but still call for decompression. The needs of those coming back from such missions might be different from what is currently provided at the CF TLD. Tailoring of the program would therefore likely be required. This would be the price to pay in order to provide Canadian soldiers with equitable access to a decompression program, regardless of the mission they deployed on.

CF leadership will have to determine the type of decompression it is prepared to provide to those soldiers coming back from smaller missions. The infrastructure requirement for these smaller missions would obviously be less significant than the full hotel required for troops coming out of Afghanistan. Decompression for smaller missions could even be conducted back in Canada. A location other than home base could be selected, where soldiers could still be secluded and kept together for a few days. Such an initiative would yet again require more mental health specialists, dedicated to an expanded decompression program.

The CF TLD program is still relatively new and it can certainly be improved. One of the most critical requirements would be to have more resources fully dedicated to it, in order to expand and standardize its content. Furthermore, making the program available to every CF deployed mission seems only fair. Finally, surveys, LL and other nations' best practices with regards to TLD will have to be monitored regularly, in order to ensure the constant improvement of the program.

Although the increase of mental health resources seems to be key to the improvement of the CF TLD and overall CF mental health program, what is as much

critical is the firm commitment of CF leadership to the care for Canadian soldiers' mental health. This is done not only through greater resources dedicated to it, but also through the fostering of an institutional culture, which openly accepts to deal with mental health issues, in a positive manner and without the stigma so often associated to them. The CF TLD initiative is a good example of such a commitment.

CONCLUSION

Working conditions in Afghanistan are highly stressful, difficult and demanding. More Canadian soldiers were killed in action in Afghanistan than in any other theatre of operation since the Korean War. Canadian soldiers now have to prepare more, and better than ever, prior to deploying to Afghanistan. They have to use new types of equipment and technology in order to face new types of enemy threat. Consequently, working conditions experienced by Canadian soldiers in Afghanistan have also triggered the development and implementation of a new process, for them to better prepare for their return home. The process, called TLD, is a transition program, helping soldiers to relieve operational stress and readapt to a more regular life, once they leave a theatre of operation and prior to them reuniting with their family. The CF TLD program was the focus of this paper.

The aim of this document was to demonstrate that soldiers returning home from an extended and stressful deployed operation may greatly benefit from a decompression period, at a location other than the theatre of operation and prior to their return to home base. This essay demonstrated that for such a process to be successful, CF leadership had to be involved at the highest level, in order to ensure uniformity, continuity and success of the approach. It also demonstrated that although decompression is not a panacea against PTSD and OSIs, it may facilitate detection of such psychological problems, by raising awareness and reducing the stigma often associated with mental health concerns. In that regard, decompression is therefore a force multiplier, which significantly contributes to the reintegration and reconstitution phase of troops returning from a deployed operation. It promotes mental health self-awareness among soldiers and

normalizes PTSD and OSIs, in order to encourage those developing symptoms to seek help.

The first time PTSD and OSIs were formally associated to CF deployed operations was in the BOI Croatia report. The DND and CF Ombudsman immediately followed-up with a series of investigations and reports, one of which led to a number of recommendations made to the CF in 2001. Interestingly enough, these recommendations came up based on the CF experience in Croatia, and before the CF first deployed to Afghanistan. One of the recommendations related to ways of allowing CF members to reintegrate their family and garrison life, once they return from a deployed operation. It was originally implemented as a TLD in Guam, with the very first Canadian contingent to redeploy from Afghanistan in 2002.

The decision to conduct a TLD for Canadian troops returning from Afghanistan could not be based on empirical evidence. No such evidence existed and it would have taken years to gather. Nevertheless, the negative impacts of operational stress had already been identified by the BOI Croatia and the Ombudsman reports. Inaction in the face of such impacts would have been a lack of due diligence. The TLD on the other hand, was a leadership initiative implemented as a mitigation strategy, in order to alleviate the impacts of PTSD and OSIs and to facilitate their detection and early treatment. By taking such concrete and positive actions related to soldiers' mental health, the CF leadership contributed to reducing the stigma associated to it. Placing soldiers' mental health in the forefront with an initiative such as the TLD undeniably expressed senior leadership's concerns with regards to it. It normalized mental health issues, by ensuring soldiers were exposed to the topic as part of their redeployment cycle.

The review of literature showed that soldiers' mental health is not only a concern for the CF Ombudsman and CF leadership. PTSD and OSIs in the military have been the subject of U.S. military publications, Canadian and foreign specialized articles, research papers and media reports. This topic proved to be highly relevant and important through the wide coverage it received in the recent years. It confirmed the TLD as a pertinent course of action for Canadian soldiers returning from deployed operations.

The CF TLD process provides a safe and relaxed environment to soldiers and enables the delivery of both a mental health and an R&R program. The delivery of such a program involves risks and challenges, which have been mitigated by the formation of multidisciplinary TLD teams and the implementation of sound procedures. Those procedures have evolved with each TLD and the accumulation of LL. Furthermore, soldiers are surveyed at the end of each TLD. It is a way to gather data and improve the process, based on the obtained feedback. Moreover, those same surveys are an indication of TLD's usefulness, based on soldiers' opinion. Short of having any empirical evidence, this is the only real measure of effectiveness currently available to determine TLD's success. It proved to be rather positive so far.

When comparing the CF TLD to what other like-minded nations are doing, it is interesting to note that the need to conduct decompression has been identified by other countries as well. Although there are some differences in the way the process is delivered, other nations have similar concerns and their intent is the same. Research for this paper showed that Canada is considered a leader among those like-minded nations, for the development of the TLD concept. Furthermore, the Canadian approach is consistent with what other nations are doing.

Even though Canada is a leader in the development and implementation of the TLD concept, improvements can still be made to the current process. The most significant potential improvements relate to the expansion of the TLD program, with a "Canadianisation" of some of its content and a widening of the mental health topics offered, in order to avoid redundancy for those going through TLD for a second or even a third time. Additionally, there should be an equitable access to TLD for all Canadian soldiers, regardless of the mission they served on and based on TF Comds' assessment. Those proposed improvements of the CF TLD program potentially involve the creation of a dedicated CF TLD team that could concentrate on both the development and steady improvement of the TLD concept and its standardized delivery.

PTSD and OSIs have become a part of today's military reality and the CF leadership cannot ignore their existence. Every effort must be made in order to mitigate their impact, be it on soldiers' quality of life or the military institution's productivity and effectiveness. The CF TLD is a concrete initiative, aimed at reducing that impact. It does not prevent PTSD and OSIs from emerging; however, it prepares soldiers for their transition back to family life, it teaches them to pay attention to PTSD and OSIs symptoms and it encourages them to seek assistance if necessary. Furthermore, since TLD is a leadership initiative, it indicates that military authorities expect that some will suffer from PTSD and OSIs following an operational deployment and that it is okay to come forward and ask for help.

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