An Exploratory Examination of Personnel Support to Operations

Nancy Otis
Personnel Generation
Personnel Generation Research

Jason Dunn
Future Personnel Concepts
Personnel and Family Support Research

Zhigang Wang
Future Personnel Concepts
Personnel and Family Support Research

DGMPRA TM 2009-016
September 2009

Defence R&D Canada
Director General Military Personnel Research & Analysis

Chief Military Personnel

National Defence Défense nationale

Canada

An Exploratory Examination of Personnel Support to Operations

Nancy Otis
Personnel Generation
Personnel Generation Research

Jason Dunn
Future Personnel Concepts
Personnel and Family Support Research

Zhigang Wang
Future Personnel Concepts
Personnel and Family Support Research

Director General Military Personnel Research & Analysis

Technical Memorandum
DGMPRA TM 2009-016
September 2009

Principal Author

(Original signed by)

Nancy Otis, PhD

Approved by

(Original signed by)

Douglas Pelchat, BA

Section Head – Personnel Generation Research

Approved for release by

(Original signed by)

Kelly Farley, PhD

Chief Scientist – Director General Military Personnel Research and Analysis

The opinions expressed in this paper are those of the authors and should not be interpreted as the official position of the Canadian Forces, nor of the Department of National Defence.

Abstract

This work is the result of a CMP request to conduct an overview of personnel support based on the CF J1 conceptual framework. The objectives of this paper are: 1) to provide an overview of CF personnel support services and programmes as well as services and programmes offered in TTCP nations; and 2) to review CF lessons learned from recent operational experiences and recommendations from Department of National Defence (DND)/CF Ombudsman Reports. In addition, interviews conducted with subject matter experts (SMEs) from different DND/CF divisions are summarized to provide additional information on personnel support. Based on the information gathered herein, recommendations are made for future work in the area.

Résumé

Le présent document est le résultat d'une demande du CPM de réaliser une phase d'aperçu du soutien du personnel en fonction du cadre conceptuel J1 des FC. Il a pour objectif : 1) de donner un aperçu des programmes et services de soutien du personnel des FC ainsi que des programmes et services offerts dans les pays membres du programme de coopération technique (TTCP); 2) de revoir les leçons apprises par les FC à partir des dernières opérations et des recommandations formulées dans les rapports du ministère de la Défense nationale (MDN) et de l'ombudsman des FC. De plus, des résumés d'entrevues menées auprès de spécialistes en la matière rattachés à différentes divisions du MDN et des FC sont présentés afin de fournir de l'information supplémentaire relativement au soutien du personnel. Fondées sur l'information recueillie et présentée ci-après, des recommandations sont faites en vue de travaux futurs sur le sujet.

This page intentionally left blank.

Executive summary

An Exploratory Examination of Personnel Support to Operations:

Nancy Otis; Jason Dunn; Zhigang Wang; DGMPRA TM 2009-016; Defence R&D Canada – DGMPRA; September 2009.

This work is the result of a CMP request to conduct an overview of personnel support based on the CF J1 conceptual framework. The objectives of this paper are: 1) to provide an overview of CF personnel support services and programmes as well as services and programmes offered in TTCP nations; and 2) to review CF lessons learned from recent operational experiences and recommendations from Department of National Defence (DND)/CF Ombudsman Reports. In addition, interviews conducted with subject matter experts (SMEs) from different DND/CF divisions are summarized to provide additional information on personnel support.

The authors acknowledge that the information gathered is exploratory in nature and is therefore limited. This work, however, does serve as a starting point for future efforts in the area of personnel support to operations.

The CF has a range of personnel support programmes and services in relation to health, spirituality, and morale and welfare for CF members and their families. In the views of interviewed SMEs, the CF provides excellent support programmes and services. These programmes and services were believed to be effective in meeting the needs of CF members. While SME feedback provided has been positive, at this time it is not possible to make conclusions in relation to the effectiveness of the programmes and services that are being offered nor is it possible to determine how the CF compares to the other countries in terms of the direct support provided to members and their families. Further research and comprehensive programme evaluations would be required before any assessments of program effectiveness could be made.

Based on the information gathered, it is recommended that:

a. This preliminary work be distributed to TTCP nations and more comprehensive and detailed information on their programmes and services be solicited;

b. The CF review and evaluate whether the intent and policies surrounding current programmes and services are meeting CF members' needs;

c. The CF develop objective performance indicators in order to properly monitor and evaluate its programmes and services. Programme evaluation should be undertake to determine the efficiency of programme and service delivery as well as CF member satisfaction;

d. Research be undertaken with CF service providers, the chain of command, as well as CF members and their families to identify barriers in the provision of support programmes and services;

e. Research be conducted into the engagement of CF family members in the deployment process and in CF programmes and services;

f. Further research be conducted to demonstrate the effectiveness of the TLD programme;

g. The CF develop a comprehensive research plan in the areas of resiliency, stress and PTSD;

h. Stress and coping components in current leadership training practices be reviewed and evaluated to ensure continuity and consistency in programme delivery; and,

i. Further research be undertaken into the different meanings and forms of spirituality.

Sommaire

An Exploratory Examination of Personnel Support to Operations:

Nancy Otis; Jason Dunn; Zhigang Wang; DGMPRA TM 2009-016; R & D pour la défense Canada – DRASPM; Septembre 2009.

Le présent document est le résultat d'une demande du CPM de réaliser un aperçu du soutien du personnel en fonction du cadre conceptuel J1 des FC. Il a pour objectif : 1) de donner une vue d'ensemble des programmes et services de soutien du personnel des FC ainsi que des programmes et services offerts dans les pays membres du programme de coopération technique (TTCP); 2) de revoir les leçons apprises par les FC à partir des dernières opérations et des recommandations formulées dans les rapports du ministère de la Défense nationale (MDN) et de l'ombudsman des FC. De plus, des résumés d'entrevues menées auprès de spécialistes en la matière rattachés à différentes divisions du MDN et des FC sont présentés afin de fournir de l'information supplémentaire relativement au soutien du personnel.

Les auteurs reconnaissent que l'information recueillie est de nature exploratoire et, par conséquent, limitée. L'étude constitue, toutefois, un point de départ pour les prochains travaux sur le soutien fourni aux opérations par le personnel.

Les FC offrent une gamme de programmes et services afférents à la santé, à la spiritualité, ainsi qu'au bien-être et au maintien du moral des membres des Forces canadiennes et de leurs familles. Selon les spécialistes en la matière interrogés, les FC proposent d'excellents programmes et services de soutien. Il semble que ces programmes et services sont efficaces et satisfont aux besoins des membres des FC. Bien que la rétroaction des spécialistes en la matière ait été positive, il est impossible, pour le moment, de tirer des conclusions en ce qui a trait à l'efficacité des programmes et services offerts, ni en ce qui a trait à la comparaison des FC avec d'autres pays quant au soutien direct fourni aux militaires et à leurs familles. Il faudrait faire des études plus approfondies et des évaluations exhaustives des programmes avant de pouvoir tirer de telles conclusions.

Compte tenu de l'information recueillie, les recommandations adressées aux FC sont les suivantes :

a. distribuer la présente étude préliminaire aux pays membres du TTCP et solliciter des données plus exhaustives et plus précises quant à leurs programmes et services;

b. revoir le but et les politiques sous-jacents aux programmes et services actuels et évaluer s'ils satisfont aux besoins des membres des FC;

c. élaborer des indicateurs de rendement impartiaux qui permettront d'encadrer et d'évaluer de manière appropriée les programmes et services des FC. Entreprendre une évaluation des programmes afin de déterminer l'efficacité de la prestation des programmes et services ainsi que la satisfaction des membres des FC;

d. mener une étude auprès des fournisseurs de services des FC, de la chaîne de commandement de même qu'auprès des membres des FC et de leurs familles afin de déterminer les obstacles à la prestation des programmes et services de soutien;

e. mener une étude sur la participation des membres des familles des FC au processus de déploiement et aux programmes et services des FC;

f. mener une étude approfondie en vue de déterminer l'efficacité du programme de décompression dans un tiers lieu (DTL);

g. dresser un plan de recherche exhaustif sur la résilience, le stress et les troubles de stress post-traumatique (TSPT);

h. examiner et évaluer les composantes du stress et des réponses face à celui-ci relativement aux pratiques employées pour l'instruction en leadership, de manière à veiller à la continuité et à l'uniformité de la prestation des programmes;

i. mener une étude approfondie sur la spiritualité et ses différentes significations et formes.

Table of contents

List of figures

Acknowledgements

The authors would like to thank the subject matter experts who participated in interviews.

1 Introduction

1.1 Background

The Chief Military Personnel (CMP) is the functional authority for all personnel-related matters for the Canadian Forces (CF). Recently, CMP put in place a CF J1 conceptual framework that is intended to provide more strategic oversight of personnel support to operations and personnel management issues related to operations. The strategic effect is to have the right soldier, sailor and airman or airwoman at the right time and the right place and to sustain their morale, spiritual and physical well-being. As shown in Figure 1, Health Services (Canadian Forces Health Services – CFHS), Chaplain Services (Canadian Forces Chaplain Branch – Chap Gen), and Morale and Welfare (Director General Personnel and Family Support Services (DGPFSS) – previously the Canadian Forces Personnel Support Agency) are the personnel support areas under CMP control that provide direct support to operations.

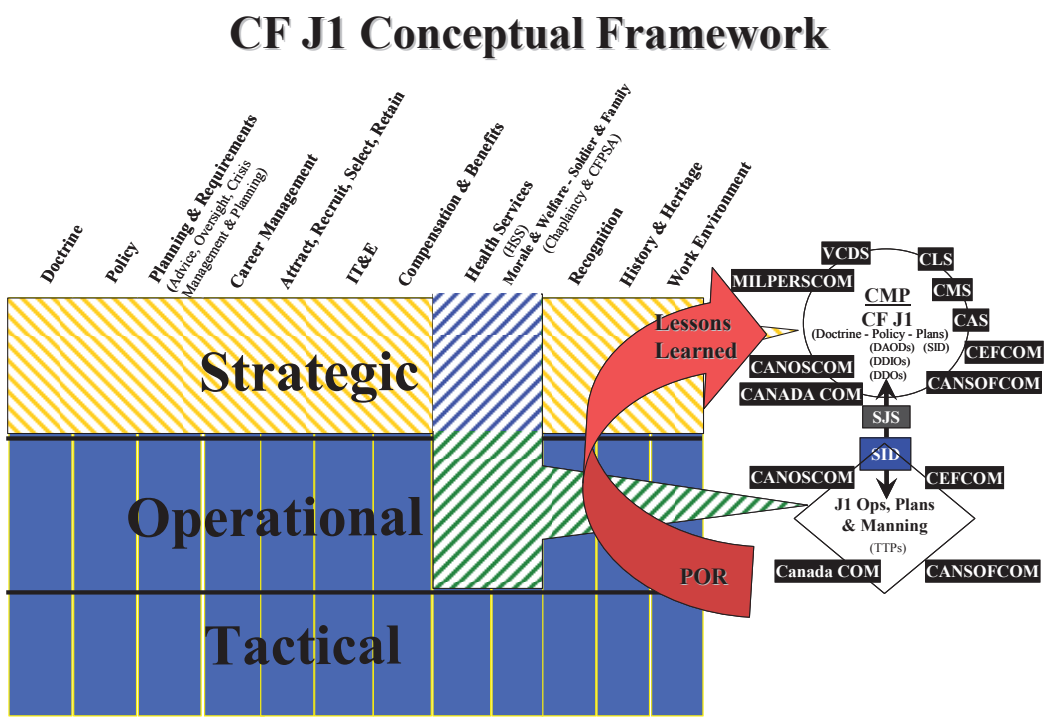

Figure 1: The CF JI Conceptual Framework[1]

[1] Cited from *Briefing to the Commanders of Canada COM, CEFCOM, CANSOFCOM and CANOSCOM*, CF Transformation J1 Functional Review Working Group, 7 Jun 2007 (the latest version of the framework).

In addition to CFHS, the Chap Gen, and DGPFSS, many other entities are involved in personnel support: the environments (Army, Navy and Air Force), the Strategic Joint Staff (SJS), and the new operational commands (Canada Command (Canada COM), Canada Operational Support Command (CANOSCOM), Canada Expeditionary Force Command (CEFCOM), and Canada Special Operations Forces Command (CANSOFCOM)). The right side of Figure 1 shows the proposed interrelationship between the players to achieve and maintain effective oversight of personnel management and support. The J1 coordination capability, which was stood up in August 2007, is responsible for providing a linkage between the operational commands and the strategic level (through liaison with the SJS). Its main task, however, is to provide better situational awareness of operational needs and requirements to CMP to enable CMP to bemore responsive. It is also responsible for the lessons learned process, involving the collection, dissemination and the tracking of lessons learned across CMP.

1.2 Aim and Scope

This work is the result of a CMP request to conduct an overview of personnel support based on the CF J1 conceptual framework. Accordingly, this paper focuses on programmes and services that directly support operations[2] in the areas of Health Services, Chaplain Services, and Morale and Welfare (before, during and after deployments). Two components of operational support, family and casualty support, are addressed in two separate papers[3].

The objectives of this paper are: 1) to provide an overview of CF personnel support services and programmes as well as services and programmes offered in TTCP nations; and 2) to review CF lessons learned from recent operational experiences and recommendations from Department of ational Defence (DND)/CF Ombudsman Reports. In addition, interviews conducted with subject matter experts (SMEs) from different DND/CF divisions are summarized to provide additional information on personnel support.

1.3 Limitations

The authors acknowledge that the information gathered is exploratory in nature and is therefore limited. The aim of this paper is to provide an inventory of programmes and services and not to assess how the CF compares to other TTCP nations in terms of the direct support provided to members and their families.

---

[2] For the purposes of personnel support, an operation is defined as the deployment of an expeditionary formation, unit or members to an area of operations in or beyond Canada for purposes other than administration or training, and subject to orders from the strategic or operational level (DDIO, Chapter 16, Article 1601-2).

[3] The first paper, by Tanner, Aker, Otis, and Wang (2008), reviews what services and support are offered to military families in each of The Technical Cooperation Program (TTCP) countries – Canada, Australia, New Zealand, the United Kingdom (UK) and the United States (U.S.). The second paper, by Wang, Dunn, and Tanner (2008), focuses on programmes and services that directly support members who become seriously ill or injured.

Information for Canada and other TTCP nations was gathered directly from open sources and may not reflect recent initiatives. While a limited number of interviews were conducted with DND/CF SMEs, no interviews were undertaken with service providers from TTCP nations.

2 Health Support to Operations

2.1 Canada[4]

2.1.1 Health Services Support to CF Operations – General

The Deputy Chief of Defence Staff (DCDS) Direction for International Operations (DDIO) states that: "Health services support consists of medical and dental support. The CF health services contribute to CF personnel effectiveness by ensuring optimal health of the forces prior to operations, force health protection, rapid evacuation, and appropriate management of the wounded, sick, and injured."[5] The group responsible for CF health services and programs is the Canadian Forces Health Services Group (CF H Svc Gp), which comprises the Canadian Forces Medical Services (CFMS) and the Canadian Forces Dental Services (CFDS), both of which are under the leadership of the Director General Health Services (DGHS).

Over the past few years, as part of the RX2000 Project, a number of initiatives have been created to improve deployment health. The RX2000 Project was developed to implement recommendations made in several reports. These reports included: the Croatia Board of Inquiry; the Chief of Review Services' Review of the CF Medical Services Report; the Standing Committee on National Defence and Veterans Affairs (SCONDVA) Report on Quality of Life; the McLellan Report on the Care of Injured Personnel and Their Families; and the Lowell Thomas Report on the issue of potential contamination in the Croatian Sector South region. These reports drew attention to the resource limitations of the CF health system, particularly its inability to keep pace with the new reality of CF operations. They also provided the impetus to act in order to improve the standard of health care provided to CF members at home and abroad.

Ongoing improvements to CF members' general health care center around four areas: Continuity of Care, Accountability, Health Protection, and Sustainability of CFHS Human Resources. For example, the *Strengthening the Forces* health promotion program developed under the Force Health Protection section of the CF H Svc Gp and delivered to bases through DGPFSS is a recent initiative directly related to the protection of the troops. It consists of providing education and information about living, injury prevention, nutritional wellness, addictions, and social wellness that will enable members to take care of their health. The goal of the program is to enhance members' health and well-being, thus enabling them to perform more effectively and safely on CF operations.

---

4 See Canadian Forces Health Services at http://hr.ottawa-hull.mil.ca/health/engraph/home_e.asp?Lev1=12.

5 DDIO, Chapter 16, Article 1601-2.

Developing recommendations to improve health care specific to deployments is also the responsibility of a variety of working groups that are part of the Standing Committee on Operational Medicine Reform (SCOMR)**.** These working groups touch on a variety of subject areas, such as the number of CF doctors, health service support personnel training, medical supplies, aeromedical evacuation, hospitalization, and personal protective measures/equipment.

Defence Administrative Order and Directive (DAOD) 5044-1, *Families* (2002) states that "the CF is committed to promoting and safeguarding the mental health of its members and providing appropriate interventions and treatments for CF members who experience mental health problems and related support to CF families where appropriate." In general, the CF working environment can affect members' mental health and their ability to perform their military duties. Preventing mental health problems and increasing members' coping skills is of great importance to the CF. The role of deployed unit commanders in terms of mental health support to deployed operations is described in a working group guidance document as follows: "to ensure that their personnel adapt to the effects of acute stress, anxiety, and/or fear, prevent Combat Stress Reaction (CSR) and to effectively manage CSR when it occurs." (Mental Health Working Group Draft Guidance Document code 7.5, 2007)

2.1.2 CF Inventory of Deployment Health Programmes and Services

2.1.2.1 Pre-Deployment Health Services

Pre-Deployment Physical Health Screening. Before CF members are deployed on a mission, a medical officer reviews each member's medical file, including a valid Periodic Health Examination (PHE) and a health questionnaire (Form CF 2078), to ensure that there are no conditions that may warrant a complete medical examination. If the member does not have a valid PHE, a complete medical examination will need to be completed. The medical review is to ensure that CF members going on deployments are in good physical condition to carry out their mission.

Pre-Deployment Psychosocial Screening. Mental health screenings take place during the course of pre-deployment medical examinations. Prior to departure, CF members undergo a rudimentary screening by a CF social worker, chaplain, or a psychologist to confirm their general suitability. The screening generally confirms the presence/absence of contra-indications (e.g., domestic situation, financial situation, unresolved legal matters, situation of extended family, local supports and resources, current/previous difficulties with substance abuse, etc.) that could impair the individual's mental well-being or ability to function effectively during the deployment. The screening also explores the member's familiarity with deployment/reunion stress, the impact of deployment on family dynamics, and critical incident stress (CIS) awareness for the family. The CF recognizes that family involvement is critical to the overall success of the process. Personnel are also required to create or review their Family Care Plan (FCP) during the deployment preparation phase.

Human Dimensions of Operations (HDO) Survey. The HDO Survey was created to assess the psychological aspects of operational readiness and unit organizational climate. Approximately two to three months prior to deployment, the contingent completes the HDO which assesses morale, cohesion, perceptions of leadership, symptoms of stress, signs of stress, and coping

mechanisms. A written report is prepared for Commanding Officers (COs) with respect to their units.

Mental Health Training. During the course of pre-deployment training, a social worker or a mental health nurse briefs members on various aspects of psychological support to operations. These briefs include stress recognition, stress management, and familiarization with the mental health services available in-theatre.

Preventive Health Measures. Surpassing the Canada Immunization Guide's requirements, these measures include updated immunizations and deployment-specific vaccines and drugs to counter anticipated threats (e.g., anti-malaria drugs and chemical prophylaxis).

Assessment of Deployment Health Threats. The multi-disciplinary Deployable Health Hazard Assessment Team (DHHAT) assesses health hazards in detail and quantifies contaminant and radiation levels. This includes an assessment of medical intelligence, reconnaissance and health hazards. The goal is to detect potential adverse health trends or exposures, assess countermeasure effectiveness, and recommend enhanced preventive measures.

a. **Medical Intelligence.** Pre-deployment Intelligence Preparation of the Battlespace includes the collection and detailed analysis of information about regional environmental, industrial, and public health hazards. Medical information in the region of the deployment is gathered and analyzed by the Medical Intelligence Section at Canadian Forces Medical Group Headquarters in Ottawa. The up-to-date information is obtained from public sources, various health organizations and allied countries. It identifies concerns, such as air pollution, altitude sickness, local communicable disease risks, immunization requirements, and medical resources available in-theatre (from the host nation or allied forces).

b. **Reconnaissance.** Reconnaissance teams deploying to the mission location include medical and engineering staff, who confirm existing health threat intelligence, obtain additional threat information, as well as assess the need for further threat assessments and mitigation measures. Prior to any deployment, an environmental team consisting of a Certified Industrial Hygienist, a Preventative Medicine Technician (P Med Tech), and an environmental engineer travels with the reconnaissance team to confirm the area's geography and various environmental conditions. These environmental conditions include any environmental threats such as industrial waste and communicable diseases, as well as the condition and state of available infrastructure. Their report serves as the basis for advising the Unit Medical Officer (UMO) of health risks in the deployment area. The P Med Tech focuses on hygiene, sanitation and pest control to keep communicable diseases to a minimum through education and inspection. The Certified Industrial Hygienist analyzes the concentration of chemical product and assesses the information in relation to the health of individuals. An epidemiologist keeps track of possible exposures and how that may affect group or individual health outcomes.

Comprehensive Briefings on Deployment Health Threats and Deployment Stress. These briefings on the findings of the complete assessment of deployment health threats are given before and during deployment based.

2.1.2.2 Deployment Health Care

Prevention. Every battalion-sized unit deploys with a P Med Tech, who is responsible for advising the UMO about the public health of the unit. The P Med Tech recommends to the UMO ways to maintain the over-all state of hygiene within the unit, and to keep the environment as safe as possible. The P Med Tech also assesses the health hazards that CF members may be exposed to while they are in-theatre. During the mission, the UMO is responsible for treating injuries and medical ailments as required. The UMO records information on a temporary medical file which is incorporated into the member's main medical file upon return to Canada. At any time during the deployment, the reconnaissance team can be used to make a health-risk assessment. Whenever a potential health risk is identified, it is officially recorded, and the patient's name is registered in a database dedicated to tracking potential exposure to contaminants.

Medical Care. The first level of care consists of "buddy aid", which is stabilizing a casualty at the point of injury, and then evacuating them to a military medical facility where they receive further stabilizing life and limb saving interventions by a health care team. The intermediate level of support emphasizes efficient and rapid evacuation of stabilized patients with en route sustaining care. On land, the evacuation vehicles are wheeled ambulances (similar to civilian ambulances) or armoured ambulances that provide more protection for patients and medical personnel. For more rapid evacuation, helicopter casualty evacuation is also available. The next level of medical support emphasizes resuscitation, initial wound surgery, post-operative care (including intensive care support), and short-term surgical and medical in-patient care. Diagnostic services, such as x-ray and laboratory, and limited internal medicine and psychiatric services are also available.

Hospital support can also be provided through partnerships with coalition allies or through agreements with host nations as long as the standard of health care matches or exceeds a Canadian standard of care. The CF currently partners with the UK and the Netherlands for the delivery of hospital-level health care to CF personnel in Bosnia and there is an agreement with Germany for the CF's mission to Afghanistan.

Mental Health Professionals. Service members are monitored on an informal basis by mental health personnel, chaplains, medical officers and supervisors. For example, four to five mental health professionals are available at the Kandahar airfield. They see people individually or as a group. Their roles are to educate and to listen.

HDO Survey. The HDO is completed in-theatre three times during the deployment (early-, mid-, and late-deployment). Written reports are prepared and briefings presented to COs with respect to their units.

Critical Incident Stress Management. Special attention is given to CIS during international operations. CSI is a stress response that occurs after being exposed to death or injuries related to training, operations, search and rescue, or emergency services response. Chapter 16, Article 1621-3 of the DDIO details the preventive and management measures taken to buffer the adverse effects of CIS:

a. "Promote and foster group cohesion;

b. Plan and conduct realistic training to include exposure to simulated situations likely to occur in-theatre;

c. Plan and conduct pre-incident education on the normal response to unusual stress;

d. Be prepared to provide CIS defusing or debriefings, as appropriate, of affected personnel and their immediate family members following an occupationally related critical incident exposure; and

e. Conduct post-deployment briefings that include information on reintegration stress, signs and symptoms of excess stress, treatment, and support resources available to the member and members of their immediate family."

The CF started to do CIS Debriefings (CISD) around 1994. The clinical standard group crisis intervention CISD consisted of a seven-step debriefing after an exposure to a traumatic event (Mitchell, 1983). In light of research results showing that CISD was ineffective and may cause harm (Wesley, Rose, & Bisson 1998), the CF stopped doing CISD in the early 2000s. Currently, the CF provides early psychological interventions after a critical stress incident but not the formal CISD. A new policy is being developed, which essentially states that different people have different requirements.

2.1.2.3 Post-Deployment Health Services

Post Deployment Briefings. Compulsory in-theatre briefings are given to members four to six weeks prior to departing the theatre of operations. Information is given about family integration, signs and symptoms of excess stress, treatment and support resources available to the member and their immediate family. Chaplains also provide support to soldiers and their families in preparation for post-deployment reintegration.

Decompression at a Third Location. The main purpose of Third Location Decompression (TLD) is to ease the reintegration process for members and their families. TLD provides members with a period of time, neither in-theatre nor at home, where members can rest, reflect on their deployment and engage in recreational activities. Resources and information are also provided to members on how to deal with various problems that might arise from having been on deployment. The Task Force Commander is responsible for deciding whether the decompression is necessary for his or her members. The decision is based on factors such as the operation tempo experienced during the deployment and the type and frequency of traumatic events.

Post-Deployment Medical Examination. A complete medical examination two days after the end of a member's disembarkation leave is conducted if an injury or illness has been declared or within 30 days of completion of leave if there is no report of injuries.

Family Reintegration Briefings. These are counselling sessions offered to family members by Military Family Resource Centers (MFRCs). MFRCs are asked to assist families through the provision of their normal and emergency services[6]. A wide variety of deployment-related resources for adults and children are available at the MFRC.

[6] See http://edmonton.mil.ca/lfwa/branches/G3/Op_Apollo_reintegration.asp.

Enhanced Post-Deployment Screening. Initially piloted for members on the first rotation ("Roto 0") of Op APOLLO, this screening is now mandatory two to six months after a member returns to Canada. It consists of a semi-structured interview with a mental health professional and the completion of a collection of validated health questionnaires (screening for health-related quality of life, general health perceptions, mental health symptoms, post traumatic stress disorder (PTSD), and common physical health symptoms). Survey results show that members support this type of screening.

Workplace Reintegration. Briefings are provided to employers about any post-deployment conditions (illnesses and operational stress injuries) that could impact a member's return to work. Personnel gradually return to work (partial workdays) at their home unit or at their civilian employment.

HDO Survey. A post-deployment administration of the HDO is carried out approximately three to four months following return to Canada to confirm the degree to which the contingent has returned to a "base-line" state. Written reports are prepared and briefings presented to COs with respect to their units.

Post-Deployment Readjustment Period. After a six-month or longer deployment, there is a 60 day period where members can not be subjected to postings, attached postings, or temporary duty, such as career courses.

Help for Problems Arising from Military Operations. CF members returning from military operations can get help for physical and/or mental problems at CF Post-Deployment Clinics, at Operational Trauma Stress Support Centres (OTSSCs), and at sites for the Operational Stress Injury Social Support (OSISS) Project. These are discussed in more detail in the concurrent paper on casualty support (Wang, Dunn, & Tanner, 2008).

Special Follow-Up. Special mission threats, such as a high-risk exposure to tuberculosis, will require members to have special post-deployment screenings.

CF Depleted Uranium Testing Program. This program was developed after the Gulf War and Balkans peacekeeping missions as a result of concerns about exposure to toxic levels of depleted uranium. While all the test results revealed that CF members have the same levels of uranium as unexposed civilians, testing for uranium levels remains available.

2.1.2.4 General Counselling Services

Canadian Forces Member Assistance Program (CFMAP).[7] The CFMAP offers confidential, voluntary, short term counselling to assist members with resolving many of the stresses that they experience at home and in the work place. CF members serving within Canada and the U.S. and their immediate family members, have direct access to the CFMAP telephone counselling service 24 hours a day, seven days a week. An appointment with a counsellor close to the member's home or work can be arranged. In relation to members serving outside Canada or the U.S. as well as their immediate family members, telephone counselling is also provided as a minimum, and every attempt is made to provide in-person counselling in close proximity to their location.

[7] See ADM (HR-Mil) Instruction 07/04: Canadian Forces Member Assistance Program. (2004).

2.2 Australia[8]

2.2.1 Pre-Deployment Health Services

Defence Injury Prevention Program. The Australian Defence Force (ADF) established the Defence Injury Prevention Program (DIPP) in 2005, which addresses injury prevention at the unit level by emphasizing and empowering local ownership and control of injury by conducting effective injury prevention activities. Often the knowledge and subject expertise required to develop sensible solutions are local. Injury rates are actively surveyed locally with regular surveillance reporting to Command. DIPP complements and builds on existing Occupational Health & Safety Systems; a core DIPP business component is the active gathering of injury information from which DIPP can monitor injury rates and trends.

ADF Mental Health Training Framework. A framework for the conduct of structured training in mental health issues throughout a member's career was implemented in 2003. This includes, for example, stress management and peer support at recruit training through to strategic operational considerations at command courses. ADF members are provided with education and intervention when involved in a critical incident to assist them to care for themselves and others post-incident. Educational material is provided for commanders and immediate family members.

E-Health System. The Distributed Systems Technology Centre (DSTC), a leading research and development centre in the field of Information Technology in Australia, was commissioned by the Centre for Military and Veteran's Health to perform a two-phase consultancy. In Phase I, the DSTC reviewed the current e-Health initiatives underway in both the Department of Defence (DoD) and the Department of Veterans' Affairs. In Phase II, the DSTC reviewed e-Health initiatives being undertaken both nationally and internationally.

In its Phase I report (2004), the DSTC reported that the DoD had actively embraced the planning and acquisition of e-Health technologies across a range of areas including:

a. Health records management;

b. Deployable e-health technologies for combat environments which either keep personnel alive or assist when casualties occur;

c. The supply chain of command; and

d. Communication infrastructure technologies.

The largest and most significant e-Health project across the DoD is HealthKEYS. It is designed to provide a single, corporate health information system for providing timely and accurate information to meet the operational, management and clinical needs of ADF health.

[8] See http://www.defence.gov.au/dpe.

The Joint Forces Project JP2060 provides strategic planning for all health-related support for the combat effectiveness of the ADF. It not only covers primary health care systems, but also includes logistics and planning support systems. It recognizes that combat-related e-Health systems will have to integrate and interoperate with National Support Area-based Defence health systems, such as HealthKEYS.

Psychological Briefings and Debriefings. Official Defence policy states that, in order to minimise the occurrence of severe stress reactions, Defence psychologists must routinely interview all contingent members before and after their deployments. These interviews relate chiefly to stress and its management. Briefings usually occur in the week prior to departure overseas.

2.2.2 Deployment Health Services

ADF Framework of Critical Incident Mental Health Support (CMS). Processes for dealing with critical incidents, or potentially traumatizing events, have been in place in the ADF since the early 1990s. Originally there were only single service policies, but one of the key goals of the ADF Mental Health Strategy was the development of Tri-Service, multi-disciplinary policies in a number of areas, including how the ADF responds to these events.

In 2002, the ADF contracted the Australian Centre for Posttraumatic Mental Health to review the literature in the field and identify best practices for implementation in the ADF. A comprehensive consultation process involving key mental health stakeholders in the ADF and the Australian Centre for Posttraumatic Mental Health, led to the development of the CMS framework.

This tri-service framework is more flexible, catering better to the needs of commanders and ADF personnel while ensuring that best practice clinical interventions are provided where required. Key elements of the CMS framework are: more comprehensive screening to determine individual needs; a clear role for chaplains in dealing with the spiritual issues that are often a major part of dealing with these types of incidents (including the grief associated with the loss that is often involved); and an assertive follow-up process.

General Medical Treatment Levels. Medical support in Australian military operations is based on a hierarchical system of casualty management. This involves five levels of treatment:

a. **Level One**. The first level of care includes the location and removal of casualties from danger, and the provision of immediate first aid. It may involve: self or buddy aid; examination and emergency life saving procedures, such as maintenance of airway, control of bleeding, prevention and control of shock; prevention of further injury; and treatment at an aid post or similar facility with trained medical personnel where treatment could include restoration of airway, use of intravenous fluids, antibiotics, and the application of splints and bandages.

b. **Level Two**. The second level of care is the collection, sorting, treatment and evacuation of casualties and the provision of resuscitative procedures where appropriate. Level Two is provided in a minimal care facility. This facility may include basic laboratory, pharmacy and temporary holding facilities. At this level,

medical examinations and observations can be conducted in a more deliberate manner than at Level One. The focus is on sustaining care and resuscitation, stabilisation and evacuation (paramedic/ambulance).

c. **Level Three**. Hospitalisation is provided for medium and high intensity nursing of the wounded, sick and injured. Facilities are staffed and equipped to provide resuscitation, surgery and post-operative treatment. Care at this level may be the initial step towards restoration of functional health, distinct from procedures that stabilise a condition or prolong life. Treatment is provided with greater preparation and deliberation. Level Three medical units are also able to prepare for evacuation of those patients who require care beyond the scope and management of the unit.

d. **Level Four**. Specialist surgery, rehabilitation and hospitalisation are provided within the limits of the holding policy. It is normally the highest level of care provided in an area of operations.

e. **Level Five**. This is the highest level of care which is normally provided only in the support area. It includes specialists, sophisticated management, and care that is associated with the most advanced range of medical capabilities.

In Iraq, Australian Defence Health Service personnel are embedded within U.S. military medical facilities (Rosenfeld, Rosengarten, & Paterson, 2006). Military casualties are treated initially at the battle lines by medics trained in advanced trauma life support, and are then transferred to forward operating bases for further resuscitation and initial surgery. For the next stage, they are transferred to field hospitals for stabilization. Field hospitals are equivalent to trauma centres in the U.S. and Australia, equipped with an emergency department, operating rooms, intensive care unit, laboratory and radiology facilities, and other ancillary services. Stable patients are evacuated to Germany and then transported to Australia.

2.2.3 Post-Deployment Health Services

Psychological Debriefings. These briefings are usually conducted in groups of 10 to 15 personnel. Debriefings can also be arranged for spouses in Australia prior to homecoming, through their local Defence Community Organisation. Psychological debriefings are not considered psychotherapy or counselling; rather they provide education about stress prevention and the opportunity to discuss non-operational aspects of the deployment. Psychological debriefings usually focus on any highly stressful incidents that may have occurred during the deployment and on the potential problems of personnel returning to their family and work in Australia.

Coming Home Readjustment Program (CHRP). This initiative recognizes that the majority of problems post-deployment are sub-clinical and related to readjustment. The CHRP is a seven-day small group program for six to ten members of similar rank. The program aims to assist members to unwind from operations, to review their work-life balance, to improve their relationships with others and to make sense of some of their operational experiences. Partners are invited to participate in selected modules of the program.

2.3 New Zealand[9]

Psychologists brief personnel prior to deploying about the impact the mission may have on themselves and their families, and what to expect when they arrive in-theatre. They ensure personnel are well-prepared with regard to the impact of being away from their family. Personnel are also debriefed as their deployment finishes, to enable them to re-integrate back easily into their life at work and home. Psychologists are also on hand to provide advice should there be a critical incident, such as a death or major trauma, during a deployment.

2.4 United Kingdom

2.4.1 Pre-Deployment Health Support[10]

PULHHEEMS[11] is a unique military system that provides a medical assessment of a soldier or recruit's functional capacity for service (physical capacity, mental capacity and emotional Stability). Each component is given its own measure, but the P (Physical capacity) quality reflects overall capacity that, together with the PULHHEEMS Employment Standard defines medical fitness for employment, both in barracks and on operations. Common gradings awarded are:

a. P0: Medically unfit for duty and under medical care;

b. P2 F2: Employable for full combatant duties worldwide;

c. P3 LE: Fit for duty with minor employment limitations; limited operational deployability;

d. P4 RE(PP): Fit for duty within limits of pregnancy; unfit for operational deployment;

e. P7 HQ: Fit for duty with major employment limitations; unfit for operational deployment; and

f. P8: Medically unfit for Services.

---

[9] See Royal New Zealand Air Force News, 74 (SEPT 06) at http://www.airforce.mil.nz/downloads/pdf/airforce-news/afn74web.pdf. At this time, no further information could be obtained on health support programmes and services from NZ.

[10] See http://www.army.mod.uk/servingsoldier/index.htm, and http://www2.army.mod.uk/linkedfiles/servingsoldier/usefulinfo/soldier_management.pdf.

[11] PULHHEEMS are routine medical examinations, the abbreviation stands for: P = Physical capacity (Including overall capacity); U = Upper limbs; L = Locomotion (legs and spine); HH = Hearing standard (left and right ear); EE = Eyesight standard (left and right eye); M = Mental capacity; S = Stability (emotional).

Attendance for PULHHEEMS medical examinations at regular intervals is a prerequisite to assessing the correct PULHHEEMS grading. This provides a platform for health promotion and regular screening, as necessary, and ultimately provides commanders with an accurate description of their soldiers' current medical fitness for tasks.

2.4.2 Deployment Health Support

Healthcare on Operations. Medical care on operations is based on "Levels of Care." If members have a minor illness or injury, they may not be evacuated to a hospital but may be treated by medical personnel in their unit. If members are seriously injured, they would likely be evacuated to a field hospital for treatment before being further evacuated to a permanent hospital.

Single Service Physical Care. The three armed forces maintain their own medical services in the provision of medical support worldwide[12]:

a. The Royal Naval Medical Service (RNMS) provides comprehensive care to the Royal Navy and Royal Marines, on warships, auxiliary vessels, and submarines. The Royal Fleet Auxiliary (RFA) Argus, the primary casualty receiving facility, provides the Royal Navy with a floating "hospital" if needed.

b. The Army Medical Services (AMS) include: the Royal Army Medical Corps, which is responsible for the care of the sick and wounded, with the subsequent evacuation of the wounded to hospitals in the rear areas. This is achieved by the provision of Close Support Medical Regiments (to treat front line casualties) and General Support Medical Regiments (where more major procedures can be carried out some distance behind the front line), before evacuation to a Field Hospital where a full range of medical facilities are available.

    (1) Each Brigade has a medical squadron (from a Close Support Medical Regiment) allocated to it, which is generally a regular unit (in some cases this may be a Territorial Army (TA) unit) that operates in direct support of the battle groups. These units are either armoured, airmobile or parachute trained. There are generally extra medical squadrons that provide support at the divisional level. These divisional squadrons provide medical support for the divisional troops and can act as manoeuvre units for the forward brigades when required.

    (2) All medical squadrons have medical sections that consist of a Medical Officer and eight Combat Medical Technicians. These sub-units are located with the battle group or units being supported, and they provide the necessary first line medical support. In addition, in a field dressing station, casualties are treated and may be resuscitated or stabilized before transfer to a field hospital. These units have the necessary integral ambulance support, both armoured and wheeled, to transfer casualties from the first to second line medical units.

[12] Cited from http://www.armedforces.co.uk/army/listings/l0077.html.

(3) Field hospitals may be Regular or TA, and all are 200 bed facilities with a maximum of eight surgical teams capable of carrying out life saving operations on some of the most difficult surgical cases. Since 1990, regular medical units have been deployed on operations in the Persian Gulf, the former Yugoslavia, Sierra Leone, Afghanistan and Iraq.

(4) In Iraq, the "Role 3" Field Hospital at Shaibah provides medical support that includes primary surgery, an intensive care unit, medium and low dependency nursing care beds and diagnostic support, as well as emergency medical care. Service personnel serving in Germany who require hospital care are treated in one of the five German Provider Hospitals.

(5) Casualty evacuation is by ambulance, either armoured or wheeled, and driven by Royal Logistic Corps personnel, or by helicopter when such aircraft are available. A Chinook helicopter is capable of carrying 44 stretcher cases and a Puma can carry six stretcher cases and six sitting cases.

(6) Queen Alexandra's Royal Army Nursing Corps, an all nursing and professionally qualified Corps, provides the necessary nursing support at all levels and covers a wide variety of nursing specialities.

(7) The Royal Army Dental Corps fulfils the essential role of maintaining the dental health of the Army in peace and war, both at home and overseas.

c. The Royal Air Forces Medical Services (RAF MS) provide a spectrum of medical, nursing, medical technical and medical support capabilities. For example, Aeromedical Evacuation involves returning patients from around the world, accompanied by a specialist medical team, utilizing available air assets. Medical care is maintained through the onward move to the final receiving UK hospital.

Hospital Services. For hospital treatment of Armed Forces personnel, National Health Service (NHS) facilities are used under a partnership arrangement, rather than dedicated military hospitals[13]. Partnering with the NHS enables the Armed Forces to provide modern and advanced clinical care.

Ministry of Defence Hospital Units (MDHUs) and the Royal Centre for Defence Medicine (RCDM) are where Defence Medical Services[14] personnel work alongside civilian colleagues in NHS hospitals. There are MDHUs at Derriford (Plymouth), Frimley Park (Aldershot), Northallerton (near Catterick), Peterborough and Portsmouth. The Defence Medical Services

---

[13] With the end of the Cold War apparently reducing the need for military deployments and spending, Britain decided to close its dedicated military hospitals in 1995.

[14] Uniformed medical personnel from the Royal Navy, Army and Royal Air Force – collectively known as the Defence Medical Services. MoD Defence News reported that there are about 6,500 regular uniformed medical personnel (MoD Defence News. FACTSHEET: Medical Support to Personnel Injured or Sick on Operations, 23 Mar 2000, at http://www.mod.uk/DefenceInternet/DefenceNews/DefencePolicyAndBusiness/FactsheetMedicalSupportToPersonnelInjuredOrSickOnOperations.htm).

also run a number of other units, which include the Royal Centre for Defence Medicine (Birmingham) and the Defence Services Medical Rehabilitation Centre (Headley Court). There are also two military hospitals, one in Cyprus and the other one in Gibraltar.

Personnel returning from operations for treatment in the UK usually go to the University Hospital Birmingham Foundation Trust (UHBFT). Selly Oak, one of the country's top performers, is a centre of excellence for treating the complex injuries being suffered by troops on operations overseas. Military patients are grouped together in this ward whenever clinically appropriate.

In 2006, the Ministry of Defence (MoD) started the concept of a Military Managed Ward at Selly Oak. To support this concept, the MoD has:

a. Increased the number of Military Qualified Nurses, including the military ward manager;

b. Introduced dedicated patient coordination and visiting nurse teams – every military patient being treated at a Birmingham hospital is now visited at least three times a day by military medical staff; and,

c. Improved travel and accommodation arrangements for families visiting patients.

In-Theatre Care. To reduce the stigma associated with mental illness (e.g., PTSD), the MoD deploys military mental health professionals on operations overseas who provide assessment and care in-theatre. Mental health teams comprise psychiatrists, mental health nurses, clinical psychologists and mental health social workers.

The Trauma Risk Management (TRiM).[15] The TRiM scheme is not a counselling technique. It is a peer-delivered risk-assessment tool that allows trained service personnel to assess their peers after operational or other traumatic incidents. This leads to the early identification and referral of those that require professional assessment and treatment by trained Defence Mental Health professionals.

Confidential Support Line (CSL).[16] This is a free phone help-line run for soldiers and their families. It offers confidential, non-judgmental guidance to the Army community, from anywhere in the world. Free phone lines operate from Germany, Cyprus, and the UK and Operational Theatres. The CSL operates seven days a week from 1030 to 2230 hrs (local UK time). Any vulnerable soldier or family member who phones, writes or emails the trained civilian support staff of the CSL receives guidance as to what his/her options are. The soldier/family member must then make his/her own decision as to how to manage the issues raised.

---

[15] See http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070604/text/70604w0042.htm.

[16] See A Guide for the Families of Deployed Regular Army Personnel (31 Oct 07) at http://www.mod.uk/NR/rdonlyres/3D062FE6-0326-4ED2-8DCC-185BB0B9A812/0/20071031Families_Guide_Regular_ArmyDPSAU.pdf.

2.4.3 Post-Deployment Health Support

Decompression Period. This is a time for relaxation with comrades in a controlled and monitored environment. Briefings on coping with stress and dealing with issues that might arise during homecoming are also available. A community psychiatric nurse and a chaplain are also available throughout this period. On return to the UK, there is a period of normalisation within barracks and with families. Events that occur during this time include: social functions; sports events; health awareness briefings; a Commander's Welfare Seminar; and a medals parade. The Battalion will then depart on Post Operational Tour Leave (POTL). Twenty working days POTL is granted for an operational tour of six months.

Briefings on the Effects of Stress. On return from POTL, further briefings on the effects of stress, how to recognise them and how to deal with them are provided. It is the chain of command's responsibility to identify and monitor those vulnerable to any form of post-operational stress, or stress-related conditions. Individuals who appear to be suffering from stress-related conditions are referred to the Army medical services for assessment and support where necessary. Army welfare support is also available.

2.5 United States[17]

2.5.1 Pre-Deployment Health Support

Pre- and post-deployment health activities are based on the deployment type, the Commander's decision, DoD and Service policies, as well as actual or potential health threats encountered during deployment.

Individual Medical Readiness. This is the commander's pre-deployment health program used to ensure service members subject to deployment have satisfied all medical readiness requirements (satisfactory dental health; all required immunizations up to date; all medical readiness laboratory tests current and on file, e.g., HIV; all required medical personal protective equipment issued, e.g., gas mask spectacle inserts; the absence of deployment-limiting medical conditions; and periodic health assessment complete).

The Pre-Deployment Health Assessment (DD Form 2795). This assessment should be administered at the home station or at the mobilization processing station within 30 days prior to deployment. Its principal purpose is to assess a member's state of health before possible deployment outside of the U.S. in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to members.

Deployment-Specific or Occupationally Related Immunizations, Chemical Prophylaxis or Other Medical Countermeasures, or Protective Measures. These are based on DoD (Health Affairs, Joint Staff, or Combatant Command (COCOM)) or Service policies and upon the deployment health risk assessment. When prophylaxis, other medical countermeasures, or protective measures are required, they must be made available to personnel. All personnel must be trained in their use.

---

[17] See http://www.pdhealth.mil/dcs/DD_form_2796.asp, and http://www.pdhealth.mil/dcs/pdhra.asp.

Biomonitoring. The need for biomonitoring will be based on the deployment health threats, possible exposures, and available bioassays. Biomonitoring involves the measurement of a natural, synthetic, and man-made chemical in human tissue or fluids.

Pre-Deployment Occupational and Environmental Health (OEH) Site Assessments. Preliminary Hazard Assessments (PLHAs) should be accomplished as part of the OEH site assessment as early as possible to identify and quantify OEH threats and to determine the scope of deployment health activities. Countermeasures or risk control actions should be determined based on the identified OEH threats as part of the overall operational planning process.

Health Threat and Countermeasures Briefings. Data are used from the PLHA and other relevant information to develop comprehensive pre-deployment health threat briefings, which are provided to deploying personnel.

Health Risk Communication Plans. Health risk communication plans are developed and implemented to provide commanders and personnel with appropriate health risk communications (written and oral) for health threats and countermeasures before, during, and after deployment.

Deployment Health Surveillance Plan. The process and the resources needed for the regular collection, analysis, archiving, interpretation, and distribution of health-related data used to monitor the health of a deployed population, and to intervene in a timely manner to prevent, treat, or control the occurrence of disease or injury, are identified in this surveillance plan. A deployment OEH sampling plan must be established for each site that has to be assessed.

PTSD Prevention and Early Intervention. By using live ammunition and having harsh, realistic, extended in-field exercises away from families, the U.S. Army prepares soldiers for the realities of battle. The U.S. Army trains leaders how to mitigate risk and build resilience in their soldiers. They also train deploying soldiers in potential emotional responses to combat.

2.5.2 Deployment Health Support

Combat Casualty Care. In general, there are three stages of combat casualty care: *care under fire, tactical field care, and combat casualty evacuation*. *Care Under Fire* is the care rendered by the medic or first responder at the scene of the injury while still under effective hostile fire. *Tactical Field Care* is the care rendered by the medic once no longer under effective hostile fire. This also applies to situations in which an injury has occurred, but there has been no hostile fire. *Combat Casualty Evacuation Care* is the care rendered once the casualty has been picked up by evacuation vehicles.

For the current wars in Iraq and Afghanistan, the general plan for access to medical care for service members encompasses five levels:

a. Level I: Medic (Army or Air Force)/Corpsman (Marine Corps)/Battalion Aid Station (Army)/Regimental Aid Station (Marine Corps). When a service member is injured during combat, he or she is trained to self-apply a tourniquet if necessary. All service members are first-aid trained in order to assist a wounded comrade. A medic (Army) or corpsman (Navy) assists if immediate lifesaving measures are required, and with evacuation.

b. Level II: Forward Surgical Team (Army)/Forward Resuscitative Surgical System (Marine Corps). They are designed to provide surgical capability far forward on the battlefield to stabilize and resuscitate those soldiers with life and limb threatening injuries.

c. Level III: Combat Support Hospital/Air Force Theater Hospital/Naval Hospital Ship. These are the first fully equipped surgical facilities that military casualties can reach. They provide resuscitative care, surgery and definitive care in low threat with multiple specialties.

d. Level IV: Landstuhl Regional Medical Center, Germany. Depending on the type and severity of the wounds, some military casualties are air evacuated to Landstuhl Regional Medical Center in Germany, where they receive additional comprehensive medical/surgical care and stabilization.

e. Level V: Continent of the U.S. Service members with any injury or illness which requires additional expertise, or which will prevent their returning to their military duties, are generally air evacuated to medical treatment facilities in the U.S. On arrival in the U.S., injured service members are taken to the appropriate medical treatment facility where they are examined and placed into inpatient or outpatient status.

Patient Encounters. Copies of all inpatient and original outpatient medical encounter documentation (including medical treatment records provided to deployed personnel by allies and coalition partners of the U.S.) must be incorporated into the member's deployment health record (DD Form 2766) or equivalent.

Validation of the Health Risk Assessment. Based on the PLHA and any OEH site assessment conducted during the planning process, the COCOM and service component commanders shall ensure the capability to conduct the activities addressed in the DoD Instruction 6490.03 (August 11, 2006) on health support. The OEH surveillance data should be collected and archived in the Defence Occupational and Environmental Health Readiness System (DOEHRS) data portal for linking deployed units and personnel with health outcome data, thus enabling the identification of cohorts of similarly exposed personnel.

Health Surveillance. The Disease, Non-Battle Injury and Battle Injury (DNBI) rates must be reviewed daily. This is done in order to: detect potential adverse health trends or exposures; assess countermeasure effectiveness; and recommend enhanced preventive measures. Biomonitoring should also be conducted as required. To identify any potential OEH and CBRN exposure as well as trends of concern, the following data must be reviewed: occupational and environmental; chemical, biological, radiation and nuclear (CBRN); food and water sanitation audits; and DNBI. Coordination is made with safety officers as well as safety and occupational health specialists for information sharing on trends to implement intervention strategies that reduce injury rates.

Documentation of OEH Monitoring Data. Periodic OEH monitoring summaries must be documented on an SF 600, "Medical Record-Chronological Record of Medical Care" for each permanent or semi-permanent basing location and be updated at least annually. The OEH monitoring summaries must be filed in the medical records of each individual for which the

exposure applies or the summaries must be archived so that they are readily available electronically to health care providers and redeployed personnel. The OEH monitoring summaries provide: monitoring results; estimated personnel exposures; assessment on whether estimated exposures are acceptable or unacceptable, and the criteria used for the estimate (i.e., above or below military exposure guidelines according to Army Technical Guide 230); and any anticipated acute, chronic, or latent health effects. The summaries should also include references to monitoring data that indicates little or no health risks associated with ambient monitoring conditions falling below the military exposure guidelines.

2.5.3 Post-Deployment Health Support

Post-Deployment Screening and Follow-Up. Post-deployment screening is critical to ensure military personnel are healthy and fit, and prepared to return to their duties. Post-deployment screening generally includes:

a. Verifying any disease and non-battle injuries military personnel experienced during the deployment are resolved and/or establish a plan for follow-up screening/exams;

b. Reviewing the Post-Deployment Health Assessment Form;

c. Verifying use of or providing prescribed immunizations/medications; and,

d. Establishing plans to continue or seek counselling from chaplain or medical personnel as needed.

The Enhanced Post-Deployment Health Assessment (PDHA) Process (DD Form 2796). This is required if a DD Form 2795 was required during the pre-deployment phase or per the decision of the COCOM commander, Service component commander, or commander exercising operational control if any health threats evolved or exposures occurred during deployment that warrant medical assessment or follow-up. Each individual who requires a DD Form 2796 must be scheduled for a face-to-face health assessment with a trained health care provider during in-theatre medical out-processing or within 30 days after returning home or to their processing station. The assessment includes a discussion of: the individual's responses to the health assessment questions on the DD Form 2796; mental health or psychosocial issues commonly associated with deployments; Force Health Protection Prescription Products (FHPPPs) taken during the deployment; and concerns about possible environmental or occupational exposures. Brief screening questions for PTSD and other mental health issues are included on the standard post-deployment health assessment and post-deployment health reassessment forms.

The Post-Deployment Health Reassessment (PDHRA) Program (DD Form 2900). This program was mandated by the Assistant Secretary of Defence for Health Affairs in March 2005 and designed to identify and address health concerns, with specific emphasis on mental health, that have emerged over time since deployment. The PDHRA provides for a second health assessment using DD Form 2900 during the three- to six-month time period after return from deployment, ideally at the three- to four-month mark.

Post-Deployment Health Debriefings and Risk Communications. A health threat de-briefing must be provided to returning DoD personnel during in-theatre medical out-processing or following a deployment. Post-deployment health debriefings inform personnel of: any health related medical, occupational, environmental, or CBRN exposures that they may have experienced; address individual concerns and information about required medical follow-up; as well as help personnel reintegrate and adjust back to routine activities following a deployment.

Post-Deployment Medical Surveillance. Appropriate medical surveillance should be conducted to detect emerging (latent) health conditions on redeployed personnel.

Integration of Medical and Exposure Documentation. Incident documentation is integrated in the individual's permanent medical health records within 30 days of redeployed personnel returning to a demobilization site or home station. This documentation includes: the Deployable Health Record Form (DD 2766) copies of the Pre-Deployment Health Assessment Form (DD 2795) and the Post-Deployment Health Assessment Form (DD 2796); documentation of theatre inpatient and outpatient health care encounters; as well as environmental and occupational exposure summaries (SF 600).

2.5.4 General Counselling Services[18]

Military OneSource. Military OneSource face-to-face counselling sessions are short term, problem-focused sessions that deal with emotional well-being on a variety of issues. These issues include: improving relationships at home and at work; marital issues; grief and loss issues; and adjusting to a change in situation (such as a return from deployment). These sessions are not designed to address long-term issues, such as child and spouse abuse, suicidal ideation, or mental illness. People in need of long-term treatment are referred to a military medical treatment facility and/or TRICARE for services. OneSource counsellors are licensed, credentialed, and experienced. These services are available through a toll-free telephone number, e-mail, and online 24 hours a day, seven days a week.

Military and Family Life Consultants (MFLCs). These consultants are Masters or PhD level, licensed, and credentialed clinical providers that offer intervention and support to military members and their families. Like Military OneSource, they provide non-medical, short-term counselling for every day issues, such as anger management, stress, parenting, communication, family relationship, deployment, and other military-related topics. MFLCs can be accessed through installation locations such as the Army Community Services, Marine Corps Community Services, Navy Fleet and Family Support Centers and Air Force Family Support Centers. MFLCs also provide support at National Guard and Reserve Component drill weekends, mobilizations, and family events.

[18] See http://mybenefits.us.army.mil.

3 Spiritual Services Support[19]

Spirituality has different meanings and can take many different forms. This section narrowly focuses on the role of chaplains[20].

3.1 Canada[21]

Presence of a Spiritual Leader. Chaplains are situated in close proximity to CF operations and conduct visits to outlying areas. During operations, chaplains are very much involved in a ministry of presence. They are known by military personnel and are available to provide services when required. They also participate in unit life.

Religious Services. While in operations, worshipping communities unite for liturgies. Given the reality of military operations, chaplains are flexible in scheduling worship services to meet the needs of dispersed members. Other religious services include: anointing of the sick, ramp ceremonies, and memorial services.

Counselling and Crisis Ministry. When deployed, military personnel often witness local civilians coping with extreme challenges such as poverty, loss of life, past social trauma, and loss of material possessions. Chaplains are often approached to make meaning out of chaos for personnel who are confronting "Man's inhumanity to Man." Chaplains are also there to assist the sick, wounded, and dying, Prisoners of War (POW), as well as Next of Kin (NOK).

Deployment Screening. Chaplains have an important role in the assessment of the readiness of individual members for deployment as members often confide in them.

Religious Instruction. Religious instruction is provided in the context of TLD, Padre's Hour and defence ethics.

Liaison with Rear Party. The chaplain is responsible for liaison between the rear party, MFRC staff and a CF member in the case of a family crisis or emergency at home. In some instances, the situation becomes extremely grim or tragedy strikes and the immediate desire is to repatriate the member. Authorization for a return from deployment is a command decision, and deployed chaplains are often directed to determine the severity of the situation and recommend a course of action.

---

[19] This Chapter will only discuss information for Canada, Australia and the U.S.; no information was available on the Internet for New Zealand or the UK.

[20] For a discussion on military chaplains in TTCP nations, see Coulthard, 2008.

[21] See *The Chaplain's Manual* (1 August 2005) at http://www.forces.gc.ca/chapgen/engraph/operations_army3_e.asp?sub=2; http://www.forces.gc.ca/chapgen/engraph/operations_air_e.asp?cat=3; and http://www.forces.gc.ca/chapgen/engraph/operations_navy_e.asp?cat=3.

Opportunities for Humanitarian Assistance. Involvement in relief and community work enhances morale during a deployment. The role of the chaplain is to identify humanitarian projects in conjunction with civil-military authorities and the chain of command. In some operations, CF personnel have painted and refurbished orphanages, distributed warm clothing and delivered emergency food supplies. CF personnel have also organized sports or entertainment events within the military camps in order to raise funds for local charitable groups. Chaplains engage as team players in these events and may be requested to offer prayers for new hospitals or schools or participate with personnel as part of a painting or repair team. Through these events, members often feel that they are making "a difference."

Conflict Reconciliation/Liaison with United Nations (UN)/Civilian Agencies. Chaplains contribute to operational effectiveness by bringing communities together and assisting with conflict reconciliation, liaising with local clergy, and building relationships between the indigenous population and the military.

3.2 Australia

3.2.1 Royal Australian Navy (RAN)[22]

Grief Counselling, Suicide, CIS Management Teams. In addition to the day-to-day pastoral care they provide, Navy Chaplains undertake training for the highly specialised type of counselling required during and after major crises. They may also be nominated as members of RAN CIS Management Teams.

Development of Character and Morale. It is important to both the member and the Navy that ample opportunity is given for spiritual development. Navy Chaplains conduct special courses on behalf of the RAN which are designed to develop the personal character, integrity and leadership of the Navy's young men and women. It is believed that the personal qualities of character, which ensure high standards of conduct and inspire courage and self-sacrifice in a crisis, can be developed by religious faith.

3.3 United States

3.3.1 United States Army[23]

Strong Bonds for Pre-and Redeployment. This program is designed to help single soldiers, couples, and families cope with the struggles associated with deployments. The program is offered through an off-site weekend retreat. In addition to relevant teaching and skills training, Strong Bonds weekends include time for relaxation, recreation, fellowship, and fun. Strong Bonds programs are offered by Army Chaplains with the full support of the CO. Personnel will attend with others from their unit and gain practical, useful information based on material

---

22 See http://www.navy.gov.au/general/chaplaincy.html.

23 See www.strongbonds.org, and www.armyfrg.org.

designed especially for soldiers and their families. Through small group and individual activities, they learn how to transition more effectively from separation to togetherness.

Deployment Cycle Support Program. This program establishes an Army-wide standard that all deployed soldiers must participate in. The Army's goal is to ease the transition for soldiers by providing standardized procedures, including psychological screening, debriefing, and identifying those at-risk soldiers that may require immediate attention. Beginning while soldiers are still in the theatre of operations, the program continues once the soldier has returned home in order to address anticipated deployment cycle issues and challenges.

During the three phases of redeployment (in-theatre actions, post deployment and demobilization, and reconstitution), chaplains and chaplain assistants provide opportunities for soldiers and their families to obtain the valuable information they require. Based on individual assessments, soldiers will participate in additional follow-up assistance as needed. The five key follow-up areas include: reunion training; suicide awareness and prevention training; marital assessments; training on changes in relationships and communication with spouse and children; as well as a voluntary one-day marriage education workshop.

4 Morale, Welfare and Recreation

4.1 Canada[24]

DGPFSS has three primary operational divisions: the CF Exchange System (CANEX), Service Income Security Insurance Plan Financial Services (SISIP FS), and Personnel Support Programs (PSP). The PSP mandate is "Serving Those Who Serve", and it is the section that offers most of the services to deployed members. The PSP Division currently deploys over 100 civilian support staff in theatre to Task Force Afghanistan (TFA) as part of their deployed operations programs. The support staff delivers rest and recreation programmes, Home Leave Travel Assistance (HLTA) services, retail operations, mess operations, fitness, sports and recreation services, barber services and other amenities. An example of PSP support is the opening of a Tim Hortons' donut shop in Kandahar in 2006 (CFPSA/NPP Annual Report 2005-2006).

DGPFSS Amenities Programs and Tim Hortons. DGPFSS operates retail stores that sell newspapers, movies, pocketbooks and goods not available in foreign countries, such as snacks, as well as Tim Hortons' products.

Barber Services. Barbers travel to all regions and provide free haircuts to all personnel.

Canada House. When possible, this is a place for members to relax and "hang out" during the Afghanistan mission. Canada House has a game room, library, theatre, ice cream parlour, barbershop and a CANEX outlet.

Canadian Forces Radio and Television. PSP provides live English and French radio and television programming (news, sports, and Canadian variety programming) to all personnel deployed worldwide.

Internet and Telephone Calls.[25] For overseas and domestic operations, the 36 Canadian Brigade Group Deployment Handbook states that "soldiers are entitled to one 15-minute phone call home every three days as arranged by the Task Force Commander. However, where communication facilities are not available, the soldier may receive a telephone call allowance. It should be noted however that most overseas deployments are well established, to the point where internet access is readily available."

Fitness. There are gym facilities "inside the wire" that provide members with different physical fitness options (free weights, cardio equipment, etc.).

Rest and Recreation Programs. Initiatives include BBQs for the troops, special dinners, casino nights, and Canada Day activities.

---

[24] See http://www.cfpsa.com/en/index.asp.

[25] This is a service delivered by the CF through J6 administered contract – not CFPSA. The Deployment Handbook is available at http://armyonline.kingston.mil.ca/LFAA/143000440001168/OVERSEAS_DEPLY_GUIDE.DOC.

Canadian Forces Show Tours. Show tours are organised for personnel serving overseas and in isolated locations. They include different types of entertainment aimed at increasing the morale of CF members.

Home Leave Travel Assistance. The primary intent of HLTA is to assist CF soldiers to reunite with their next-of-kin when granted leave out of post or mission area.

"Support Our Troops". This program offers concrete ways for Canadians to show their support and appreciation to CF members. Current initiatives include wearing red on Fridays, writing to the troops, and buying "Support the Troops" merchandise.

Public Donations. Money is collected for several programs/organizations to improve members' quality of life and morale. Programs include: Operation Santa Claus, CF Personnel Assistance Fund, CF Hospital Comforts Program, and MFRCs.

Corporate Sponsors. Canada's corporate community is approached by the CF and engages in morale and welfare activities.

4.2 Australia[26]

Amenities. *Frontline* is a Defence organisation that provides services in both deployed and base settings. Services include: canteens; convenience stores; retail electrical products; and Pay-Plan which involves interest-free loans for the purchase of a range of goods. *Frontline* operates within a limited market on a commercial and self-supporting basis. In accordance with its charter, *Frontline* aims to return the majority of profits to the Army and Air Force in the form of dividends.

Support Our Troops. The DoD has set up a 24-hour email service to provide members of the public with an opportunity to send their messages of support. The DoD collates all messages and sends them in hard copy form to personnel serving away from home. This service is not designed to forward messages of support to individual service men and women as other arrangements have been put in place for family members and friends.

4.3 United Kingdom[27]

Communication. British personnel receive: 30 minutes of free telephone calls per week to anywhere in the world; free e-mail and internet access; a free Forces Aerogramme letter (colloquially known as an "e-bluey" because of its colour), electronic letter service, and a subsidised postal packet service (free in the run-up to Christmas); and access to television, radio, and British Forces Broadcasting Service (BFBS) television and radio transmissions. BFBS Digital Terrestrial Television (DTT) transmitters operate at the Contingency Operations Base in Iraq and four camps in Afghanistan, so that it is possible to watch the six BFBS channels

---

[26] See www.defence.gov.au/news/armynews/editions/1108/letters.htm, and www.defence.gov.au.

[27] See www.ssvc.com/bfbs/tv/dtt/index.htm, and www.naafi.co.uk/in-theatre.php?menu_list=111.

anywhere there is a power source. No longer limited to a TV attached to a satellite dish in a communal area, personnel can even watch on their laptop or PC with a DTT USB stick.

Operational Welfare Package. As long as there are no operational, resource or technical constraints, support is provided to personnel to safeguard their emotional and physical well-being. Forms of support include: access to DVD players and video game machines; books, newspapers, magazines; board games; Combined Services Entertainment live shows and celebrity visits; the provision of basic shop facilities; a Christmas box; and fitness equipment.

Expeditionary Force Institute (EFI). The Navy, Army and Air Force Institutes (NAAFI) operate the EFI. The EFI is a voluntary military unit that is officially part of the Territorial Army with members subject to Army rules and regulations. The EFI' s role is to deliver NAAFI services to British Forces stationed in operational areas (currently Iraq, Afghanistan, Bosnia, Kosovo) and on exercise around the world. The service itself is mainly retail based.

HIVE Information Centres. These centers provide help, information and signposts to professional agencies. Their core function is the provision of information ranging from bus times to "confidential welfare signposting. Although they cannot resolve all member problems, HIVE information officers can point a person towards the best sources of advice and assistance across both military and civilian organisations. HIVE information centres can give practical assistance in sending e-blueys and messaging through the BFBS and in some cases free internet access.

4.4 United States

Army and Air Force Exchange Service (AAFES).[28] The AAFES operates shops and telecommunication centers. According to the Official U.S. Air Force Website:

> *"in keeping with the AAFES credo of "We Go Where You Go," employees operate from old, bombed-out buildings, truck beds and even from aircraft. Despite the danger, employees continue to occasionally convoy to remote outposts to organize "rodeos" where employees sell merchandise off truck tailgates and from the back of aircraft so that troops can at least buy the essentials -- like toiletries, socks and underwear. They do this only when an outpost has no base or post exchange. Today, base and post exchanges in-theatre carry everything from DVD players to laptop computers. Commercial cargo planes fly in magazines, CDs and DVDs so patrons can buy the same merchandise as their counterparts in the United States -- not outdated material. Soldiers and Airmen can even get pedicures, manicures and massages at some camps -- amenities many stateside bases don't offer."*

America Supports You. This is a DoD program that provides opportunities for citizens to show their support for the U.S. Armed Forces. The program was launched in 2004 in an effort to highlight citizen support for military men and women and communicate that support to the members of the Armed Forces at home and abroad.

---

[28] See Desjarlais, O.F. Jr. (Feb 2005). *The store that goes to war: AAFES has been in every major conflict since World War I. Airman*. FindArticles.com. 11 Jul. 2008 at http://findarticles.com/p/articles/mi_m0IBP/is_2_49/ai_n13794855.

5 Subject Matter Expert Interviews

Interviews were conducted with nine DND/CF SMEs that are involved with personnel support services and programmes. SMEs included employees/CF members from: DGPFSS, CFHS, Chap Gen, Director General Military Personnel Research and Analysis (DGMPRA), CEFCOM and CANOSCOM. Interviewees were asked for their general opinion on: the effectiveness of current personnel support programmes and services, problems or challenges they are facing at the policy, program, service delivery level; and ways to improve current programmes and services. The interview questions can be found in Annex A.

5.1 General Findings

The three primary themes findings that emerged from interviews with SMEs include:

a. The CF provides excellent personnel support programmes and services;

b. More research and evaluation of programmes need to be conducted to ensure accountability; and,

c. Most problems and challenges associated with current programmes and services are at the service delivery level.

5.1.1 Excellence in Programmes and Services

Most interviewees painted a positive picture of CF personnel support programmes and services for operations. There was a strong belief that current programmes and services were effective in meeting the needs of CF members.

> *"Very effective medical services on deployment. Members have confidence in the competence of medical personnel and quality of health services. They are quickly evacuated. Also, contributing to this feeling of confidence is the Tactical Combat Casualty Care training given to selected members. These members often feel very competent after receiving the training and their confidence is communicated to other members."*

> *"We have in place a "robust safety net". Returning members are looked after by their leaders, families, and peers who have been trained to look for signs of operational stress. Outreach, visits to units, and the chaplain presence are other ways continuity of care is achieved."*

> *"Members show social workers their appreciation for in-theatre briefings. They appreciate having the briefing before leaving theatre because it lets them think ahead."*

5.1.2 Required Research

Most interviewees thought that more research on CF personnel support programmes, services, and policies was needed. In particular, it was repeatedly expressed that the CF needs to better monitor and evaluate, with objective performance indicators, its programmes and services. There was a general belief that decisions and policies need to be driven by "hard facts".

> *"Assess better the effectiveness of our programmes. For example, we know that members appreciate the TLD program but we have no objective assessment of its consequences on mental health. We need to go beyond asking members whether they like it or not."*

> *"We need more monitoring of our recreation and welfare programmes in Afghanistan but it is hard to get people there to do programme assessments."*

> *"Now rely mostly on anecdotal data to assess the effectiveness of social work interventions. Would benefit from a statistical evaluation of the effectiveness of interventions in order to be more accountable."*

> *"In order to get a sound picture of personnel support to operations, we need to touch on everybody not only the commanders. Suggest an automated on-line survey that the troops would fill in while in-theatre and after. The survey could ask questions like whether received care was adequate and whether their rights were adequately described."*

Given the events that CF members witness and the work environment they find themselves operating in while deployed, interviewees also believed that more research should be undertaken on stress and PTSD.

> *"Abundant research in the civilian world on PTSD. However, PTSD related to military combat is somewhat different. We need to do more research."*

> *"There is a need for large systematic research, longitudinal research on operational stress (following soldiers from cradle to grave). For example, longitudinal research on resiliency and risks for operational stress."*

5.1.3 Service Delivery and Resource Problems

Interviewees were asked about problems or challenges with the current programmes and services and whether they thought the problems were at the policy, programme, service delivery, or resource level. The majority of interviewees identified problems at the resource level, which ultimately impacts service delivery.

> *"Biggest problem is human resources. We have many open positions. Many of us have to wear two hats and are overworked."*

> *"We don't have the resources, software, and people."*

"Issues concerning how we use our mental health resources. Most of our resources are dedicated to providing help and screening immediately after soldiers return from deployment. It is estimated that 10% will experience problems and need professional help. The majority of members will get through the post-deployment experience by using their own strength and resilience. We should perhaps put more resources on long-term follow-up and monitoring to help members who develop symptoms long after a deployment."

Apart from personnel shortages, most discussions centered on policies. Interview participants expressed concerns over the intent and formulation of policies.

"The policies are well-intentioned but not detailed enough; questions come up (confusion) when trying to execute them. Need to answer the question: "What we are doing it for?""

"Not to change a policy because of one incident. In the past, there were instances when mediatisation of an incident sparked a 'mass panic' among leaders and led them to rethink a policy."

"Difficulty enforcing policies. A good example is the PERSTEMPO issue. A new program and a working group on PERSTEMPO were formed. It was well-intentioned but did not get translated well and later we realized that there was nobody to actually do it (enforce the policy). It is thus difficult to answer the question: Were we successful at reducing PERSTEMPO?"

5.2 General Comments Concerning CF Programmes and Services

Interviews with SMEs led to the identification of issues and recommendations concerning programmes and services. One issue identified by SMEs was related to the role of the family in the provision of CF services. Some interviewees believed that CF spouses should be more engaged in deployment related briefings.

"The CF should emphasize the importance of the spouse being present at the pre-deployment briefing. Currently member's spouse presence at pre-deployment is optional. It is the members who decide to bring their spouse or not. From a legal point, the CF can't force a member's spouse to attend the screening. However, the CF could do better at strongly recommending it. The briefing could be advertised in a way that would get the spouse to want to take part of it. Further, the scheduling of briefing is often challenging. Units allow time during day but many spouses work during the day. Briefings in the evening might interfere with members' training."

"Difficulty to reach spouses for reintegration briefing to family. Now many military families live off base. Spouses work and the briefing interferes with the activities for kids."

"Suggest that in-theatre briefing inform members of what it has been like for their families. The struggles they had, and what was positive and negative during the deployment (growth, opportunity for gain and loss). Currently, in-theatre briefing is not standardized, and those who deliver it can choose whether they include this information."

Interviewees pointed out the important role that the chain of command plays in the acceptance and delivery of services. An important theme that emerged was the requirement for a trusting relationship and improved communication between leaders and service providers.

"At the strategic level, the chain of command needs to trust the judgment of medical personnel. Sometimes, changes meant to improve health services are proposed but, these may, in fact, have the opposite effect. For example, a commander may react quickly to an issue brought up in the media (antibiotic-resistant strain found in Afghanistan) and may push for changes in policy or propose a program to address the issue. However, in many cases, the problem is not as important as portrayed in the media and it would in fact be a mistake to change something. Medical personnel need to educate the chain of command."

"The chain of command needs to communicate with their medical advisers for each rotation."

"Decisions concerning deployment health services need to be taken rapidly. Issues have to go through a three step process from CF Health Svc, to CMP, and finally to Strategic Joint Staff. In case of uncertainty at one level, it is recommended to forward the issue quickly to level 3 in order to avoid delays."

Concerns over the lack of clear direction in training, the perceived emphasis on some illnesses over others as well as a lack of continuity in leadership training were raised by some.

"No clear direction to peer support counselling training. Sometimes train 1 in 10 members, sometimes train 1 in 20 members. There is a need for more consistency."

"The focus on Operational Stress Injuries (OSI) only could be a problem and backfire. There is the danger that OSI will be perceived as the only acceptable mental illness and that other mental illnesses will be perceived as less important and deserving less respect. Should try to have the same kind of success for people without OSI."

"Concern that now stress awareness is mission specific. Stress and coping training need to be a continuous process. Stress coping needs to begin at recruit level. Junior leadership and senior level courses need to include information about stress and coping and about how to help other people deal with stress. In sum, there is a need to acknowledge that stress is there (not all bad); refresh it, and emphasize during the tour."

"Recommend continuity in leadership training. Leaders need more than a module on how to help their people deal with stress. They need to initiate discussion as soon as they know they will be deploying, educate their people, and be attentive to any stress symptoms people may have. Leadership training needs to be institutionalized and not be a last minute thing. Some get the feeling that some leaders are just thrown in."

During the interviews, TLD emerged as a point of discussion. There was a belief that aspects of TLD needed to be examined in greater detail and that more rigorous research should be undertaken to demonstrate the effectiveness of the programme.

"Determine whether satisfaction with TLD and its award component is sufficient to keep the programme. Results now indicate that members are very satisfied with TLD in general and highly satisfied with most of its components (e.g., time to rest, location and accommodation). At six months, satisfaction with the various components of TLD is still very strong. Results with reintegration are less clear. The survey given by the Deployment Health Section shows that TLD facilitates reintegration and closure for approximately half of the respondents. However, when interpreting these results, it should be kept in mind that: 1) These results were obtained with a survey instrument that was not validated and its reliability needs to be demonstrated; 2) To assess adequately the impact of TLD on reintegration we would need an objective measure of reintegration; and 3) Most experts think that it is unlikely that TLD could reduce mental health problems. Most of the time the issues were there before the deployment. The results from the HDO survey are more positive concerning the impact of TLD on reintegration. The different results could be explained by the response rate for each survey (approximately 50% for HDO and 100% for deployment health). The only way to know for sure the effectiveness of TLD for reintegration is to conduct a randomized study. This would involve comparing members who got the TLD with those who did not while controlling for other variables (mission intensity, same unit, etc.). However, if the other beneficial effects of TLD (satisfaction, reward) are sufficient, then the randomized study is not necessary."

"Recommend not doing in-theatre briefings when members go to TLD. CANFORGEN 118/05 states that reintegration has 4 phases: 1. In-theatre briefing; 2. TLD; 3. Reception, post-deployment administration, workplace reintegration and leave; and 4. Post-deployment follow-up activities. The CANFORGEN does not say that there is no need for in-theatre briefing when members go to TLD. However, people who give the briefing feel that doing both is overkill and consists of too much repetition, and members get frustrated by having to endure two briefings. In most cases, it is not necessary to do one-on-one. Only members for whom a supervisor (or buddy) has concerns. Should be a leadership responsibility to talk to their folks. They know best their members and their environment, and they know where there are problems."

"Determine whether we need to take a more restrictive approach with alcohol on TLD. There were reports of serious events associated with alcohol abuse. However, most incidents and stories are anecdotal. Decisions concerning the use of alcohol need to be driven by hard figures. There is a need to keep track of incidents."

Identifying organisational and personal barriers in seeking care was also deemed important.

"Identify barriers to care within the organisation, the military, and within the person. Barriers that prevent a person to come forward could be family, peers, or leadership. Is getting treatment once a week well perceived by leader/peers or does the member get comments like "again?" When they get back to work are they fully accepted? Do they feel less respected and trusted? Stigma is not necessarily the only problem. They may not understand that their confidentiality is protected. There is also the issue of access to service. Because services are often provided during working hours, it may be difficult to hide why they need to go to an appointment every week for personal reasons. Further, group training may interfere with the appointment if members cannot step out of it."

"Stigma associated with mental health in the CF may not be different than in the civilian world. Men tend to hold stronger stigma against mental health. Men tend to consult less in general for physical and mental symptoms."

6 Issues and Suggestions for Improvement Identified in Evaluative Studies

6.1 CF Lessons Learned Reports

In this section, CF Lessons Learned that could be useful in improving personnel support to operations are presented. The first set of Lessons Learned are taken directly from post-operation reports (TFA Roto 1 from February to August 2006 and TFA Roto 2 from August 2006 to February 2007 Observations), the CMP Lessons Learned Knowledge Warehouse (LLKW), and the J1 Coord Lessons Learned After Action Report (AAR). Since a methodology for Lessons Learned within CMP is currently being established, lessons from the LLKW and AAR can only be referred to as lessons "identified" with associated recommendations. This first set of Lessons Learned is presented in Annex B, which is divided along the three components of this paper (health services, spiritual services, and moral and welfare).

The second set of Lessons Learned are taken from the Land Force AAR on the Canadian Contribution in Afghanistan in Regional Command (South) Kandahar (2006-2007). These recommendations (presented below) focussed on how to survive the mental impacts of working in a contemporary operational environment. The recommendations were derived from discussions among individuals with personal operational experiences and individuals who had worked directly to train or support the forces deployed in Afghanistan.

a. Soldiers should have some contact with mental health services personnel prior to deployment in order for a relationship of trust to be developed. The goal is to bring soldiers to progressively perceive mental health personnel as part of their group.

b. The arrival of augmentees to a unit prior to deployment should facilitate bonding with their fellow soldiers. Peer support and attachment to a group may buffer stress symptoms.

c. Soldiers should be briefed on physical reactions that are normal for combat situations and be told that anyone can experience them (i.e., having symptoms is not an indicator of weakness).

d. To reduce the higher risk of stress reaction for soldiers who see combat for the first time, they should be exposed to simulated combat conditions and battle casualties prior to deployment.

e. There is a necessity to provide more support to reservists and their families. Currently, MFRCs are found only on bases, and thus reservists and their families who do not live close to a base cannot access this crucial service.

f. Be on the alert to identify any signs that a soldier is in distress before they become combat ineffective. Help should be offered promptly to enhance recovery.

g. There should be an informal AAR at the section/platoon level.

h. Commanders need to ensure that soldiers' time off during the tour is spent "doing nothing", not doing minor maintenance tasks.

i. During decompression time, be ready to deal with members "letting off steam".

j. Soldiers suffering from minor wounds should be re-integrated back into their sections as quickly as medically possible. The longer a soldier is away from Canadian contact and particularly contact with his or her peers, the deeper his or her emotional trauma is likely to be.

6.2 DND/CF Ombudsman Reports

Concerns and suggestions have also been taken directly from three DND/CF Ombudsman Reports. In the first report, *TLD: From Tents to Sheets: An Analysis of the CF Experience with Third Location Decompression After Deployment* (September 2004), it was recommended that the following factors be considered in determining whether decompression at a third location is warranted after an operational deployment:

a. Level of threat/danger experienced on the mission;

b. Casualties/major incidents experienced during the mission;

c. Mission mandate and its extent and clarity;

d. Public awareness and support for the mission;

e. Tour length;

f. Number of tours/operational tempo;

g. Tempo of the mission;

h. Living and working conditions during the tour;

i. Ability to communicate with family/loved ones;

j. Opportunities for leave during the tour;

k. Training and education to assist in reintegration;

l. Input from the professional community;

m. Input and feedback from members; and

n. Recognition for members' participation in the mission.

The above recommendations were accepted as part of the *DCDS Chapter 12 Deployment Requirements and a CANFORGEN* was issued.

In the second report, *Military Family Members: A Sniper's Battle- A Father's Concern: An Investigation into the Treatment of a Canadian Forces Sniper Deployed to Afghanistan in 2002 . (April 2007)***,** it was recommended that:

a. The DND/CF should ensure that family members, who express significant concerns over the health or well-being of a CF member or DND employee, be formally recognized and diverted, through an established and robust mechanism, to immediate, supportive, personal and timely intervention.

b. The current policy related to the issue of CIS, CF Administrative Order 34-55, should be reviewed with the view of harmonizing the policy to reflect the current and more comprehensive approach to the issue.

c. The DND/CF should ensure that every deployed unit provide adequate training in peer support counselling to its members.

d. The CO of a deploying unit should ensure that, where possible, every sub-unit and every operational sub-grouping contain at least one member with peer support counselling training.

Recommendations from this report have yet to be fully implemented.

In the third report, *Heroism Exposed: An Investigation into the Treatment of 1 Combat Engineer Regiment Kuwait Veterans, 1991 (October 2006)*, it was recommended that:

a. DND/CF should ensure that it has the ongoing ability to produce complete and accurate lists of all personnel deployed on each mission, including reservists and "augmentees" assigned to the mission.

b. A form that remains on the medical file of each deployed individual should contain reference to every deployment in which that individual has served. (The Croatia Board of Inquiry made the same recommendation, which was not accepted at that time.)

c. The medical file of each deployed individual should contain reference to any environmental exposure he or she has sustained in the course of each deployment – whenever such exposure has been identified by DND/CF through an assessment.

d. Individuals should be encouraged to file Declaration of Injury or Illness Forms (CF98) to record environmental exposures that cause them concern, and a copy of such forms should be retained on their medical files.

e. DND/CF should review its current standard questionnaire, CF 2078, with a view to better address occupational health issues, including members' concerns about potential health exposure.

f. Finally, and most importantly, DND/CF should take concrete steps to build a culture of trust with respect to environmental exposure and the health of its personnel

by implementing the above recommendations and through ongoing and proactive communication with Regular Force and Reserve members regarding measures taken:

i. to manage the risks associated with environmental exposure; and

ii. to support individuals and their families by acknowledging their concerns about health issues and by providing them with accurate and timely information about what is known and not known about the cause of their condition.

Recommendations from this report have yet to be fully implemented.

6.3 Other Evaluative Reports

6.3.1 Auditor General of Canada

A report by the Auditor General of Canada to the House of Commons on military health care was published in 2007. Two main observations are of relevance to this report. First, a shortage of mental health professionals at some bases had been observed. At some bases, the demand for mental health services from members returning from Afghanistan is so high that the mental health professionals on these bases find themselves incapable of extending their services to members' families. Second, it had been observed that in some instances, healthcare providers are not sufficiently exposed to emergency/trauma conditions prior to them deploying.

6.3.2 Canadian Medical Association

The shortage of military health professionals had also been observed by the Canadian Medical Association in 2007. Ruth Collins-Nakai, the Past President of the Canadian Medical Association, visited military health professionals in Afghanistan to: 1) provide support and recognition for the health services staff, and especially the physicians, serving there; 2) witness first-hand why these health care personnel are needed in Afghanistan and in the military in general; and 3) raise public awareness of the superb job that Canadian medical doctors, nurses, and other health professionals are doing under extremely difficult and challenging circumstances.

The following quotation summarizes issues surrounding the shortage of health care personnel in the CF:

> "*The CF are experiencing a 35% shortage at the rank of Captain/Major, the rank levels most crucially required to provide "coal face medical care" both in Canada and on deployment. The military has a requirement for at least 150 of these medical officers but at the moment has only 100. There is also an extremely pressing operational need for more specialists in general medicine, trauma, plastic and orthopedic surgery, internal medicine, radiology, psychiatry, anesthesiology and emergency medicine. There is also a need to ensure the military has enough specialists available in the fields of urology, psychiatry, obstetrics/gynecology, general pediatrics and general cardiology, and for more specific mission requirements. There is also an ongoing requirement for dentists, maxillofacial surgeons, pharmacists - there is currently a 50% shortfall in the*

number of pharmacists - critical care and emergency nurses, nurse practitioners, physiotherapists, physician assistants, highly trained paramedics and most other health care professionals, including social workers." [29]

6.3.3 Others

In their report on surgical care at Kandahar, Afghanistan, Tien, Farrell, and Macdonald (2006) reported that planned retirements may reduce the number of general surgeons and orthopedic surgeons in the Canadian military substantially. Therefore, active recruitment and retention initiatives should be continued. Strategies, such as encouraging military personnel to pursue fellowship training as well as embedding military surgeons in civilian centres, make the CF a more attractive career option.

Erskine (2007) has argued that the CF still does not recognize the specialty of emergency medicine, while the U.S. and British militaries have been welcoming emergency medicine specialists with open arms for years (see Lai & Lewin, 2003; Strode, Adams, & De Lorenzo, 2004; Dyer, 2002). Specialists in emergency medicine have acute care experience and advanced skills in airway management, trauma resuscitation, procedural sedation, pre-hospital care and aeromedical evacuation.

[29] See http://www.cma.ca/index.cfm?ci_id=48755&Ia_id=1.

7 Conclusion

This report provides an overview of CF programmes and services related to personnel support to operations. In addition to interviews with CF/DND SMEs, information was gathered on programmes and services offered by TTCP nations' readily available through open sources. The authors acknowledge that the information gathered is exploratory in nature and is therefore limited. This work, however, does serve as a starting point for future efforts in the area of personnel support to operations.

The CF has a range of programmes and services in relation to health, spirituality, and morale and welfare. According to interviewed SMEs, the CF provides excellent support programmes and services. These programmes and services were believed to be effective in meeting the needs of CF members. While SME feedback provided has been positive, at this time it is not possible to make conclusions in relation to the effectiveness of the programmes and services that are being offered nor is it possible to conclude how the CF compares to the other countries in terms of the direct support provided to members and their families. Such conclusions would only be possible through further research and comprehensive programme evaluations.

Based on the information gathered, it is recommended that:

a. This preliminary work be distributed to TTCP nations and more comprehensive and detailed information on their programmes and services be solicited;

b. The CF review and evaluate whether the intent and policies surrounding current programmes and services are meeting CF members' needs;

c. The CF develop objective performance indicators in order to properly monitor and evaluate its programmes and services. Programme evaluation should be undertaken to determine the efficiency of programme and service delivery as well as CF member satisfaction;

d. Research be undertaken with CF service providers, the chain of command, as well as CF members and their families to identify barriers in the provision of support programmes and services;

e. Research be conducted into the engagement of CF family members in the deployment process and in CF programmes and services;

f. Further research be conducted to demonstrate the effectiveness of the TLD programme;

g. The CF develop a comprehensive research plan in the areas of resiliency, stress and PTSD;

h. Stress and coping components in current leadership training practices be reviewed and evaluated to ensure continuity and consistency in programme delivery; and,

i. Further research be undertaken into the different meanings and forms of spirituality.

References

Canada-

Health Support:

ADM (HR-Mil) Instruction 07/04: Canadian Forces Member Assistance Program. (2004).

Defence Administrative Order and Directive (DAOD) 5044-1, Families. (2002).

Deputy Chief of Defence Staff (DCDS) Direction for International Operations (DDIO), Chapter 16, article 1601-2.

Mental Health Working Group Draft Guidance, National Defence Publication. Document code 7.5, 2007.

Mitchell, J.T. (1983). When disaster strikes…the critical incident stress debriefing process. Journal of Emergency Medical Services, 13, 49-52.

"Overseas and Domestic Operations. Deployment Handbook for the Soldier, the Soldier's Family and the Soldier's Unit". Publication of the 35 Canadian Brigade Group. September 2005. Retrieved Jan 14, 2008 from <http://armyonline.kingston.mil.ca/LFAA/143000440001168/OVERSEAS_DEPLY_GUIDE.DOC>

Wesley, S., Rose, S., & Bisson, J. (1998). Review of Brief Psychological Interventions ("Debriefing") for the Treatment of Immediate Trauma Related Symptoms and Prevention of Post Traumatic Stress Disorder. London. The Cochrane Library, 2, 1-17.

Canadian Forces Health Services: Canada's Military Health System Website: http://hr.ottawa-hull.mil.ca/health/engraph/home_e.asp?Lev1=12

Military Family Resource Centers Website: http://edmonton.mil.ca/lfwa/branches/G3/Op_Apollo_reintegration.asp

Spiritual Support:

Coulthard, J. (2008). A Preliminary Review of Chaplains in the Military. DRDC CORA Technical Memorandum 2008-16.

The Chaplain's Manual. National Defence Publication, B-GL-346-001/PT-001, 1 August 2005.

Army Chaplaincy Website: http://www.forces.gc.ca/chapgen/engraph/operations_army3_e.asp?sub=2

Air Force Chaplaincy Website: http://www.forces.gc.ca/chapgen/engraph/operations_air_e.asp?cat=3

Navy Chaplaincy Website: http://www.forces.gc.ca/chapgen/engraph/operations_navy_e.asp?cat=3

Morale and Welfare:

Department of National Defence. CFPSA/NPP Annual Report 2005-2006. Retrieved 28 January 2008 from <http://cfpsa.com/en/corporate/services/media/Reports/2006/CFPSA%Annual%20Report%202006.pdf>

Overseas and Domestic Operations. Deployment Handbook for the Soldier, the Soldier's Family and the Soldier's Unit. Publication of the 35 Canadian Brigade Group. September 2005; Retrieved Jan 14, 2008 from <http://armyonline.kingston.mil.ca/LFAA/143000440001168/OVERSEAS_DEPLY_GUIDE.DOC>

Canadian Forces Personnel Support Agency Website: http://www.cfpsa.com/en/index.asp

CF Lessons Learned Reports:

Joint Task force Afghanistan (JTF-A) J1 Coord Lessons Learned After Action Report (AAR). Covering Letter. December 2007.

Land Force After Action Report of Canadian Contribution in Afghanistan in Regional Command (South) Kandahar (2006-2007). Draft Report 29 August 2007.

Task Force 1-06 (1 PPCLI BG) Post Operation Report February to August 2006. Subject: Quality of Life

Task Force Afghanistan Roto 1 Post Operation Report February to August 2006. Role 3 Health Service Support Observations. Subject: Medical.

Task Force Afghanistan Roto 1 Post Operation Report February to August 2006. National Command Element Observations. Subject: Arrival Assistance Group (AAF)/ Departure Assistance Group (DAG).

Task Force Afghanistan Roto 2 Post Operation Report August 2006 to February 2007 Observations. Subject: Personnel Administration.

A Report from Afghanistan. Message from President of Canadian Medical Association Released July 5, 2007. Retrieved Feb 20, 2008 from <http://www.cma.ca/index.cfm?ci_id=48755&la_id=1>

DND/CF Ombudsman's Reports:

Department of National Defence and Canadian Forces Ombudsman. A Sniper's Battles-A Father's Concern: An Investigation into the Treatment of A Canadian Forces Sniper Deployed to Afghanistan in 2002. April 2007.

Department of National Defence and Canadian Forces Ombudsman. Heroism Exposed: An Investigation into the Treatment of 1 Combat Engineer Regiment Kuwait Veterans (1991). October 2006.

Department of National Defence and Canadian Forces Ombudsman. From Tents to Sheets: An Analysis of the CF Experience with Third Location Decompression After Deployment. September 2004.

Other Evaluative Reports:

Dyer, O. (2002). Doctors in the armed forces to get £50,000 "golden hellos". BMJ, 325, 1261.

Erskine, M. (2007). Emergency medicine in the Canadian military. Canadian Medical Association Journal, 176 (10).

Lai, M.W., & Lewin, M.R. (2003). Emergency physicians in the United States military: a primer. Annals of Emergency Medicine, 42, 100-9.

Report of the Auditor General of Canada to the House of Commons, Chapter 4: Military Health Care-National Defence, October 2007.

Strode, C.A., Adams, B., & De Lorenzo, R.A. (2004). Emergency physicians in the military: A sequel. Annals of Emergency Medicine, 43, 669-70.

Tien, H., Farrell, R., & Macdonald, J. (2006). Preparing Canadian military surgeons for Afghanistan. Canadian Medical Association Journal, 175, 1365.

General:

Tanner, L., Aker, T., Otis, N. & Wang, Z. (2008). A Compendium of Military Family Support Programs Across TTCP Countries. DRDC CORA Technical Memorandum, TM 2008-062.

Wang, Z., Dunn, J., & Tanner, L (2009). Care of the Ill and Injured in the Canadian Forces. DRDC CORA Technical Memorandum, TM 2009-015.

Australia-

Health Support:

Australian Government-Department of Defence-Personnel Portal Website: http://www.defence.gov.au/dpe/

Rosenfeld, J., Rosengarten, A., & Paterson, M. (2006). Health support in the Iraq War. ADF Health (Vol 7), at http://www.defence.gov.au/health/infocentre/journals/ADFHJ_apr06/ADFHealth_7_1_2-7.pdf

Spiritual Support:

Royal Australian Navy Website: http://www.navy.gov.au/general/chaplaincy.html

Morale and Welfare:

Australian Army: Army the Soldiers' Newspaper Website: www.defence.gov.au/news/armynews/editions/1108/letters.htm

Australian Government-Department of Defence Website: www.defence.gov.au

New Zealand-

New Zealand Defence Force Website: www.nzdf.mil.nz

United Kingdom-

Health Support:

Ministry of Defence (2007). A Guide for the Families of Deployed Regular Army Personnel. Retrieved 2 February 2008 from: <http://www.mod.uk/NR/rdonlyres/3D062FE6-0326-4ED2-8DCC 185BB0B9A812/0/20071031Families_Guide_Regular_ArmyDPSAU.pdf>

Ministry of Defence. Soldier Management: A Guide for Commanders, Retrieved 2 February 2008 from: <http://www2.army.mod.uk/linkedfiles/servingsoldier/usefulinfo/soldier_management.pdf>

British Army Website: http://www.army.mod.uk/servingsoldier/index.htm;

UK Parliament Publications Website: http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070604/text/70604w0042.htm

Morale and Welfare Support:

British Forces Broadcasting Service Website: www.ssvc.com/bfbs/tv/dtt/index.htm

Navy, Army and Air Force Institutes Website: www.naafi.co.uk/in-theatre.php?menu_list=111

United States –

U.S. Health Support

Department of Defence- Deployment Health Clinical Center Website: http://www.pdhealth.mil/dcs/DD_form_2796.asp http://www.pdhealth.mil/dcs/pdhra.asp

MyArmyBenefits Website: http://myarmybenefits.us.army.mil/EN/

Spiritual Support:

Strong Bonds Website: www.strongbonds.org

Army Family Readiness Group Website: www.armyfrg.org

Morale and Welfare:

Desjarlais, O.F. Jr. (Feb 2005). The Store that Goes to War: AAFES has Been in Every Major Conflict Since World War I. Airman. FindArticles.com. Retrieved 15 February from <http://findarticles.com/p/articles/mi_m0IBP/is_2_49/ai_n13794855>

This page intentionally left blank.

Annex A Discussion Questions Asked of Subject Matter Experts

1. From your perspectives, how effective are current programmes and services?

2. According to your personal experience, what is contributing the most to the troops' overall feeling of support?

3. In your opinion, what could be done to further improve the support provided to CF members and their families?

4. Are there problems or challenges with current programmes and services? If so, do you think the problems are at the policy level, the program level, the service delivery level or the resources level? Please explain.

5. Any lessons learned you want to share? These can be anecdotal observations/advice.

This page intentionally left blank.

Annex B Lessons Learned From CF Post-Operation Reports

C.1 Appendix 1 – Health Services

Issue	Observations	Recommendation
Individual Training (TFA Roto 1 – Feb to Aug 2006)	Lack of user familiarity with medical equipment. It has become quite apparent, from the amount of equipment in the shop for repair and the problems with the kit, the users do not have a thorough understanding of how the equipment operates.	During pre-deployment training, time should be dedicated to teaching the operators, Medical Technicians (Med Techs), Nurses and Doctors, the proper use and care of medical equipment. In order to ensure that staff are properly trained on the equipment that will be used in theatre, duplicate equipment for specific items used in the Multi-national Medical Unit (MMU) should be purchased for 1 Canadian Field Hospital.
	The pre-deployment clinical training requirement has to be oriented towards emergency/trauma and internal medicine mostly to be more comfortable in the handling of the different medications involved in a trauma centre.	A minimum of four weeks in both Intensive Care Unit and Internal Medicine Departments is recommended in order to be more at ease with the different terminology and medications used in these types of environments. An exposure to different trauma would also be beneficial.
	Training of Med Tech working in pharmacy.	A period of two weeks of training should be included for the nominated Med Tech at their Base Medical Centre pharmacy to get a familiarization with a variety of generic names of drugs and the pharmacy program, Simplicity Plus. In addition, the required training on Med Stores should be obtained from their home Base Medical Centre if possible.

Issue	Observations	Recommendation
Medical Manpower and Personnel (TFA Roto 1 – Feb to Aug 2006)	The requirements of the Technical Assistance Visit (TAV) were met only by rescheduling the day to day PMed requirements of KANDAHAR, and conducting those activities in the evening and early morning.	Future redeployment TAVs that require PMed services should be deployed with their own dedicated PMed Tech.
	During pre-deployment training, when the exercise portion commences, there is no requirement for the Biomedical Electronics Technologists (BE Techs) to be within the facility, as there is nothing they can do to repair the equipment.	Biomedical Equipment Technicians may be more effective during pre-deployment training at the repair facility of 1 Canadian Field Hospital. That way, they can see and repair equipment that is specific to 1 Canadian Field Hospital, e.g., field sterilizer, ATS-2000 tourniquet system, etc.
	Too much time spent transmitting and receiving images via TeleRad services. This has placed an incredible burden on the diagnostic imaging section in regards to the time and manpower required.	Hire more technologists for the DI dept.
Equipment (TFA Roto 1 – Feb to Aug 2006)	Too much time to get items and replacement parts delivered in theatre. This results in medical personnel having sometimes to do without some of their critical supplies and increased downtime spent repairing equipment.	Find an alternative to the shipment of critical replacement parts. Have a complete replacement parts kit on stock at all times within theatre. Better inform BE Tech when the parts will arrive or when they do arrive, to start preparing for the installation and contact the company for tech support. To make sure equipment can endure conditions in-theatre, equipment trials should be conducted in Canada instead in-theatre.

Issue	Observations	Recommendation
	The constant staff checks from technical advisors at CF Health Services Group Headquarters HQ reference the functionality and repair issues of their field equipment. The need to constantly justify the reasons for downtime and methods of repair has meant that the BE Techs have had to spend numerous hours explaining their actions to HQ. This has had a two-fold effect on the repair shop: it is demoralizing to have one's abilities constantly questioned and because they have to justify their actions, it has meant increased repair times for other broken equipment.	Staff checks should be minimized on critical equipment downtime justifications.
	Too much time spent reproducing requisitions electronically.	Need scanner and software to scan requisitions.
Mental Health Support (TFA Roto 1 – Feb to Aug 2006)	Commanders were not prepared enough to deal with "stress" casualties. Although there was a general pre-deployment training session for all deploying personnel at the Peace Support Training Centre on general stress, etc; there was nothing formally available from a command/leadership perspective. All the traditional avenues were available in-theatre such as Padre, Social Workers, etc but they are generally a treatment and not a prevention option.	Future commanders should discuss stress casualties and preventive measures with appropriate agencies prior to deploying into theatre, get as much information on the subject to read and retain and learn from the soon to be numerous lesson from previous OP ARCHER personnel.

Issue	Observations	Recommendation
Reintegration (TFA Roto 2 – Aug 2006 to Feb 2007)	Strategic lift will dictate the flow of soldiers out of theatre and the NCE/CEFCOM will determine the Re-Integration Plan from theatre to the decompression centre (if applicable) to Canada. The number of spots on any given flight will vary but as with HLTA the plan can be based on individuals or formed sections/troops.	In order to achieve the maximum benefit of decompression and re-integration, soldiers must go through those processes with those with whom they fought with. As such, it is highly recommended that ideally troops return home together and, at a minimum, sections retain their integrity while travelling.
Pre-deployment Screening (J1 Coord AAR Dec 2007)	Of 12 repatriations processed on this tour for R3 MMU personnel, four were for compassionate reasons, two were for medical reasons and six were to attend courses. Repatriation causes an administrative burden to the Task Force and replacements were difficult to obtain in a timely manner.	It is recommended that pre-deployment screening include a check for potential career course loading and considerations be made not to send those that will likely need to redeploy early.
Prescriptions for Civilians (J1 Coord AAR - Dec 2007)	Entitlement to draw medications requires further review. Those not eligible for care, including civilian contractors, should not be drawing over-the-counter or chronic medications from the Role 3 pharmacy. There is an informal policy whereby individuals can obtain one month of medication until they can make other arrangements such as mail or internet resupply. However, the clinicians in primary care need to be vigilant of who is entitled and the pharmacy should implement a tracking system.	Civilian Contractors must be informed in advance that medication will NOT be provided in theatre and that they must either arrive with enough chronic meds or have arranged supply. All clinicians should be made aware of entitlements and the pharmacist in-theatre must enforce the policy.

C.2 Appendix 2 – Spiritual Services

Issue	Observations	Recommendation
Chaplaincy – Notification of NOK upon death in SDA. (CMP LLKW, 20 August 2007)	For members who are employed with International Security Assistance Force (ISAF) HQ, notification of Primary NOK was done using ISAF procedures. As such, the TFA Command Chaplain was not made aware until after the notification had occurred. However, this was followed up from Chaplain sp from CFSU (Europe) and Chaplaincy out of Land Force Central Area to notify the Secondary NOK in Canada.	ISAF HQ procedures should include notification to JTFA HQ. This procedural change would need to be coordinated by JTFA (via CEFCOM).
No legitimate decompression for Chaplains (CMP LLKW, 27 September 2007)	Upon completion of a tour with JTFA, Chaplains are expected to continue to provide support (both at the TLD site and in Garrison) as they are an unofficial part of the redeployment support group. Although they may be the best qualified for this purpose as a result of their experiences, they must be able to decompress as well.	Either Chaplains need to decompress separately or there has to be a clear statement of the Chaplain's responsibilities during this period. There needs to be very clear standard operating procedures and expectations.
Reserve Chaplains are not guaranteed the same post-deployment reduced tempo status as their Regular Force counter-parts (CMP LLKW, 27 September 2007)	DDIOs direct Force Generators to ensure that Class C contracts are extended, as necessary, to enable the completion of all post-deployment processes, up to and including all Phase Three activities and leave (i.e., the 60-day respite period). A "one-size fits all" approach cannot be applied to Chaplains – in some cases, continued employment will meet the need but in other cases, the employer (church) will provide employment. In many other cases, chaplains will be attach-posted to a base (not necessarily in the local area) and even the 60 days (during which they are not re-integrating with family) may be a hardship, keeping them even longer away from home.	The issue is not entirely that of "reduced tempo" status but an awareness that Reserve Force chaplains work as professionals within a very limited and restricted workplace that places limits on their ability to re-integrate into the workforce. Awareness of this fact, and flexible policies to accommodate this, are required.

Issue	Observations	Recommendation
Weapons effects and familiarization training not part of Chaplains' pre-deployment training requirements (CMP LLKW, 27 September 2007)	Under the terms of the Geneva Convention, Chaplains are non-combatants. The policy of the Interfaith Committee on Canadian Military Chaplaincy and Chaplain General is that chaplains shall not bear arms. But Chaplains are working in an environment where they are exposed to a broad variety of weapons. Should Chaplains deploying on operations be provided with a basic knowledge of weapons capabilities, effects and functioning (only so far as to "make them safe")? There are two safety concerns here: a. personal safety (it helps to know which end goes bang); and b. unit safety (who might have concerns about having to bear an extra level of security for a chaplain's safety or who feel that mission effectiveness is compromised by having someone in uniform who is not fully weapons-familiar).	a. Clearly define what is meant by "non-combatant" b. Determine whether the restriction against bearing arms also includes training with those arms.

C.3 Appendix 3 – Morale and Welfare

Issue	Observations	Recommendation
CFPSA Services (TFA Roto 1 – Feb to Aug 2006)	It was noted by TF Orion Chain of Command that the CFPSA support to the TF was poor as it provided mainly support to those personnel on Kandahar Airfield (KAF) or at a major camp.	CFPSA should provide more welfare programs for those personnel who live at austere camps, Forward Operating Bases (FOBs) and patrol bases.
	On a comparable basis, Canada through its operation division CANEX has less quality retail outlets than the US (AAFES) and the UK (NAAFI). However, it was noted that the Tim Hortons was appreciated.	Hours need to be extended. Outlets should sell what members want (i.e., souvenir, items of kit and equipment, and Canadian magazines).
	The travel co-ordination office was largely viewed as ineffective. A number of errors in travel claims and debit/credits to members pay have been observed	Hire a person within the cell with an understanding of the CCPS (i.e., the automated system database that processes pay and pay related services for members serving outside Canada) and claims system to review all acquaintance rolls' and claims prior to processing.

Issue	Observations	Recommendation
Re-integration Issues (TFA Roto 1 – Feb to Aug 2006)	Sometimes personnel are posted or are planning moves during the re-integration period. This places a burden on personnel while they have to deal with post deployment administration. Members cannot fully enjoy the benefits of the re-integration period.	As much as possible, personnel on operational tours should not be posted until after completion of the mission and post deployment administration.
Leave Issues (TFA Roto 1 – Feb to Aug 2006)	Leave policy in DDIO is not clear for the Afghanistan theatre of operations. CEFCOM provided interim guidance to address the policy of three-day/month mission leave. Despite the restriction of tactical aviation assets to one aircraft per day, the Special Mission Leave (SML) program was carried out with surprisingly few problems. The issue of personnel deployed for nine months and thus earning 27 days of mission leave caused some difficulty due to the length of time that personnel would be absent from theatre vis-à-vis benefit cut-off and currency. This was addressed by the creation of an R&R program in the host nation with residual SML being converted at the end of the tour. The leave program was almost entirely administered by the military, less the travel arrangements and interim decompression/R&R activities, which were coordinated by CFPSA.	If the Canadian Army is likely to continue employing individuals for nine-month tours, a separate leave policy may be required to address this.
DAG Administration (TFA Roto 1 – Feb to Aug 2006)	Units preparing for operation deployments have to mount, train and DAG themselves (DAG personnel administration)	Another unit must be tasked to do this.

Issue	Observations	Recommendation
Replacements (TFA Roto 1 – Feb to Aug 2006)	The turn around time for replacements in-theatre was four to eight weeks with a mean of six weeks. In some cases, specialty trades such as intelligence analysts, CP Teams, and Local Cultural Advisors were unable to be filled.	A sufficient replacement pool must be mounted and prepared for deployment. Casualties in this theatre are guaranteed. Once deployed, better tracking of replacements is necessary.
Quality of life (TFA Roto 1 – Feb to Aug 2006)	The set-up and construction of permanent quarters on KAF for TF ORION was particularly poor. Originally slated for completion in February 2006 they have yet to be either completed or occupied. The interim solution of placing troops in large white tents was, although workable, not the ideal. The close confines for extended periods cause problems, including a general lack of privacy and problems with sanitation.	Weatherhaven or modular tentage is a better solution than the big white tent. Sufficient modular tentage should always be brought into theatre, to include special shelters for sanitation and office space. At the time of writing sub-unit offices for TF Orion have only just arrived, and there are only sufficient to allow coys to share offices.

Issue	Observations	Recommendation
Leave – Annual and Pre-Deployment (CMP LLKW, 22 October 2007)	OP ARGUS Strategic Assessment Team (SAT)-A ROTO 2 POR Annex A Serial 14"Policy requires all members on one-year mission tours expend all annual leave entitlements. No one on SAT was able to accomplish this (as per O:\DGMP_Pearkes\Lessons Learned\PORs\OP ARGUS - SAT-A Roto 2 Ph 1 – 3\Annex D). The fractured nature of the pre-deployment administrative process meant that team members had to remain available for training and administrative processing as each step was separately identified and executed."	From the TF Commander: "In subsequent rotations the nominated Force Generator should develop an Operational Synchronization Matrix that details all events from Declaration of Operational Readiness (FOC) back to Warning Order, using critical path methodology. Each critical event, on that path, both training and administrative, must be identified, planned and managed on behalf of the team by the desk officer in the Force Generator HQ. This OP Sched must then be shared interactively with all team members so that required actions and changes are promulgated easily and promptly. Leave must be a programmed event in the Op Sched, in the same way as any other mandated activity."

Issue	Observations	Recommendation
Task Force Movement (CMP LLKW, 22 October 2007)	OP ARGUS SAT-A ROTO 2 POR Annex A Serial 19 Strategic Advisory Team (SAT) -Afghanistan is not covered under the Technical Agreement for the purposes of visas, and members must travel into and out of an official port of entry and have visas stamped on both entry and exit. Initially, the staff deployment solution was to place the SAT into the JTF-A RIP airflow, meaning SAT members would not enter at an international port of entry...the implications of not having a properly stamped entry visa are very serious. Members cannot leave the country, and are subject to arrest and detention at the airport. Leaving without having a properly stamped exit visa (via military air) means members cannot re-enter and are subject to the same treatment should they try. Finally, service with OP ARGUS constitutes a posting, and as such, personnel assigned fall under DCBA rules for deployment and repatriation.	From the TF Comd: SAT deployment-redeployment is best undertaken via CAL under DCBA posting regulations. The deployment of SAT personnel must meet visa regulations.
Briefings on HLTA to military members (J1 Coord AAR – Dec 2007)	Current roto 4 did not support CFPSA/HLTA briefings to deploying members. As a result, only 13 pers from TF had info on HLTA prior to deploying. It was assessed by TF that as briefings were not obligatory on the pre-deployment training syllabus, they would not make attendance by TF members compulsory. It became necessary to conduct briefings in theatre. Roto 5 included briefings based on understanding of Joint Task Force (JTF) leadership.	Briefings on HLTA entitlements must be compulsory for deploying personnel. Include HLTA briefings as a required activity in the pre-deployment training syllabus ideally during collective training period.

This page intentionally left blank.

List of symbols/abbreviations/acronyms/initialisms

AAFES	Army and Air Force Exchange Service
AAR	After Action Report
ADF	Australian Defence Force
BAF	Bagram Air Force Base
BE Tech	Biomedical Electronics Technologist
BFBS	British Forces Broadcasting Service
CANEX	CF Exchange System
CANOSCOM	Canada Operational Support Command
CANSOFCOM	Canada Special Operations Forces Command
CBRN	Chemical, Biological, and Radiological, and Nuclear Release
CEFCOM	Canada Expeditionary Force Command
CF	Canadian Forces
CFDS	Canadian Forces Dental Services
Chap Gen	Canadian Forces Chaplain Branch
CFHS	Canadian Forces Health Services
CF H Svc Gp	Canadian Forces Health Services Group
CFMS	Canadian Force Medical Services
CFPSA	Canadian Forces Personnel Support Agency
CHRP	Coming Home Readjustment Program
CIS	Critical Incident Stress
CISD	Critical Incident Stress Debriefing
CSL	Confidential Support Line
CMP	Chief Military Personnel
CMS	Critical Incident Mental Health Support
CO	Commanding Officer
COCOM	Combatant Command
CORA	Centre for Operational Research and Analysis
CP	Close Protection
CSR	Combat Stress Reaction
DAG	Departure Assistance Group

DAOD	Defence Administrative Order and Directive
DCDS	Deputy Chief of Defence Staff
DDIO	DCDS Direction for International Operations
DGHS	Director General Health Services
DHHAT	Deployable Health Hazard Assessment Team
DIPP	Defence Injury Prevention Program
DNBI	Disease, Non-Battle Injury and Battle Injury
DND	Department of National Defence
DoD	Department of Defense
DOEHRS	Defense Occupational and Environmental Health Readiness System
DRDC	Defence Research & Development Canada
DGMPRA	Director General Military Personnel Research and Analysis
DSMPRA	Director Strategic Military Personnel Research and Analysis
DSTC	Distributed Systems Technology Centre
EFI	Expeditionary Force Institute
FCP	Family Care Plan
FHPPP	Force Health Protection Prescription Products
FOB	Forward Operating Base
FS	Financial Services
HDO	Human Dimensions of Operations
HLTA	Home Leave Travel Assistance
ISAF	International Security Assistance Force
JTF	Joint Task Force
KAF	Kandahar Airfield
LLKW	Lessons Learned Knowledge Warehouse
MASCAL	Mass Casualty Response
Med Tech	Medical Technician
MFRC	Military Family Resource Center
MFLC	Military and Family Life Consultant
MMU	Multi-national Medical Unit
NAAFI	Navy, Army and Air Force Institutes
NOK	Next of Kin

NSE	National Support Element
NZDF	New Zealand Defence Force
OEH	Occupational and Environmental Health
OSI	Operational Stress Injuries
OSISS	Operational Stress Injury Social Support
OTSSC	Operational Trauma Stress Support Centres
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PHE	Periodic Health Examination
PLHA	Preliminary Hazard Assessment
P Med Tech	Preventative Medicine Technician
POTL	Post-Operational Tour Leave
POW	Prisoner of War
PRT	Provincial Reconstruction Team
PSP	Personal Support Programs
PTSD	Post-Traumatic Stress Disorder
PULHHEEMS	Physical capacity, Upper limbs, Locomotion, Hearing (right & left), Eyes (right & left), Mental capacity, and emotional Stability
RAN	Royal Australian Navy
R & R	Rest & Recuperation
SAT	Strategic Advisory Team
SCOMR	Standing Committee on Operational Medicine Reform
SCONDVA	Standing Committee on National Defence and Veterans Affairs
SISIP	Service Income Security Insurance Plan
SJS	Strategic Joint Staff
SME	Subject Matter Expert
SML	Special Mission Leave
TAV	Technical Assistance Visit
TF	Task Force
TLD	Third Location Decompression
TRiM	Trauma Risk Management
TTCP	The Technical Cooperation Program
UK	United Kingdom

UMO	Unit Medical Officer
UN	United Nations
U.S.	United States

Distribution list

Document No.: DGMPRA TM 2009-016

LIST PART 1: Internal Distribution by Centre

1 CMP List 1
1 Asst CMP
1 DG Air Pers
1 DG Air FD
1 DG Land Staff
1 DG MPR
1 CFLI (Kingston)
1 RMC (Kingston)
1 CFC (Toronto)
1 DG CORA
1 DRDC CORA Chief Scientist
1 DRDC CORA Library (1 copy)
2 DRDKIM Library (2 copies)
1 DRDC/DGSTO/DSTP
1 DGMPRA
1 DGMPRA – Chief Scientist
1 DGMPRA – Deputy DG
1 DGMPRA – Personnel Generation Research – Section Head
1 DGMPRA – Personnel and Family Support Research – Section Head
1 DGMPRA – Organizational and Operational Dynamics – Section Head
1 DGMPRA – Team Leaders
1 CMS/D Mar Strat 2-6
1 SJS DOSS Pers Ops
1 DRDC (Toronto)
1 CFHA
1 D Mar Pers
1 DLPM/G1
1 D Air Pers Mgt
1 VAC LO
1 DGMP
1 DCSM
1 DGPFSS/PSP
1 DHSO
1 DFHP
1 D Med Pol
1 DMPSC
1 DPOCS
1 CANOSCOM/COST
1 D Mar Pers – LCdr Boyes
1 DGLS/LPCP – LCdr Lyon

1 D Air Pers Strat – Maj Norris
1 MORT – L. Tanner
1 DST (Pers)/DRDC
1 Colonel Peter Murphy, Australia
1 Ms Elizabeth Edgar, United Kingdom
1 Dr. Jane Arabian, United States
1 Wing Commander Emma Davis, New Zealand

48 TOTAL LIST PART 1

LIST PART 2: External Distribution by DRDKIM

1 Library and Archives Canada

1 TOTAL LIST PART 2

49 TOTAL COPIES REQUIRED

DOCUMENT CONTROL DATA

(Security classification of title, body of abstract and indexing annotation must be entered when the overall document is classified)

1. ORIGINATOR (The name and address of the organization preparing the document. Organizations for whom the document was prepared, e.g. Centre sponsoring a contractor's report, or tasking agency, are entered in section 8.)

DGMPRA
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

2. SECURITY CLASSIFICATION (Overall security classification of the document including special warning terms if applicable.)

UNCLASSIFIED
(NON-CONTROLLED GOODS)
DMC A REVIEW:GCEC JUNE 2010

3. TITLE (The complete document title as indicated on the title page. Its classification should be indicated by the appropriate abbreviation (S, C or U) in parentheses after the title.)

An Exploratory Examination of Personnel Support to Operations:

4. AUTHORS (last name, followed by initials – ranks, titles, etc. not to be used)

Otis, N.; Dunn, J.; Wang, Z.

5. DATE OF PUBLICATION (Month and year of publication of document.)	6a. NO. OF PAGES (Total containing information, including Annexes, Appendices, etc.)	6b. NO. OF REFS (Total cited in document.)
September 2009	78	51

7. DESCRIPTIVE NOTES (The category of the document, e.g. technical report, technical note or memorandum. If appropriate, enter the type of report, e.g. interim, progress, summary, annual or final. Give the inclusive dates when a specific reporting period is covered.)

Technical Memorandum

8. SPONSORING ACTIVITY (The name of the department project office or laboratory sponsoring the research and development – include address.)

DGMPRA
101 Colonel By Drive
Ottawa, Ontario K1A 0K2

9a. PROJECT OR GRANT NO. (If appropriate, the applicable research and development project or grant number under which the document was written. Please specify whether project or grant.)	9b. CONTRACT NO. (If appropriate, the applicable number under which the document was written.)

10a. ORIGINATOR'S DOCUMENT NUMBER (The official document number by which the document is identified by the originating activity. This number must be unique to this document.)	10b. OTHER DOCUMENT NO(s). (Any other numbers which may be assigned this document either by the originator or by the sponsor.)
DGMPRA TM 2009-016	

11. DOCUMENT AVAILABILITY (Any limitations on further dissemination of the document, other than those imposed by security classification.)

Unlimited

12. DOCUMENT ANNOUNCEMENT (Any limitation to the bibliographic announcement of this document. This will normally correspond to the Document Availability (11). However, where further distribution (beyond the audience specified in (11) is possible, a wider announcement audience may be selected.))

13. ABSTRACT (A brief and factual summary of the document. It may also appear elsewhere in the body of the document itself. It is highly desirable that the abstract of classified documents be unclassified. Each paragraph of the abstract shall begin with an indication of the security classification of the information in the paragraph (unless the document itself is unclassified) represented as (S), (C), (R), or (U). It is not necessary to include here abstracts in both official languages unless the text is bilingual.)

This work is the result of a CMP request to conduct an overview of personnel support based on the CF J1 conceptual framework. The objectives of this paper are: 1) to provide an overview of CF personnel support services and programmes as well as services and programmes offered in TTCP nations; and 2) to review CF lessons learned from recent operational experiences and recommendations from Department of National Defence (DND)/CF Ombudsman Reports. In addition, interviews conducted with subject matter experts (SMEs) from different DND/CF divisions are summarized to provide additional information on personnel support. Based on the information gathered herein, recommendations are made for future work in the area.

14. KEYWORDS, DESCRIPTORS or IDENTIFIERS (Technically meaningful terms or short phrases that characterize a document and could be helpful in cataloguing the document. They should be selected so that no security classification is required. Identifiers, such as equipment model designation, trade name, military project code name, geographic location may also be included. If possible keywords should be selected from a published thesaurus, e.g. Thesaurus of Engineering and Scientific Terms (TEST) and that thesaurus identified. If it is not possible to select indexing terms which are Unclassified, the classification of each should be indicated as with the title.)

Personnel Support to Operations; Deployment Support; Pre-deployment Services; Post-deployment Services; Health Services Support; Spiritual Services Support; Morale and Welfare; Lessons Learned

DRDC CORA

www.drdc-rddc.gc.ca