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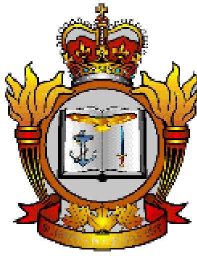

A LEADER CENTRIC APPROACH TO THE CAF SOLDIER SUPPORT SYSTEM

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By Maj S.A. Heer

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ABSTRACT

Soldier support is a shared responsibility between leaders, medical professionals, family members and individual members. Recognition of all support providers is important; however in order for the CAF soldier support system to be enhanced a greater onus must be placed on leadership. From an institutional perspective, as a result of the combat mission to Afghanistan, there has been a renewed focus on soldier mental health.

From a leadership perspective, guidance has been provided to assist leaders in fulfilling their responsibilities in sustaining the mental readiness of their personnel. However leaders face challenges fulfilling their roles in the current soldier support system where they are relegated to a supporting role. Leaders should take ownership of education and prevention of mental health in the CAF. Empowered and well-trained Non-Commissioned Officers and junior leaders are ideally suited to assume responsibility for the continuation of resilience training and the implementation of a formal peer support system. Moreover leaders should also take ownership of combatting stigma and barriers to care to mental health support by fostering a healthy climate where soldiers embrace their fighting spirit in order to enhance their well-being.

Leaders have taken great strides in increasing awareness for mental health issues in the CAF; however comprehension alone will not enhance the soldier support system. Leaders must lead the way in knowing their soldiers and promoting their well-being. This paper proposes a leader-centric approach to the CAF soldier support system focused on education, prevention and combating stigma and barriers to health.

The day soldiers stop bringing you their problems is the day you have stopped leading them. They have either lost confidence that you can help them or concluded that you do not care . . .

- General Collin Powell.[1]

INTRODUCTION

Leaders are responsible for people. This statement appears simple yet the responsibility of looking after people is one of the most challenging aspects of leadership. In the Canadian Armed Forces (CAF), promoting subordinate's welfare is an underlying principle engrained in leadership training and officer development. The maintenance of healthy personnel in physical terms has historically been thought to increase operational effectiveness and mission success. Over the past decade, mental health has also gained greater attention as leaders and health care professionals investigate how to maintain and strengthen the mental health of CAF personnel. The military exposes personnel to "unlimited liability" by frequently putting them in harm's way to achieve missions around the globe. Military leaders are therefore thought to have an increased responsibility to promote the health of their subordinates in comparison to supervisors in a civilian profession.

From an institutional perspective, the combat mission in Afghanistan has highlighted a renewed focus on soldier well-being and more specifically on mental health. Over 29,000 CAF members deployed to Afghanistan in support of the mission from its commencement in 2001. The mission was not without significant loss as 158 soldiers made the ultimate sacrifice for Canada. In addition between 2006 and 2011 the

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[1] NATO Research and Technology Organisation. (2008). *A leader's guide to psychological support across the deployment cycle " in NATO Technical Report - Stress and Psychological Support in Modern Military Operations RTO-HFM-081. France: NATO Research and Technology Organisation, 2008,* 327.

CAF reported more than 760 soldiers suffered from battle related injuries and there were over 1300 estimated cases of mental health related injuries.[2] The need for additional health services and research was recognized and significant commitments were made. The Canadian government committed an additional $11.4 million to improve the CAF mental health care system; this investment supplemented the $38.6 million spent annually in the field.[3] Moreover twenty-six mental health clinics and seven Operational Trauma and Stress Support Centers (OTSSC) were established across Canada.[4] In terms of research, in 2010, Queens University and the Royal Military College of Canada conducted the first Military Veterans Health Research (MVHR) forum. This forum was widely successful and resulted in the formation of the Canadian Institute for Military and Veterans Health Research (CIMVHR).[5] Today the organization has grown to coordinate the collaboration of work from thirty universities in an effort to address military health research for CAF members, veterans and their families.

The majority of soldiers within the CAF are functioning well, progressing with their military careers and living satisfying personal lives. Nevertheless, there are some members that struggle with mental health issues. In considering mental health issues, it is recognized that some soldiers will use programs that are available within the CAF while others prefer self-care. Some are able to work through their mental health issues while others develop more serious, chronic injuries that impact their professional and personal

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[2] Colonel Rakesh Jetly, "Mental Health, Leadership and Resilience in CAF"(lecture, Canadian Forces College Toronto, ON, October, 24 2013) with permission. This number is based on the OSI cumulative incidence study of 2011 and it is an estimate from a 5 year cumulative incidence.

[3] Canada. Department of National Defence. Backgrounder - Mental Health Services in the Canadian Forces - 12.043 - September 12, 2012. Last accessed on 21 January 2014. http://www.forces.gc.ca/en/news/article.page?doc=mental-health-services-in-the-canadian-forces/hgq87xjq.

[4] *Ibid.,*

[5] Stephanie Belanger and Alice A. Aiken. *A New Coalition for a Challenging Battlefield: Military and Veteran Health Research.* (Kingston: Candian Defence Press, 2012).

lives. The CAF continues to seek out improvements to assist soldiers with mental health issues and encourage those that need help to come forward. However, recent public scrutiny following the wake of a series of suspected CAF suicides have left many wondering if it is enough to deal with the complexity of issues facing today's soldiers, veterans and families.[6] Veteran's advocacy groups have raised a number of concerns with the military support system citing that too many veterans are slipping through the cracks without the proper services and support.[7] In the political arena, the Leader of the Opposition, Tom Mulclair has demanded that the Conservative Government take responsibility and address the crisis.[8]

Public opinion on soldier well-being can be shaped by an array of public figures, politicians, advocacy groups and soldiers themselves who have been increasingly vocal in their frustrations with a perceived lack of support they have received from the CAF. Moreover recent research has suggested that the media coverage of military suicides has the potential to shape unrealistic expectations and/or fear in members. *Archives in Suicide Research* article published in 2011 concluded that media articles covering military suicides tended to refer to ineffective behavioral health treatment as a contributor to the suicide. "Such emphasis can imply that seeking help for depression and suicide may lead

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[6] Chris Cobb. "Canada's military confirms another suicide amidst criticism", *Ottawa Citizen*, January 9, 2014. Last accessed on 21 January 2014. http://www.ottawacitizen.com/news/Canada+military+confirms+another+suicide+amid+renewed+criticism/9369926/story html

[7] Canadian Veterans Association website, *Mental Health Alert – Suicide prevention – Buddy System,* posted by Mike L. Blais on 21 December 2013. Last acessed on 21 January 2014. http://www.canadianveteransadvocacy.com/blog/?p=919,

[8] Canadian Press, "Mulcair urges Harper to address military suicides amid word of another death", *Maclean's*, 10 January 2014. Last accessed on 21 January 2014. http://www2.macleans.ca/2014/01/10/mulcair-urges-harper-to-address-military-suicides-amid-word-of-another-death.

to suicide instead of preventing it."[9] Although research of this kind is in its infancy, the findings are important in a military culture where combating the stigma associated with mental health illness is an ongoing issue.

The highest levels of government and leadership have responded to the criticisms. The Prime Minister and Minister of National Defence both stated on numerous occasions the government's commitment to CAF soldiers. CAF senior specialist officers have also provided their medical expert opinions. Deputy Surgeon General, Colonel MacKay, Director of Mental Health, Colonel McLeod and Senior Psychiatrist Colonel Jetly all reached out to the media in an attempt to educate the public on the strengths of the CAF medical system.[10] Most notably, on December 4, 2013, the Chief of Defense Staff (CDS), General Lawson released a public service video addressing his stance on soldier mental health.[11] The CDS began by asserting that the health care system within the CAF is exceptional. He then went further and stated:

> As you're already aware, we each have a role to serve in identifying and assisting those affected by mental health concerns. Don't underestimate the direct, positive impact you can have as a leader, as a friend, or as a subordinate. We can all note changes in behavior, we can all listen to each other, and we can all aid in seeking help.[12]

General Lawson recognized a shared responsibility in addressing soldier's mental health. Additionally, his public message communicates a clear commitment by the highest level

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[9] Amanda Edwards-Stewart, Julie T. Kinn, Jennifere D. June and Nicole R. Fullerton. "Military and Civilian Media Coverage of Suicide," *Archives of Suicide Researc 14, no 4 (2011):309.* Last accessed on 4 March 2014. *http://www.tandfonline.com/doi/abs/10.1080/13811118.2011.615692#.UxXhiU8o6P8*.

[10] Chris Cobb. "Top medical officers offer a defence of the military's mental health system," Ottawa Citizen, December 21, 2013. Last accessed 21 January 2014. http://www.ottawacitizen.com/news/medical+officers+offer+defence+military+mental+health+system+with+video/9312191/story html,

[11] Canada. Department of National Defence. Video - Statement by General Lawson on Mental Health in the Canadian Armed Forces, 4 December 2013. Last accessed 21 January 2014. http://www forces.gc.ca/en/video.page?doc=statement-by-general-lawson-on-mental-health-in-the-canadian-armed-forces/hosl5n9p.

[12] *Ibid*.,

of leadership to improve the soldier mental health system in the CAF. An essential follow up question is how does this commitment translate into action for first line leaders who directly influence soldiers?

In order to explore how leaders can positively impact soldier mental health, a comprehensive understanding of the CAF soldier support system is necessary. The CAF soldier support system is made up of a number of key players. Health care providers, leaders, family members and individuals themselves all impact soldier support. There is no mistaking the considerable amount of resources and research that have been invested in order to improve the mental health within the CAF or the commitment of our institutional leaders. However this investment appears to be mostly focused on enhancing the medical support system while other components of the soldier support system, such as leadership assume a supporting role. This paper will contend that the CAF should adopt a leader-centric approach to the soldier support system where leaders are the primary agents of soldier well-being.

In order to develop the leader-centric approach to soldier support this paper will be broken down into three chapters. The first chapter will commence with an overview of the current situation within the CAF in order to identify potential areas that could be further developed. The chapter will also describe the current CAF medical support system which consists of a variety of clinical and non-clinical resources that are available for soldier support. In addition this chapter will highlight some key areas of research that have been pursued to date relating to soldier mental health. The second chapter will use the current institutional guidance and direction that has been issued to CAF leadership to discuss the current roles of leaders in soldier support. This chapter will identify key areas

where potential challenges exist for leaders. The third chapter will commence with an expansion of the soldier support system to include the role of individuals and families in the social support structure. With all the components of the soldier support system examined, this paper will present the leader-centric approach to soldier support that specifies where leaders will have the greatest impact on soldier well-being.

Given the vast scope of mental health in the military and society as a whole, this paper will solely focus on the support system for currently serving Regular and Reserve Force members, understanding the magnitude of issues facing retired veterans should not be underestimated and is considered to be an extremely worthy topic for future research.

CHAPTER ONE

THE CURRENT MENTAL HEALTH SITUATION

> *. . . Like all Canadians, it is essential that military personnel and former members alike recognize mental health issues when they occur. I want to remind those who may be going through difficult times that they are not alone and there is support available to get them through this. As Canadians and members of the Canadian Armed Forces, we must all be vigilant of our subordinates, peers, superiors and family members . . .*
>
> *- The Honourable Rob Nicholson, MND*[13]

INTRODUCTION

Personal well-being and mental health initiatives are not unique to the CAF. A great deal of resources and financial investment has been committed across Canada to improve mental health awareness in today's society. What is unique however is the

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[13] Canada. Department of National Defence. Statement by Minister Nicholson on Mental Health in the Canadian Armed Forces, NR - 13.358 - December 4, 2013. Last accessed 21 January 2014. http://www forces.gc.ca/en/news/article.page?doc=statement-by-minister-nicholson-on-mental-health-in-the-canadian-armed-forces/hosl5n7x.

significant responsibility the institution carries to take care of its members and their families. The CAF Profession of Arms cornerstone publication, *Duty with Honour*, discusses the " . . . extraordinary relationship of trust among the people of Canada, the Canadian Forces as an institution and those members of the Forces who have accepted "unlimited liability" inherent in the profession of arms.[14] Moreover there has been a perception of enhanced public support and gratitude for the military in recent years. This support can be contributed to a number of factors, such as the increased risk and adversity to soldiers along with the ultimate cost of human lives.[15]

In order to fully understand the complexities of a soldier's support system it is essential to gain a better appreciation for the current situation within the CAF. This chapter will be broken into two sections. The first section will summarize the current state of mental health within the CAF as it compares to Canadian society, this will also include a detailed look at suicide within the CAF as these personal tragedies often cause the soldier support system to face close scrutiny in the public domain. The second section of this chapter will discuss the current mental health strategy within the CAF and the enhancement of resources and overall medical care that have occurred over the past two decades.

Prior to delving too fully into the topic it is useful to briefly discuss the links between some of the key terms that will be used throughout this paper. Well-being is a term that is used in a variety of contexts and therefore has varying definitions throughout the academic, military and medical communities. In a military context the term soldier

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[14] Canada. Department of National Defence. A-PA-005-000/AP-001. *Duty with Honour: The Profession of Arms in Canada 2009*. (Ottawa: DND Canada, 2009), 4.

[15] Canada. Department of National Defence. A-PA-005-000/AP-004. *Leadership in the Canadian Forces: Conceptual Foundations*. (Ottawa: DND Canada, 2005), xv.

wellness, welfare and well-being are often used interchangeably. The US Army defines soldier well-being as "the personal—physical, material, mental, and spiritual— state of Soldiers [Active, Reserve, Guard, Retirees, Veterans], civilians, and their families that contributes to their preparedness to perform and support of the Army's mission."[16] The recent *Canadian Armed Forces (CAF) Surgeon General Mental Health Strategy Report* focuses more specifically on mental health as a state of well-being, using the following World Health Organization (WHO) definition of mental health:

> "Mental health is a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.[17]

This paper will assume that soldier well-being is an all-encompassing term and therefore define it as state of being that includes mental, social and physical health. This paper will concentrate specifically on the mental health aspects of soldier well-being and how it is supported in the CAF.

MENTAL HEALTH IN CANADIAN SOCIETY AND THE CAF

Is there a mental health crisis is the CAF? Are soldiers worse off than Canadian citizens? Politicians such as Thomas Mulcair and Veterans Advocacy leaders such as Mike Blais have argued that the system needs improvement and is looking to the government and the CAF to make the necessary changes. [18] The Canadian Government

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[16] Department of the US Army, Vice Chief of Staff. Well-Being Strategic Plan. Office of Vice Chief of Staff: Washington, 5 Jan 2001. Last accessed on 21 January 2014. http://www.armyg1.army.mil/hr/wellbeing/StratPlan.doc.

[17] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence.* (Ottawa: DND, 2013), 3.

[18] Canadian Press, "Mulcair urges Harper to address military suicides amid word of another death", *Maclean's*, 10 January 2014. Last accessed on 21 January 2014.

and DND leadership continue to promote the system as sufficient to address the needs and concerns of the CAF. An interesting start point for the discussion is to examine the status of mental health in Canadian society and how it relates to the CAF. The Surgeon General's Mental Health Strategy Report, published in 2013 stated that "Mental illness in Canadian society poses a greater burden of disease on the health care system than all cancers combined, and one in five Canadians will develop a mental illness in their lifetime."[19] The Canadian Mental Health Association in 2003 advised that nearly one million Canadians were living with a severe mental illness.[20] The Mental Health Commission of Canada has stated that the number of Canadians suffering from mental health illness has increased dramatically to 6.7 million in 2013.[21] Moreover the cost on the Canadian economy for mental health problems and illnesses is estimated to be close to $50 billion (approximately 2.8% of GDP) per year.[22] The impact on the Canadian workplace is staggering with estimates ranging as high as 30% of all short term disability claims being attributed to mental health problems and upwards to 80% of all long term disability claims.[23] These national indicators suggest that the scope of mental illness is growing in the country and will continue to be a drain on the nation's health care systems and economies unless improvements are made.

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http://www2.macleans.ca/2014/01/10/mulcair-urges-harper-to-address-military-suicides-amid-word-of-another-death.

[19] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence.* (Ottawa: DND, 2013), 3.

[20] Canadian Mental Health Association, Citizens for Mental Health, *Backgrounder: Mental Illness in Canada.1 April 2003.*Last accessed 21 January 2014. *http://www.cmha.ca/public-policy/backgrounders/*.

[21] Mental Health Commisison of Canada. *Why Investing in Mental Health will contribute to Canada's economic prosperity and to the sustainability of our health care system: backgrounder- key facts*, 21 Mar 2013, 1. Last accessed 21 January 2014. http://www.mentalhealthcommission.ca/English/document/5210/making-case-investing-mental-health-canada-backgrounder-key-facts?terminitial=41.

[22] *Ibid.*, 2.

[23] *Ibid.*, 2.

As the CAF is a subset of Canadian society it is natural to assume that the organization will have similarities to society in regards to mental health.[24] In 2002, the similarity was confirmed with the CAF Mental Health Survey that concluded that 15% of all CAF personnel experienced one of five common mental health symptoms in the previous year.[25] This survey was significant as it was conducted by Statistics Canada on behalf of the Surgeon General of the CAF as military personal were often excluded from regular Statistics Canada's health surveys. Although similarities were observed between the CAF Mental Health Survey and surveys of Canadian society, it should be noted that this survey was conducted prior to the CAF commitment to Afghanistan. Additionally not all the questions were directly comparable to the civilian version of the survey therefore any similarities must be weighed carefully.

In 2008/2009 a Health and Lifestyle Information Survey (HLIS) was conducted by Directorate of Force Health Protection (DFHP) and the Canadian Forces Health Services Group Headquarters (CF H Svcs Gp) . The aim of the survey was to assess the overall physical and mental health status of CAF members.[26] In an attempt to determine the prevalence of a major depression disorder in CAF members, the survey concluded that 7% of those surveyed would have screened positively for depression.[27] There are limitations with the results of the HLIS as it did not use the same metrics as the Statistics Canada surveys and also did not have the same response rate or depth. The HLIS also does not account for which mental health systems were accessed for operational or non-

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[24] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (*Ottawa: DND, 2013), 3.

[25] *Ibid.,*3. Five common systems were depression, phobia, PTSD, panic attack, and anxiety.

[26] Canada. Department of National Defence. *Results from Heatlth and Lifestyle Information Survey of Canadian Forces Personnel 2008/2009: Regular Force Version*. (Ottawa: DND, 2009), 13.

[27] *Ibid*., 32.

operational reasons. Therefore the results of the HLIS may be effective in conducting a broad comparison within the CAF but it is limited when comparing the CAF to the rest of Canadian Society. Although the results of both the 2002 and 2011 surveys have limitations, both surveys have been used in recent CAF reports to demonstrate a stable and well managed mental health system in the CAF.

Although general similarities can be found in comparing CAF mental health statistics to those of the general Canadian population, there are some key differences between the CAF and Canadian society in regards to mental health and mental illness. First, given the dangerous environments that CAF members operate in, there is a higher prevalence of mental illness symptoms in military members than Canadian civilians.[28] Secondly, in the CAF, it is necessary to evaluate the impact operational deployments have on the prevalence of mental health illnesses. In 2011, CF H Svcs Gp published an Operational Stress Injury (OSI) Cumulative Study that showed that 13% of personnel who deployed to Afghanistan (up until 2008) were reporting to have experienced OSI related symptoms after more than four years of follow up.[29] This study demonstrated that combat exposure is a potential risk factor for mental health issues. It is important to note that the reporting of OSI symptoms does not equate to a medical diagnosis of Post-Traumatic Stress Disorder (PTSD) which is a medical diagnosis made by a medical mental health professional, such as a psychiatrist. Moreover, the OSI study only covers three years of combat from 2005-2008, it does not account for the additional years of combat that CAF personnel conducted in Afghanistan or the potential impact that

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[28] *Ibid*., 3.

[29] David Boulos, and Mark A. Zamorski. "Deployment-related mental disorders among Canadian Forces personnel deployed in support of the mission in Afghanistan, 2001–2008." *Canadian Medical Association Journal* 185 no. 11 (6 August 2013): E548.

multiple tours could have on the prevalence of mental illness symptoms in soldiers. Additionally this study was not able to determine if there is any mental health significance to the amount of time individuals have between tours or how reconstitution activities can influence the prevalence of mental health injuries post deployment. With the close out of the Afghanistan mission, additional research is being initiated to gain a more thorough understanding of the impact operational deployments have on soldier well-being.

Thirdly, a major difference that should be considered when comparing the CAF to Canadian society is the unique composition of the military workforce. Although within Canadian society there are part time and full time employees, in the CAF when called upon, reserve members deploy in dangerous environments with regular force members. Some have suggested that the stress on reserve force members on deployment may be greater than for regular force soldiers.[30] Reserve soldiers face unique stressors due to their part-time military status. Irregular interaction with members of their deployed units and having to return to a civilian full-time job upon their return from deployment are just two examples of the unique stressors that reserve soldiers face. However the *Surgeon General Mental Health Strategy* asserts that there is no increased risk to one group over the other in developing a mental illness. "In fact, the research based from the 2002 CF mental health survey suggests that CAF Reservists appeared to have slightly better mental health, on average, than Regular Force personnel."[31]

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[30] Timothy Wells et Al. "Mental health impact of the Iraq and Afghanistan confl icts: A review of US research, service provision, and programmatic responses", *International Review of Psychiatry*. (April 2011; 23), 146.

[31] David Boulos, and Mark A. Zamorski. "Cumlative Incidence of PTSD and Other Mental Disorders in Canadian Forces Personnel Deployed in Support of the Mission in Afghanistan, 2001-2008". Report prepared for the *Surgeon General's Health Research Program (SGR-2001-002).* Ottawa: DND Canada,

Currently there are no all-encompassing CAF statistics published that provide the total number of mental health illnesses or injuries within the CAF on a yearly basis. Using the 2011 study, an approximate figure of 1300 mental health injuries in the CAF has been assessed by subject matter experts, such as Colonel Jetly based on the five year cumulative incidence from 2006-2011.[32] In addition the final draw down of CAF personnel from Afghanistan in March 2014 adds another layer of complexity to assessing mental health in the CAF as it will take considerable time to analyse the true extent of how over a decade of combat in a counter-insurgency fight has impacted the mental health of CAF members. For this reason, the CF H Svcs Gp is currently working with Statistics Canada in the conduct of the 2013-2014 Mental Health Survey on the Prevalence of Mental Illness in the CAF. The focus of this survey is to determine the mental health impact of the Afghanistan mission and to assess the performance of the CAF mental health system.[33] In addition this survey could provide greater insight on whether the prevalence of mental illness is increasing within the CAF or remaining consistent with the national averages.

SUICIDE IN THE CAF

It is beyond the scope of this paper to discuss all the threats to soldier well-being; however it is recognized that along with the clinical threats to well-being, occupational psychologists continue to investigate the non-clinical threats such as burnout and its

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2011., 4. The document does not provide details of the research other then to state that three large population based studies were conducted.

[32] Colonel Rakesh Jetly, "Mental Health, Leadership and Resilience in CAF"(lecture, Canadian Forces College Toronto, ON, October, 24 2013) with permission. This number is based on the OSI cumulative incidence study of 2011 and it is an estimate from a 5 year cumulative incidence.

[33] *Ibid*., 10.

impact on well-being. The threat of suicide will be examined in this section due to the gravity and seriousness of the act. Suicides within the CAF are not normally made public. Guidelines exist to ensure that only those suicides involving significant public figures are to be reported to the media.[34] However the number of suicides in recent months has led to increased media and national attention.[35] Suicides are tragic whether it be an everyday Canadian or a CAF member, however when a soldier commits such a desperate act, there is an immediate emotional response by both institutional leaders and recently the public. This response is normally one of shared responsibility. Questions such as "Was the member deployed to Afghanistan? Does the member suffer from PTSD or depression? Did he/she get enough help?" are almost immediately asked.

In the United States Army suicide rates have doubled over the past decade and increases have also been identified in the United States Marine Corps (USMC).[36] In 1996, the United States Air Force (USAF) took action after witnessing a steady increase in the number of suicides amongst their ranks. The USAF developed a comprehensive Suicide Prevention programme to address the issue and has seen a significant decrease since the program was introduced.[37]

From a CAF perspective "A *Report of the Canadian Forces Expert Panel on Suicide Prevention*" was published in 2010. This report explains that suicide is the second leading cause of death amongst middle age men in Canada, which is a demographic that

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[34] Mark A. Zamorski, *Report of Canadian Forces Expert Panel on Suicide Prevention. (*Ottawa: DND Canada, 2010), 25.

[35] The recent media attention could be viewed as cyclical. In the 1980s and 1990s following several suicides in a short period of time there was also an increase in media interest.

[36] *Ibid.,* 8.

[37] Kerry L Knox, Litts D.A, Talcott GW, Feig JC, Caine ED. "Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study." *British Medical Journal* 327 (2003): 1376.

makes up a large component of the CAF.[38] However CAF suicides are 20% lower than the Canadian population of the same age and sex.[39] Moreover the report also concluded that despite increases in deployments to Afghanistan, there was no increase in the male suicide rate up to and including 2008. A follow up Surgeon General Report was published in July 2013 that also concluded that there were no statistically significant increases in suicide rates from 1995-2012 within the CAF and history of deployment does not increase one's risk factor for suicide.[40]

It is difficult to draw broad comparisons between the US military suicide increases and the consistent CAF numbers. Not only are their structural differences in the organizations themselves, but there are also significant differences in tour lengths of Forces. US personnel can deploy for upwards of twelve months whereas the majority of CAF deployments are six months in duration. Moreover the availability to lethal means through hand guns in the US may also have implications on the increased suicide rate.

In addition comparing Canadian society suicide rates to those in the CAF may not provide any insight on whether the CAF has issues with suicides. Suicide rates in Canada were consistently decreasing on an annual basis between the mid 1980's and 2006.[41] However since 2006, suicides in Canada have gradually increased and are now 11.1% per

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[38] Mark A. Zamorski, *Report of Canadian Forces Expert Panel on Suicide Prevention. (*Ottawa: DND Canada, 2010), 8.

[39] *Ibid*., 2. This statistic may seem logical given that the CAF screens out serious MH illnesses that are a huge contributor to suicides in Canada.

[40] Canada. Department of National Defence. "Suicide in the Canadian Forces 1995-2012". *Surgeon General report. Surgeon General research program SGR-2012-011*. (July 2013),.i. The number of Regular Force male suicides was generally lower than that expected based on Canadian male suicide rates. SMRs comparing CAF suicide rates by deployment history to Canadian suicide rates demonstrated that the number of Regular Force male suicides was consistently less than that expected based on Canadian male suicide rates. Rate ratios indicated that those with a history of deployment were not at an increased risk of suicide compared to those who have never been deployed.

[41] The Conference Board of Canada. "Suicides". Last assessed 5 April 2014. http://www.conferenceboard.ca/hcp/details/society/suicides.aspx

100,000 people, which is up from 10.4 % in 2006.[42] Moreover in comparison to other peer countries Canadian suicides rates are higher then Italy, Australia and the UK.[43] The investigation and comparison of statistics with other militaries, Canadian society and other countries around the world do not necessarily provide any insight on the scope of any potential suicide or mental health issue in the CAF. Furthermore if statistics are not the best measure for determining whether we have a suicide issue in the CAF what is? This question is not easily answered as there are various factors that need to be considered.

One conclusion that can be made is that the onus of responsibility does not solely lie on the CF H Svcs Gp, even though considerable responsibility has been placed on this organization to guide the CAF soldier support system. The next section of this chapter will examine the CAF medical system, through the CF H Svcs Gp in greater detail by describing the programs and services that are available in the CAF to contribute to the soldier support system.

CAF MENTAL HEALTH PROGRAMS AND SERVICES

The CAF medical system has been constantly evolving over the last two decades. In the mid-1990s, there were significant reductions with the rationalization of the CF H Svcs Gp. This was followed by significant reinvestment and reform in the early 2000s and a significant increase in resources and initiatives as a result of the beginning of

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[42] *Ibid*.,

[43] *Ibid*., Canadian suicide rates are nearly double those of Italy which is assessed as having the lowest peer county suicide rate.

combat operations in Afghanistan.[44] A historical perspective ofthe reports and policy changes in the evolution of care is provided in Figure 1.1.

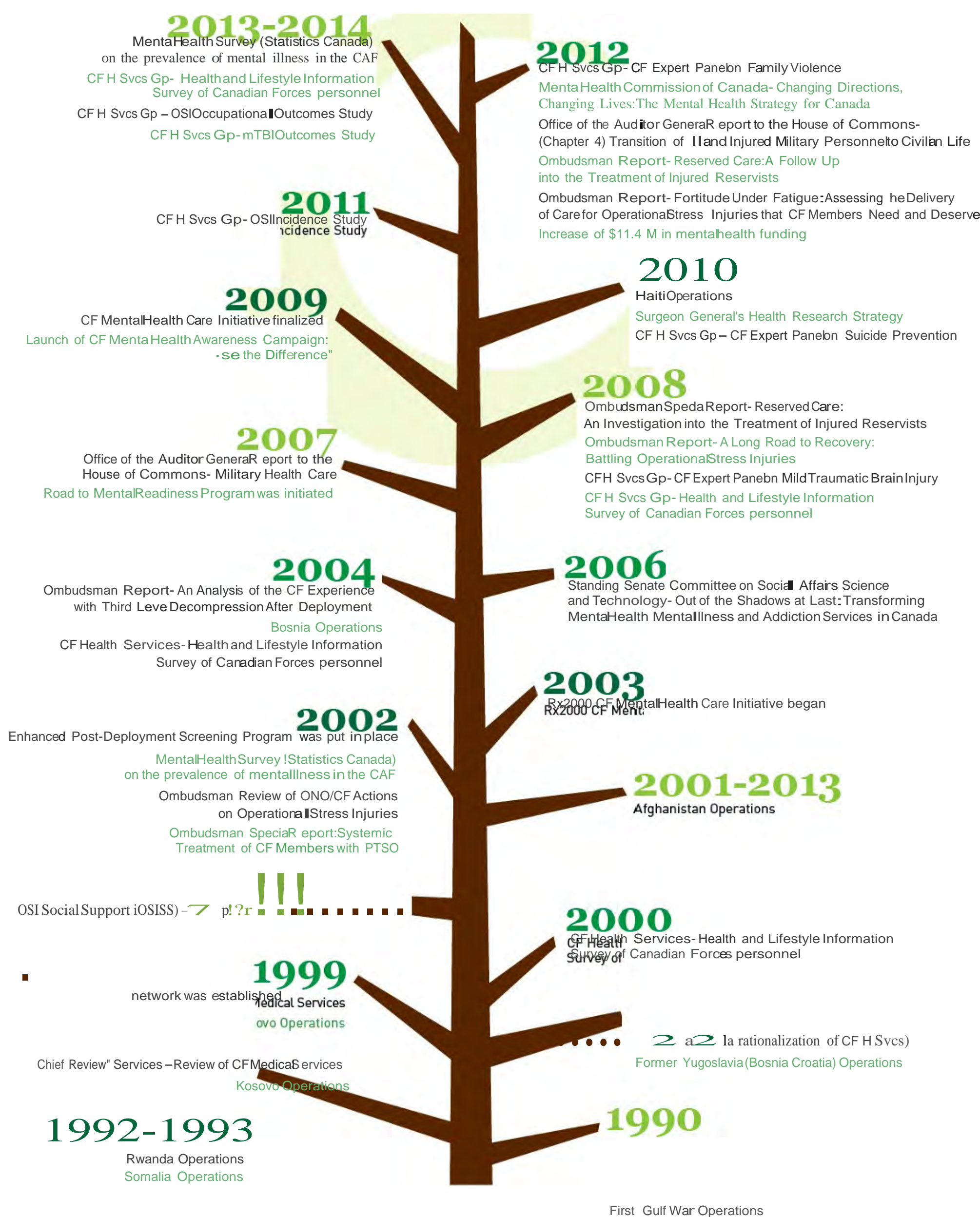

Figure 1.1 – CAF Mental Health Programs and Services – A Historical Perspective
Source: *Surgeon General's Mental Health Strategy,* 8.

[44] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence.* (Ottawa: DND, 2013), 8. Note this figure does not include the initial Ombudsman's reports in 1998 which led to the CRS review in 1999.

The mental health system of the CAF provides programs and services that cover three components: *Understand, Educate and Care*.[45] These three components will be used to categorize the services and programs that are available within the CAF.

UNDERSTAND

In this component the CF H Svcs Gp focus is mental health research. The CF H Svcs Gp understands that the military is faced with unique mental health challenges and that they are required to be on the leading edge of research if enhancements to the CAF medical system are going to be timely and productive.[46] The CF H Svcs Gp, through the Surgeon General's Health Research Program is working hand in hand with CIMVHR and the Defence Research and Development Canada (DRDC) to conduct research on a variety of topics that includes: reducing self-termination of care and increasing tolerance to therapies; expanding the understanding of the psychological underpinnings of PTSD; exploring novel therapeutic approaches to mental health; and validating a multidisciplinary approach to PTSD treatment.[47] In addition to the research areas already mentioned some of the most current examples of research projects are the following:

- 2013 CAF Cross-Sectional Mental Health Survey[48]
- OSI Incidence and Outcomes Study[49]

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[45] *Ibid*., 8.

[46] *Ibid*., 10.

[47] *Ibid*., 10. Although it is beyond the scope of this paper to discuss all areas of research, it is recognized that considerable research is also being conducted on non-clinical aspects of mental health such as burnout. Burnout has a significant impact on well-being even though it is not a clinical diagnosis. Considerable work is being done in the occupational health psychology field on burnout.

[48] *Ibid*., 10. This survey of approx. 9000 Reg F and Res F personnel is conducted by Stats Canada, focusing on mental health impact of the Afghanistan Mission and the performance of the CAF mental health system.

- Group Randomized Trial of Road to Mental Readiness (R2MR) in CAF Recruits.[50]

All of these topics are extremely relevant to enhancing the mental health of CAF members however little research appears to focus on a larger holistic approach to the soldier support system which involves incorporating leadership and the chain of command into the system.

EDUCATE

The *Educate* component of the mental health system is focused on mental health training and education systems for all members of the CAF. The key evidence based program is the Road to Mental Readiness (R2MR) program that was introduced in 2007.[51] "R2MR is based on the principles of sports psychology and is designed to demystify mental illness, provide individuals with tools for dealing with stressful situations and reduce the risk of developing mental illness."[52] R2MR incorporates the Mental Health Continuum Model (MHCM) that was adopted from the USMC. This model highlights a continuum that exists between the state of good mental health and a serious mental health illness.[53] This continuum along with the R2MR program have been incorporated into a variety of training packages that are conducted throughout a CAF member's career including pre-deployment, post-deployment and during career courses.

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[49] *Ibid*., 10. This study looks at OSI diagnoses and occupational outcomes in a random sample of those deployed in support of the mission in Afghanistan from 2001-2008.

[50] *Ibid*., 10. This study randomizes over 1000 CAF recruits to receive R2MR training or a control intervention. It will evaluate the effect of R2MR on well-being, stress, strain and attitudes towards mental health care.

[51] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence.* (Ottawa: DND, 2013), 12.

[52] *Ibid*., 12.

[53] *Ibid*., 12.

Additionally in recent years, the R2MR program has also been conducted in conjunction with the Military Family Resource Centers (MFRC) across Canada to ensure both family members and CAF members are receiving the same skills and knowledge to recognize and understand mental illnesses.

The CAF Surgeon General recognized that "performance measurement and quality improvement are essential for all health systems . . ."[54] The R2MR program is part of the system and therefore requires comprehensive evaluation of the program to ensure the goals of the program continue to be met. There are a number of different educational programs being implemented in various militaries around the world. Two such programs that will be described in greater detail in follow on chapters are the Trauma Risk Management (TRiM) program in the UK[55] and the 360 degree Program[56] used by the US Army.

It is recognized however that it is difficult to measure the effectiveness of broad-scale preventative training programs. Moreover, a program that is effective in one organization may not have similar utility in another depending on cultural and organizational differences. US researchers Paul Bliese, Amy Adler and Carl Andrew Castro explored the efficacy of large-scale preventative mental-health programs on different organizations.[57] They concluded that individuals in the same work group share

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[54] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (*Ottawa: DND, 2013), 20.

[55] N. Greenberg, V. Langston, A. C. Iversen and S. Wessely, "The acceptability of 'Trauma Risk Management' within the UK Armed Forces," *Occupational Medicine* 61, 3(April 2011):184. Overview of TRiM Program attached in Appendix 1.

[56] Hope Mypers. "Soldier 360 brings hope, healing to Bragg Troops," *The Paraglide* (14 Febuary 2014) Last accessed on 18 Febuary 2014 http://paraglideonline.net/articles/2014/02/14/Soldier-360-brings-hope,-healing-to-Bragg-troops

[57] Amy B., Alder, Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 104.

similar mental health variables and therefore these small group level properties should be leveraged when designing education programs to increase the efficacy of the program.[58] They also concluded that instead of focusing on attempting to apply programs universally in large scale groups, programs are more useful if they are designed to demonstrate specific effects for a group.[59] Although smaller group programs may be more effective for mental health programs they are also more time consuming and costly. However the CAF initiative of building R2MR into foundation training at all levels as well as providing it to family members in various venues demonstrates an attempt to enhance the effect of R2MR using smaller group level implementation.

The evaluation of resiliency programs such as R2MR is challenging. Self-report tools are often used for assessment of education programs, however the validity and reliability of these tools remains controversial.[60] Determining whether a program can actually change behavior or attitudes for the long term and have sustainable effect on an individual is likely a stronger evaluation measure then self-reporting however it is also more difficult to determine as it takes a longer period to assess. Additional research is necessary to determine whether there are more efficient assessment tools then self-reporting for the R2MR program.

In addition to R2MR, the CF H Svcs Gp's DFHP also works closely with the Canadian Forces Morale and Welfare Services in the delivery of their health promotion and awareness services (Strengthen the Forces (STF) Program) to CAF members. The

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[58] *Ibid*., 104.

[59] *Ibid*., 120-121.

[60] Brenda J. Morgan and Sandra C. Garmon Bibb. "Assessment of Military Population-Based Psychological Resilience Programs," *Military Medicine* 176, no 9 (September 2011), 982. Evidence-based intervention programs are suggested to be a more reliable assessment tool then self-reporting surveys.

four major areas of interest for STF are: addictions awareness and prevention, injury prevention and active living, nutritional wellness and social wellness.[61] Valuable courses are offered at CAF establishments across the country on topics that include stress management, anger management, suicide awareness, healthy interpersonal communications and family violence awareness and prevention. These courses have been incorporated into most units' annual training plans to ensure a sufficient number of personnel are qualified in health promotion. Although some courses suggest a minimum rank for attendance, there does not appear to be a focus on specific leaders attending these courses.

In regards to education, the Surgeon General has recognized that the responsibly must be shared amongst all elements of the CAF, including the institutional leaders. A key initiative that highlights the shared education responsibly is the establishment of the Mental Health Education Advisory Committee to coordinate all mental health education programs. This committee is chaired by the Director of Mental Health and includes representatives from all operational branches of the CAF, as well as the Chaplain branch, Directorate of Family Services and Directorate of Military Personnel Operational Research and Analysis and DRDC.[62] The establishment of this committee along with the joint effort to educate all members of the CAF demonstrates an attempt by the CF H Svcs Gp to broaden the scope of awareness on mental health in the CAF. It also perhaps is an attempt to increase the responsibility of those components external to the CF H Svcs Gp to play a greater role in the soldier support system.

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[61] Canada. Department of National Defence. *Strengthening the Forces: The CAF's Health Promotion Program* 23 July 2013. Last accessed 24 March 2014. http://www forces.gc.ca/en/caf-community-health-services-wellness/index.page?

[62] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (*Ottawa: DND, 2013), 13.

CARE

The *Care* component of the mental health strategy encompasses all the CF H Svcs Gp services that are available to CAF across the country and internationally on overseas deployments. Currently there are nineteen CF Health Service Centers and sixteen Detachments at Bases across Canada and in Europe.[63] There are also twenty-six mental health clinics in Canada with the five largest mental health clinics operating in Halifax, Esquimalt, Valcartier, Ottawa and Edmonton. These clinics provide a full range of care including addictions counseling, psycho-social support and operational trauma and stress support.[64] There are also seven Operational Trauma and Stress Support Centers (OTSSC) operating in key centers spread across the country. These facilities are considered centers of excellence in caring for those suffering from PTSD.[65] In addition there are OSI clinics established throughout Canada that have shared DND, Veterans Affairs and RCMP funding. All of these facilities and services incorporate a multidisciplinary approach using a wide variety of mental health care professionals.

A mental health care professional can be defined as anyone providing clinical support; it includes primary care clinicians, mental health nurses, psychiatrists, psychologists, social workers, additions counselors and others.[66] The current strength of the CF H Svc Gp is 6610 personnel which comprise both Regular and Reserve Force,

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[63] *Ibid*., 14.

[64] Canada. Department of National Defence. Backgrounder - Mental Health Services in the Canadian Forces - 12.043 - September 12, 2012, Last accessed on 21 January 2014. http://www.forces.gc.ca/en/news/article.page?doc=mental-health-services-in-the-canadian-forces/hgq87xjq.

[65] *Ibid*.

[66] *Ibid*., 14. Also in NATO - A leader's guide to psychological support across the deployment cycle, 2008, p 320 states that Psychological Support Professionals is a broad term that encompasses a range of disciplines including psychiatrists, psychologists and social workers.

Public Service employees and civilian contractors.[67] Currently there are 397 mental health care professionals working in support of the CAF.[68] Recent political and public debate has suggested that this number is insufficient and has resulted in a nation-wide recruitment drive to attempt to hire additional health care professionals to increase the total number to more than 450 mental health professionals including administrative and clinical staff.[69] This target would see the CAF with the highest ratio of mental health care providers to service members in NATO.[70] Although the commitment to increasing qualified staff is evident in the CAF, the question remains whether soldiers will access the services that these medical professionals can provide.

Since 2002, the CF H Svcs Gp has been working to improve the access to care for CAF members and studies have shown that CAF members are significantly more likely to receive care then the average Canadian.[71] Moreover increased awareness and education has seen an increase in the number of soldiers seeking mental health support post deployment. A survey conducted following Op ARCHER/Rotation 1 in Afghanistan in 2007 found that 32% of soldiers sought mental health support in the first twelve months following their deployment.[72] In addition, the 2008/2009 HLIS survey found that, out of all the Regular Force members that conducted the survey, 31.8% had consulted a health care professional about their mental health in their lifetime, and approximately 15% had

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[67] Canadian Forces Health Service Group Headquarters. "Strategic Concepts, Performance Measurement". *PAA PMF 4.1.8: Military Health Care Program Measurement Report December 2013.* The strength of the CFHS was reported as 2966 RegF, 1600 ResF, 1536 public service, 508 contractors (Calian) for a total 6610 personnel.

[68] Lieutenant-Colonel Laplante. *Big Picture Staffing Summary for the CAF Mental Health Program*.

[69] *Ibid*.

[70] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence.* (Ottawa: DND, 2013), 14.

[71] Mark A. Zamorski, *Report of Canadian Forces Expert Panel on Suicide Prevention.* (Ottawa: DND Canada, 2010), 29.

[72] *Ibid*. 29.

consulted a health care professional in the 12 months prior to the survey.[73] Moreover 78% of those that sought medical assistance were satisfied with the care that they received.[74] Perhaps a more telling statistic from the HLIS survey was that 89% of those surveyed did not feel they required any mental health care and did not perceive any barriers to care, but there was also 11% that felt they needed care and did not receive it.[75] A structural barrier to mental health care that was identified in this survey was that personnel did not request assistance due to a belief that asking for help would negatively affect their career. This negative stigma to receiving care may be a potential institutional barrier to enhancing a soldier's support system. This issue will be analyzed further in chapter 2.

The current medical mental health strategy is a logical framework for addressing the mental health needs of CAF members. The three components of *understand*, *education* and *care* have all seen significant improvements over the years in the services provided by the CF H Svcs Gp. However there are also additional resources available to CAF members that are not strictly medical in nature. These resources cover a wide range of services including: pastoral care (Chaplain Branch), mental health education (Joint Speakers Bureau), military family support (MFRC) as well as casualty support for ill and injured by the Directorate of Casualty Support Management (DCSM) through the Joint Personnel Support Unit (JPSU). Moreover the recent January 2014 announcement of a 24/7 expanded toll-free support line for Military members and families is another

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[73] Canada. Department of National Defence. *Results from Heatlth and Lifestyle Information Survey of Canadian Forces Personnel 2008/2009: Regular Force Version*. (Ottawa: DND, 2009), 35.
[74] *Ibid*., 37.
[75] *Ibid*., 37.

example of a valuable resource that is available.[76] It is beyond the scope of this paper to describe the full range of these services and programs however a brief overview of the current status of the Joint Personnel Support Unit (JPSU) will be discussed as this unit has become an increasingly important resource for ill and injured soldiers within the CAF including those suffering from mental health related illnesses.

CURRENT STATUS OF THE JOINT PERSONNEL SUPPORT UNIT

In 2009 the CDS approved the stand-up of the JPSU in order to ensure consistent quality of care for CAF ill and injured members. These units were deemed necessary given the increased tempo of operational deployments and the subsequent requirement for more individualized care for casualties and their families. Individual units were deemed to be insufficient in dealing with casualty support as it became increasingly more complex and often required coordinating with a variety of different medical and administrative organizations to ensure members received the necessary care. The intent behind the establishment of the JPSU was to provide both patients and leadership with a "one stop service" to all the necessary care providers. [77] Moreover first line units were directed in a Canadian Forces General Order (CANFORGEN) to post members to JPSU if their Medical Employment Limitations (MEL) precluded a member from performing their duties in their home unit for six months or more.[78]

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[76] Murray Brewster. "Military support line now operating 24/7, 8 months after being announced" *Associated Press*. 22 January 2014. Last accessed on 15 March 2014 http://www.ctvnews.ca/canada/military-support-line-now-operating-24-7-8-months-after-being-announced-1.1651418.

[77] Canada. Department of National Defence, Backgrounder - The Joint Personnel Support Unit BG-09.006 - May 28, 2009. Last accessed on 24 February 2014. http://www forces.gc.ca/en/news/article.page?doc=the-joint-personnel-support-unit/hnps1uqv.

[78] Canada. Department of National Defence. *Canadian Forces General Order (CANFORGEN) 114/11 Posting to Joint Personnel Support Unit (JPSU/SPHL),* Chief of Military Personnel, 29 June 2011

The JPSU is currently comprised of twenty-four centers across Canada. The preliminary Assessment by the Canadian Forces Ombudsman on the JPSU published on 31 October 2013 stated that the JPSU had 1921 posted in CAF members with an additional 3000 CAF members and 554 CAF families receiving assistance from the organization.[79] Moreover from July 2012 to July 2013 there was an increase of approximately 800 members posted into JPSU units across Canada.[80] It is difficult to determine the total number of JPSU postings that are for mental health related issues however based on the author's personal experience as a Sub-Unit Commander in an operational unit from 2011-2013, over 80% of postings to JPSU from her sub-unit were for strictly mental health related injuries.[81] The extensive increase in JPSU postings has raised concerns on the unit's capacity to provide care to soldiers. The ombudsman's assessment determined that "There is a consistent reporting of staff shortages and a need for better training to inspire staff confidence and resiliency while supporting and administering to ill and injured clients who are posted to the IPSCs".[82] However it also concluded that significant efforts are being made by Chief Military Personnel (CMP) to address these shortages. JPSUs are working on ways of approving their delivery of services in order to expand accordingly. However the expansion of JPSU also raises some concerns in regards to soldier support. Does a posting to JPSU alleviate first-line leader's

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[79] Canada. Department of National Defence and Canadian Forces Obudsman. Preliminary Assessemnt-JPSU 31 October 2013. Last accessed 4 Feburary 2014. http://www.ombudsman.forces.gc.ca/en/ombudsman-news-events-media-letters/jpsu-ipsc.page.

[80] Chief of Military Personnel. "State of the Joint Personnel Support Unit and Integrated Personnel Support Centre in the National Capital Region." *Media Response Lines ADMPA*, 8 August 2013.

[81] Author was a Battery Commander 2 RCHA from 2011-2013, in two years in Commander 6 pers from Bty were posted to JPSU and 5 were for mental health related concerns (83%).

[82] Canada. Department of National Defence and Canadian Forces Obudsman. Preliminary Assessemnt-JPSU 31 October 2013. Last accessed 4 Feburary 2014. IPSCs refer to Integrated Personal Support Agencies. http://www.ombudsman.forces.gc.ca/en/ombudsman-news-events-media-letters/jpsu-ipsc.page.

responsibility for their subordinates' well-being? Are units prematurely posting injured soldiers to JPSU to backfill positions with operational fit soldiers? Is a JPSU posting always in the best interest of the injured member? These questions are difficult to answer as any response depends on a variety of factors. The leadership aspects of these issues will be addressed in the next chapter.

SUMMARY CHAPTER 1

The current situation of mental health within the CAF can be classified as a consistent yet stable issue in comparison to the mental health status of Canadian society as whole. Improving the mental health of soldiers continues to be a top priority for the government. Mental health has received a considerable amount of financial support which has been invested over the past decade to enhance the CF H Svcs Gp mental health strategy to provide a multidisciplinary approach to meeting the needs of CAF members. In addition the ongoing research in the field of mental health research through the CIMHVR is encouraging and has already resulted in significant improvements to how mental health illnesses are treated within the CAF. The target of 450 mental health care professionals supporting CAF personnel is extraordinary when compared to level of care provided to civilian Canadians.

The availability of appropriate medical and support services is actively being addressed within the CAF. Both the quality and quantity of CF H Svcs Gp services along with the additional resources and support offered by JSPUs demonstrate a commitment to providing care to soldiers in need. However reports remain that soldiers are still "slipping through the cracks" and not receiving the help they require. How can these soldiers be

reached? Perhaps there are other aspects of the soldier support system that can be engaged to reach these soldiers. Leaders are often said to share the responsibility with Health Care professionals in terms of their soldiers' mental health. The next chapter will use the institutional guidance and direction that has been issued to CAF leadership to identify the expectations on leaders in regards to soldier well-being and attempt to identify challenges that leaders face in sharing responsibility in the current soldier support system.

CHAPTER TWO LEADERSHIP AND SOLDIER SUPPORT

Remember that in any man's dark hour, a pat on the back and an earnest handclasp may work a small miracle.

- Brigadier-General S.L.A. Marshall, 1950[83]

INTRODUCTION

The care and well-being of soldiers is no small task in the CAF. Former Chief of Defence Staff, General (retired) Rick Hillier stated that "Soldiers are a countries most important resource."[84] It could be suggested that soldier well-being is considered a "no fail" task and therefore remains a significant focus for leadership at all levels. From a Master Corporal (MCpl), Section Commander up to a Unit Commanding Officer (CO), tactical leaders at all levels are entrusted with the care and well-being of their personnel. When asked about leadership's role in mental health, Brigadier General (BGen) Eyre,

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[83] Canada. Department of National Defence. DGM-10-07-00285. *Road to Mental Readiness- Aide Memoire*. Ottawa: DND Canada, 2011. 11.

[84] Canadian Broadcast Corporation. "Indepth: A World of Difference – Lieutenant-General Rick Hillier, Officer Commanding ISAF interviewed by Peter Mansbridge", *CBC News Online*, Febuary 17, 2004. Last accessed on 15 March 2014. http://www.cbc.ca/news2/background/world/hillier.html.

former Commander of 2nd Canadian Mechanized Brigade Group and current Director of the Afghan National Security Forces (ANSF) stated:

> Leadership is a people business; mental health is part of that people business. So as leaders one of your skill sets has to be able to deal with these issues. Know how to identify them, what to look for and not necessary cure it yourself or treat it yourself but be aware of what help is available and connect them with that help.[85]

The Queen's Regulations and Orders (QR&O) that lay out the responsibilities of officers and non-commissioned members state that a common responsibility is to "promote the welfare, efficiency and good discipline of all subordinates."[86] These orders are rules of law in the Canadian military and therefore leaders must be empowered with the knowledge and tools to be successful in fulfilling these responsibilities. Institutional doctrine, guidebooks and directives provide further direction to leaders on what their roles and responsibilities are in relation to their personnel. This chapter will examine the guidance and direction issued to CAF leadership to identify the expectations placed on leaders in regards to soldier well-being and attempt to identify challenges that leaders face in sharing responsibility in the current soldier support system.

DOCTRINE

The profession of arms in Canada is unique. The demands, hardships and environments that Canadian military personnel operate in around the world cannot be compared to other professions. As such it is essential that the CAF has specific doctrine

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[85] Brigadier-General W.D. Eyre. Personal Communications with author on 18 Feb 2014, with permission.

[86] Canada. Department of National Defence. Queens Regulations and Orders (QR&O) 4.02(c) – *General Responsibility of Officers. QR&O 5.01(c) – General responsibility of Non-Commissioned members.* Last accessed 5 April 2014. http://www.admfincs forces.gc.ca/qro-orf/index-eng.asp QR&O 5.01(c) – General responsibility of Non-Commisioned members virtual the same "promote the welfare , efficiency and good discipline of all who are subordinate to the member.

to address the unique professional and leadership challenges that it faces. In 2003, the CAF first published *Duty with Honour: The Profession of Arms in Canada* as a foundation document on Canadian Forces professional development system.[87] This document was revised and a second edition was promulgated in 2009. Section four of the publication discusses responsibility as one of the attributes of the profession of arms. It is well understood that the primary responsibility of CAF personnel is the defence of Canada and Canadian interests. However *Duty with Honour* stipulates that members also have a responsibility for the well-being of their subordinates. "All leaders must understand, both professionally and personally, that this vital responsibility is the basis for fostering and maintaining an effective and cohesive force with high morale."[88] By explaining the importance of looking after personnel, the foundation document highlights a crucial link between mission success and soldier well-being.

Leadership doctrine is a critical component of CAF professional development. As the Canadian military transformed throughout the past two decades there has also been a constant evolution of leadership doctrine in the CAF. The cornerstone document that provides a broad conceptual understanding of military leadership within the CAF is *Leadership in the Canadian Forces: Conceptual Foundations,* which was published in 2005. Although this publication was not the first leadership manual for the CAF, unlike its predecessors that focused on examining leadership from a tactical, operational and strategic perspective, it was an all-encompassing foundation document that described a

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[87] Department of National Defence, A-PA-005-000/AP-001 *Duty with Honour: The profession of Arms in Canada 2009.* (Ottawa: DND Canada, 2009), 1.

[88] *Ibid*., 14.

contrast between leading the people and leading the institution.[89] More relevant to this paper was that *Conceptual Foundations* clearly articulated soldier well-being and commitment as an effective dimension of leadership.[90] The leadership doctrine described two key roles for primary leaders pertaining to member well-being. The first role is that of a sustainer where:

> In the sustainer role, the Officer-NCM leadership team is responsible for enhancing the meaningfulness of individual tasks and jobs, establishing a healthy unit climate, managing interpersonal conflict, responding to complaints and concerns, representing the individual and collective interests of their people to administrative staffs and superiors, and generally monitoring and building morale and commitment to serve.[91]

The second role is that of developer, where the leaders are responsible to cultivate, mentor and encourage subordinates both professionally and personally throughout their career.[92] Although both roles are critical, the sustainer role focuses on the key leadership responsibility in regards to a subordinate's mental health and well-being.

With the foundations established, the doctrine went a step further and in 2007, *Leadership in the Canadian Forces: Leading People* was published in which a complete chapter was dedicated to *Looking After your People*.[93] This publication introduced leaders to a comprehensive approach to looking after personnel. The comprehensive approach of looking after a soldier's well-being involves looking after their physical, intellectual and emotional health.[94] Although the identification of emotional health is

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[89] A. Okros, "Afterword: Leadership and the Human Dimension of Mililtary Effectiveness" *in The Human Dimensions of Operations: A Personal Research Perspective* (Kingston: Canadian Defence Academy Press, 2014), (DRAFT)

[90] Department of National Defence, A-PA-005-000/AP-004 *Leadership in the Canadian Forces: Conceptual Foundations.* (Ottawa: DND Canada, 2005), 48.

[91] *Ibid*., 50.

[92] *Ibid*., 50.

[93] Department of National Defence, A-PA-005-000/AP-005 *Leadership in the Canadian Forces: Leading People.* (Ottawa: DND Canada, 2007), 55.

[94] *Ibid*., 66.

valuable, the chapter only broadly discusses how a soldier's emotional health can be addressed. Facilitating the resolution of interpersonal conflict, treat followers fairly, and recognize and reward success[95] are all identified as key components of looking after a soldier's emotional health but no specifics on how those tasks are to be executed or provided. With the key doctrinal principles and concepts laid out in regards to a leaders responsibilities to soldier well-being, this paper will now turn to specific guidance and direction that has been issued in various forms to aid leaders in fulfilling their responsibilities.

DIRECTION AND GUIDANCE

A CO of a Unit is a pinnacle leadership position. A CO holds the ultimate authority over all aspects of their unit and is empowered and trusted to use their judgment to the best of their abilities in determining what is best for the unit. The position also comes with a great deal of professional and personal responsibility for not only the successful execution of the unit's tasks but also for the personnel which make up the unit. The CDS provides overarching institutional guidance to all COs in his *CDS Guidance to Commanding Officers* publication. Chapter 19: *Physical and Mental Health Issues and Programs* communicate the expectations for senior leaders to support and promote health in their subordinates. [96] It states:

- Take responsibility for the promotion of health and physical fitness in your unit;[97]

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[95] *Ibid*., 61-64.

[96] Canada. Department of National Defence. Chief of Defence Staff Guidance to Commanding Officers. (2009). Chapter 19: Physical and Mental Health Issues and Programs. Last assessed 3 March 2014. http://cda.mil.ca/CDSGuidance/engraph/2006/chapter19_e.asp.

[97] *Ibid*.,

- Lead by example - embrace a healthy and active lifestyle and facilitate the achievement of optimum health and fitness in your personnel. Create and reinforce a culture of healthy lifestyle through local policy initiatives, and support for programs that educate, motivate and facilitate personnel to make positive health choices;[98]

- Support your personnel's access to health promotion programs offered at your unit or Base/Wing and provide support to your local health promotion program's O&M budget;[99]

- Work with the Health Services staff to identify and address significant health issues facing your personnel;[100]

- Employment restrictions recommended by medical officers will be scrupulously respected. However, wherever safe, prudent, and possible, accommodations in the workplace will be made to allow ill and injured members to continue to function in a capacity compatible with their limitations;[101] and

- Create, to the greatest extent possible, a climate of information, trust and understanding around health care issues. CF members must know that the privacy of their health information is absolute and will be vigorously defended. They must also know that the chain of command will support them to the greatest extent possible, to maximize their chances of recovery from illness and injury.[102]

The expectations as they are laid out by the CDS leave no doubt as to the leader's responsibilities for the welfare of their subordinates. In addition to the CDS guidance, there are two other key documents that will be elaborated on as they support the CDS direction and provide useful guidance to both COs and leaders at different levels.

The North Atlantic Treaty Organization (NATO) Task Group HFM-081/RTG produced a technical report in April 2008, *Stress and Psychological Support in Modern Military Operations.* This report also included a key annex titled *A Leader's Guide to*

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[98] *Ibid*.,
[99] *Ibid*.,
[100] *Ibid*.,
[101] *Ibid*.,
[102] *Ibid*.,

Psychological Support Across the Deployment Cycle.[103] The guide elaborates on the sustainer role of a leader in regards to soldier mental health and highlights how a leader can influence the operational stress on a unit member's performance (see Figure 2.1 below).

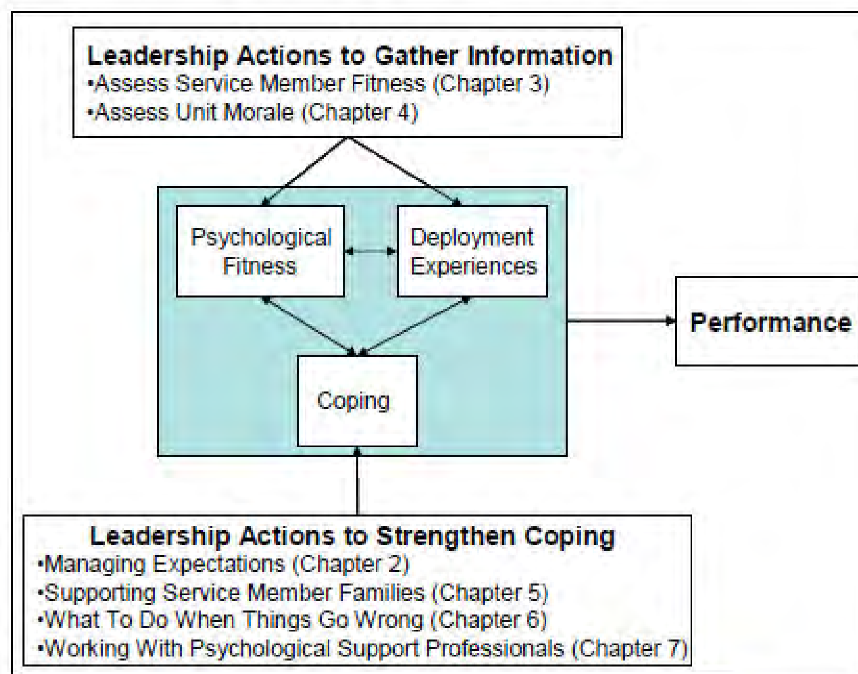

Figure 2.1 - How Leaders Influence the Impact of Operational Stress on Unit Member Performance

Source: NATO "A Leader's guide to psychological support across the deployment cycle" in *NATO Technical Report*, 2008, G-14.[104]

The NATO guide also discusses how leaders play a vital role in managing the expectations of their subordinates and how this needs to be balanced with meeting their obligations to the mission at hand. The guide not only discusses different methods leaders can use to assess psychological morale but also provides strategies to help leaders detect

[103] NATO Research and Technology Organisation. "A leader's guide to psychological support across the deployment cycle" in NATO Technical Report - Stress and Psychological Support in Modern Military Operations RTO-HFM-081. France: NATO Research and Technology Organisation, 2008, G-8.

[104] *Ibid*., G-14.

signs and symptoms of stress in their soldiers.[105] A key conclusion that resulted from this guide was the need for individual nations to provide more specific information to their own leaders on mental health issues.

The Canadian Army published a document titled *Senior Leadership Guide to Mental Health: Roles and Responsibilities* in 2011. This leader's guide addresses the concluding recommendation of the NATO guide in an attempt to provide Canadian leaders with specific information relevant to the CAF. The guide describes methods which leaders can use to enhance the mental fitness of unit members, and care for those members who develop mental health issues. The general purpose of the guide was to provide leaders with a better understanding of all aspects of mental health, from prevention to intervention.[106] The guide expresses the importance that leaders play in developing the mental health of their soldiers but also goes further to break down a leader's responsibility along the MHCM.[107] Figure 2.2 depicted below, divides leader's tasks into three distinct areas: shield, sense, and support. *Shielding Actions* refer to those actions that enhance soldier's abilities to cope with stress in order to improve their general health and foster a healthy work environment.[108] *Sensing Actions* can be summarized as those actions that focus on early warning or recognition of mental health injuries such as identifying the signs and symptoms that indicate a soldier may require assistance.[109] Thirdly, *Support Actions* refer to those actions that leaders can take to

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[105] *Ibid*., 365.
[106] Canada. Department of National Defence. *Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*. (Ottawa: DND Canada, 2011), 4.
[107] *Ibid*., 17.
[108] Canada. Department of National Defence. *Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*. (Ottawa: DND Canada, 2011), 4., 17.
[109] *Ibid*., 17.

support their soldiers in seeking professional mental health care.[110] The information within the guide was summarized into the *Road to Mental Readiness Aide Memoire* in 2011 to provide all leaders with the CAF with a useful reference document.[111]

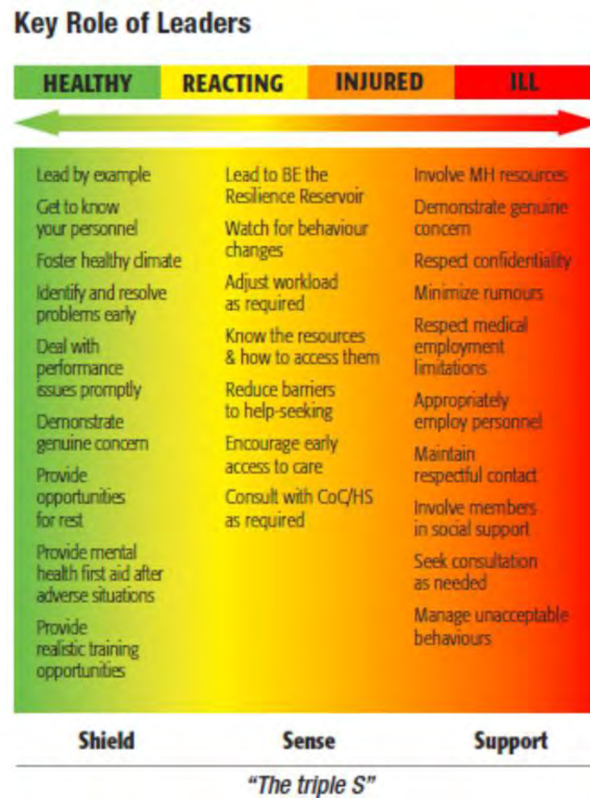

Figure 2.2 – Key Role of Leaders
Source: *Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*, 17.

It is interesting to note that the guide places a greater degree of importance and involvement of leaders in the preventative and management of soldier well-being, but as the severity of a mental health illness increases the leader adopts a more supportive role in comparison to health care professional. The guide summarizes "Leaders should leave the "CARE" to the appropriate Mental Health Specialists, but should foster the

[110] *Ibid*., 17
[111] Canada. Department of National Defence. DGM-10-07-00285. *Road to Mental Readiness- Aide Memoire*. Ottawa: DND Canada, 2011

appropriate climate/environment for the healing process to include reducing stigma."[112] All of the leaders guidebooks discussed thus far describe four major roles for leaders: fostering a healthy unit climate, prevention and education, reducing stigma and barriers to care and working in collaboration with Health Care Professionals. The next section of this paper will address some challenges leaders possess in fulfilling these four responsibilities within the current soldier support structure.

FOSTERING A HEALTHY UNIT CLIMATE

One of the crucial shielding responsibilities of leaders is to foster a healthy unit climate. In accordance with *the Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*, "This not only includes providing the appropriate command climate that fosters the growth of resilience within the organization but to also tend to the needs of subordinates when required."[113] This responsibility is often a key concern for COs upon assuming command of a unit as time can be limiting when command is limited to two to three years in duration. COs also need to engage their entire leadership cadre including all officers and non-commissioned officers (NCO) to create the appropriate culture.

Commanders' success in creating a healthy command climate is influenced by their leadership abilities as well as their ability to earn the trust of their subordinates. The importance of trust cannot be understated; a United States Military Academy Study conducted in Iraq with a group of 72 US Army soldiers in 2010 concluded that the

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[112] Canada. Department of National Defence. *Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*. (Ottawa: DND Canada, 2011), 4., 17.
[113] *Ibid*., 16.

majority of soldiers reconsidered the trust in their leaders prior to combat operations.[114] Moreover findings determined that the trust established during work up to the deployment appeared to transfer over to combat operations.[115] Although the sample for this study was relatively small it does highlight the importance of creating a command climate and building trust.

Various researchers from DRDC conducted six studies to investigate trust in section level teams in the Canadian Army from 2003 to 2008.[116] The studies found that trust was essential for team effectiveness. Not only did trust foster free flowing communication but it was also noted as strengthening morale and cohesion.[117] A leadership challenge for building trust especially at the lowest levels of leadership can be personnel turnover.

> In fact 50% of the CAF Army personnel surveyed in garrison indicated that they had experienced changes in personnel assignments on their team in the previous three months. Only 6% of participants indicated that their teams had experienced no personnel changes in the past year.[118]

Although some degree of personnel turnover is unavoidable, frequent changes in first line leaders may be detrimental to the development of healthy unit climates. Lieutenant-General (LGen) Vance, Deputy Commander, Allied Joint Force Command Naples is a Canadian Commander with various levels of experience from Battalion Command to Commander Joint Task Force Afghanistan. LGen Vance is an advocate of the importance

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[114] Patrick J. Sweeney. "Do Soldiers Reevaluate Trust in Their Leaders Prior to Combat Operations?" *Military Psychology* 22, Suppl. 1. (2010), S70.

[115] *Ibid*., S80.

[116] Megan M. Thompson, Barbara D. Adams, and Wayne Niven "Trust in Military Teams" in *The Human Dimensions of Operations: A Personal Research Perspective* edited by Gary Ivey, Kerry Sudom, Wayln Dean and Maxime Tremblay 205-220. Kingston: Canadian Defence Academy Press, (In Press), 130. These studies involved a total of 542 Regular Force and Primary Reserve Army personnel, representing a variety of military occupations, but mainly drawn from the infantry. Most participants were NCMs, although 50 of them were junior officers. A variety of methodologies were used to investigate trust.

[117] *Ibid.,* 134.

[118] *Ibid*., 137. Taken from DRDC Contract Report 2004-007.

of creating a healthy command climate to soldier well-being. LGen Vance explained that soldiers need to feel a part of something that they believe in and that they must feel comfortable enough to admit when they are not feeling well and in need of assistance.[119] The role of leaders is therefore to get to know their soldiers well enough so that they can recognize when someone is not well and attempt to do something to assist.[120] It can be asserted that trust between soldiers and leaders not only impacts team effectiveness but also a soldier's belief that a leader has concern for their well-being.[121] Essentially trust enables leaders to effectively support their soldiers.

Trust is not a given and must be earned over time and experience. One way a leader can earn the trust of his or her subordinates is through meeting their personal and professional expectations. A leader's ability to manage expectations often has a direct impact on the climate of a unit. *The NATO Leaders guide to Psychological support across the Deployment Cycle* refers to the importance of how leaders manage soldier expectations. The guide explains that there are two main reactions soldiers take when there are violations to their expectations. Soldiers may react adaptively by complying with what they are asked to do or by requesting a change both of which do not affect the overall operational effectiveness of the mission.[122] Soldiers may also react maladaptively by being insubordinate or by requesting a release. Both responses negatively impact the overall effectiveness of a unit.[123] Leaders play a crucial role in managing the expectations

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[119] Lieutenant-General J.H Vance. Personal Communications during telephone conversation with author 12 Feb 2014, with permission.

[120] *Ibid*.

[121] Megan M. Thompson, Barbara D. Adams, and Wayne Niven "Trust in Military Teams" in *The Human Dimensions of Operations* . . . 144.

[122] NATO Research and Technology Organisation. "A leader's guide to psychological support across the deployment cycle" in NATO Technical Report - Stress and Psychological Support in Modern Military Operations RTO-HFM-081. France: NATO Research and Technology Organisation, 2008.G-18.

[123] *Ibid*., G-18.

of their subordinates however the difficulty exists when a member's expectations conflict with reality and/or mission obligations.[124] Situations such as an unexpected policy change affecting a soldiers benefits or a forecasted extension of a deployment are both examples of situations which may need to be managed by leaders to reduce stressors on their soldiers. Thomas Britt, a well published Professor of Social and Organizational Psychology at Clemson University recognized that although there are some stressors that leaders have no control over, they can still affect certain stressors by providing soldiers with clear expectations.[125] Situations where expectations and obligations conflict are challenging for leaders as they have little ability to influence these obligations but are entrusted with the responsibility to address them. The challenge is more evident at the lower levels of leadership such as a Senior NCO or junior officer. At this first line of leadership the knowledge and tools must be available to empower the leader to moderate the stressors of his or her subordinates, as it is difficult for trust to be built without it.

Another challenge with creating a healthy climate surrounds a discussion of how far a leader's engagement should extend. Does a commander's influence cease with a soldier or should it extend to the family members as well? Margaret E. Phillips, a family volunteer readiness coordinator in the US describes an "Engaged leader paradigm" where leaders must not only engage with their soldiers but also understand how to support the soldier's family as well.[126] The concept suggests that knowledgeable leaders at the lowest level will create a more effective health promotion team and in turn have a positive impact on soldier and family well-being. This is a challenging situation for leaders to

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[124] *Ibid*., G-22.

[125] Thomas W Britt, James Davison, Paul D. Bliese, and Carl Andrew Castro. "How Leaders can Influence the Impact that Stressors have on Soldiers." *Military Medicine* 169, no. 7 (July, 2004): 542.

[126] Margaret E. Phillips."Engaged Leader Paradigm". *Military Review (July-August 2013) 49.*

determine to what extent a soldiers' private life should be kept private and when the chain of command should engage. However there is little doubt that family stressors such as relationship issues, financial matters or dependant health concerns can affect a soldier's well-being and therefore impact their operational effectiveness. Margaret Phillips suggests "A leaders concern must extend to the family if true soldier readiness is the goal."[127] However if leaders determine that creating a healthy command climate must extend to include the families of their soldiers then they must be educated and knowledgeable on all services that are available within the CAF. From a unit CO's perspective this is feasible as most COs are well educated on the mental health resources available throughout the CAF. However as previously discussed command climate is a shared responsibility with all members of the leadership cadre and educating all NCOs and officers is an additional challenge. LGen Vance commented on the empowerment of NCOs by stating:

> The focus should be on the NCO corps. They can advocate up and down the chain but sometimes we don't make it easy for them to do both extremely well. We need to empower them, educate them and provide them with the training to lead soldier support.[128]

Empowering NCOs is only one aspect of creating a proper unit climate. Forming relationship and creating the right climate can also be challenged by operational and mission requirements. Operational requirements are constantly weighed against individual soldier needs. On deployed operations, mission success will always take priority, yet it can never be the only priority. The challenge in garrison is finding that right climate to balance operational effectiveness with soldier well-being. Building trust,

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[127] *Ibid*., 49.

[128] Lieutanent-General J.H. Vance. Personal Communications with author on 12 Feb 2014, with permission.

fostering strong relationships and determining the level of engagement in soldiers' lives are all challenges that leaders face in creating a healthy climate.

PREVENTION AND EDUCATION

A crucial role for leaders in the mental health of their subordinates is prevention and education. This paper has already touched on the need for leaders to know and understand what resources are available and how to access them for their subordinates. However gaining awareness is only a small part of a leader's role. Although leaders are directed to play essential roles in the prevention and education aspects of mental health, their exact contribution in the current construction is more of a supporting position. Dr. Allan English suggested that the most effective system for decreasing preventative stress-related casualties was through an integrated system. "The central principle for success in designing and running this type of system has always been that military commanders must bear the ultimate responsibility for the system."[129] The current mental health strategy of the CAF was developed by the Surgeon General and educational courses such as R2MR were developed and are currently led by CF H Svcs Gp. The Surgeon General recognized that the educational aspect of the mental health strategy should be shared and created the Mental Health Education Advisory Committee.[130] This committee includes various members from all environments and training centers, researchers, chaplains and family services personnel. It is chaired by the Director of Mental Health who reports directly to Surgeon General. It goes without saying that the medical expertise and

[129] Alan English."Leadership and Operational Stress in the Canadian Forces", *Canadian Military Journal* (Autumn, 2000), 36.

[130] Canada. Department of National Defence. Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (Ottawa: DND, 2013), 13.

experience of CF H Svcs Gp is imperative to the effectiveness of any system of prevention of mental health issues, however Dr. English suggests that "they are only parts of what should be an integrated system that is focused on leadership."[131] Commanders at various levels are currently not in a position to lead the prevention and education aspects of mental health. Training programs such as R2MR remain relatively new and therefore primarily taught by medical experts. Some training institutions such as Land Force Central Training Center in Meaford have begun to implement a "train the trainer" approach to resilience training due to the demand for the courses and to the desire to arm the candidates with the basic resilience skills.[132] In high tempo units, leaders are challenged to commit the appropriate time and resources to the mental health training. Like any skill, erosion and turnover can impact the effectiveness of the training. Leaders need to ensure that mental health awareness prevention and education is incorporated into their unit training plans. An examination of the US Army psychological education training program found that leaders at times viewed education programs as a distraction with comments such as "just one more thing taking me from the mission."[133] A lack of understanding about the usefulness of mental health prevention training may be a cause of the frustration. Moreover the competing priorities that leaders face often cause them to disregard the priority they do not have ownership of.

The institutionalization of resilience training in the CAF has the potential to positively impact a leader's ability to influence prevention and education. The R2MR

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[131] Alan English."Leadership and Operational Stress in the Canadian Forces", Canadian Military Journal (Autumn, 2000), 37.

[132] Personal Communications with Col M.A. Lipcsey via email on 27 March 2014, with permission.

[133] Amy B., Alder, Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 43.

approach provides CAF members with mental health education commencing at the basic training stage and continues throughout various aspects of their careers including leadership training and deployment specific training.[134] The R2MR program has five objectives: increase mental health literacy, decrease stigma, overcome the barriers to mental health, enhance psychological resilience and provide tangible and useful tools to assist subordinates, peers and loved ones.[135] The system is currently designed to ensure that the right training is given to the right personnel at the right time. By building resilience training into various aspects of a member's career, leaders should gain a better understanding of prevention and education programs and perhaps be in a better position to adopt a leadership role.

The CAF also has two non-clinical programs that assist in the prevention and education component of mental health. The Mental Health and Operational Stress Injury Joint Speakers Bureau were established in 2007 to educate CAF members on mental health issues. As well the Operational Stress Injury Social Support (OSISS) program was established in 2001 by now retired Lieutenant-Colonel Grenier as a joint DND and VAC initiative to provide peer intervention support to CAF veterans and families.[136] Both of these programs have gained momentum since they were established, however, although supported strategically through DND and VAC, at the tactical level they operate independently from the unit command teams. Although OSISS coordinators interact with units through various committees and periodic unit visits, this contact is normally driven

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[134] Canada. Department of National Defence. Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (Ottawa: DND, 2013), 13.

[135] Colonel M.A. Lipcsey,"Mental ResilenceTraining: How to be more effective under pressure." Lecture, Canadian Forces College, Toronto, ON, October 24 2013, with permission.

[136] J.Don Richardson, Kathy Darte, Stephane Grenier, Allan English and Joe Sharpe. "Operational Stress Injury Social Support: A Canadian Innovation in Professional Peer Support." *Canadian Military Journal* 9, no.1 (August 2008), 57.

by OSISS and not the chain of command.[137] Although peer support programs such as OSISS have gained wide-spread strategic support, further integration at the tactical level may be required for the programs to enhance their effectiveness. The Royal Marines in the United Kingdom introduced a unique peer-support system TRiM that incorporates leaders directly into a peer support structure. In order to implement this system, Neil Greenberg and Norman Jones addressed the concerns of a group of seasoned Warrant Officers who were skeptical of the program. Three factors were deemed to be essential to positive outcomes:

> The first was the presence of a highly experienced and respected commando officer who had previously voiced his support for the project. The second was the operational experience of the trainers, which gave credibility to the training system. The third factor was the conversion of the most senior warrant officer present from a skeptic to a supporter of the training philosophy.[138]

The impact of senior leaders support along with the concurrence of Senior NCOs was deemed to be essential in the success of the program. It is also interesting to note that TRiM is currently run internally by Royal Marine Warrant Officers with support of military medical professionals who provide audits and quality assurance for the training courses.[139]

CAF leadership continues to face challenges in the prevention and education aspects of mental health. Although decreasing, a reliance on medical health care professionals to provide education and training continues to exist. The institutionalization of resilience training may increase the awareness and understanding of leaders in order to

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[137] Major Carl Walsh, OSISS Program Manager, personal communications with author via email on 4 April 2014, with permission. Maj Walsh explained that units are normally occupied with multiple issues but at times they do contact OSISS to conduct unit briefings or for informal meetings in the unit.

[138] Amy B. Alder, Paul D. Bliese and Carl A. Castro. Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military. (Washington: American Psychological Association, 2011), 90.

[139] *Ibid*., 90.

allow them to take on an enhanced role in the educational aspects of mental health. Peer support programs also play an important role in the prevention and education of mental health; however leaders are challenged in that they are not currently directly responsible for these programs.

REDUCING STIGMA AND BARRIERS TO CARE

Stigma is often referred to but rarely defined in considerable detail. Patrick Corrigan, a leading academic and author on mental illness and stigma from the University of Chicago, defines stigma as "a negative and erroneous attitude about a person; it is a prejudice or a negative stereotype."[140] He further makes a distinction between public and self-stigma however both are interconnected as they each contain stereotypes, prejudice and discrimination.[141] Some have suggested that the definition surrounding the framework of stigma and mental health put a greater responsibility on the individual to stop the stigma.[142] Historically, it was argued that since stigma developed within a person then the onus to sort out the problem lies within that individual.[143] Such a limited view of stigma is less prevalent in today's society with national initiatives such as the "Bell Let's Talk" campaign introduced in 2010. In Canada, this campaign has dramatically increased public awareness on mental health. To date, the campaign has raised over $62 million for

[140] Thomas Britt et al. "The stigma of mental health problems in the military," *Military Medicine* 172 (Febuary 2007), 157.

[141] Patrick Corrigan. "How Stigma Interferes with Mental Health Care," *American Psychologist* 59 no.7.(October 2004), 616. Public Stigma is defined as what a naïve public does to a stigmatized group when they endorse the prejudice about that group. Self-Stigma is defined as what members of a stigmatized group may do to themselves if they internalitze the public stigma. Other sources also make reference to a third level, structural stigma which is the economic and political forces operating on a culture.

[142] Amy B Alder, Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 82.

[143] *Ibid*., 82.

Canadian mental health initiatives by focusing on their four pillars of: anti stigma, care and access, research, and work-place best practices.[144] Combatting stigma, although gaining national attention, is perhaps a greater issue within a military culture as characteristics such as strength, resilience and self-improvement are rewarded and recognized.[145] If CAF personnel do not come forward freely to seek help with mental health issues then the potential exists for their issues to worsen and pose a greater risk to their own safety and the safety of those around them.[146] The challenge for leaders is to determine how to effectively combat the stigma and encourage subordinates to seek help. Often it is suggested that the greatest way that leaders can combat the stigma associated with Mental Health is to be consistent. One common message from the top down is seen as essential along with openly addressing negative views on coming forward and seeking help.[147] A challenge to consistency is clearly communication. Leaders need to communicate an understanding and promotion of seeking help if you are struggling with mental health issues. However leaders need to balance this carefully with training their soldiers to be resilient and strong warriors ready to win on the battlefield at all costs. The manner in which these messages are expressed down to the most junior ranks in a unit can often times be confusing and result in a miscommunication of the CO's intent. "Seeking mental health care early needs to be viewed as a sign of resilience and strength not a weakness."[148]

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[144] Bell Let's talk website, http://letstalk.bell.ca/en/ accessed on 21 January 2014.

[145] Amy Iverson et al. "The stigma of mental health problems and other barriers to care in the UK Armed Forces," *BMC Health Services Research* (2011) 15.

[146] Canada. Department of National Defence. *Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*. (Ottawa: DND Canada, 2011), 4., 18.

[147] *Ibid*., 18.

[148] *Ibid*., 18.

The impact various levels of leadership have on stigma is also a factor for discussion. In 2011, Walter Reed Army Institute of Research published the results of a study conducted by Thomas Brit, Kathleen Wright and DeWayne Moore to examine positive and negative leadership behaviours as predictors of stigma and practical barriers to mental health treatment.[149] The study focused on randomly selected brigade combat team members who participated in a 2008 deployment to Afghanistan and who completed at least one of three monthly assessments following the deployment.[150] Soldiers completed surveys on their self-rated assessment of stigma and barriers to care and NCO and officer leadership.[151] The results of the study indicate that although both officer and NCO behaviour were related to stigma, " . . . only positive and negative NCO behaviors were uniquely predictive of stigma . . ."[152] Although the positive NCO behaviours were not explicitly stated in the study the negative NCO behaviours included embarrassing and humiliating subordinates in front of others and spreading incorrect information about subordinates.[153] This study is limited by the use of only self-reporting as the sole measurement tool which brings into question the credibility of the results. However when dealing with perceived stigma the authors assert that a subjective measure such as self-reporting is an effective tool as only individuals can express how they are feeling about

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[149] Thomas Brit, Kathleen Wright and DeWayne Moore. "Leadership as a Predictor of Stigma and Practical Barriers Toward Receiving Mental Health Treatment: A Multilevel Approach" *Psychology Services 9, no. 1 (2012) 26-37.*

[150] *Ibid*., 28.

[151] *Ibid*., 29. The study assessed perceived stigma (7 items) and practical barriers (5 items) using a scale validated in previous research with military personnel (Britt et al., 2008; Hoge et al., 2004; Wright et al., 2009). Participants were asked to consider how much each of a series of factors would influence their decision to seek mental health care. The leadership scale was also used in previous research to investigate the role of NCO and Officer leadership in military settings (Castro, Adler, & Bienvenu, 1998; Wright et al., 2009). In the present study, soldiers rated both their NCOs and officers on 10 different behaviors using a five-point scale ranging from "Strongly Disagree" to "Strongly Agree."

[152] *Ibid*., 34.

[153] *Ibid*., 27.

any potentials barriers to care.[154] The results of this study highlight the importance of NCO leader behaviors on their subordinates' perceptions of stigma. The challenge of communicating the right message is crucial along with the enhanced role of NCOs in soldier support.

Soldier's perceptions of barriers to care greatly influence their willingness to seek help. The HLIS survey of 2008 identified the two most common perceived barriers to mental health care as: a preference to manage their problems themselves (64%) and fear of career implications (37%).[155] These perceived barriers are not surprising given it is quite normal for soldiers to want to sort out their own problems and are trained to be self-resilient and responsible. Moreover subordinates rarely see their leaders asking for help, and therefore could assume that sorting out your own problems is the preferred approach. Author Eugene H. Kim, in an *Armed Forces Journal* article titled "Do as I Do" commented on the absence of the key US Army leadership tenet, lead by example in the implementation of current help seeking resources.[156] Kim suggests that a common challenge for leaders is the perception that seeking help will cause subordinates to lose confidence in the leaders abilities.[157] However, Kim concludes that if institutional leadership truly wants to combat the stigma associated with seeking help then mature self-disclosure by leaders at all levels is necessary. Tracy Stecker conducted a survey of a US National Guard soldiers in 2007 that deployed to Iraq and Afghanistan and found that higher ranking officers would not want their subordinates to know if they were seeking

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[154] *Ibid*., 35.

[155] Canada. Department of National Defence. *Results from Heatlth and Lifestyle Information Survey of Canadian Forces Personnel 2008/2009: Regular Force Version*. (Ottawa: DND, 2009), 42.

[156] Eugene H. Kim. "Do as I Do", *Armed Forces Journal* (Jun 1, 2009). Last accessed 18 December 2013, 1. http://search.proquest.com/docview/200708468?accountid=9867.

[157] *Ibid*., 1.

mental health treatment.[158] An officer responded to the survey with “And there is the stigma. I wouldn’t want anyone ranked below me knowing. They would think that I am not capable of making decisions for them.”[159]

Although Kim’s article and Stecker’s study are US military examples, Canadian Army Major, Christian Breede applied Kim’s ideas in his auto ethnographic examination of his infantry company following their deployment to Kandahar Afghanistan in 2008.[160] Breede openly briefed his Company members on his own use of CF resources and counselling services to attempt to make sense of his emotionally issues post deployment.[161] Various leaders within the company also modelled the mature self-disclosure techniques in an attempt to encourage other soldiers seek help.[162] Interestingly Breede commented that results remained mixed despite all the efforts made by his Company leadership to remove the stigma associated with mental health.

> In the two years that have passed since our redeployment, several soldiers are still dealing with challenges to their mental health and two in particular took their own lives during the summer 2010. However, many soldiers are in treatment and receiving care, as well many soldiers have returned to full duties and continue in the infantry, putting their experiences to work for the benefit of others, ready for the next mission.[163]

It is difficult to fully assess the effectiveness that a “lead by example” approach has on removing barriers to care for mental health assistance. Additional research and analysis on the subject is required, however the work of Kim and Breede does highlight the

[158] Tracy Stecker and John Fortney, “Barriers to Mental Health Treatment Engagement among Veterans” in *Caring for Veterans with Deployment Related Stress Disorders: Iraq, Afghanistan, and Beyond*. (Washington: American Psychological Association, 2011), 249.

[159] *Ibid*., 249.

[160] Christian Breede. “Mental Health and Small Unit Leadership: An Autoethnographic Examination”, in *A New Coalition for a Challeging Battlefield: Military and Veteran Health Research* (Kingston: Canadian Defence Academy Press, 2012), 35-48, 25.

[161] *Ibid*., 43.

[162] *Ibid*., 43.

[163] *Ibid*., 45.

challenge leaders face in attempting to remove barriers to seeking mental health care as leaders are constantly balancing their own self confidence and perceptions with the best interest and expectations of their subordinates.

The second common barrier to care is the fear of long term career consequence. This fear presents an increasingly difficult challenge for leaders as long term mental health issues do have the potential to result in career implications if a soldier can no longer meet their service requirements of their military trade. For example, some mental health conditions may result in medical employment limitations that could restrict a soldier's ability to carry a weapon or operate heavy machinery.[164] Moreover, statistics from JPSU from January 2011 to June 2013 indicate that while 3000 of 5400 personnel posted to JPSU participated in the return to work program only one third of those were able to return to full service and the remainder transitioned into civilian life.[165] Although the percentage of personnel suffering from mental health injuries cannot be determined, this statistic does demonstrate that career implications is a potential reality for those posted to JPSU. Soldiers may see other soldiers leaving the CAF due to mental health injuries and hesitate in seeking assistance themselves. This observation is concerning as seeking help early and promoting self-referral has been suggested to be important in getting back to full fitness quickly. A study of 1,068 US Air force personnel referred for mental health assessment and treatment showed that patients that self-referred were less likely to have career-affecting recommendations then those that were referred by a

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[164] Amy Iverson et al. "The stigma of mental health problems and other barriers to care in the UK Armed Forces," *BMC Health Services Research* (2011) 15.

[165] Chief of Military Personnel. "State of the Joint Personnel Support Unit and Integrated Personnel Support Centre in the National Capital Region." Media Response Lines ADMPA, 8 August 2013.

Commander for more complex issues.[166] Leaders are challenged in encouraging their soldiers to seek help but also in managing their expectations in terms of their realistic concerns about the career implications when help is sought.

COLLABORATION WITH MENTAL HEALTH CARE PROFESSIONALS

Unit COs are often asked to collaborate with a number of external agencies throughout their time in command. The CDS guidance to COs is explicit in describing how COs are to work with CF H Svcs Gp to address health issues of subordinates and respect the employment restrictions that are recommended by medical officers.[167] Although the guidance is clear, COs are often faced with a communication challenge when working with MH Professionals as they are confronted with respecting the medical confidentiality requirements of a soldier medical files while attempting to assist in promoting their soldier's well-being.

Interim policy was published in 2008 to clarify the roles and responsibilities of all parties involved in the sharing of CAF member's medical information.[168] Medical Employment Limitations (MEL) reports are tools that health care providers use to provide the Chain of Command with the necessary information about what a patient can and cannot do in the performance of their duties given their existing medical condition.[169] However MELs are often not enough to assist COs in maintaining the welfare of their

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[166] Amy B. Alder, Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 87. Study referred to in the citation was conducted by Rowan and Campise in 2006.

[167] Canada. Department of National Defence. Chief of Defence Staff Guidance to Commanding Officers. (2009). Chapter 19: Physical and Mental Health Issues and Programs. Last assessed 3 March 2014. http://cda mil.ca/CDSGuidance/engraph/2006/chapter19_e.asp.

[168] Canada. Department of National Defence . Canadian Forces General Order (CANFORGEN) 018/08 Disclosure of medical and social work info to a Commanding Officer, Chief of Military Personnel 13 February 2008.

[169] *Ibid*.

subordinates. In certain circumstances COs may require additional non-clinical information or insight on MELs and prognosis. Obtaining this additional information must be weighed carefully with the professional duty of health care providers to safeguard medical information from inappropriate disclosure.[170] LGen Vance explained the importance of unit leadership in the CAF health care system. "It isn't enough to just be told soldier limitations, unit leadership needs to be part of the solution, and leaders need to understand the potential strategies for helping soldiers improve."[171]

The centralization of unit medical officers under the CF H Svcs Gp has created additional separation and communication barriers between medical professionals and unit leadership. Although the centralization of medical personnel was deemed necessary under the RX 2000 initiative, one of the long term consequences was that front line units no longer had a unit Medical officer working within their unit lines. BGen Eyre discussed the importance of Medical officers to unit leadership:

> Part of communication is trust, and having a single point of contact, of trusted contact, for the leaders and the led to work their issues through, I think that pays all sorts of dividends. To have someone in your unit lines who is trusted and respected, who knows the soldiers and knows the leaders . . . having a single point of contact is the way to go.[172]

Whether medical officers return to units or remain centralized, the essential issue remains communication. The absence of an open dialogue between a medical professional and unit leadership can be detrimental to soldier welfare and operational effectiveness. Sharing of information is a joint responsibility of the individual, medical professionals

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[170] *Ibid*.

[171] Lieutanent-General J.H. Vance. Personal Communications with author on 12 Feb 2014, with permission.

[172] Brigadier-General W.D. Eyre. Personal Communications with author on 18 Feb 2014, with permission.

and CO.[173] In addition, the influx of civilian mental health providers into the CAF structure may also add to the communication issues. Credibility and understanding of how to provide clear guidance that meets the commander's priorities is necessary for a mental health care provider to be successful.[174] Civilian mental health care professionals may find it difficult to gain that credibility and awareness unless there is close communication with the unit leadership and a consistent awareness of the unit and its priorities. Unit leaders and Medical Professionals clearly face a challenge in determining the right balance of information sharing in terms of providing soldier support.

SUMMARY CHAPTER 2

In any leadership profession there is an expectation to know your personnel and promote their welfare. However unlike other professions, in the CAF, these expectations are formalized in doctrine, formal authorities, and specific rules of law in order to hold leaders accountable if soldier well-being is not maintained. The QR&Os alone do not provide enough guidance on what the roles and responsibilities are for leaders in terms of soldier support. The evolution of leadership doctrine over the past two decades has seen an increased focus on clarifying the expectations for leaders in terms of soldier support. Moreover the development of additional guidance directed by the CDS, along with Senior Leadership guide books from NATO and from within the CAF provides further information to leaders. These guides are constructed to provide leaders with the tools and

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[173] Canada. Department of National Defence . Canadian Forces General Order (CANFORGEN) 018/08 Disclosure of medical and social work info to a Commanding Officer, Chief of Military Personnel 13 February 2008.

[174] Amy B Alder, Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 41.

information they need to fulfill their responsibilities and gain a better understanding of mental health and psychological well-being.

The guides discussed in this chapter summarize four major roles for leaders: fostering a healthy unit climate, prevention and education, reducing stigma and barriers to care and working in collaboration with Health Care Professionals. This chapter has identified a number of existing challenges for leaders in attempting to fulfill these roles. Fostering a healthy unit climate can be challenged by time limitations and a leader's ability to manage soldier expectations with operational requirements. The engaged leader paradigm highlights another challenge for leaders as they must determine whether their influence should extend into a member's family life. A healthy unit climate is reliant on consistent leadership, therefore communication and trust amongst NCOs and officers is essential for success.

Leaders currently play a supporting role in the prevention and education of mental health in the CAF. There is a heavy reliance on medical professionals to develop, implement and train personnel on R2MR and resilience training. The UK TRiM model provides a different perspective as it is a leadership-led peer support model that is supported by medical professionals. Reducing stigma and barriers to care also presents challenges to leaders. Encouraging soldiers to seek help and promoting it as a sign of resilience and strength instead of weakness can be complicated for leaders. Leaders must ensure their soldiers feel comfortable seeking help when required but also train them to be resilient warriors capable of performing a full range of combat operations.

Finally working in collaboration with Health Care professionals also presents challenges for leaders as information sharing can be sensitive when balancing medical

professional obligations to safeguard private information with a CO's need to know in order to provide adequate soldier support. The next chapter will provide a framework for an enhanced emphasis on a leader's role in soldier support.

CHAPTER THREE

WHERE CAN LEADERS MAKE A DIFFERENCE

> *One concept… which is a central theme of Canadian Forces leadership, but is not necessarily thought of by many in the public at large is 'caring'. Reduced to its simplest form, the military ethos is rooted in caring for subordinates. This issue is core to ethical leadership. It implies caring for troops before operations by training, equipping and supporting them to have a fair chance to fight, win and come home; caring for them during operations by professional leadership and support; and caring for them after operations by meeting their needs arising from that service, as well as honouring their deeds.*
>
> *General (ret'd) Ramsey Withers,*
> *In Generalship and the Art of the Admiral*[175]

INTRODUCTION

The previous chapters of this paper have described two major components of soldier support. Chapter one described the current mental health situation in the CAF and also examined the medical resources available within the CAF for soldier support. Chapter two focused on the leadership aspects of soldier support. Using institutional guidance and direction on soldier support, an analysis of the expectations placed on leaders were conducted. Four specific leadership responsibilities were identified in terms of their soldier's mental health. This final chapter will commence by first describing the two remaining components of soldier support. The individual soldier will be discussed as

[175] Department of National Defence, A-PA-005-000/AP-004 *Leadership in the Canadian Forces: Conceptual Foundations.* (Ottawa: DND Canada, 2005), 20.

he/she is the only constant component in the support system. Social support and the impact of families will also be discussed as their influence on soldier support is often under emphasized. With the final two aspects of soldier support discussed, the paper will transition to provide a framework based on an analysis of the existing CAF approach. The framework will suggest that the two main areas where leaders must become primary agents of soldier support are in education and prevention and combating stigma and barriers to care.

A graphical representation will be used to highlight the support gap in these two specific areas where leaders can have the greatest impact on soldier support. The follow on sections of this chapter will describe a leader-centric approach to education and prevention with a specific focus on resilience training and peer support systems of education using examples from the UK and US to propose modifications to the current approach. The importance of direct first level leadership of NCOs will be emphasized in this section. The following section will provide a leader-centric approach to reducing stigma and barriers to care through the application of basic leadership principles, and a greater empowerment of first line leaders.

WHAT ABOUT THE SOLDIER?

Prior to describing the leader-centric approach to soldier support, it is necessary to highlight a constant in the soldier support system that has not yet been emphasized in this paper. The only component of the soldier support system that has a constant role throughout the Mental Health Continuum Model (MHCM) is the members themselves. A *triad of care* is used to describe a shared responsibility between all players in the CAF

mental health system. In accordance with the *Surgeon General's Mental Health Strategy*: "A balance between the patient, the chain of command and the health system is essential to high-quality mental health care."[176] Moreover the member is seen as the most essential component of the triad of care as they have a personal responsibility to be involved in their care and recovery.[177] Dr. C Everett Koop, former US Surgeon General stated "the plain fact is that we Americans do a better job of preventative maintenance on our cars than on ourselves."[178] Although this quote describes Americans and not the CAF, the comment is relevant as it suggests a need for individuals to be held responsible for not just their care and recovery but also in preventing risks to their health and well-being.

Some would suggest that the onus of personal responsibility in terms of preventive health cannot be viewed in such simplistic terms. Harlad Schmidt, Assistant Professor, Department of Medical Ethics and Health Policy at the University of Pennsylvania, argues that a polarized view of personal responsibilities for health care is misguided and unhelpful.[179] Schmidt suggests a concept of "co-responsibility"[180] is more appropriate. This concept "acknowledges health is affected by both individual behaviour and factors beyond their immediate control, therefore, it is neither exclusively an

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[176] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (*Ottawa: DND, 2013), 19.

[177] *Ibid*., 19.

[178] Derek Licina, "Negative Health Behaviour: A Personal Responsibility or Not?", *The Army Medical Department Journal*, (October-December 2012), 15. Last accessed on 25 March 2014. http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=6c48c114-5b64-4230-b0cc-42df5ed70da2.

[179] Harald Schmidt. "Personal Responsibility For Health: A proposal For a nuanced approach," *The 4th International Jerusalem Conference on Health Policy 297.* Last accessed on 24 March 2014. http://www.researchgate.net/publication/246044581_Personal_Responsibility_For_Health_A_proposal_For_a_nuanced_approach/file/e0b4951d8f5d09f0c1.pdf.

[180] Derek Licina, "Negative Health Behaviour: A Personal Responsibility or Not?", *The Army Medical Department Journal*, (October-December 2012), 16. Last accessed on 25 March 2014. http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=6c48c114-5b64-4230-b0cc-42df5ed70da2

individual nor social responsibility".[181] The concept of co-responsibility can easily be seen in the triad of care where the chain of command and health care professionals work with the individual to support the member along their continuum of health.[182] At different points along the continuum it can be more challenging to know what the individual needs are and therefore there is a greater requirement for the individual to guide the process. The quote "It takes a village to reintegrate a service member and support his or her journey home, and it takes a service member to teach us how to do it,"[183] summarizes how reintegration home from a deployment can be one of those crucial time periods that can be challenging for soldiers. Unlike physical injuries that often have common accepted recovery practices, mental health injuries and illnesses are unique and often their care and recovery vary depending on the individual, therefore it is essential that the individuals are engaged throughout the process to address their mental health concerns.

Not only are soldiers expected to be engaged in their care and recovery but they also need to be held accountable for their actions. The onus of personal responsibility is a key aspect of the military culture. Soldiers are expected to be responsible for their own physical fitness level, deportment, job performance and discipline. Both administrative and disciplinary measures are often issued when soldiers demonstrate deficiencies in key performance or potential areas of their occupation. In some case, soldiers with mental health injuries can demonstrate negative coping behaviours such as substance abuse, family violence, insubordination and absent without leave.[184] These behaviours violate

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[181] *Ibid*., 15.

[182] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (*Ottawa: DND, 2013), 19.

[183] Raymond M Scurfield,.and Katherine Theresa Platoni. *Healing War Trauma: A Handbook of Creative Approaches*. (New York, Routledge:2013), 73.

[184] Canada. Department of National Defence. *Senior Leadership Guide to Mental Health Leadership Roles and Responsibilities*. (Ottawa: DND Canada, 2011), 4., 31.

the code of service discipline in the CAF and leaders must address these behaviours in accordance with the military justice system.

> The mere presence of a mental health issues does not make a member any less accountable for his/her actions. In fact, failure to hold someone accountable risks enabling the behaviours and sets a poor example for the rest of the unit.[185]

There are often various factors that contribute to the negative behaviour. All leaders are trained extensively in the CAF military justice system along with the administrative orders and policies that are at their disposal. Leaders in key command positions have the responsibility to weigh all mitigating and aggravating factors that could have potentially led to the negative behaviour.

Balancing all potential factors involved in disciplinary proceedings can also be complex when a soldier's mental health is a concern. The USAF instituted a large scale suicide prevention program in 1996.[186] The program emphasized leadership involvement and a wide spread community approach to implementing eleven key initiatives that targeted strengthening social support and encouraging others to seek help when needed.[187] One interesting aspect of the program is the "Hands off" policy for service members under disciplinary investigation.[188] This policy ensures that any time a military member is investigated that they are "handed off" to their direct supervisor or first line

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[185] *Ibid*., 31.

[186] Kerry L Knox, Steven Pflanz, and Gerald Talcott. "The US Air Force Suicide Prevention Program: Implications for Public Health Policy." *American Journal of Public Health* 100, no. 12 (December, 2010): 2457.

[187] Knox Kerry L, Litts D.A, Talcott GW, Feig JC, Caine ED. "Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study." British Medical Journal 327 (13, 2003): 1377.

[188] United States Airforce. US Airforce Suicide Prevention Program: A Description of Program Initiatives and Outcomes AFPAM. (April 2001): 44-160, 20.

NCO.[189] The intent behind this policy is not to circumvent the disciplinary process or the legal rights of an individual. The policy recognizes that legal or disciplinary issues can contribute significant stress on military members and often cause them to feel isolated and alone.[190] The USAF program attempts to ensure members in these situations have a social support group that can guide them to the necessary resources and services as needed. The "hands off" approach may be valuable to be implemented into a CAF context, however in order for this policy to be effective it requires a significant investment in the training and development of junior leaders and NCOs to ensure they are well equipped with the tools and resources to provide an effective support system to soldiers.

Regardless of what approach leadership takes to support a member with disciplinary issues, the onus of personal responsibility of the individual cannot be overlooked. Individuals play a crucial role in their own soldier support and should be held responsible for their actions regardless of their mental health status. Leadership is key to assisting soldiers with this responsibility. Leaders guide soldiers and encourage them to seek help. Additionally, leaders should establish the unit culture of personal responsibility and communicate their expectations throughout the unit to ensure that all soldiers understand their personal responsibilities in regards to not only their professional duties but also their personal health and well-being.

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[189] Mark A. Zamorski, *Report of Canadian Forces Expert Panel on Suicide Prevention. (*Ottawa: DND Canada, 2010), 26.

[190] United States Airforce.US Airforce Suicide Prevention Program: A Description of Program Initiatives and Outcomes AFPAM. (April 2001): 44-160, 20.

Military families are unique. The demands of high risk deployments, frequent postings, geographical isolation and unpredictability are just a few examples of the demands that military families endure. "Military families are often referred to as the strength being the uniform."[191] Family members are often asked to carry the burdens of military members and rarely receive the recognition for what they do to support their loved ones. Although family members are not directly included in the *Triad of care*, the CAF does recognize their importance in soldier support. The Senior Leadership Guide to Mental Health, states "the role of the family to military members is integral to the support network."[192] The Surgeon General has also included families in his mental health strategy by the initiative of working with MFRCs in the implementation of R2MR training for families. Moreover the inclusion of Family Liaison Officers and Casualty Support Services such as child care and programs for children and youth are all examples of an investment in family support.[193] In the CDS Guidance to the CAF, he highlights a renewed focus moving forward where the framework of member and family support programs will be pragmatically examined to ensure the CAF is delivering the best outcomes for our families while ensuring the programs remain affordable for the long-term.[194] It is clear that the CAF recognizes the value of families in the support structure.

A distinct definition of who is included in the term "family" can vary widely depending on the individual. For the purposes of this paper a family member will be

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[191] Canada. Department of National Defence. *Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (*Ottawa: DND, 2013), 22.

[192] *Ibid*., 36.

[193] *Ibid*., 22.

[194] Canada. Department of National Defence. *Chief of Defence Stafff Guide to the Canadian Armed Forces* (Ottawa: DND Canada, 2013), 16.

defined as any loved ones that are important to a CAF member. A member's social relationships can often be linked to their work performance. The WHO's *Health Impact of Psychosocial Hazards at Work: An Overview*, found that "Both work-to-family and family-to-work conflict contributed significantly to the explanation of individual and organizational level variance in job stress.[195] These stressors also impact military families. The high tempo and high unpredictability of some military employments can cause significant stress on family members. Evidence shows that family stress can not only impact the psychological well-being of a CAF member but also influence the organization as a whole.[196] If the organization can decrease family or social stressors then there is potential for attrition to be reduced and operational effectiveness to be increased.[197] Soldiers who are less stressed at home should be more focused at work and therefore contribute in a more productive manner.

Alla Skomorovsky and Kerry Sudom conducted a study to determine the role of self-efficacy and coping in the well-being of military spouses.[198] This study found that both self-efficacy and emotional and humour coping strategies can buffer the negative impact of stress on psychological well-being.[199] There are several limitations to this study, a few of which being that some families may have self-selected for the study given their experiences (either positive or negative), also there is no distintion between dual-

[195] Leka Stavroula and Aditya Jain. *Health Impact of Psychosocial Hazards at Work: An Overview*. (World Health Organization: Geneva: 2010), 60. Document defines "Work-to-family conflict" as conflict that occurs when efforts to fulfill the demands of the employee role interferes with the ability to fulfill demands of the roles as a spouse, parent or carer. Therefore family-to-work conflict would be the opposite.

[196] Alla Skomorovsky, PhD and Kerry A. Sudom "The Roles of Self-Efficacy and Coping in the Well-Being of Military Spouses" in *Shaping the Future: Military and Veteran Health Research.* (Canadian Defence Academy Press: Kingston: 2011), 186.

[197] *Ibid*., 186.

[198] *Ibid*., 187-188. Self efficacy refers to an individual's belief in his or her capability to organize and execute a course of action needed to meet the demands of a situation and produce a desired outcome. Coping refers to the constantly changing cognitive and behavioural efforts to manage external and/or internal demands when an event is perceived as stressful.

[199] *Ibid*., 186.

service couples or Reservist families.[200] Regardless of these limitations, the study does suggest that providing self-efficiacy and coping training to spouses, such as resilence training may be valuable in improving psychological well-being outcomes. "Stress and coping training should provide military families with information on the adaptive coping strategies that may be used to deal with military-related stressors."[201] The CAF has taken great strides in providing this training to family members through the R2MR training program. Moreover the establishment of a 24/7 family information line offers a confidential conselling service for all military members and their families in addition to the support from the local MFRCs. [202]

Support from families is an important aspect of the CAF soldier support system. Leaders and medical professionals can work closely with family members to enhance the soldier support system. Families also need the support of the organization in order to effectively contribute to the soldier support system and for their own mental health. Additionally, leaders will not be able to fully know their soldiers and promote their welfare without understanding the dynamics of their soldiers' families and social support systems outside of work. Leaders must therefore assume a greater responsibility to enable soldiers mental health along with the mental well-being of their families. With all the components of the soldier support system presented, this paper will move to present a leader-centric approach to the CAF soldier support system.

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[200] *Ibid*., 197.
[201] *Ibid*., 197.
[202] Military Family Services Program. Welcome to the Family Information Line. Last accessed on 28 March 2014. https://www.familyforce.ca/sites/FIL/EN/Pages/default.aspx.

THE ROLE OF LEADERS IN SOLDIER SUPPORT

A widely accepted model for introducing the impact leaders can have on soldier combat stress was first introduced in 1995 by Gal and Jones.[203] The *Combat Stress Reaction Model* demonstrates that a soldier's appraisal of a combat situation and subsequent reactions are moderated by the interaction of several antecedent and meditating variables including experience, expectations and the nature of the stressor.[204] The *Combat Stress Reaction Model* was initially designed around the experiences of the Israeli Defence Force (IDF) and in the model "the leader has an important intervention role in the appraisal process in which he or she can have a positive influence on the methods of responding and coping."[205] The *Combat Stress Reaction Model* can be seen in Figure 3.1. A central concept of the model that remains at the heart of this paper is the central role leaders' play in a soldier's appraisal process. A leader can shape both an individual's expectations and interpretations of a combat situation and assists them with their response and coping mechanisms.

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[203] E.R Black, Force Mobile Personnel Research Report – Human Performance in Combat Working Paper 88-1. (Quebec: Canadian Forces Mobile Command Headquarters, 1988), 11.

[204] Nathan Keller. "The moderating effects of leadership, cohesion, and social support on the relationship between stress in combat and psychological well-being of soldiers participating in combat operations in Iraq." Presented to the Faculty of the Graduate School of The University of Texas at Arlington in Partial Fulfillment of the Requirements for the Degree of DOCTOR OF PHILOSOPHY THE UNIVERSITY OF TEXAS AT ARLINGTON May 2005, 26.

[205] E.R Black, Force Mobile Personnel Research Report – Human Performance in Combat Working Paper 88-1. (Quebec: Canadian Forces Mobile Command Headquarters, 1988), 11.

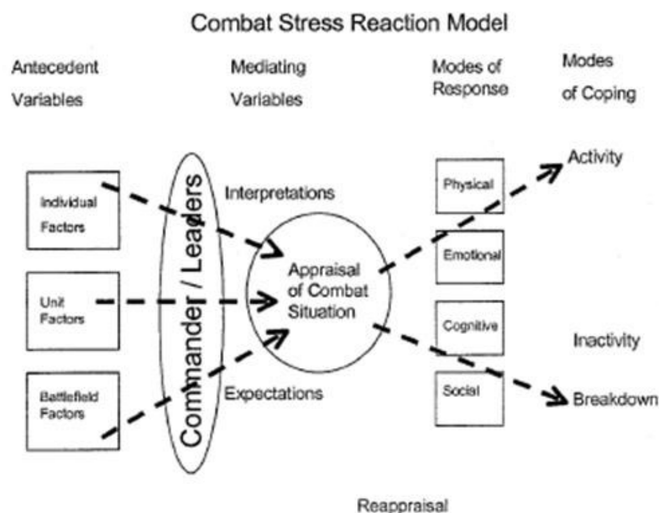

Figure 3.1 – The Combat Stress Reaction Model
Source: E.R. Black, "Human Performance in Combat" Force Mobile Research Report, 11.

Although the *Combat Stress Reaction Model* reinforces the importance a leader plays in how soldiers react to combat stress, it provides a limited view of a leader's influence as it does not cover the entire continuum of mental health. Moreover this model cannot be used to extract specific roles and responsibilities for leaders to influence soldier support.

In order to address a more all-encompassing approach to soldier support and to determine exactly where and how leaders can impact soldier support, a graphical representation (Figure 3.2 below) was constructed using a combination of the CAF MHCM, the Triad of Care and the Roles and Responsibilities of Leaders.

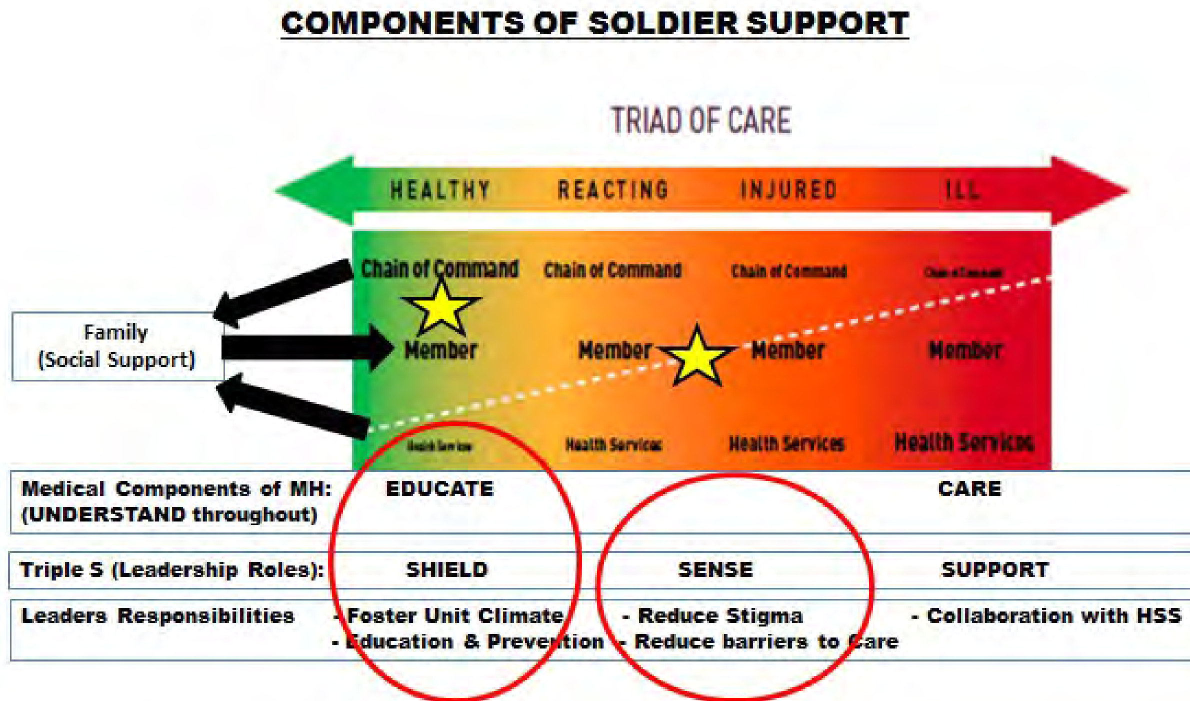

Figure 3.2 – Components of Soldier Support
Source: Author's interpretation of pre-existing models

By combining the pre-existing models with the medical components of mental health and the roles and responsibilities of leadership, the gaps or potential areas for leadership influence become apparent. The *Triad of Care* depicts an enhanced role for the Chain of Command when an individual is healthy, this correlates with the medical component of *EDUCATE* and a leader's role of *SHIELD* where key responsibilities for leaders are fostering unit climate and education and prevention. The previous chapters have demonstrated that leaders are currently not fulfilling a principal role in the education and prevention of mental health in the CAF as this aspect has historically been led by the CF H Svcs Gp. A recommendation that arises from this graphic is that in order to support the *Triad of Care*, leaders must become the primary agents of education and prevention of mental health. Empowering leaders to champion education and prevention in turn allows

the health care professionals to focus on the *UNDERSTAND* and *CARE* components of Mental health which is where there expertise and training sets them apart from unit leadership.

The graphical representation also identifies a potential gap in the middle of the MHCM where individuals are in between the reacting and injured spaces along the continuum. This space represents an extremely vulnerable stage for the individual as they start to experience some difficulties but have not yet sought assistance. This space may indicate a post deployment period of a soldier's life where they are struggling to adapt to life at home or it could be a pre-course time period where the stress of what is to come overwhelms the soldier. The graphic demonstrates that leaders have the ability to positively influence soldiers in this position. First line leaders, such as NCOs and junior officers have the most direct interaction with soldiers and therefore are in an ideal position to *SENSE* an issue and assist an individual in seeking help. Early engagement on the part of leadership may decrease the probability of acute mental health issues from becoming more problematic for their soldiers thereby maintaining the operational effectiveness of their units. In addition to identifying soldiers in need, leaders can also fill a gap by becoming the primary agents to combat stigma and barriers to care. Leaders are in the strongest position to influence the unit climate. Soldiers relate to their first line leaders and therefore look to their leadership to foster a climate that promotes soldier well-being.

The inclusion of family social support in the graphical representation highlights the underlying role family members' play in supporting soldier well-being. As previously indicated in this chapter, families can have a positive impact on soldier support, however

there is also a need for the Chain of Command and health care providers to assist families as they go through the continuum of health with their soldiers. The follow on sections of this chapter will describe in greater details how leaders can fill identified gaps in soldier support.

LEADERSHIP IN EDUCATION AND PREVENTION

Training and seeking self-improvement are inherent in any military culture. In order to meet the needs of the Canadian government and society, the CAF is constantly evolving and adapting to an ever changing battle space with unique challenges and threats. A significant part of training is education, either learning lessons from past experience or expanding the knowledge with new ideas and concepts. Soldiers support requires the same level of commitment and focus as any other military line of operation or effort. This section of the paper will demonstrate how leaders can take ownership of the education and prevention component of soldier support.

For training and education to be effective it must be focused and command driven. Although the objectives of the R2MR training were previously introduced in this chapter it is important to emphasize the third objective of enhancing psychological resilience as this objective is closely linked to leadership. Resilience is more than just being effective under pressure. Military resilience is defined in the *Road to Mental Readiness Aide Memoire* as "the capacity of a soldier to recover quickly, resist, and possibly even thrive in the face of direct/indirect traumatic events and adverse situations in garrison, training and operational environments."[206] A broad definition of leadership is

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[206] Canada. Department of National Defence. DGM-10-07-00285. *Road to Mental Readiness- Aide Memoire*. (Ottawa: DND Canada, 2011), 2.

"directly or indirectly influencing others, by means of formal authority or personal attributes, to act in accordance with one's intent or shared purpose.[207] The linkage between these two definitions rests in how leadership and resilience influence each other. The definition of resilience suggests that if soldiers are more resilient they may be able to be more operationally effective in difficult situations. Therefore military resilience directly impacts a leader's ability to successfully complete their mission.

The military is a learning environment. Most soldiers do not join the military with all the skills necessary to fulfill their job requirements. A soldier is taught basic soldier skills such as firing a weapon or conducting a fighting patrol. Mental health skills should be taught in a similar manner. Resilience has become the accepted foundation of basic mental health skills that soldiers also need to possess to do their jobs effectively. In order for the CAF soldier support system to be effective, leaders must take ownership of the education and prevention component of mental health by fostering a unit climate that allows resilience not only to exist but to flourish.

The current training design of R2MR is progressive in nature as mental health education programs are implemented along various stages of a member's career.[208] Progression can increase a member's awareness with repetition and also enhances their basic skills sets through practical application. Entrenching resilience skills along a member's career also potentially fosters a healthier climate within the institution by generating a greater acceptance of resilience and acceptance of mental health. The "Big

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[207] Department of National Defence, A-PA-005-000/AP-004 *Leadership in the Canadian Forces: Conceptual Foundations.* (Ottawa: DND Canada, 2005), 7.

[208] Canada. Department of National Defence. Surgeon General's Mental Health Strategy Canadian Forces Health Service Group: An Evolution of Excellence. (Ottawa: DND, 2013), 13.

Four" R2MR stress mitigating skills[209] provide the basic foundation for soldier preparedness. However, for these skills to be truly effective and remain relevant they need to be nurtured and developed by leaders. Leadership is required to implement resilience into all aspects of training if the CAF soldier support system is to be enhanced. Moreover training should not only be supported by unit leadership but executed by leaders themselves. Although the development and initial implementation of the R2MR training required the expertise of CAF Health Care Professionals and scientists, the training has progressed to a level where it can now be handed over to the chain of command to execute. The Canadian Army Doctrine and Training Centre (CADTC) has taken ownership of resilience training and institutionalized psychological resilience training into both individual and collective training and professional development.[210] The next step is for individual units to take ownership of resilience training for their personnel and incorporate it into all aspects of the unit training plans.

Physical fitness is incorporated into almost all aspects of military training. Physical fitness is conducted on a daily basis to ensure all individuals are fit to fight and ready to perform any physical demands that are asked of them. Exercise is known to have physical benefits as well as numerous psychological benefits such as stress reduction.[211] Stress Inoculation training (SIT), like physical fitness should also be incorporated into all aspects of training. University of Waterloo researcher, Donald Meichenbaum examined twenty-eight studies that support SIT and his common conclusion was that SIT can

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[209] Canada. Department of National Defence. DGM-10-07-00285. *Road to Mental Readiness- Aide Memoire*. (Ottawa: DND Canada, 2011), 7. Big four skills to mitigate stress are: goal setting, mental rehearsal/visualization, self talk and arousal reduction: tactical breathing.

[210] Colonel M.A. Lipcsey, Personal communications with author 27 March 2014, with permission.

[211] Stephen C. Flanagan "Losing Sleep" *Armed Forces Journal* (Dec 19, 2011): 12.

improve soldiers 'combat stress response.[212] Unit leaders must build SIT into all aspects of unit life. Most military job skills are taught using a phased approach; SIT can be implemented in a similar fashion. SIT commences with a conceptualization or education phase which is followed by a skill acquisition phase and subsequent application and follow-through phase.[213] Incorporating SIT into all aspects of unit training will further develop the resilience skills of the unit members.

In addition to SIT training, leaders can also take ownership of education and prevention by instilling chain teaching methods into their units. Chain teaching refers to a top-down method of education where each level of leadership is responsible for training service members under their direct command.[214] Chain teaching not only promotes small group discussion and participation of all members but also demonstrates to the soldiers how important the topic is to leadership.[215] This method is often used when educating members on safety issues and can include the requirement for leaders to report back through the chain of command when the teaching is complete.

A risk to this method is that its effectiveness depends on the competence and proficiency of the leader conducting the chain teaching. It is also essential that it is executed at an appropriate time and place. A leader must do more than simply regurgitate a policy and or directive in order to foster a healthy learning environment. In order to mitigate these risks there needs to be a commitment from the highest levels of leadership on the importance of the subject. Commanders must publicly demonstrate a commitment

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[212] *Ibid*., 12.
[213] *Ibid.*, 12.
[214] Amy B Alder, Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 44.
[215] *Ibid*., 44.

to mental health education and prevention either by emphasizing the importance of specific training at weekly orders groups or when addressing the unit in both formal and informal settings. Careful consideration should also go into planning when and where chain teaching sessions will occur to ensure both leaders and soldiers are not preoccupied with other tasks. If done correctly chain teaching will not only enhance the soldier support system within a unit but also provide leaders with the ability to gauge their soldiers understanding and acceptance of mental health. Moreover if done correctly chain teaching also has the potential to enhance the individual leader's understanding of mental health.

First level leaders need to have an active role in education and prevention component of soldier support. The direct interaction NCOs have with their subordinates on a daily basis allows them to know their soldiers better than other leaders within the organization. Due to the closeness and trust that is formed at the lowest levels of leadership, NCOs must adopt a greater responsibility for educating members and supporting soldier's mental health. In order for NCOs to adopt a greater leadership role in terms of soldier support, they must be empowered with the knowledge and skills to be effective. The professional development of NCOs is ongoing with the institutionalization of R2MR training, however to truly empower NCOs as leaders in soldier support, the CAF must first focus on the NCOs themselves. In 2010, the US Army implemented their 360 Degree Leaders Course which targets NCOs as it is believed that they have the greatest impact on the health and wellness of a unit.[216] The program "is a comprehensive multifaceted hands-on holistic research-based leadership course focused on enhancing

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[216] Colonel (Ret'd) M Lopez,. 360 Degree Leaders Course – 360 Degree Program Outcomes. Provided to author in an email on 19 Febuary 2014.

strength and balance in leaders while providing relevant and essential tools for leaders to manage and respond to soldier and marine Issues."[217] The intent behind the program is to teach leaders life skills so that they are in a better position to manage their own lives and therefore can mentor and apply the same skills with their subordinates. Although the program is relatively new, performance measurement has begun and demonstrated favorable results. A long-term (60 days to 3 years post course) outcomes assessment was conducted using over 1300 soldiers and marines who had attended the course and it was determined that over 80% felt that the course made a difference in their lives and the lives of their soldiers.[218] Although the validity of a self-assessment survey has already been suggested to lack objectivity, the positive feedback from the participants demonstrates that they felt they learned valuable skills on this course that assisted them in assisting their subordinates. It remains to be seen if an adaptation of this course could be applied in the CAF, however the 360 degree leaders course does emphasize greater requirement to invest and empower the professional NCO in order for them to act as a crucial leader in soldier support.

It is difficult to measure the true impact education and prevention programs such as R2MR are having on the mental health of CAF as research is ongoing. Craig Bryan and Chad Morrow, US Air Force psychologists, suggest that current mental health programs although admirable in intent are questionable in effectiveness.[219] Bryan and Morrow suggest that traditional mental health approaches contradict the military culture

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[217] *Ibid.*, Course is 5 day program covers a variety of topics including, self care, stress, anger management, relaxation, mindfulness, spiritually, injury prevention etc.

[218] US Department of Defence. Defense Center of Excellence for Psychological Health and Traumatic Brain Injury report, Nov 2012.

[219] Craig Bryan and Chad Morrow. "Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lesson Learned from the Defender's Edge Program." *Professional Psychology: Research and Practice* 42, no 1. (2011), 16. This was a general statement of all mental health services in the US and not a direct statement against R2MR.

and therefore are limited in their effectiveness as soldiers are reluctant to seek help. [220] Examples of the contradiction include isolating individuals from groups for individual care, the promotion of seeking external assistance and allowing for emotional vulnerability.[221] These examples contradict the military culture which thrives on toughness, close knit group bonds and looking after each other. This point of view will be expanded on further in a follow section that discusses leading culture.

PEER SUPPORT PROGRAMS

> *Four brave men who do not know each other will not dare attack a lion. For less brave men, but knowing each other well, sure of their reliability and consequently their mutual aid, will attack resolutely. This is the science of the organization of armies in a nutshell.*
>
> *- French Colonel, Ardant du Picq 1880.*[222]

NCO empowerment can have additional advantages on soldiers support. Social support in the military begins as early as basic training when members are socialized into the military culture and become affiliated or supported by specific groups. These group affiliations can be referred to as a component of the structural support model.[223] However the relationship between a NCO and a subordinate is better described by functional support model as it "considers not just whether support is present but whether the support provides what an individual might need at a particular time."[224] Peer support systems

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[220] *Ibid*., 17.
[221] *Ibid*., 17.
[222] Neil Greenberg and Norman Jones "Optimizing Mental Health Support in the Military: the Role of peers and leaders." In Amy B Alder., Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 80.
[223] *Ibid*., 73. Structural support model efers to the availability of social teies and is often grouped into four categories: marriage-related, family-related, church related, and other group affiliations.
[224] *Ibid*., 75.

attempt to fill a functional support void for soldiers. Research conducted by Neil Greenberg has demonstrated the value of peer support. Using a sample of UK peacekeepers, he found that the majority preferred to speak to their colleagues who deployed with them as opposed to external agents or their chain of command.[225] The study also found that those soldiers that did speak to colleagues about their experienced were less distressed then those that did not.[226]

The OSISS program previous introduced in this paper is one example of a peer support program. Other more informal programs have grown through social media outlets. The "send up the count" initiative was established by two CAF NCOs using a social media campaign to encourage their fellow soldiers to get in touch with peers.[227] With close to 10,000 members in a four month period on Facebook the initiative has grown substantially. Although numbers demonstrate a considerable degree of support for the initiative, it is difficult to determine exactly how successful the initiative has been at providing soldiers with functional support. However one might wonder what it says about the CAF as an institution if CAF members have to create their own informal social support networks instead of relying on the institution for support. A more productive alternative to informal social support programs would be a formal CAF peer support program that was led and executed by NCOs.

It is interesting to note that prior to the implementation of OSISS, the CAF investigated the use of another formal intervention technique called Critical Incident

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[225] Neil Greenberg and Norman Jones "Optimizing Mental Health Support in the Military: the Role of peers and leaders." In Amy B Alder,., Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 79.

[226] *Ibid*., 79.

[227] James Cudmore."Soldiers join forces to combat suicide and PTSD: 'Send up the count' campaign encourages troops to stay in touch", CBC News 12 December 2013. Last accessed on 1 April 2014. http://www.cbc.ca/news/politics/soldiers-join-forces-to-combat-suicide-and-ptsd-1.2461855.

Stress Debriefing (CISD). In the mid-1990s, the CAF followed American, Israeli and British research that proposed " . . . that psychological casualties can be returned to duty quickly if frontline treatment is carried out close to the battlefield soon after the trauma occurred."[228] This crisis intervention process was originally proposed by American Trauma Specialist and Ph D., Jeffery Mitchell in 1974 for use with small groups of emergency workers who were exposed to trauma events.[229] The aim of CISD is to reduce distress and restore group cohesion and unit performance in the aftermath of a significant traumatic event that generates strong reactions from personnel in a particular homogeneous group.[230] The efficacy of CISD remains controversial. Although CISD has been demonstrated to reduce distress in some individuals, it is also suggested that it has increased PTSD symptoms such as anxiety, depression, recurring nightmares and flashbacks in others.[231] Additionally CISD is not found to be appropriate for all individuals. It is designed specifically for emergency service workers who belong to small homogenous groups. "The literature [on CISD] emphasizes that "direct victims" of critical incidents, family members of those seriously injured or killed . . . require more

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[228] Rhona Birenbaum. "Peacekeeping stress prompts new approaches to mental-health issues in Canadian Military." *Canadian Medical Association Journal* 151 no. 10 (15 November 1994), 1485. Much of the change in thinking in terms of soldier mental health occurred because of Vietnam war. Many Vietnam war vets are unable to put their experiences behind them. Article also provides statistics that there were 58 000 Americans killed in Vietnam and it is estimated that more then 15 000 American veterans have commited suicide since the war ended in 1975.

[229] Jeffrey T. Mitchell, "Critical Incident Stress Debriefing (CISD)". *I trama website*. Lasted accessed 27 April 2014. http://www.info-trauma.org/flash/media-e/mitchellCriticalIncidentStressDebriefing.pdf, 2.CISD is a specific, seven phase, small group, supportive crisis intervention process. It is just one of the techniques included under the umbrella of Critical Incident Stress Management (CISM) program. CISD does not constitute any form of psychotheory it is simply a supportive, crisis focused discussion of a traumatic event.

[230] *Ibid*., 1.

[231] Rhona Birenbaum. "Peacekeeping stress prompts new approaches to mental-health issues in Canadian Military." *Canadian Medical Association Journal* 151 no. 10 (15 November 1994), 1486.

extensive treatment and should not attend CISD."[232] In the late 1990s, with no clear consensus reached in regards to the strengths and weaknesses of CISD on military members, the CAF continued to investigate other techniques to respond to soldiers suffering from stress-related injuries. In May 2001, OSISS was created to respond to this need.[233]

Over the past decade, the OSISS program has done a remarkable job of establishing a nationwide outreach and peer-support network for CAF serving and retired veterans. However, there are certain contrasting features between OSISS and the UK TRiM program which highlight potential areas where OSISS may be enhanced. OSISS, although a joint DND and VAC program, currently operates as an external organization from tactical units. Although there are five regional coordinators across the country and front line peer coordinators who interact with the various Wings and Bases they are not integral to the unit chain of command construct.[234] The TRiM program uses an alternative approach. TRiM practitioners are embedded into units to provide integral support and psychological mentoring to soldiers on behalf of the Commander.[235] All members of the

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[232] Brett Liz, Matt Gray, Richard Bryant and Amy Adler. "Early Intervention for Trauma: Current Status and Future Directions: National Center for PTSD Fact Sheet", *Clinical Psychology: Science and Practice* 9 no 2 (June 2002). 121.

[233] J.Don Richardson, Kathy Darte, Stephane Grenier, Allan English and Joe Sharpe. "Operational Stress Injury Social Support: A Canadian Innovation in Professional Peer Support." *Canadian Military Journal* 9, no.1 (August 2008), 57. OSISS was created in response to an increased incidence of military members suffering from debilitating stress-related injuries which became apparent following the Croatia Board of Inquiry conducted in 1999-2000. During the BOI a board member recognized a homeless man on the streets as a fellow soldier who had served in Croatia. The man had been released and suffered serious mental health problems. The board member intervened and helped the soldier improve his situation. This demonstrated to the BOI the enormous potential of peer support.

[234] Major Carl Walsh, OSISS Program Manager, email to author, 4 April 2014, with permission.

[235] Neil Greenberg and Norman Jones "Optimizing Mental Health Support in the Military: the Role of peers and leaders." In Amy B Alder,., Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 92.

unit are familiar with who the TRiM practioners are in order to avoid any perception of a special situation for those seeking assistance.

Training of peer-support personnel is crucial to ensure any formal peer support system is effective and credible. OSISS is largely comprised of public servants. OSISS does employ a small number of regular forces officers such as the originator of the program, LCol Grenier and the current OSISS National Program Manager, Major Carl Walsh along with a small number of volunteers.[236] All OSISS personnel conduct the standard public service screening requirements in addition to a four day Peer Helper training and a four day staff training program.[237] In the UK, TRiM is managed by Royal Marine Master Warrant Officers and practitioners are non-medical, junior management personnel who have been selected and trained in the system.[238] TRiM personnel receive up to a five day training package that covers the basics of trauma psychology, how to manage traumatic events, and psychological risk assessments.[239] Moreover the TRiM program recognizes that not all NCOs are effective TRiM practitioners. Military members that do not have a "personnel-focused"[240] attitude cannot be successful as a TRiM practitioner.

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[236] Major Carl Walsh, OSISS Program Manager, email to author, 4 April 2014. Maj Walsh estimated that OSISS has approximately 20 volunteers who are serving in the CAF. The remainder of approximately 120 person staff is made up of public servants who are mostly either veterans of the CAF or family members.

[237] *Ibid*., All OSISS personnel must meet the public service background checks (Legal, financial etc) and have experience providing support to those who have been impacted by an OSI. For training purposes, OSISS uses a PHD Psychologist who provides an intensive 4 day Peer Helper training. This is followed by a 4 day staff training program which is geared towards peer support in the organization. Volunteers go through the same screening and training process as the staff. After personel have completed the training, they are supervised and mentored by OSISS staff.

[238] N Greenberg, V Langston, N Jones. "Trauma Risk Management (TRiM) in the UK Armed Forces." Journal of Royal Army Medical Corps 154 no. 2 (2008): 124.

[239] *Ibid*., 92.

[240] *Ibid*., 73.

Performance measurement methods are a necessary component of any program. OSISS has established core competencies for peer support. These core competencies are incorporated into their performance measurement framework which involves conducting annual surveys for those that have participated in peer support.[241] OSISS is also in the process of implementing a new validated computer based assessment tool that measures and records the progress of the peer/clients in terms of their health and social functioning.[242] In order to ensure quality assurance with the TRiM program, it is evaluated by external TRiM personnel. Military health professionals support the program through monitoring, auditing and assisting in the development of training packages.[243] Research has also been conducted to determine the effectiveness of the TRiM program. In 2010, the results of a survey conducted on a sample of Royal Marines and UK Army personnel prior to, during and following their deployment to Afghanistan in 2007.[244] The results of the survey found that those soldiers that had experience with TRiM reported lower levels of psychological distress than those that did not.[245] Limitations of this study include small sample size, all male participants and the use of self-reporting measures that are subjective and open to interpretation.[246] After considering the limitations of this survey, it is assessed that the TRiM program provides value to soldier support. The Royal Marines continue to demonstrate confidence in the TRiM program as they have recently

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[241] Major Carl Walsh, OSISS Program Manager, email to author, 4 April 2014, with permission.

[242] *Ibid*.,

[243] N Greenberg, V Langston, N Jones. "Trauma Risk Management (TRiM) in the UK Armed Forces." Journal of Royal Army Medical Corps 154 no. 2 (2008):124, 90

[244] W. Frappell-Cooke et al, "Does trauma risk management reduce psychological distress in deployed troops?" *Occupational Medicine* 60 (2010) 646. http://occmed.oxfordjournals.org accessed on April 3, 2014

[245] *Ibid*, 649.

[246] *Ibid*., 648. The researchers reported having difficulty tracking down soldiers following their deployment Sample size was less then 100 male Royal Marines and Coldstream Guards. Using self-reporting measures is common for psychological health research.

announced a new initiative in conjunction with Naval Command Headquarters and other external partners to implement a new project called "TRiM for Veterans (T4V).[247] This thirty week pilot project is an initiative to expand the TRiM program to support all Royal Marines and Royal Navy Veterans serving and retired.

There is no denying the contribution peer support plays in the soldier support system, however the manner in which it is executed can influence the extent of its effectiveness. When asked what the challenges were for his organization, Major Carl Walsh, OSISS National Program Director remarked

> We have been seeing a strong and steady increase in the number of peers we are seeing and we have been able to respond by building a robust volunteer resource base; however, the numbers continue to increase and when this does, we are challenged to maintain the same outreach activities when we are taxed in trying to maintain the direct one on one and group peer support activities; thus, our challenge is to manage and provide the demand for direct peer support while still doing the much needed outreach part of our mandate.[248]

Peer support continues to be in increasing demand for CAF veterans. Major Walsh's remarks along with the growth of informal peer support groups such as the "Send up the Count" initiative are evidence of the growing demand. What is striking is that neither the formal or informal peer-support systems are driven by first line leadership. The TRiM program demonstrates the potential benefits of an internal, formal peer-support system that is integrated with the units and driven by the Chain of Command with support from the medical professionals. Within the CAF, the OSISS program should be re-examined to incorporate greater collaboration with the NCO corps as well as a greater role for tactical leadership to promote and manage the peer-support program. These enhancements will

[247] TRiM for Veterans Website. "Trauma Risk Management for Veterans." Last accessed on 3 April 2014. http://www.TRiM4veterans.org/TRiM-4-veterans/.

[248] Major Carl Walsh, OSISS Program Manager, email to author, 4 April 2014, with permission.

have the potential to strengthen the peer-support structure within the CAF and positively influence the CAF soldier support system.

Education and peer support training programs must be driven by leadership in order to be effective. The most important method in which leaders can guide these programs is by fostering a healthy culture. Building resilience training into everyday aspects of unit life, using SIT and properly planning out chain teaching methods will help foster a healthy environment. Additionally taking ownership of mental health training programs such as R2MR will demonstrate the importance CAF leadership places in soldier's mental health. NCOs need to be empowered using specialized training or programs that offer them the tools they need to be effective in providing soldiers with mental health support. An investment in the NCO ranks also has the potential to strengthen the CAF peer-support structure. The ownership of education and prevention by leadership will not only increase the effectiveness of training but will also help foster an environment that is conducive to combating stigma and barriers to care.

LEADERSHIP IN COMBATING STIGMA AND BARRIERS TO CARE

> *Every military leader bears responsibility for addressing stigma: leaders who fail to do so reduce the effectiveness of the service members they lead.*
>
> - Department of Defense Task Force on Mental Health 2007[249]

One of the most common questions in terms of mental health support is why most people are healthy while others are not. In earlier chapters, stigma and barriers to care

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[249] Defense Health Board Task Force on Mental Health. *An Achievable Vision: Report fo the Defense Health Board Task Force on Mental Health* (Virgina: Department of Defense, June 2007) quoted in Richard B. O'Connor, "Collateral Damage: How Can the Army Best Serve a Soldier With Post-Traumatic Stress Disorder?"*The Institute of Land Warfare, Land Warfare Papers* 71 (Febuary 2009) (Arlington Virgina:Association of the United States Army, 2009), 22.

were identified as potential contributing factors to address this question. The Components of the Soldier Support System represented in Figure 3.2 show that a soldier is most vulnerable when they are in between the reacting and injured stages along the MHCM. Whether they reach out and seek help or continue to suffer in silence is greatly influenced by their social support system. A leader's ability to "sense" what a soldier needs and establish a healthy climate that reduces barriers to care is essential for the CAF soldier support system. This section of the paper will summarize how leaders can become primary agents in overcoming stigma and barriers to care within their units.

Any intervention for reducing stigma should address both public and personal stigma if it is to have long term results for not only the individual involved but for the institution as a whole. In 1999, psychiatry professors, Patrick Corrigan and David Penn proposed three methods for reducing stigma attached to mental illness: protest, education and contact.[250] Protest involves an attempt to supress stigma by informing society about the truths regarding mental illness to counter any negative stereotypes.[251] These efforts can be observed in the manner in which the CAF leadership responded to the media attention surrounding recent CAF suicides. By providing the public with information on the resources and services that are available within the CAF, leadership has attempted to dispel the notion that the CAF does not have adequate mental health assistance.

Although protest has been found to decrease negative attitudes in the public, studies have also found that it fails to promote positive attitudes in individuals.[252] Education is

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[250] Patrick W. Corrigan and David L. Penn, "Lessons from social psychology on discrediting psychiatric stigma." *American Psychologist*, 54, no. 9, (September 1999): 765.

[251] Thomas W Britt, Tiffany M. Greene-Shortridge, and Carl Andrew Castro, "The stigma of mental health problems in the military," *Military Medicine* 172 (Febuary 2007): 160.

[252] Patrick W. Corrigan,. "How Stigma Interferes with Mental Health Care," *American Psychologist* 59 no.7 (October 2004): 620.

needed to "provide realistic descriptions of problems, including accurate information on the underlying causes of the problem and emphasize that many problems can be addressed through different forms of treatment."[253] The implementation of educational programs such as R2MR by leaders, have the potential to improve individual attitudes toward mental health. Public educational tools such as the "You're not alone - Mental Health Resources for CAF members and families" website along with a March 31, 2014 released CAF video "Addressing the Stigma of Mental Health" are powerful tools for combating stigma.[254] In addition to the educational benefit, the video also demonstrates another important aspect of leadership in combating stigma, which is contact.

The strategy of contact involves combating stigma by promoting contact with individuals who have mental illness.[255] In the CAF video, there are various levels of leadership, including the CAF Chief Warrant Officer Kevin West, who not only promote seeking assistance but also lead by example, providing his own personal account of his mental health injuries and the treatment he pursued. [256] Leading by example in terms of self-disclosure of mental health issues is not widely accepted. Leaders such as Major Christian Breede had mixed results when his company leadership attempted self-disclosure techniques post deployment.[257] It is much more widely accepted for leaders to encourage others to seek help as long as it does not involve exposing themselves to the

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[253] Thomas W Britt, Tiffany M. Greene-Shortridge, and Carl Andrew Castro, "The stigma of mental health problems in the military," *Military Medicine* 172 (Febuary 2007): 160.

[254] Canada. Department of National Defence. *You're not alone – Mental Health Resources for CAF members and Families*. Last accessed 8 April 2014. http://www.forces.gc.ca/en/caf-community-health-services/mental-health-resources.page?

[255] Thomas W Britt, Tiffany M. Greene-Shortridge, and Carl Andrew Castro, "The stigma of mental health problems in the military," *Military Medicine* 172 (Febuary 2007): 160.

[256] Canada. Department of National Defence. Video. *Addressing the Stigma of Mental Health*. Last accessed 8 April 2014. http://www forces.gc.ca/en/video.page?doc=addressing-the-stigma-of-mental-health/htfhtue8.

[257] Christian Breede. "Mental Health and Small Unit Leadership: An Autoethnographic Examination", in *A New Coalition for a Challeging Battlefield: Military and Veteran Health Research* (Kingston: Canadian Defence Academy Press, 2012), 35-48, 25.

perception of weakness or vulnerability. This reluctance to provide self-disclosure in essence supports the stigma that leaders are attempting to combat. Research suggests that stigma can be diminished if individuals have contact with someone with mental illness.[258] Knowing someone with a mental illness can remove the abnormality of the issue. Self-disclosure, although uncomfortable, is one method leadership can use to decrease stigma. All officers and NCOs, given their closeness to their subordinates, have the greatest potential to decrease stigma using self-disclosure techniques. If a soldier can identify with a peer or superior seeking assistance then it is possible that they may be more likely to seek help as well.

For leaders to truly combat stigma they must be actively engaged in all aspects of the process. For those leaders that have not experienced mental health distress, contact can be achieved through other methods. A Leader/supervisor support strategy is "an intervention [that] encourages leaders to take an active role in identifying and assisting soldiers in receiving mental health support."[259] The manner in which leaders are seen to support and assist soldiers that need mental health assistance can have a major impact on stigma.[260] Leaders must be engaged from the onset of any potential mental health issue and actively be seen to encourage those soldiers in need to seek help. Leaders should not shy away from engaging their subordinates about their mental health. This could involve asking questions about their progress or discussing different treatment techniques that they are involved in. In addition, leaders should not shy away from engaging with specialists such as Unit Padres, Garrison Social Workers and Medical Officers. A strong

[258] Patrick W. Corrigan,. "How Stigma Interferes with Mental Health Care," *American Psychologist* 59 no.7 (October 2004): 620.

[259] Thomas W Britt, Tiffany M. Greene-Shortridge, and Carl Andrew Castro, "The stigma of mental health problems in the military," *Military Medicine* 172 (Febuary 2007): 160.

[260] *Ibid*., 160.

working relationship between specialists and leaders is valuable for all components of the soldier support system. Providing specialists with the chain of command point of view can assist them in determining how to support a soldier and also potentially allow the specialist to encourage the soldier in need to engage with their chain of command. Some soldiers may chose not to disclose their mental health concerns with their chain of command; however this should not deter a leader from attempting to support the member. As mental health can be a sensitive topic, leaders should take careful consideration in choosing an appropriate venue for any conversations regarding a soldier's mental health. Some soldiers may be more comfortable in an informal environment while others may prefer a closed door, formal discussion. By demonstrating their overall compassion for a soldier through their willingness to support and remain in close contact with the member, leaders can decrease the stigma associated with mental health.

LEADING THE CULTURE

The stigma surrounding mental health in the military is perhaps deeply rooted. Stigma and negative stereotypes regarding mental health did not develop overnight and therefore it cannot be assumed that these attitudes can be changed quickly. On the other hand, research has shown that stigma is learned and therefore it has the potential to be unlearned.[261] When US Army General Peter Chiarelli was assigned as the Army Vice Chief of Staff he took on the responsibility of addressing mental health issues in the US Army. General Chiarelli recognized that soldiers were reluctant to ask for help because of stigma he was quoted as staying on numerous occasions "I've got to try and change the

[261] Amy Iverson et al. "The stigma of mental health problems and other barriers to care in the UK Armed Forces," *BMC Health Services Research* (2011), 30.

culture."[262] Military culture is unique from civilian society and differs depending on the military, environmental service, squadron, regiment or ship that individuals belong to.[263] However in the CAF, regardless of the unit or environmental affiliation, all members share a common military ethos. "Military ethos, as an expression of culture, is essentially the social glue that holds the organization together by providing appropriate standards of behaviour, . . . and shaping the attitudes of members."[264] The fundamental aspects of the CAF military ethos are unlimited liability, fighting spirit, discipline, teamwork and physical fitness.[265] These five concepts help shape the CAF profession of arms and the members that serve within it.

Interestingly, it has been suggested that aspects of a military culture, such as the concept of fighting spirit are counterproductive in combating stigma regarding mental health.[266] The notion is that a warrior culture based on strength, perseverance and physical and mental toughness discourages soldiers' willingness to seek help due to a perception of weakness. However as described earlier in this chapter, others such as US psychologists, Craig Bryan and Chad Morrow suggest a more effective strategy for combating stigma is to change the messaging instead of attempting to change the military culture.[267] Rather than attempting to alter a soldier's mindset, which guides his or her

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[262] David, Finkel. *Thank you for your Service*. Canada: Penguin Random House Company, 2013, 70.

[263] Karen, Davis. *Cultural Intelligence & Leadership: An Introduction for Canadian Forces Leaders*. (Kingston: Canadian Defence Academy Press, 2009), 48.

[264] *Ibid*., 41.

[265] Canada. Department of National Defence. A-PA-005-000/AP-001. *Duty with Honour: The Profession of Arms in Canada 2009*. (Ottawa: DND Canada, 2009), 27.

[266] Neil Greenberg, and Norman Jones "Optimizing Mental Health Support in the Military: the Role of peers and leaders." In Amy B Alder., Paul D. Bliese and Carl A. Castro. *Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military*. (Washington: American Psychological Association, 2011), 82. Fighting spirit can also be referred to as warrior culture dominated by toughness and physical strength.

[267] Craig Bryan and Chad Morrow. "Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lesson Learned from the Defender's Edge Program." *Professional Psychology: Research and Practice* 42, no 1. (2011), 17.

profession, stigma can be combatted by embracing the fighting spirit of its members to promote mental health.

CAF leaders are the primary agents for establishing a healthy unit climate that fosters and promotes the fighting spirit. Leaders must fully embrace not only the resilience training previously discussed, but also a full spectrum of health promotion and prevention techniques for their subordinates. Bryan and Morrow's mental health promotion initiative, the Defender's Edge (DEFED) program for the United States Air Force Special Forces provides an example of a philosophy that leaders could employ.[268] The DEFED program is based on five core concepts philosophy that aligns with specific job skills as summarized below in Figure 3.3.

DEFED Core Principles

DEFED Philosophy	Core Skill/Concept
• Combat is akin to an athletic event	• Controlled breathing/ relaxation
• Warriors are inherently resilient and strong	• Mindfulness/meditation/Situational Awareness
• Warriors already possess resiliency skills, but would benefit from additional "coaching"	• Sleep hygiene/stimulus control
• MH skills framed as job skills, performance enhancement	• Cognitive restructuring/ behavioral activation/ Mind tactics
• Trauma is less important than daily "benign stressors"	• Values clarification/ Warrior Ethos
	• Resiliency/ Mental Toughness

Figure 3.3 – DEFED Core Principles
Source: Author's Extraction from Bryan & Morrow. "Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lesson Learned from the Defender's Edge Program."[269]

Although this program was geared specifically for Special Forces soldiers, the philosophy is well suited to be adapted to conventional forces as well. Similarities can be

[268] *Ibid*., 16.
[269] *Ibid*., 16-22.

observed between the "Big Four"[270] counter measures that are taught within the CAF R2MR training and the DEFED philosophy. Although both programs use distinct language there is a common focus on mental awareness, tactical breathing and resilience in mitigating or preventing stress and subsequent mental health illness. Although the education of these physiological and psychological aspects skills can greatly improve a soldier's preparedness under stress, to be truly effective across an entire organization this philosophy must be nurtured by leadership. Colonel Lipcsey, CAF Director of Health Services Personnel described how leaders can foster a command climate as follows:

> . . . I believe they [leaders] should also foster a command climate that allows resilience to flourish. This can be achieved in a leader's attitude and bearing to everything he/she does. Further, training design should also have aspects of building resilience in a progressive manner. Command teams at all levels have a great amount of influence and how they use it in terms of resilience capacity building has a direct impact on the overall mental health of their organization.[271]

Fostering a command climate that embraces resilience training or the DEFED philosophy is not intended to suggest that leaders refrain from promoting traditional mental health programs. Rather, fostering a resilient unit climate complements the pre-existing mental health programs and strengthens the soldier support system as a whole. "Instead of feeling stigmatized by asking for psychological help, veterans should realize that it takes strength and courage to request assistance."[272] By fostering a healthy climate leaders in turn will encourage soldiers to stop perceiving asking for help as a weakness but rather their personal responsibility as a professional soldier.

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[270] Canada. Department of National Defence. DGM-10-07-00285. Road to Mental Readiness- Aide Memoire. Ottawa: DND Canada, 2011, 7-8. The "Big Four" refers to Goal setting, mental rehearsal/visualization, self talk and Arousal reduction: tactical breathing. These are stress countermeasures within the R2MR training.

[271] Colonel M.A. Lipcsey, Personal communications with author 27 March 2014, with permission.

[272] Daryl S. Paulson and Stanley Krippner. *Haunted by Combat: Understanding PTSD in War Veterans*. (Lanham, Maryland: Rowman & Littlefield Publishers, Inc., 2010), 54.

Leaders as primary agents of combating stigma and barriers to care should also be open to more non-traditional approaches to support their soldiers. Elements of the psychology concept of *mindfulness,* made popular by the works of Jon Kabat-Zinn[273] are incorporated into all aspects of the "Big Four" of R2MR training. Karen Davis and Justin Wright introduced the implications of mindfulness on cultural intelligence (CQ) using the work of David C. Thomas who described the role of mindfulness as a mediating link between cognition and behavior.[274] Davis and Wright suggest that CQ[275] relies upon a number of different cognitive activities of mindfulness. Being aware of our own assumptions and emotions and using all senses to perceive situations are just two elements of mindfulness[276] that are integrated into R2MR training. The practice of mindfulness, or living in the moment, has far reaching applications that have only begun to be experimented with in the military both in terms of resilience training as well as for mental health treatments. Leaders must be open to exploring this concept in more detail as soldiers experiment with various methods and approaches to thinking about their health and wellness.

Another example of a new concept that goes beyond resilience is *Antifragile*. This concept was introduced by author Nassim Taleb in his book *Antifragile: Things that gain from Disorder*. Taleb suggests that individuals operating in stressful environments

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[273] John Kabat-Zinn. *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, pain and Illness*. (New York: Bantam Books, 2013). The concept is based on Buddist mediation but has gained popularity in western society through the works of Kabat-Zinn.

[274] Karen Davis,. Cultural Intelligence & Leadership: An Introduction for Canadian Forces Leaders. Kingston: Canadian Defence Academy Press, 2009, 11. According to Thomas, mindfulness regulates cognitive processing and response by: bringing to mind knowledge relevant to the focus of attention; choosing not to respond automatically; inhibiting undesirable responses; and editing responses to be consistent with motives and goals.

[275] *Ibid.,* 142. CQ is defined as the ability to recognize the shared beliefs, values, attitudes and behaviours of a group of people and the capacity to effectively apply this knowledge toward a specific goal or range of activities.

[276] *Ibid*., 14-15.

should not aim to be resilient but strive for antifragility which is the ability to benefit or be strengthened in volatile environment.[277] Although it is beyond the scope of this paper to delve too deeply into this concept, there are elements of it that leaders could use to foster a healthy unit climate. Leaders should look to create environments where soldiers' mental skills can be strengthened, such as progressive SIT scenarios in training exercises. Decreasing negativity and adding physical and mental challenges to a unit environment may also strengthen soldier's mental health. The concept of Antifragile remains relatively new in a military context however the notion of excelling in the face of adversity relates well in the current military environment where soldiers are required to be operationally effective in an increasingly disorderly and chaotic environment.

Combating the stigma and barriers to care associated with mental health does not require a change in culture. Leaders need to embrace the fighting spirit that is already entrenched in their subordinates and build on it to promote a healthy climate where soldiers recognize their personal responsibility to seek help when required. Additionally, fostering a resilient philosophy that is based on key practical job skills will assist soldiers in preventing mental health injuries and militating stressors. In the future, leaders must continue to be open to non-traditional approaches to soldier support and work with soldiers to develop new ways of thinking about their mental health and well-being.

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[277] Nassim N Taleb. *Antifragile: Things that gain from Disorder*. (New York: Random House Publishing Group, 2012), 4-5. The author suggests that resilience is not enough as it suggests "the status quo" when presented with volatility. Taleb suggests that individuals should strive to become mentally stronger in adversity.

SUMMARY OF CHAPTER 3

The final two components of soldier support were described in this chapter to provide a holistic view of the CAF soldier support system. The impact that both family members and individual soldiers have on the soldier support system was identified. In order to examine the role of leaders in soldier support a graphical representation in Figure 3.2 was provided in order to highlight two distinct gaps in soldier support that should be filled primarily by leaders. The leader-centric approach to soldier support focuses on education and prevention with a specific focus on resilience training and formal peer support systems. Empowered, informed NCOs are valuable primary agents in effective soldier support. A leader-centric approach to soldier support also includes the responsibility of leaders to reduce stigma and barriers to care. Leaders must foster a healthy climate where soldiers embrace their fighting spirit in order to enhance their mental health and well-being.

CONCLUSION

Soldier support is a shared responsibility between medical professionals, leaders, family members and individual members. Recognition of all the support providers is important; however in order for the CAF soldier support system to be enhanced a greater onus must be placed on leadership. This paper has presented a leader-centric approach to soldier support where leaders are the primary agents of support for education and prevention and overcoming stigma and barriers to care. Many positive steps have been taken within the CAF to address a greater responsibility of leadership in providing soldier support. This paper has highlighted numerous mental health programs and services within

the CAF as well as research studies that are ongoing that demonstrate a commitment by the institution to provide the best possible care for soldiers. Institutional leaders have provided clear guidance and expectations for leaders at various levels in terms of soldier support. This paper described some of the challenges leaders face in meeting those expectations given their current supporting role.

By taking a holistic view of the CAF soldier support and all the key players within that system, two gaps in support became apparent. Using the mental health continuum, gaps were identified in two areas. A gap was first identified at the beginning of the continuum where soldiers are healthy and leaders are responsible to shield soldiers from mental health issues. This paper proposed that leaders become primary agents of soldier support for education and prevention in order to address this gap. More specifically, a leader-centric approach to education and prevention should focus on resilience training and formal peer support systems. Empowered and informed NCOs should be the primary agent to implement these educational systems in order to maximize effectiveness.

A second gap along the mental health continuum was identified where leaders are responsible for sensing mental health issues in their soldiers. A soldier is most vulnerable between the reacting and injured stages of the continuum. This paper proposed that a leader-centric approach to soldier support should also empower leaders to take ownership of reducing stigma and barriers to care. Leaders must foster a healthy climate where soldiers embrace their fighting spirit in order to enhance their mental health and well-being.

Mental health and well-being are complex subjects which are further complicated in unique environments such as the military. The requirement to gain a better understanding of mental health in the CAF as well as identify new approaches to support soldiers is internally recognized by institutional leadership. The support for mental health research both in relationship to the CAF and other militaries around the world is growing. However, there are challenges in research both in the ability to track CAF members throughout their careers and the time that is needed to fully analyze the impact of operations such as the Afghanistan mission on the organization as a whole.

There is also a need for greater performance measurement of the current programs and services that are in use in the CAF. Progress needs to be monitored and tracked, ideally using evidence-based strategies for assessment opposed to the more common self-reporting techniques. In today's economic climate, it is also important for programs to institute methods for tracking successes in order to justify continued funding. However, given the significant public attention mental health has received over the past few years, it is unlikely cuts to mental health programs would be an acceptable course of action.

Additionally the substantial growth of programs such as the JPSU should be examined in closer detail. Does an increase in soldiers posted to JPSU equate to more soldiers getting help or are soldiers' issues being passed off to another unit? These and other second order effects of JPSU growth should be analyzed further to determine if there are modifications to the current construct that can be made.

The CAF also potentially faces challenges with its future work force. New generations of CAF members may be more comfortable with evolving forms of communication such as social media, text messaging and emails. Additional research is

necessary to determine if these potential communication issues may impact a leader's ability to reach soldiers and support their well-being.

Open communication and partnership between all components of soldier support are essential to soldier well-being. Leaders must develop and foster strong relationships with their soldiers, their families and all medical health care providers that support their subordinates. The aim of this paper was not to suggest that leaders will always have all the answers in terms of soldier support. The medical expertise of the CF H Svcs Gp through the Mental Health Directorate is outstanding. Medical professionals have the intellectual knowledge that leaders lack in terms of mental health and medicine. As reflected in the *Triad of Care,* at certain stages along the MHCM, leaders must be prepared to follow the lead of medical professionals. In spite of what leaders lack in medical expertise they make up for in credibility, loyalty and understanding with soldiers. The bond between leaders and soldiers is substantial. Leaders influence their soldier's actions with their guidance and mentorship. Leaders, at times unknowingly, also influence their soldier's mental health. Personal relationships, enduring similar hardships and consistent day to day interactions between leaders and soldiers all contribute to soldier well-being. Leaders have taken great strides in increasing awareness and understanding for mental health issues in the CAF; however comprehension alone will not enhance the CAF soldier support system. Leaders must lead the way in knowing their soldiers and promoting their well-being.

Appendix 1 – OVERVIEW OF TRAUMA RISK MANAGEMENT PROGRAM (TRiM)

Source: N Greenberg, V Langston, N Jones. "Trauma Risk Management (TRiM) in the UK Armed Forces." *Journal of Royal Army Medical Corps* **154 no. 2** (2008):123-127.

TRiM is a proactive, post traumatic peer group delivered management strategy that aims to keep employees of hierarchical organizations functioning after traumatic events, to provide support and education to those who require it and to identify those with difficulties that require more specialist input. Initially developed within the Royal Marines, TRiM practitioners are embedded within all units and after traumatic events they ensure that the psychological needs of personnel involved in the event are assessed and managed. Practitioners are non-medical personnel in junior management positions who have been trained in the system.

TRiM practitioner training aims to equip non medics to manage the psychological aftermath of a traumatic incident or series of incidents. Training covers a wide subject matter including psychological aspects of incident site management, how to plan for personnel's psychological needs after an event, how to conduct a semi structured risk assessment interview and how to conduct basic psycho educational briefings. Personnel are also taught how and when to liaise with managers and medical/welfare staff. The TRiM course is a combination of didactic teaching and role play and has been carried out within the Royal Marines Command for the last nine years.

Because TRiM practitioners are within units, they are well placed to provide informal support in response to some, but not all, concerns that arise outside of the immediate aftermath of an incident. For instance if someone has been experiencing hyper arousal and heightened alertness for a few weeks as the result of regular of exposure to indirect fire, and being concerned that "they might be going crazy", they informally approach a well-respected TRiM practitioner, who might be able to normalize the individual's reaction, if doing so is appropriate. However if someone were to approach a TRiM practitioner and want to discuss their ongoing distress about sexual abuse they had experienced during their childhood, the practitioner would be well advised to, sensitively, refer that person to the medical, chaplaincy or welfare services. Such "boundary" issues are discussed during training.

Well respected TRiM practitioners can effectively become the "eyes and ears" of the defence medical and mental health services because they are likely to be trusted by unit members who will confide in them. Current experience from both Afghanistan and Iraq is that commanders highly value their unit TRiM practitioners. Such is their support of the system that deploying brigades have been very keen to get personnel TRiM trained in advance of the formal implementation of TRiM by the Army.

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