MFS MILITARY FAMILY SERVICES
SFM SERVICES AUX FAMILLES DES MILITAIRES
A division of CF Morale & Welfare Services
Une division des Services de bien-être et moral des FC

MFSP MILITARY FAMILY SERVICES PROGRAM
PSFM PROGRAMME DES SERVICES AUX FAMILLES DES MILITAIRES

The Needs of Medically Releasing Canadian Armed Forces Personnel & Their Families – A Literature Review

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Abstract

There is increasing public attention on the challenges faced by Canadian Armed Forces personnel who are transitioning from active service through the medical release process to Veteran status. There is also increasing concern for the families caring for ill and injured personnel and Veterans. In preparation of a national collaborative pilot project between Military Family Services and Veterans Affairs Canada, a literature review was conducted in conjunction with an environmental scan and survey of Military Family Resource Centre subject matter experts. The purpose of this literature review was to assess the needs of medically releasing personnel and their families, prioritize the support services they require, compile existing resources and best practice programmes, and determine priority areas to care for caregivers. Findings show that approximately 1,000 military members are medically released each year, with 700 spouses and 900 children impacted. The impacts on these families vary greatly based on a number of factors. Most families transition to civilian life successfully, but some require additional supports. Based on this literature review, five recommendations were offered to guide the development of a successful pilot project to serve the families of medically releasing personnel:

1. Tailor services using the injury recovery trajectory;
2. Use existing evidence-based strategies including family education on the injury/illness and recovery process, family care management, emotion regulation skills development, injury communication training, and development of problem-solving and shared goals;
3. Train and evaluate clinicians in these evidence-based strategies;
4. Understand and support community provider capacity; and
5. Research the full constellation of Canadian military families to ensure services match the needs of all families, not just traditional nuclear families.

Résumé

Les médias portent de plus en plus leur attention sur les défis auxquels font face les membres des Forces armées canadiennes qui sont en transition du service actif à une libération pour raisons médicales et au statut d'ex-militaire. On se préoccupe également davantage des membres de la famille qui s'occupent des militaires et des ex-militaires malades ou blessés. En vue d'un projet pilote à l'échelle nationale conjoint entre les Services aux familles des militaires et Anciens Combattants Canada, nous avons mené une revue de la littérature ainsi qu'une analyse du contexte et un sondage auprès des experts en la matière des centres de ressources pour les familles des militaires. L'objectif de cette revue de la littérature était d'évaluer les besoins des militaires en voie de libération pour raisons médicales et de leur famille, prioriser les services de soutien dont ils ont besoin, compiler les ressources déjà en place et les programmes exemplaires, et identifier les principaux soins à fournir aux fournisseurs de soins. Les résultats démontrent qu'environ 1000 militaires obtiennent une libération pour raisons médicales chaque année, touchant du même coup 700 conjoints et 850 enfants. Les répercussions sur ces familles varient grandement selon un nombre de facteurs. La plupart des familles vivent une transition en douceur vers la vie civile, mais certaines ont besoin de plus d'appui. Selon la revue de la littérature, nous soulevons cinq recommandations pour diriger l'élaboration d'un projet pilote réussi pour desservir les familles des militaires en voie de libération pour raisons médicales :

1. adapter les services selon les étapes du rétablissement à la suite d'une blessure;
2. se fonder sur des stratégies éprouvées, dont l'éducation des membres de la famille au sujet de la blessure ou de la maladie et du processus de rétablissement, la gestion des soins à apporter à la famille, le développement des habiletés de contrôle des émotions, la formation sur la communication à la suite d'une blessure, et l'élaboration de buts communs et de stratégies de résolution de problème;
3. former et évaluer les cliniciens selon ces stratégies éprouvées;
4. comprendre et appuyer la capacité de soutien de la communauté; et
5. faire des recherches auprès de toute la population de familles de militaires canadiennes afin de s'assurer que les services correspondent aux besoins de toutes les familles, et non seulement à ceux des familles nucléaires traditionnelles.

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1. Introduction

In November 2014, a joint announcement by the Ministers of Veterans Affairs and National Defence dedicated resources to respond to gaps in services for Canadian Armed Forces (CAF) members and their families as they transition from active service to Veteran status. Of primary significance to Military Family Resource Centres (MFRC) was the introduction of a four-year pilot project that gives access to MFRCs at 7 locations to medically releasing CAF personnel and their families for two years post-release.

This comes at a time when there is also increasing public attention on the challenges faced by families caring for ill and injured personnel, and as MFRCs are seeing a rise in the number of family caregivers experiencing fatigue, secondary trauma and other negative impacts.

In order to accurately inform this pilot project's strategy, as well as better serve all of the families caring for ill and injured personnel, a literature review was conducted in conjunction with an environmental scan and survey of MFRC Subject Matter Experts in order to:

- Assess the needs of medically releasing personnel and their families;
- Prioritize the support services they require;
- Compile existing resources and best practice programmes; and
- Determine priority areas to care for caregivers.

2. Methods

Approximately 75 different research reports, peer-reviewed journal articles, factsheets and other publications were examined totalling over 3,300 pages. Of these, 47 were Canadian and 27 were international (predominantly US). All of these are listed in the References section.

While there are many more research reports and articles on the various conditions leading to medical release (e.g. post-traumatic stress disorder, traumatic brain injury, musculoskeletal injuries, etc.), for the purpose of this literature review, documents were limited to only those that addressed either the impacts on or services to families caring for an ill/injured military member.

As well, documents were chosen based on those that were most relevant to the Canadian context rather than the American context. While this caveat greatly reduces the number of sources, it is important as there are significant differences in the military context between Canada and the US. The socioeconomic status and demographics

between the two militaries are very different (visible minority representation, income level, cultural and family backgrounds, etc.), as are the military requirements and services (deployment duration and frequency, pay levels, benefits and support services, etc.). And there is evidence that the effects of military life are significantly different across the border. For example, according to recent studies (Verlezza, 2015) Canadian Veterans returning from Afghanistan suffer post-traumatic stress disorder (PTSD) at a rate that is only marginally higher than the general population (13.5% vs 9.2%), while rates of PTSD in returning US Veterans is considerably higher (20%) than both the Canadian rate and the broader US population (7.8%). Finally, there are important societal differences, such as access to health care, that make the realities of medically releasing military personnel very different. As such, the experiences of Canadian military families are very different than those of American military families.

Upon review of the 75 different reports, some common themes emerged. These include demographics (the numbers), differences among physical and mental illnesses / injuries, the recovery process, the transition to civilian life and return to work, the impacts on spouses and children, and the issues faced by family caregivers. Each of these themes is explored in the Discussion section.

Finally, those reports that were deemed most valuable in the development of the MFRC VAC Pilot Project to assist families of medically releasing CAF personnel through their transition are included in the Suggestions for Further Reading section.

3. Discussion

3.1 The Numbers

According to National Defence and the Canadian Armed Forces (CAF), during the six years from 2006 to 2011, a total of 98,866 Forces members were released, including 8,026 who were released for medical reasons; although the other members released for reasons other than medical may also subsequently develop physical and mental health problems associated with their military service (Office of the Auditor General of Canada, 2012).

As the table below demonstrates, about 1,000 Regular Force personnel have been medically released in each of the past five years for reasons ranging from illness, off-duty injury, training or employment issues, to severe injuries sustained during operations (Canada News Centre, Government of Canada, 2014).

Medical Releases , 2008-2013			
Year	**Force**	**Total Strength**	**Medical Releases**
2008	Regular	64403	1107
	Reserve	47762	188

Year	Force	Total Strength	Medical Releases
2009	Regular	65897	1074
	Reserve	48342	189
2010	Regular	68132	856
	Reserve	49325	929
2011	Regular	68251	998
	Reserve	48566	229
2012	Regular	67720	1066
	Reserve	47403	297
2013	Regular	66968	1190
	Reserve	56260	276

Data on medical releases is not comprehensive. In the 2012 Auditor General's report (Office of the Auditor General of Canada, 2012), they found that the CAF does not maintain consolidated information on all ill and injured Forces members, including members with permanent medical employment limitations, those receiving case management services, those who will be released for medical reasons, and those receiving transition support services. However, there is some data related to the reasons for medical releases.

Musculoskeletal injuries are one of the most prevalent sources of disability – between 35%-45% of CAF sick parade visits and 42% of medical releases are related to musculoskeletal conditions (Canadian Forces Health Services Group, 2014).

Other physical illnesses and injuries leading to medical release could include such things as heart disease, stroke, cancer, or any other permanent physical limitations that do not allow them to comply with the Universality of Service principles.

Mental or psychological reasons for medical release frequently fall under the CAF term "operational stress injury" (OSI). An OSI is any persistent psychological difficulty resulting from operational duties performed while serving in the CAF. It is used to describe a broad range of problems which include diagnosed psychiatric conditions such as anxiety disorders, depression, and PTSD as well as other conditions that may be less severe, but still interfere with daily functioning.

According to the 2014 CAF Surgeon General's Report, about 13.2% of serving CAF personnel were diagnosed with an OSI (but not necessarily medically released) within 4.5 years of deployment in support of the Afghanistan mission. (Canadian Forces Health Services Group, 2014).

In a recent report (Poisson, 2015), administrative data from the Canadian Forces Health Services Group shows that most CAF personnel who medically released suffered from either musculoskeletal injuries (42.1%) or mental health injury or illness (41.3%). These data are reasonably consistent year by year, as the figure below shows (p.12).

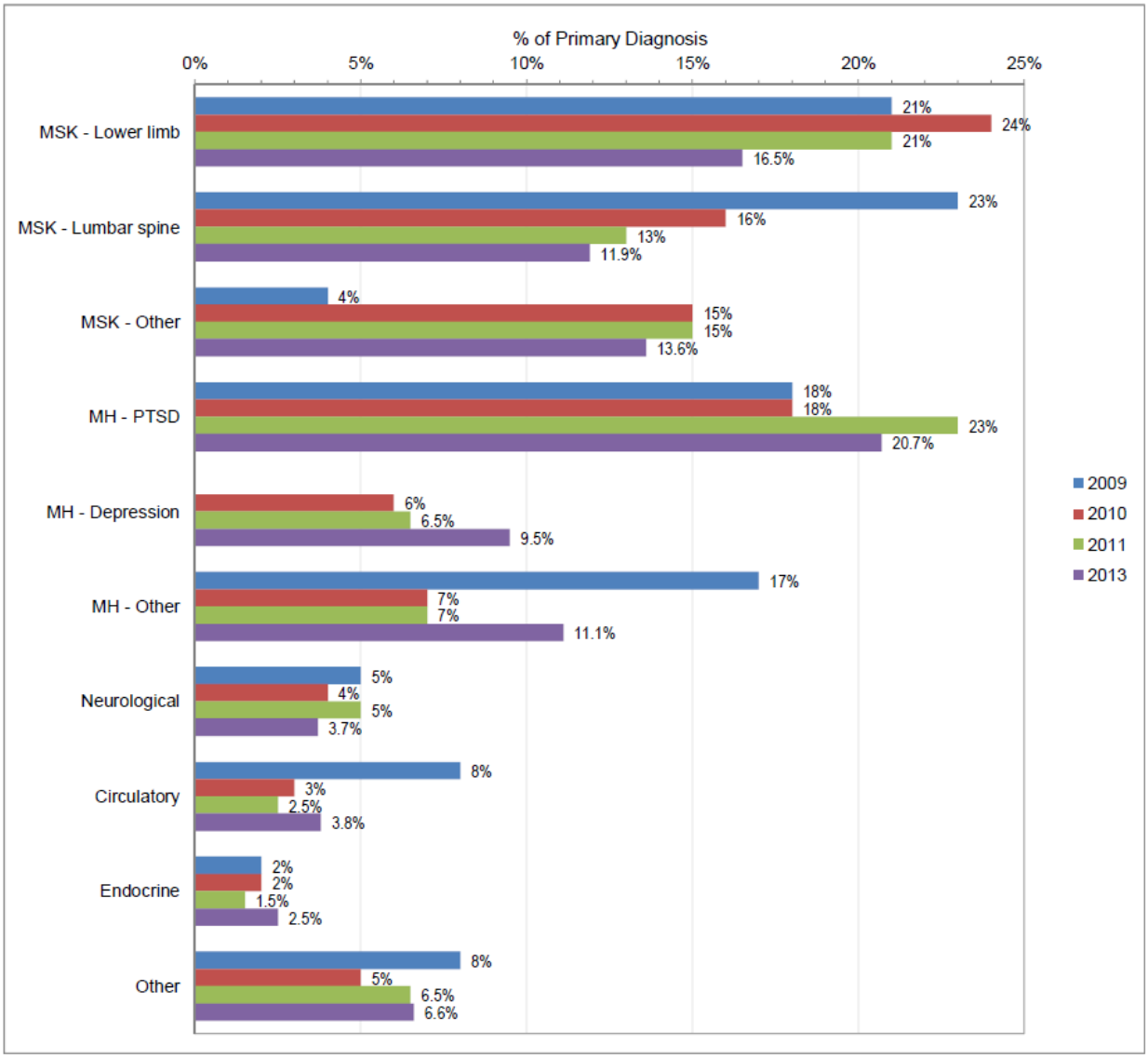

Figure 1. Medical releases based on primary diagnosis, 2009–2013
Source: Canadian Forces Health Services Group administrative data

Given these statistics, it is safe to assume that the majority (approximately 60%) of the approximate 1,000 medical releases each year is due to permanent physical limitations, and approximately 40% is due to psychological limitations.

And given that approximately 70% of military members have families, and on average military families have approximately 1.3 children under the age of 18, we can then estimate that as 1,000 military members are released, each year approximately 700

military spouses and 900 children are also impacted. These numbers necessarily increase when we consider that the informal caregivers of single military members dealing with permanent medical employment limitations are typically the parents, siblings or girlfriends/boyfriends (without legal married / common-law status).

While demographic data is not specifically available for medically released Veterans, there is some demographic data on Veterans in general. The most comprehensive study on Canadian Veterans (Van Til, et al., 2014) found that Reserve Class A/B Veterans were younger than Reserve Class C Veterans, and they in turn were younger than Regular Force Veterans. There were also differences in the proportions of women and marital status. These differences in age, gender and other indicators are important to consider when comparing prevalence of conditions and developing support programs – for example, physical health conditions are more prevalent with age, and mental health conditions are more prevalent in adult middle years. The following table from that study (p.13) compares the prevalence of various characteristics and indicators by Veteran group to the general Canadian population.

Table 1. Observed Prevalence of Health Indicators, by Veteran groups

Indicator	Regular Force released 1998-2012	Reserve Class C released 2003-2012	Reserve Class A/B released 2003-2012
Mean age	44 ⇩	40 ⇩	31 ⇩
Women	13% ⇩	23% ⇩	19% ⇩
Married	74% ⇧	72% ⇧	56% ⇧
Education post-secondary	52% ⇩	71% ⇔	73% ⇧
Unemployment	7% ⇔	5% ⇔	6% ⇔
Labour force employed in 2013	72%	80%	84%
Low income[6]	8% ⇩	8% ⇩	12% ⇩
Adjustment to civilian life	56% easy 27% difficult	61% easy 24% difficult	74% easy 11% difficult
Self-rated health very good/excellent	53% ⇩	61% ⇔	69% ⇔
Self-rated mental health very good/excellent	62% ⇩	67% ⇩	74% ⇔
Arthritis	22% ⇧	16% ⇧	6% ⇔
Back problems	35% ⇧	32% ⇧	17% ⇧
Hearing problem	9% ⇧	5% ⇧	<5% ⇔
Obesity	26% ⇧	24% ⇧	18% ⇔
Chronic pain	34% ⇧	28% ⇧	13% ⇔
Activity limitation[7]	50% ⇧	40% ⇧	23% ⇔
Mental health condition[8]	24% ⇧	17% ⇧	9% ⇔
Past year suicide ideation	7%	5%	<5%
Community belonging strong	58% ⇩	60% ⇔	57% ⇔
Satisfaction with life satisfied/very satisfied	86% ⇩	89% ⇩	94% ⇔
Daily smoking	17% ⇩	13% ⇩	10% ⇩
Heavy drinking	25% ⇔	28% ⇔	32% ⇔

⇔ equal to Canadians ⇧ higher than Canadians ⇩ lower than Canadians

Almost half of Regular Force Veterans served more than 20 years and released voluntarily. The majority had a regular family doctor, but 16% experienced an unmet

need for health care in the past year. The following table excerpts (Thompson, et al., 2014, pp. 4-6) compare various characteristics / indicators across groups.

Characteristic or Indicator	Regular Force	Reserve Class C	Reserve Class A/B
Length of service	21% <2 years 20% 2-9 years 12% 10-19 years 48% > 20 years	F* <2 years 41% 2-9 years 36% 10-19 years 22% > 20 years	21% <2 years 66% 2-9 years 10% 10-19 years F* > 20 years
Release type	52% (50-55%) voluntary 7% (5-8%) involuntary 21% (19-23%) medical release 16% (14-17%) service complete 5% (4-5%) retirement age	65% (61-68%) voluntary 10% (8-12%) involuntary 13% (11-15%) medical release 8% (6-10%) service complete 5% (4-7%) retirement age	76% (72-80%) voluntary 16% (12-20%) involuntary4 F* for other types, including medical release
Service Environment	54% Army 16% Navy 30% Air Force	80% Army 13% Navy 7% Air Force	83% Army 13% Navy F* for Air Force
1+ chronic mental health condition	24% (22-26%)	17% (15-20%)	9% (7-12%)
Chronic mental health conditions	17% (15-19%) Mood disorder 11% (10-13%) Anxiety disorder 13% (12-15%) Posttraumatic stress disorder (PTSD)	12% (10-14%) Mood disorder 8% (6-10%) Anxiety disorder 8% (6-9%) Posttraumatic stress disorder (PTSD)	F*
Likely mental disorders	9% (7-10%) mild 5% (4-6%) moderate 8% (6-9%) severe	8% (6-10%) mild F* moderate 6% (5-8%) severe	7% (5-9%) mild F* moderate and severe
Both physical and mental health condition	22% (20-24%)	16% (14-18%)	F*
Regular medical doctor	81% (79-83%)	78% (76-81%)	76% (71-79%)
Home care paid by government	7% (6-9%)	4% (3-5%)	F*
Home care not paid by government	8% (7-9%)	9% (7-11%)	F*
Unmet need for health care past year	16% (14-18%)	16% (14-18%)	12% (9-15%)

3.2 Release Experiences – Physical and/or Mental Illnesses and Injuries

Injuries are broadly categorized as either visible or invisible in nature. The distinction of injury types is important given their unique and differential impact on individuals, families and children. Visible injuries include amputations, musculoskeletal injuries, shrapnel injuries, blindness/eye injuries, auditory damage, burns, etc. Invisible injuries are neurological and psychological wounds without external indication of trauma, such as traumatic brain injury (TBI), PTSD and other mental health disorders (e.g. depression, anxiety, substance use disorders).

A recent Canadian study (Van Til, et al., 2014) confirmed that chronic physical health conditions and mental health conditions were more prevalent for Veterans of the Regular Force and Reserve Class C than for Canadians or Reserve Class A/B.

Those having “visible” combat injuries are also at significant risk of developing invisible injuries long-term, suggesting either the mental health status changes throughout the recovery process of physically injured, or that the initial mental symptoms go unnoticed (Cozza, Holmes, & Van Ost, 2013). One Canadian study (El-Gabalawy, et al., 2015) found that anxiety disorders and physical health problems co-occur at high rates among Canadian Veterans, and this comorbidity is linked to poorer physical health-related quality of life and activity limitations. This presents significant challenges to health care providers and consumers because comorbidity is associated with greater clinical severity, poorer treatment outcomes, and decreased quality of life. It is important to understand these complex relationships and to identify Veterans with anxiety disorders who have multiple physical health problems, because these individuals may be at increased risk of poorer functioning than Veterans without anxiety disorders.

Whether the illness/injury is physical or mental may result in different impacts on the family. While there is little research examining these differences, one study (Gupta & Sharma, 2013) found significant difference in the amount and types of family burden in caregivers of psychiatric patients as compared with cancer patients. They theorized that the more disrupted domestic and daily routine activities, distress, social isolation and psychological strain, sadness and frustration and less comfort, companionship, happiness and satisfaction in the caregivers of psychiatric patients may be due to the varied nature of mental illness.

Another study (Arzi, Soloman, & Dekel, 2000) found that wives of PTSD and Post-Concussion casualties had similar levels of functional and emotional independence as those wives without. However, they did report more anger, suspicion, anxiety and blame towards their spouses.

In a recent Canadian study (Hachey K. , 2014 in press), parents talked about how their children had an easier time understanding physical or “visible” injuries (e.g., arm injury), as compared to “invisible” injuries, such as a TBI or PTSD. And MFRC subject matter experts revealed that those CAF parents who have an illness such as an OSI often sheltered their children from the reality of the situation, in comparison to a physical injury.

Just as there may be differences in the impacts of physical versus mental illnesses/injures, there may also be differences in the impacts on families among the various psychiatric conditions within the overarching category of OSIs.

In 2013, about 1 in 6 full-time Regular Force members of the CAF reported symptoms of at least one of the following disorders: major depressive episode, panic disorder, PTSD, generalized anxiety disorder, and alcohol abuse or dependence (Pearson, Zamorski , &

Janz, 2014). Statistics Canada (Statistics Canada, 2014, p. 1) found the following percentages of full-time Regular Force members meeting criteria for various disorders in the 12 months prior to the survey:

Major depressive episode	8.0%
Post-traumatic stress disorder	5.3%
Generalized anxiety disorder	4.7%
Panic disorder	3.4%
Alcohol abuse	2.5%
Alcohol dependence	2.0%

Regular Force members had higher rates of depression and generalized anxiety disorder than the general Canadian population (Pearson, Zamorski , & Janz, 2014). And for those members who had been deployed in support of the mission in Afghanistan, their rates for PTSD and panic disorders were twice as high as those who had not deployed (Pearson, Zamorski , & Janz, 2014).

Further consideration needs to be given to the experiential differences among types of Operational Stress Injuries, including traumatic brain injuries, PTSD, depression, anxiety disorders, alcohol abuse / dependence, and others. For instance, depression and PTSD have different symptom profiles and hence different potential effects on behaviour, such as perpetration of physical and/or sexual intimate partner violence (Zamorski & Wiens-Kinkaid, 2013).

Gender differences are also important to consider. While male Regular Force members reported more symptoms of alcohol abuse or dependence, females reported more symptoms of depression, PTSD and generalized anxiety disorder (Pearson, Zamorski , & Janz, 2014).

An area not well researched but important to consider is medical release stemming from past military sexual trauma. Women constitute approximately 14% of the Canadian Regular Force. And although all military personnel are exposed to high levels of workplace stress, women in the military may face some additional unique stressors. In the US, research has found that women in their military face unique stressors such as military sexual trauma (a risk factor for the development of PTSD) which may affect their mental health and well-being; and female Veterans report a higher burden of medical illness and worse quality-of-life outcomes than do men who are exposed to the same levels of trauma (Committee on the Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine of the National Academies, 2013).

While the realities of Canadian military are very different than those of the US, the External Review into Sexual Misconduct and Sexual Harassment in the CAF concluded that there is an undeniable problem of sexual harassment and sexual assault in the CAF (Deschamps, 2015). While CAF Military Policy record only an average of 160 sexual assault investigations a year (Canadian Armed Forces and National Defence,

2014), the External Review concluded that there is a very serious problem of underreporting in the CAF in part due to the underlying norms of conduct that have given rise to pervasive low-level harassment, a hostile environment for women and LGTBQ members, and in some cases, more serious and traumatic incidents of sexual assault.

These differences in type of injury and gender may result in different impacts on family members; therefore, different support strategies may be required depending on the diagnoses and larger context.

3.3 Injury Recovery Trajectory

While the member is healing physically and psychologically, family members must manage their own reaction to the illness/injury, while also ensuring their medical care. This may require changes in residence to be closer to medical care, altered caretaking responsibilities, adjustments in employment and financial support, and changes in child care and schooling arrangements (Cozza, Holmes, & Van Ost, 2013).

Using an injury recovery trajectory is helpful to understanding how the challenges faced by military members and their families changes over time, especially in the context of physical injuries. The injury recovery trajectory (Cozza, Holmes, & Van Ost, 2013) has four phases:

1. Acute Care – the immediate life-saving and life-sustaining medical interventions that are sometimes done at a great distance from the family, especially in the case of combat injuries.
2. Medical Stabilization – the medical / surgical care that prepares the ill/injured service member to function outside the hospital environment which also often occurs away from the family, creating upheaval for partners who may have to leave their households or employment to visit the hospital and for the children who may either accompany their parents, remain at home with different caregivers or relocate to the residences of extended family or friends.
3. Transition to Outpatient Care – the plans for follow-up treatment and ongoing rehabilitation that begin prior to discharge can cause additional challenges to families who must now take on additional roles and responsibilities as they lose the resources that were available to them in the hospital setting.
4. Long-Term Rehabilitation and Recovery – the period where the ill/injured personnel learns to adapt to their illness/injury and settle into new lives, often transitioning into Veteran status, and their families must also transition to their new lives, sometimes in new communities engaging new healthcare providers. Over time, continuity of care may be complicated by changes in healthcare facilities as well as changes in family living arrangements and associated disruptions in community connections.

In the context of mental illness and psychological injuries, the injury recovery trajectory may not be as linear, as mental illness can be more unpredictable and fluctuating. So the types of support that family caregivers provide to those with OSIs, as well as their

own support needs often change over time. The nature and intensity of caregiving varies, and is based on many factors, such as the illness trajectory, the preferences of the person living with mental illness, competing needs, and availability of resources and support for the family caregiver (MacCourt, Family Caregivers Advisory Committee, & Mental Health Commission of Canda, 2013).

In general however, by using the injury recovery trajectory, support strategies can be tailored based on which phase the family is currently experiencing.

3.4 Transition to Civilian Life

Over the past fifteen years, more than 140,000 people left the CAF and transitioned to civilian life. Most of them experienced a positive transition process. In one study (Subcommittee on Veterans Affairs, Standing Senate Committee National Security and Defence, 2014), 62% of the CAF Veterans who released from the service between 1998 and 2007 reported an easy adjustment to civilian life. However, some do not, with 25% of the people that were released from the CAF in the 1998 to 2007 timeframe reporting a difficult adjustment to civilian life. These findings are similar to another study (Van Til, et al., 2015) where they found 27% of Regular Force Veterans, 24% of Reserve Class C Veterans, and 11% of Reserve Class A/B reported that their adjustment was difficult. Further, those who experienced a difficult adjustment were more likely to be Veterans with a medical or involuntary release and/or those who released mid-career.

One Canadian study (Thompson, et al., 2014) found that when they compared a sample of Regular Force Veterans to the general Canadian population, the Veterans had lower prevalence of excellent/very good self-rated health and self-rated mental health and higher prevalence of arthritis, back problems, gastrointestinal problems, cardiovascular disorders, migraine, obesity, hearing problems, pain or discomfort, mood disorders, anxiety disorders, and activity limitations. They less often had a strong sense of community belonging, were less often satisfied with life than Canadians in the general population, but also less often experienced either quite a bit or extreme life stress.

CAF members and Veterans, as well as departmental staff responsible for assessing eligibility and managing the delivery of services and benefits within National Defence and the CAF and Veterans Affairs Canada (VAC), find the transition process complex, lengthy, and challenging to navigate (Office of the Auditor General of Canada, 2012). A list of just some of the programs is detailed in Appendix A (Subcommittee on Veterans Affairs, Standing Senate Committee National Security and Defence, 2014). And Appendix B details the programs that are available through National Defence, CAF and VAC broken down by Regular Force and Veteran eligibility (Office of the Auditor General of Canada, 2012).

Research has shown that in an all-voluntary military, patients and families transferring from a military medical facility to a civilian healthcare system often experience a sense of loss and abandonment (Collins & Kennedy, 2008). There is a sense of security,

comfort, and support from the shared military culture, and moving away from that into the civilian community can be challenging.

In another study (Black & Papile, 2010), they found that the third and fourth highest factors that attributed to successful transitions were relationships with family and with significant others (following the highest factor, satisfying employment and the second highest, mental health). As such, they recommended that family members should be given information concerning the transition from military to civilian life so that they may be better equipped to support their veteran, and that they should be made aware of potential struggles and informed about what to expect and how best to understand the transition their family member is undergoing.

Therefore, medically releasing personnel and their families require support to navigate the vast array of services and benefits, to establish their new civilian identity, and to connect to new civilian physical and mental health service providers when additional supports are required.

3.5 Return to Work

One Canadian study (Thompson, et al., 2011) showed that 89% of Veterans worked after their release from the CAF and about 72% felt that their military experience helped them in their civilian jobs. The majority reported to be satisfied with their work and their levels of satisfaction increased as time went on. Moreover, 73% reported that they were satisfied with their current financial situation. The Veterans' unemployment rate of 8% was said to be comparable to the rest of the Canadian population.

However Veterans seeking job opportunities in civilian society must sometimes cope with lower paying jobs. Although the proportion of low-income individuals is substantially less among Veterans than in the general population, a joint study (MacLean, et al., 2011) reported that Veterans' incomes drop an average of 10% during the first three years following their release from military service. Moreover, declines in income tend to differ considerably between different groups of Veterans. For example, women Veterans experience a 30% decline, Veterans discharged for medical reasons a 29% decline, and Veterans who served from 10 to 19 years a 21% decline.

In a Canadian systematic literature review, "Individual Placement and Support" clearly emerged as the most promising tool to facilitate workplace reintegration for Veterans with mental disorders, and is now standard practice for the US Department of Veterans Affairs (Van Til, et al., 2013).

3.6 Impacts on Families

While there have been significant increases in the amount of research conducted and support programs developed to address the needs of military members who are medically releasing due to physical or mental illnesses or injuries, there have been very

little research or support programs addressing the needs of military spouses or children. And that which does, tends to exist for the purpose of better enabling civilian spouses to support the health of their military family members, rather than their own health or that of their children (Nash & Litz, 2013).

There are substantial gaps in knowledge about the effects of military life on families that hinder the ability to meet the needs of military families effectively. One US study found that much of the research heretofore has been methodologically flawed, suffering from the use of small convenience samples, use of cross-sectional designs, to mention just a couple (Committee on the Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine of the National Academies, 2013). And quality Canadian-specific research is even more scant.

What is known is that the behaviour and reactions of each family member affects everyone in the family system, children and adults alike, in a reciprocal fashion, and these interactions potentially support family equilibrium or lead to family disequilibrium (Cozza, Holmes, & Van Ost, 2013).

Another common knowledge is the importance of meaning making (Wadsworth, 2013). The most destructive events human face are those that fracture their belief in a positive future, and in order to recover from traumatic experiences, people must find ways to construct meaning that restores their confidence. Families who exhibit resilience also construct shared meaning of their challenging experiences.

There may be different impacts on the family depending on whether the illness/injury is physical or mental. While all types of parental illness/injury influence various components of family functioning, there is some evidence that families are more resilient in relation to visible wounds and struggle more with changes related to invisible aspects of injury, such as irritability, rapid mood swings, emotional numbing, memory loss, and behavior control (Gorman, Fitzgerald, & Blow, 2010).

Further, unlike other neurological disorders and traumatic injuries (e.g. stroke, spinal cord injury, etc.) families of patients with TBI show an increase in stress, caregiver burden, depression, and social isolation over time (Collins & Kennedy, 2008). Subjective caregiver burden is most strongly related to the emotional, neurobehavioural, and personality changes in the family member with TBI, compared to the cognitive and physical changes or the severity of neurological injury. And unlike other physical injuries, the impact of TBI on children and families may not improve over time – some studies have underscored the very long-term impact on family stress and the continued need for intervention by professionals 10-15 years after injury (Cozza, Holmes, & Van Ost, 2013).

A US commissioned-study summarized US research and found that a service member's psychological issues are related to increases in marital distress, divorce, and disruptions in family life. Findings also suggest that the reverse is true: family

relationships, both before and after deployment, can influence how a service member experiences PTSD in terms of coping with symptoms and symptom severity. Moreover, relationship quality may have an impact on treatment seeking by a service member. A spouse's perception of a service member's psychological health (for example, perceptions of the apparent cause for symptoms or of the service member's control over symptoms) influences the level of personal and marital distress experienced by the spouse. (Committee on the Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine of the National Academies, 2013).

No research was found that addressed the impacts on parents of single serving military personnel who are ill or injured. However it is safe to assume that is they are living in the same household, those in the family system will be impacted similarly as spouses and children in the traditional nuclear family.

The impacts on the family definitely vary depending on illness/injury type, illness/injury severity, phase of the injury recovery trajectory, the functional impact on the injured person, the preferences of the person living with the illness/injury, the developmental stage of the children, pre-existing family characteristics, competing needs, and availability of resources and support for the family.

3.7 Impacts on Children

As with the impacts on families, research on the specific impacts on children at various developmental stages is limited and mixed. In one study (Cozza, et al., 2010), they found that spouses who reported high deployment-related family distress prior to an illness/injury were more likely to report high child distress post-injury than those reporting low family distress prior, suggesting that these families may be more vulnerable in the face of added stressors. In addition, families experiencing high disruption following the illness/injury were also more likely to report high child distress. Importantly, injury severity was not associated with child distress.

In another study on the perception of child functioning by CAF veterans with OSIs (Duranceau, Fetzner, & Nicholas Carleton, 2015), they found that CAF veterans with PTSD reported significantly more concerns about their children's affective and behavioral functioning than veterans without PTSD. However it was unclear whether these veterans identified more concerns because their children effectively displayed more emotional and behavioral problems, or whether the emotional numbing and irritability associated with PTSD may have caused veterans to misidentify their children's emotions and behaviors as problematic. Additionally, it was also possible that both occurred in a self-maintaining cycle, whereby the veterans' PTSD symptoms and the children's emotional and behavioral problems exacerbated one other.

The review of literature underscores the complexity of challenges faced when a parent is ill/injured (Gorman, Fitzgerald, & Blow, 2010). The service member must adapt to physical and emotional changes, and the entire family system must adapt to meet the

changing needs of all family members. Because early child development is dependent upon the parent-child relationship and family functioning, targeted efforts must be made to ensure that support communities are aware of both risk and protective factors associated with parental illness/injury.

Despite limited research on the impact of parental illness/injury on children, some possible responses of children have been identified (especially those who have a parent with an OSI) and may involve one or more of the following (Center for the Study of Traumatic Stress):

- Increased acting out behaviours, such as disobedience, tantrums, or risk-taking behaviours;
- Emotional distress, such as crying, increased anxiety, or withdrawal;
- Feelings of loss and grief related to the change in the injured parent;
- Feelings of isolation;
- Taking on additional responsibilities, such as caring for younger children, household tasks, and caring for the injured parent;
- Feelings of embarrassment about the injured parent's appearance or behaviour;
- Misinterpreting parent TBI-related fatigue and apathy as indicators that the parent no longer loves them;
- Feelings of anger or resentment about new responsibilities or changes in the family; or
- Feelings of self-blame for the injured parent's irritability.

Researchers in the US (Cozza, Chun, & Miller, 2011) have established the following key goals for children of the combat injured that may be useful in the development of a pilot project for Canadian medically releasing personnel and their families:

- Develop an age-appropriate understanding of what happened to the parent.
- Develop an age-appropriate understanding of the illness/injury and required medical care that can result in:
    - Family separations;
    - Lengthy hospitalizations;
    - Multiple procedures; and
    - Change in family structure/routine.
- Accept that they did not create the problems they may now see in their families.
- Learn to deal with the sadness, grief, and anxiety related to parental illness/ injury.
- Accept that the parent who deployed may be "different" than the person who returned, but is still their parent.
- Adjust to the "new family" situation by:
    - Staying hopeful;
    - Having fun;
    - Being positive about life; and
    - Maintaining goals for the future.

3.8 Impacts on Family Caregivers

Spouses, adult children and parents frequently assume a significant role in caring for ill and injured military personnel and Veterans. In addition to providing emotional support, they often provide assistance with their loved ones' physical care. This informal caregiving is often unpaid. It typically involves helping with "activities of daily living" (such as getting out of bed, dressing, and bathing) as well as "instrumental activities of daily living" (such as managing finances, shopping, and housework). In addition, family members might also aid with therapies, coordinate formal health care services, and help navigate health insurance and legal systems (Committee on the Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine of the National Academies, 2013).

One US study (Tanielian, Ramchand, Fisher, Sims, Harris, & Harrell, 2013) found that military caregivers tend to be younger women who are also raising children and holding jobs outside the home. And they are additionally challenged by limited help – many government programs are still in their infancy and community resources are scattered and uncoordinated. Difficulties are presented by differing eligibility criteria, lack of access and the way the injured members/Veterans and the military caregivers' needs change over time. While this is an American study, the Auditor's report suggested similar challenges with the support programs available in Canada (Office of the Auditor General of Canada, 2012).

Another study of military caregivers conducted in the US found that military caregivers consistently experience worse health, greater strains in family relationships, and more workplace problems than non-caregivers, and it is worst for post-9/11 caregivers (Rand Corporation, 2014a). They also found that military caregivers face an elevated risk for depression – those caregivers who spend more time caregiving and those who help care recipients cope with behavioural problems are most likely to exhibit symptoms of depression.

This study also found that caregiving can pose a financial burden to caregivers, employers, and society. Almost half of all caregivers report needing to adjust their work schedules as a result of caregiving, and more than half reported that caregiving caused them financial strain.

An earlier study on the family caregivers of younger Canadian Veterans released from active duty with high levels of disability found the following impacts of greatest need (Fast, Yacyshyn, & Keating, 2008, pp. 15-16):

a) Economic needs. Employment impacts on spouses (and other main supporters) are high. Main supporters need assistance with maintaining or increasing their labour force engagement in order to support their families. Strategies to support labour force engagement might be direct (such as retraining or employment counseling) and indirect (such as providing caregiving assistance to free the main supporter to engage in the labour force). Since care is long-term, attention

needs to be paid to strategies to assist families in developing adequate pension coverage to reduce their long-term employment-related economic costs.

b) Health needs. Main supporters experience high levels of physical and mental health problems as a result of their high levels of caregiving over long periods of time and of their distress related to the acquired disabilities of a family member. Strategies need to be developed to provide spouses with long term relief from caregiving, tailored to their needs. Mental health needs of caregivers and their children must be addressed directly (such as through access to family therapists, and other skilled family supports) and indirectly through health promotion (such as work with school counselors to increase their understanding of the needs of children of Veterans with acquired disabilities).
c) Social needs. Families are at risk of isolation and burn out because Veterans' disabilities and care needs may preclude vacations or recreation, and make social contact difficult. Concerted effort to assist families in developing new strategies for social connections may reduce long term mental health problems of spouses and children.
d) Access to services. High levels of distress about service availability and access were evident among caregivers.

3.9 Support Services and Resource Requirements

In a needs assessment conducted in 2004 (Operational Stress Injury Social Support, 2004), a number of issues were identified as assistance and support needs by families of CAF personnel with OSIs. In general, their needs were to be educated, involved, listened to, and provided with adequate services. These are detailed in Appendix C.

A US study (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011) showed that a greater percentage of soldiers in intimate relationships reported more interest in couples therapy than individual therapy, and similarly a greater percentage of soldiers who were parents or caregivers were also more interested in family counseling over individual treatment. These findings support the importance of developing family-based interventions that are tailored to address specific injuries/illnesses and co-occurring family problems.

VAC has suggested that once in civilian life, Veterans might not recognize or respond to the need for mental health care after leaving service (Shields, White, & Egan, 2009). This attitude not only influences whether they seek help but also whether they become and remain engaged in treatment. Other studies (Coulthard, 2012) have suggested that military personnel were unable to recognize their own illness/injury and that it was their spouse who often first identified it. Further, these personnel were reluctant to come forward and seek help and stated it was their spouse/family who played a crucial rule in motivating the service member to get help. Engaging families and peers of military Veterans at the outset of the medical release process can inform treatment plans and provide additional support to maintain treatment gains.

In one study (Hachey K. , 2014), parents revealed several resilience-based factors that enabled their children to overcome the challenges associated with having a parent who is ill or injured. These included doing well in school, the ability to express emotions, good communication between parents and children, having social supports in place whether through their school or family, having consistent schedules, and at least one stable parent who constantly expressed love and support.

Parents also revealed resources that would have been beneficial to them, including social support, talking with families who had gone through the same thing, access to counselling, more support for spouses and families, better access to services from the MFRC including specialized services, and being involved with their spouse's care. Parents also revealed a need to have more support from schools.

Although there are many services and programs offered by the MFRCs to support children and adolescents, the same study found that parents had mixed opinions and reasons as to why they would or would not access the services. For example, one parent noted that "I'm not sure that peer groups are necessary… it is not really something they wanted to participate in…", while another parent revealed that "I was not overly impressed with their services." Other parents were not happy about the locations of the MFRCs, when the programs were offered, sharing information with the MFRC, and accessibility to professional staff. However, in other cases, parents were happy the MFRC was there to help in their time of need.

There is evidence that there are limitations to relying on the services of independent parties that do not fall within the military chain of command. Findings suggest that military families may encounter providers who are not as well prepared to deliver culturally sensitive care (Rand Corporation, 2014), and that when care departs from the scientific evidence base and varies significantly from clinician to clinician, patients may receive poor quality care (Institute of Medicine, 2013). However, providers who have received training in evidence-based approaches are more likely to deliver such care routinely to their patients. And systematic and periodic evaluation of clinicians after training can ensure they administer therapeutic interventions in ways that are supported by scientific evidence.

Researchers in the US (Cozza, Chun, & Miller, 2011) have established the following key principles of caring for families and children of the combat injured:

- Principles of psychological first aid are primary to supporting families of combat injured service members.
- Medical care for the combat injured must be family focused.
- Service providers should anticipate a range of responses to combat injury.
- Injury communication is an essential component of care of the families of injured service members.
- Programs to assist the families of combat injured service members must be developmentally sensitive and age appropriate.
- Care of the family of injured service members is longitudinal, extending beyond immediate hospitalization.

- Effective family care requires an interconnected community of care.
- Care must be culturally competent.
- Communities of care should address any barriers to service.

Other researchers (Collins & Kennedy, 2008) have identified specific strategies that are most helpful in addressing family responses to polytrauma, including the medical family therapy approach and the theory of ambiguous loss.

Medical family therapy (MFT) utilizes cognitive-behavioural, narrative, and family systems methods to promote the goals of agency and communion. In this context, agency is a sense of making personal choices related to the medical condition and the health care system, and communion is a sense of connection to the community of family, friends, and health care professionals. The MFT techniques that they found most helpful are (a) soliciting the illness story, (b) respecting defenses, (c) accepting unacceptable feelings, and (d) externalizing the illness.

Ambiguous loss is defined as an unclear loss that defies closure and paralyzes individual and family grieving and coping processes. The two types are: (a) the ambiguous loss created when a family member is psychologically present within the family, but physically absent (e.g., abduction, missing in action, prisoner of war); and (b) the ambiguity of having a family member who is physically present, but psychologically absent (i.e., coma, dementia, severe TBI). With no closure or social validation, the persistent ambiguity begets confusion, immobilization, and exhaustion. In this contextual approach, traumatic responses are viewed as stemming from the ambiguity of the relational loss, not from individual pathology.

Building on both Walsh's "Family Resilience Theory" and Saltzman et al's "Mechanisms of Risk and Resilience in Military Families Model" (see Suggestions for Further Reading for theory/model references), the following 5 evidence-based strategies promote family equilibrium and resilience under the stress of illness and injury (Cozza, Holmes, & Van Ost, 2013). These strategies must be done alongside connections and linkages to supportive community and military services. Descriptions of the 5 strategies are detailed in Appendix D.

1. Educate adults and children about the impact of the illness/injury and the expected recovery process (e.g. psychoeducation).
2. Reduce family distress and disorganization through family care management and provision of practical and socioeconomic support (e.g. motivational interviewing, linkages to services and referral assistance).
3. Develop emotion regulation skills necessary for ongoing dialogue and collaboration (e.g. mindfulness-based stress reduction, cognitive behavioural therapy).
4. Promote helpful and ongoing communication about the injury that incorporates developmentally appropriate language (e.g. injury communication).
5. Encourage optimism through development of successful problem-solving and shared future goals (e.g. medical family therapy, ambiguous loss, individual placement and support).

The FOCUS-CI (Families Over Coming Under Stress – Combat Injury) is a unique evidence-based intervention program developed by University of California Los Angeles and Harvard researchers to help military families deal with the critical issue of combat injury and its impact on current and future family health and functioning. The FOCUS-CI program should be carefully examined as a potential model for incorporation as it builds on these 5 evidence-based strategies, and it is also undergoing a full-scale academic randomized study conducted by the Uniformed Services University of the Health Sciences in collaboration with the Walter Reed National Military Medical Center, the San Antonio Military Medical Center and the University of North Carolina.

In terms of providing support to family caregivers, there is considerable evidence that caregiver training is effective for increasing knowledge and ability to provide care, as well as reducing caregiver burden and improving mental health outcomes (Ramchand, et al., 2014). Other support services and resource requirements recommended in a large US study on military caregivers (Rand Corporation, 2014) include:

- Provide high-quality education and training to help military caregivers understand their roles and to teach them necessary skills.
- Help caregivers get health care coverage and use existing structured social support.
- Increase public awareness of the role, value, and consequences of military caregiving.
- Promote work environments that support caregivers, protect them from discrimination and promote workplace adaptations.
- Incorporate caregivers as part of the health care team in all health care environments catering to military and veteran recipients.
- Ensure that caregivers are supported based on the tasks and duties they perform, rather than their relationship to the care recipient.
- Make respite care more widely available to military caregivers, including alternative respite care strategies.
- Encourage caregivers to create financial and legal plans to ensure caregiving continuity for care recipients.
- Enable sustainability of programs by integrating and coordinating services across sectors and organizations through formal partnership arrangements.
- Foster caregiver health and well-being through access to high-quality services.
- Invest in research to document the evolving need for caregiving assistance among veterans and the long-term impact of caregiving on the caregivers.

4. Conclusion and Recommendations

Summary

As approximately 1,000 military members are medically released each year, it is estimated that 700 military spouses and 900 children are also impacted. These numbers increase when we consider the informal family caregivers of single military members (parents, siblings, adult children, girl/boyfriends, etc.). It is safe to assume that the majority (60%) of the medical releases each year is due to permanent physical limitations, with less than half (40%) due to psychological limitations.

Whether the illness/injury is physical or mental may result in different impacts on the family. And just as there may be differences in the impacts of physical versus mental illnesses/injures, there may also be differences in the impacts of various psychiatric conditions on families. And since there are different impacts, different support strategies may be required depending on the diagnoses.

In terms of transitioning to civilian life and returning to work, the majority of families transition successfully. But some military families require support navigating the vast array of services and benefits, establishing a new civilian identity, and connecting with new civilian service providers if additional supports are required. In particular, women Veterans and Veterans discharged for medical reasons experience a 29%-30% decline in income after release, and as such may require additional supports.

Key Recommendations

Based on this literature review, five recommendations are offered to guide the development of a successful pilot project between Military Family Services, MFRCs and VAC to serve the families of medically releasing personnel. These recommendations should be reviewed by MFRC subject matter experts to ensure that they are tailored to both the Canadian and the local context.

Recommendation #1: Injury/Illness Recovery Trajectory

The impacts on the family definitely vary depending on illness/injury type, illness/injury severity, phase of the injury recovery trajectory, the functional impact on the injured person, the preferences of the person living with illness/injury, the developmental stage of the children, pre-existing family characteristics, competing needs, and availability of resources and support for the family. By using the injury recovery trajectory, support strategies can be better tailored based on which phase the family is currently experiencing.

Recommendation #2: Evidence-Based Strategies

Evidence-based strategies for supporting families of medically releasing personnel through their transition to civilian life and Veteran status are available and should be considered in the development of any Canadian military family service program. The FOCUS-CI program is one example of an evidence-based

program that incorporates the 5 effective strategies and could be tailored to the Canadian context. Specifically the 5 effective strategies (detailed in Appendix D) that should be incorporated into any Canadian program include:

1. Educate adults and children about the impact of the illness/injury and the expected recovery process (e.g. psychoeducation).
2. Reduce family distress and disorganization through family care management and provision of practical and socioeconomic support (e.g. motivational interviewing, linkages to services and referral assistance).
3. Develop emotion regulation skills necessary for ongoing dialogue and collaboration (e.g. mindfulness-based stress reduction, cognitive behavioural therapy).
4. Promote helpful and ongoing communication about the injury that incorporates developmentally appropriate language (e.g. injury communication).
5. Encourage optimism through development of successful problem-solving and shared future goals (e.g. medical family therapy ambiguous loss, individual placement and support).

Recommendation #3: Training and Evaluation

Clinicians and military family service providers must be trained in these evidence-based strategies and they should also be evaluated. Providers who have received training in evidence-based approaches are more likely to deliver such care routinely to their patients (Rand Corporation, 2014b). When care departs from the scientific evidence base and varies significantly from clinician to clinician, patients may receive poor quality care. And only systematic and periodic evaluation of clinicians after training can ensure they administer therapeutic interventions in ways that are supported by scientific evidence (Institute of Medicine, 2013).

Recommendation #4: Community Provider Capacity

In line with training and evaluation of standard evidence-based strategies, there are limitations that need to be mitigated when relying on service from providers outside of National Defence. Based on research (Rand Corporation, 2014b), Military Family Services should consider implementing the following actions to improve community-based provider capacity to deliver mental health care to Veterans and their families:

- Conduct better assessments of civilian provider capacity;
- Assess the impact of trainings in cultural competency on provider capacity;
- Expand access to effective trainings in evidence-based approaches for supporting families with OSIs; and
- Facilitate providers' use of evidence-based approaches.

Additionally Military Family Services should ensure all community-based providers are following the key principles of caring for families and children of ill and injured personnel (such as those described earlier by Cozza, Chun & Miller).

Recommendation #5: Definition and Understanding of Family

It is unclear if Canadian policies, programs and practices are taking into consideration the full spectrum of military families. However, as many of our programs have been informed by US, it is important to carefully consider the results of a US study that showed their policies, programs and practices focused almost exclusively on traditional families (married heterosexual spouses and their children), thereby missing critical opportunities to support the readjustment needs of many service members' non-traditional families (Committee on the Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine of the National Academies, 2013). To be able to support all families, Military Family Services will need a new definition of "military family" and populations served. To do this, Military Family Services will also need data on the full constellation of the families of Canadian military personnel.

Future Directions

It is probable that Canada faces similar challenges with respect to the future of family caregiving support as the following identified in a US study (Rand Corporation, 2014a), and therefore should begin to consider mechanisms to confirm and address these challenges:

- 25 percent of ill/injured military/Veterans rely on their parents who are aging and who, starting in 15 years, will no longer be able to provide caregiving support;
- 33 percent rely on spouses and as these relationships are young as many as one-third of these marriages may dissolve;
- More than half of support programs for caregivers were established in the past ten years, and 80 percent are non-profit, and as such they are vulnerable to waning public interest, lowered philanthropic support, and shortfalls in capacity to deliver services effectively.

Suggestions for Further Reading

The Combat Injured Family: Guidelines for Care. Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences. (no date).

Family-Centered Care for Military and Veteran Families Affected by Combat Injury. Cozza, S. J., Holmes, A. K., & Van Ost, S. L. (2013).

Mechanisms of Risk and Resilience in Military Families: Theoretical and Empirical Basis of a Family-Focused Resilience Enhancement Program. Saltzman, W. R., Lester, P., Beardslee, W. R., Layne, C. M., Woodward, K., & Nash, W. P. (2011). Clinical Child and Family Psychological Review, 14, 213–230.

*Strengthening Family Resilience (2nd ed.).*Walsh, F. New York: Guilford Press. (2006).

The Guide to Benefits, Programs, and Services for Serving and Former Canadian Armed Forces Members and the Families. Director Casualty Support Management. (2014).

Caring For Our Own: A Comprehensive Approach for the Care of CF Ill and Injured Members and Their Families. National Defence. (no date).

The Transition to Civilian Life of Veterans. Subcommittee on Veterans Affairs, Standing Senate Committee National Security and Defence. (2014).

National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses. MacCourt, P., Family Caregivers Advisory Committee, & Mental Health Commission of Canda. (2013).

References

Arzi, N., Soloman, Z., & Dekel, R. (2000). Secondary Traumatization Among Wives of PTSD and Post-Concussion Casualties - Distress, Caregiver Burden and Psychology Separation. *Brain Injury, 14*(8), 725-736.

Black, T., & Papile, C. (2010). Making it on Civvy Street - An Online Survey of Canadian Veterans in Transition. *Canadian Journal of Counselling and Psychotherapy, 44*(4), 383-401.

Brereton, P., Orme, G., & Kehoe, E. (2013). The Reintegration of Reservist Veterans: An Australian Perspective. *Australian Defence Force Journal, 87*, 87-98.

Buydens, S. (2002). *The Lived Experiences of Women Veterans of the Canadian Forces.* University of Victoria.

Canada News Centre, Government of Canada. (2014, May 15). Medical Releases: Universality of Service and Support to Our Ill and Injured - Backgrounder. Ottawa, ON, Canada. Retrieved from http://news.gc.ca/web/article-en.do?nid=848259&_ga=1.264905671.974265623.1430414792

Canadian Armed Forces and National Defence. (2014, February 6). *Canadian Forces Military Police and the investigation process into alleged sexual assault offences.* Retrieved from News Fact Sheets: http://www.forces.gc.ca/en/news/article.page?doc=canadian-forces-military-police-and-the-investigation-process-into-alleged-sexual-assault-offences/hrbto8jk

Canadian Forces Health Services Group. (2014). *Surgeon General's Report 2014.* Ottawa, ON: National Defence.

Center for the Study of Traumatic Stress. (n.d.). *The Impact of Traumatic Brain Injury on Military Families and Children.* Retrieved June 25, 2015, from Resources for Recovery: http://www.centerforthestudyoftraumaticstress.com/assets/media/documents/RFR_Impact%20of%20TBI%20for%20Providers.pdf

Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences. (n.d.). *The Combat Injured Family: Guidelines for Care.* Retrieved June 25, 2015, from Resources for Recovery, Advancing the Health and Care of our Nation's Combat Injured Service Members, Their Families and Children: www.centerforthestudyoftraumaticstress.com/assets/media/documents/CSTS_evidence_based_management_PTSD.pdf

Collins, R., & Kennedy, M. (2008). Serving Families Who Have Served: Providing Family Therapy and Support in Interdisciplinary Polytrauma Rehabilitation. *Journal of Clinical Psychology: In Session, 64*(8), 993-1003.

Committee on the Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine of the National Academies. (2013). *Returning Home From Iraq and Afghanistan: Assessment of the Readjustment Needs of Veterans, Service Members, and Their Families.* Washington, DC: National Academic Press.

Coulthard, J. (2012). *The Canadian Forces Return to Work Program Study: Results and Recommendations* [Director General Military Personnel Research and Analysis

Letter Report to Director Casualty Support Management]. Defence Research and Development Canada, Ottawa, ON.
Cozza, S. J., Holmes, A. K., & Van Ost, S. L. (2013). Family-Centered Care for Military and Veteran Families Affected by Combat Injury. *Clinical Child and Family Psychological Review, 16*, 311-321.
Cozza, S., Chun, R., & Miller, C. (2011). *The Children and Families of Combat-Injured Service Members*. Retrieved from Borden Institute: https://ke.army.mil/bordeninstitute/published_volumes/combat_operational/combat2.html
Cozza, S., Guimond, J., McKibben, J., Chun, R., Arata-Maiers, T., Schneider, B., et al. (2010). Combat-Injured Service Members and Their Families. *Journal of Traumatic Stress, 23*(1), 112-115.
Deschamps, E. (2015). *External Review into Sexual Misconduct and Sexual Harassment in the Canadian Armed Forces.* Ottawa, ON: National Defence and the Canadian Armed Forces.
Director Casualty Support Management. (2014). *The Guide to Benefites, Programs, and Services for Serving and Former Canadian Armed Forces Members and the Families.* Ottawa, ON: National Defence.
Duranceau, S., Fetzner, M., & Nicholas Carleton, R. (2015). The Home Front: Operational Stress Injuries and Veteran Perceptions of Their Children's Functioning. *Traumatology, 21*(2), 98-105.
El-Gabalawy, R., Thompson, J., Sweet, J., Erickson, J., Mackenzie, C., Pietrzak, R., et al. (2015). Comorbidity and functional correlates of anxiety and physical conditions in Canadian Veterans. *Journal of Military, Veteran and Family Health, 1*(1), 37-46.
Elhai, J., Richardson, J., & Pedlar, D. (2007). Predictors of General Medical and Psychological Treatment Use Among a National Sample of Peacekeeping Veterans with Health Problems. *Journal of Anxiety Disorders, 21*(4), 580-589.
English, A. (2011). Not Written in Stone: Social Covenants and Resourcing Military and Veterans Health Care in Canada. In A. Aiken, & S. Belanger, *Shaping the Future* (pp. 230-238). Kingston, ON: Canadian Defence Academy Press.
Fast, J., Yacyshyn, A., & Keating, N. (2008). *Wounded Veterans, Wounded Families.* Edmonton, AB: University of Alberta.
Frey, L., Blackburn, K., Werner-Wilson, R., Parker, T., & Wood, N. (2011). Posttraumatic Stress Disorder, Attachment, and Intimate Partner Violence in a Military Sample - A Preliminary Analysis. *Journal of Feminist Family Therapy, 23*, 218-230.
Garber, B. (2014). *The Impact of the Mission in Afghanistan on the Mental Health of the Reserve Component of the Canadian Armed Forces Surgeon General Report.* Ottawa, ON: National Defence.
Garber, B., Zamorski, M., & Jetly, R. (2012). Mental Health of Canadian Forces Members While on Deployment to Afghanistan. *Canadian Journal of Psychiatry, 57*(12), 736-744.
Gifford, S., Hutchinson, J., & Gibson, M. (2011). Lifespan Considerations in the Psychological Treatment of Canadian Veterans with Post Traumatic Stress

Disorder. In A. Aiken, & S. Belanger, *Shaping the Future* (pp. 204-215). Kingston, ON: Canadian Defence Academy Press.

Gill, R., & Febbraro, A. (2013). *Sexual Harassment Among Women in the Canadian Forces Combat Arms.* Retrieved June 25, 2015, from http://smartsheep.org/sexual-harassment-among-women-in-the-canadian-forces-combat-ar

Gorman, L., Fitzgerald, H., & Blow, A. (2010). Parental Combat Injury and Early Child Development: A Conceptual Model for Differentiating Effects of Visible and Invisible Injuries. *Psychiatric Quarterly, 81*, 1-21.

Griffen, J., Friedemann-Sanchez, G., Jensen, A., Taylor, B., Gravely, A., Clothier, B., et al. (2011). The invisible side of war: Families caring for US Service Members with traumatic brain injuries and poytrauma. *Journal of Head Trauma Rehabilitation*.

Guest, K., Prefontaine, A., & Grenier, S. (2006). Looking After the Clinical and Social Support Needs of Military Families Impacted by Operational Stress Injuries. *RTO Meeting Proceedings MP-HFM-134. Paper 19*, pp. 1-22. RTO.

Gupta, A., & Sharma, R. (2013, October). Burden and Coping of Caregivers of Physical and Mental Illnesses. *Delhi Psychiatry Journal, 16*(2), 367-374.

Hachey, K. (2014 in press). *Experiences of Children of Ill and Injured Canadian Armed Forces Members: A Parental Perspective. DRDC-RDDC-2014-R9999.* Ottawa: National Defence.

Hachey, K. (2015 in press). *Experiences of Children of Ill and Injured Canadian Armed Forces - Perspectives from Subject Matter Experts. DRDC-RDDC-2015-R9999.* Defence Research and Development Canada. Ottawa: National Defence.

Institute of Medicine. (2013). *Returning Home From Iraq and Afghanistan: Assessment of the Readjustment Needs of Veterans, Service Members, and Their Families. Report Brief.* Institute of Medicine.

Khaylis, A., Polusny, M., Erbes, C., Gewirtz, A., & Rath, M. (2011). Posttraumatic Stress, Family Adjustment and Treatment Preferences Among National Guard Soldiers Deployed to OEF/OIF. *Military Medicine, 176*, 126-131.

Kroch, R. (2009). *Living with Military-Related Posttraumatic Stress Disorder - A Hermeneutic Phenomenological Study.* Calgary, AB: University of Calgary.

MacCourt, P., Family Caregivers Advisory Committee, & Mental Health Commission of Canda. (2013). *National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses.* Calgary, AB: Mental Health Commission of Canada.

MacLean, M., Van Til, L., Thompson, J., Poirier, A., Sweet , J., Sudom, K., et al. (2011). *Income Study: Regular Force Veteran Report.* Charlottetown and Ottawa: Veterans Affairs Canada, Research Directorate and Department of National Defence, Director General Military Personnel Research and Analysis.

Mahar, A., Aiken, A., Groome, P., & Kurdyak, P. (2015). A new resource to study the health of Veterans in Ontario. *Journal of Military, Veteran and Family Health, 1*(1), 3-5.

Military Family Research Institute . (n.d.). *How to Help Military & Veteran Families Before, During and After Deployment.* West Lafayette, Indiana: MFRI.

Nash, W., & Litz, B. (2013). Moral Injury: A Mechanism for War-Related Psychological Trauma in Military Family Members. *Clinical Child and Family Psychological Review, 16*, 365-375.

National Defence. (n.d.). *Caring For Our Own: A Comprehensive Approach for the Care of CF Ill and Injured Members and Their Families.* Ottawa: Government of Canada.

National Defence. (2014). *Designated Assistant Guide: Casualty Support and Administration.* Ottawa, ON: National Defence.

Office of the Auditor General of Canada. (2012). *Report of the Auditor General of Canada to the House of Commons - Chapter 4 - Transition of Ill and Injured Military Personnel to Civilian Life.* Ottawa, ON: Government of Canada.

Operational Stress Injury Social Support. (2004). *Family Support Needs Analysis.* Ottawa: National Defence.

Paré, J. (2013). *Post-traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans - Library of Parliament Background Paper.* Ottawa, ON: Library of Parliament Publication No. 2011-97-E.

Pearson, C., Zamorski , M., & Janz, T. (2014). *Mental Healath of the Canadian Armed Forces.* Ottawa, ON: Statistics Canada Catalogue no. 82-624-X.

Perlick, D. (2011). Multifamily group treatment for veterans with traumatic brain injury. *Professional Psychology: Research and Practice, 42*, 70-78.

Poisson, R. (2015). The imperative of military medical research and the duty to protect, preserve, and provide advanced evidence-informed care. *Journal of Military, Veteran and Family Health, 1*(1), 11-13.

Ramchand, R., Tanielian, T., Fisher, M., Vaughn, C., Trail, T., Epley, C., et al. (2014). *Hidden Heroes: America's Military Caregivers.* Santa Monica: CA: Rand Corporation.

Rand Corporation. (2014a). *Military Caregivers. Who are they? And who is supporting them?* Santa Monica, CA: Rand Corporation.

Rand Corporation. (2014b). *Ready to Serve: Community-Based Provider Capacity to Delivery Culturally Competent, Quality Mental Health Care to Veterans and Their Families.* Santa Monica: CA: Rand Corporation.

Ray, S., & Heaslip, K. (2011). Canadian military transitioning to civilian life: a discussion paper. *Journal of Psychiatric and Mental Health Nursing, 18*, 198-204.

Ray, S., & Vanstone, M. (2009). The Impact of PTSD on Veterans' Family Relationships. *International Journal of Nursing Studies, 46*(6), 838-847.

Renshaw, K., Allen, E., Rhoades, G., Blais, R., Markman, H., & Stanley, S. (2011). Distress in spouses of service members with symptoms of combat-related PTSD: Secondary traumatic stress of general psychological distress? *Journal of Family Psychology, 25*, 461-469.

Richardson , J., Darte, K., Grenier, S., English, A., & Sharpe, J. (n.d.). Operational Stress Injury Social Support: A Canadian Innovation in Professional Peer Support. *Canadian Military Journal, 9*(1), 57-64.

Richardson, J., Thompson, J., Boswall, M., & Jetly, R. (2010). Horror comes home: Veterans with posttraumatic stress disorder. *Canadian Family Physician, 56*, 430-434.

Shields, N., White, M., & Egan, M. (2009). *Battlefield blues - Ambivalence about treatment among military Veterans with depression.* Ottawa, ON: Veteran Health Files.

Statistics Canada. (2014, August 11). *Canadian Forces Mental Health Survey, 2013.* Retrieved from The Daily.

Subcommittee on Veterans Affairs, Standing Senate Committee National Security and Defence. (2014). *The Transition to Civilian Life of Veterans.* Ottawa, ON: Government of Canada.

Tanielian, T., Ramchand, R., Fisher, M., Sims, C., Harris, R., & Harrell, M. (2013). *Military Caregivers: Cornerstones of Support for Our Nation's Wounded, Ill and Injured Veterans.* Santa Monica, CA: Rand Corporation.

Tenhula, W., Nezu, A., Maguth Nezu, C., Stewart, M., Miller, S., Steele, J., Karlin, B. (2014). Moving Forward: A Problem-Solving Training Program to Foster Veteran Resilience. *Professional Psychology: Research and Practice,45:6,* 416-424.

Thompson, J., MacLean, M., Van Til, L., Sudom, K., Sweet, J., Poirier, A., et al. (2011). *Survey on Transition to Civilian Life: Report on Regular Force Veterans.* Charlottetown, PE and Ottawa, ON: Research Director, Veterans Affairs Canada and Director General Military Personnel Research and Analysis, Department of National Defence.

Thompson, J., Scott, K., & Dubinsky, L. (2008). Battlefield Brain - Unexplained symptoms and blast-related mild traumatic brain injury. *Canadian Family Physician, 54*, 1549-1551.

Thompson, J., Van Til, L., Poirier, A., Sweet, J., McKinnon, K., Sudom , K., et al. (2014). *Health and Well-Being of Canadian Armed Forces Veterans: Findings from the 2013 Life After Service Survey.* Charlottetown, PE: Research Directorate, Veterans Affairs Canada.

Van Til, L., Fikretoglu, D., Pranger, T., Patten, S., Wang, J., Wong, M., et al. (2013). Work Reintegration for Veterans With Mental Disorders: A Systematic Literature Review to Inform Research. *Physical Therapy, 93*(9), 1163-1174.

Van Til, L., Macintosh, S., Thompson, J., MacLean, M., Campbell, L., Sudom , K., et al. (2014). *2013 Synthesis of Life After Service Studies.* Charlottetown, PE: Veterans Affairs Canada.

Van Til, L., Macintosh, S., Thomspon, J., MacLean, M., Campbell, L., Sudom, K., et al. (2015). Fast facts on Veterans' transition experiences. *Journal of Military, Veteran and Family Health, 1*(1), 7-8.

Verlezza, M. (2015). What is Canada doing that produces better outcomes for Veterans? *Journal of Military, Veteran and Family Health, 1*(1), 9-10.

Wadsworth, S. (2013). Understanding and Supporting the Resilience of a New Generation of Combat-Exposed Military Families and Their Children. *Clinical Child and Family Psychological Review, 16*, 415-421.

Wang, Z., Dunn, J., & Tanner, L. (2009). *Care of the Ill and Injured in the Canadian Forces. DGMPRA Technical Memorandum 2009-015.* Director General Military Personnel Research and Analysis. Ottawa: National Defence.

Zamorski, M., & Wiens-Kinkaid, M. (2013). Cross-sectional prevalence survey of intimate partner violence perpetration and victimization in Canadian military personnel. *BMC Public Health, 13*(1019).

Zamorski, M., Rusu, C., & Garber, B. (2014). Prevalence and Correlates of Mental Health Problems in Canadian Forces Personnel Who Deployed in Support of the Mission in Afghanistan - Findings from Postdeployment Screenings, 2009-2012. *Canadian Journal of Psychiatry, 59*(6), 319-326.

Zamorski, M., Watkins, K., & Rusu, C. (2015). Are military personnel with a past history of mental health care more vulnerable to the negative psychological effects of combat? *Journal of Military, Veteran and Family Health, 1*(1), 14-25.

Appendix A – Some Key Transition to Civilian Life Programs & Services

Source: Subcommittee on Veterans Affairs, Standing Senate Committee National Security and Defence, 2014.

A) FEDERAL GOVERNMENT

1. Department of National Defence
   - Career Transition Assistance Programs (CTAP)
   - Second Career Assistance Network Program (SCAN)
   - Transition Assistance Program (TAP)
   - Vocational Rehabilitation Program for Serving Members.
   - Federal Public Service Employment – Priority Appointment for Eligible Released Canadian Armed Forces Members
   - Military Civilian Training Accreditation Program
   - Canadian Forces Continuing Education Program
   - SISIP Financial Services' Vocational Rehabilitation Program

2. Veterans Affairs Canada
   - Career Transition Services Program
   - Vocational Rehabilitation Program
   - Veterans Transition Advisory Council (with True Patriot Love Foundation)
   - Hire a Veteran / Jobs-Emplois Initiatives

B) NON-GOVERNMENT ORGANIZATIONS

1. Canada Company
   - Military Employment Transition Program

2. Helmets to Hardhats Canada

3. Prince's Charities
   - Operation Entrepreneur

4. Prospect Human Services
   - Forces@WORK Program

5. Royal Canadian Legion / University of British Columbia / Veterans Transition Network
   - Veterans Transition Program

6. Royal Canadian Legion / British Columbia Institute of Technology
   - Legion Military Skills Conversion Program

7. Treble Victor Group

Appendix B – Support Programs for Ill & Injured Military Personnel (National Defence, CAF & VAC)

Source: Office of the Auditor General of Canada, 2012.

Exhibit 4.1 Support for ill and injured military personnel offered by the Department of National Defence and the Canadian Forces, and Veterans Affairs Canada

Support offered by the Department of National Defence and the Canadian Forces (DND/CF)	Available to Forces members (pre-release)	Available to veterans (post-release)
CF Case Management	✓	
Comprehensive Health Care	✓	
Operational Trauma and Stress Support Centres	✓	
Operational Stress Injury Social Support	✓	✓
Military Family Resource Centre	✓	
CF Family Peer Support Network	✓	✓
Chaplaincy services	✓	
Soldier On program	✓	
Injured Soldier Network	✓	
Shoulder 2 Shoulder Program	✓	✓
CF Member Assistance Program	✓	
CF Accidental Dismemberment Insurance Plan (SISIP)	✓	
Education Reimbursement	✓	
Skills Completion Program	✓	
Second Career Assistance Network	✓	
Return to Work Program	✓	
Joint Personnel Support Units / Integrated Personnel Support Centres	✓	✓
Transition Assistance Program	✓	✓
SISIP Financial Services, Vocational Rehabilitation Program	✓	✓
SISIP Financial Services, Long-Term Disability		✓
Support offered by Veterans Affairs Canada (VAC)		
VAC Case Management	✓	✓
Treatment benefits for awarded condition* (if not provided by CF)	✓	
Treatment benefits for awarded condition*		✓
Integrated Personnel Support Centres	✓	✓
Transition interview	✓	
Operational Stress Injury Clinics	✓	✓
Operational Stress Injury Social Support	✓	✓
VAC Assistance Line	✓	✓
Disability Award	✓	✓
Veterans Independence Program	✓	✓
Career Transition Services	✓	✓
Public Service Health Care Plan		✓
Long-Term Care		✓
Rehabilitation Program (medical, psycho-social, and vocational)		✓
Financial Benefits (for example, earnings loss, permanent impairment allowance, supplementary retirement benefit, CF income support)		✓

*An awarded condition is a service-related injury or illness for which Veterans Affairs Canada has granted a Disability Award.

Source: Department of National Defence and the Canadian Forces, and Veterans Affairs Canada

Appendix C – 2004 OSISS Needs Assessment

In a needs assessment conducted in 2004 (Operational Stress Injury Social Support, 2004), a number of issues were identified as assistance and support needs by families of CAF personnel with OSIs (not in order of importance):

1. Be informed about the symptoms and behaviours associated with operational stress injuries.
2. Be involved in the treatment protocol of the OSV.
3. Be listened to and receive emotional support.
4. The need the most frequently expressed by the family members: to have access to specialized psychological services for the treatment of PTSD or compassion fatigue (for spouses and children).
5. Legitimize the emotions, experiences and suffering of family members.
6. Learn concrete crisis management tricks and tools.
7. As informal caregiver, recognize the signs of stress and depression in oneself.
8. Develop and enhance skills (communication, anger management, coping with life transitions, meeting one's needs, etc.).
9. Reduce isolation.
10. Receive help which is adapted to the family's specific needs.
11. Be recognized as an informal caregiver and primary support by the VAC (social and financial recognition).
12. Recognize that the caregiver can be a secondary victim of the primary trauma experienced by the combatant (compassion fatigue or secondary traumatic stress) (social and financial recognition).
13. Have a greater knowledge of the assistance services already available.
14. Simplify access to services offered by the CF and VAC.
15. Feel empathy and receive support from peers, immediate supervisors and CF personnel with regard to OSV and their families.
16. That the OSI no longer be considered a shameful defect which must be hidden.

Appendix D – Five Evidence-Based Strategies

Building on both Walsh's "Family Resilience Theory" and Saltzman et al's "Mechanisms of Risk and Resilience in Military Families Model" (see Suggestions for Further Reading for theory/model references), the following 5 evidence-based strategies promote family equilibrium and resilience under the stress of illness and injury (Cozza, Holmes, & Van Ost, 2013). These strategies should be done alongside linkage to supportive community and military services.

1. **Educate adults and children about the impact of the illness/injury and the expected recovery process.**

   The family should be encouraged to locate their progress within the injury recovery trajectory while acknowledging that setbacks may occur. Because the injured family member's changed behaviour is typically a direct result of the injury, providers must offer helpful psycho-education about diagnoses and likely long-term outcomes. Clinicians often need to remind family members to attribute new and unexpected interactions with the service member or Veteran to the injury or combat-related illness rather than to a change in the emotional commitment of the relationship or to some action of their own. A key principle is that everyone, parents and children alike, is affected by the injury. Children, especially, must be reminded that the tension they see at home is not their fault and that it is not their responsibility to ''fix'' it. Adolescents should be relieved of adult responsibilities that conflict with academic, occupational, or emotional development. In general, parents must provide their children with opportunities for normal growth and development that are independent from any struggle the family is having with injury recovery.

2. **Reduce family distress and disorganization through family care management and provision of practical and socioeconomic support.**

   Family Care Management incorporates motivational interviewing techniques (eliciting change and commitment talk, increasing awareness of personal discrepancies, clarifying goals, making change plans) to facilitate the family's awareness of and interest in unrecognized issues (substance abuse, clinically significant mental health problems) that can undermine family relationships. Case management services are prioritized based on the family's expressed satisfaction or concern with services in physical health, medical access, psychological/ mental health, social interactions, child care/education, health, work/finance, housing, military status, and legal. Effective management of these basic needs provides a sense of order and predictability that allows family members to be less distracted, function more effectively, and be supportive of each other as the family moves through the course of injury recovery. Continuous coordination of services promotes family organization by reducing worry about basic needs and providing overburdened caretakers with support and respite. Adults are calmer, and the frequency of impulsive, threatening, or

disruptive behaviour among family members is reduced when there is access to systems for household maintenance, meals, medical care, money management, and child care. Children are calmer when adults provide a predictable daily routine and model restraint.

3. **Develop emotion regulation skills necessary for ongoing dialogue and collaboration.**

   Similar to all families, interpersonal transactions and communication will be more effective in combat-injured families if delivered in a measured, calm manner. Given the higher likelihood of emotional dysregulation in combat-injured families, particularly those with PTSD or TBI, there is greater need for clinical attention. As a result, children and adults should be taught to practice personally effective stress reduction strategies. This training should include instruction on how to monitor changes or extremes in emotional states by first learning to label and express feelings, then to identify when and how positive or negative responses are precipitated.

4. **Promote helpful and ongoing communication about the injury that incorporates developmentally appropriate language (injury communication).**

   Injury communication must be judicious communication that is ongoing and occurs across a variety of relationships. Injury communication must also be developmentally appropriate. The Workgroup on Combat Injured Families has proposed that parents and professionals be aware of the following guidelines:
   (a) The importance of speaking with children as soon as possible after the injury. Children infer from adult behaviour that something has happened and can be protected from unfounded worry if informed in a timely manner.
   (b) Adults should speak in a calm and matter-of-fact manner using language that is comprehensible to the child but excludes unnecessary or frightening detail. When speaking with younger children, it may be helpful to use a doll or puppet to show the location of the injury.
   (c) The type of provided information will vary with each child's developmental status. For younger children, reassurance about the care being administered to the injured parent and about the ongoing safety of both the child and the uninjured parent are important. Teenagers will require more detailed and logical explanations of the injury, its impact on the family, and reasons for carefully calibrated expansions of their own household responsibilities.
   (d) Create a family atmosphere in which discussion is encouraged regarding the injured parent's changed behaviour. When they are prompted to express confusion or voice questions, children can be relieved of feeling personally responsible for changed interactions between the injured parent and other household members. Maintaining this dialogue allows children and adults alike to develop an ongoing understanding of how the recovery process differentially affects each family member.

5. **Encourage optimism through development of successful problem-solving and shared future goals.**

   During recovery, the family often must engage in a process of grieving their previous life while developing hope and optimism about a changed future. The changed personality and interpersonal skills of a service member suffering from OSIs can create a sense of grief in family members who mourn their previous relationship. Ambiguous loss is a particularly useful way of referencing a family's grief and confusion over the presence of someone who resembles the previously loved person, but no longer behaves in a way that is similar to prior experience. Professionals can encourage acceptance of this changed reality while developing the family-based skills by which to create a positive, though different future. If a family can develop a sense of safety and competency in their management of daily life with the injured loved one (through the strategies described above), then they can look to the future with greater hope. In addition, when families reduce isolation and feel embedded in a larger, potentially helpful context of interested people and connections, they develop greater self-advocacy and confidence about their ability to manage future challenges. Future hopefulness also develops when families are able to share new and positive experiences together while recognizing and respecting changes brought about by the illness or injury.