

Accessing Mental Health Care in the Canadian Armed Forces: Soldiers' Stories

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“Man is least himself when he talks in his own person.

Give him a mask, and he will tell you the truth.”

Oscar Wilde

“Out of suffering have emerged the strongest souls;

the most massive characters are seared with scars.”

Khalil Gibran

Thesis Abstract

Background: Recent Canadian Armed Forces operations involved multiple deployments and exposure to traumatic events that are associated with post-traumatic stress disorder, depression and substance abuse. Despite efforts to facilitate mental health care, some soldiers do not get the help they need.

Objective: To understand soldiers' experiences and explore barriers and facilitators they encountered accessing mental health care.

Results: Qualitative descriptive interviews with 11 Canadian Armed Forces members revealed six major categories that provide insights into their experiences accessing mental health care. Participants' revealed significant barriers to care including fear of damaging their career or being released, stigma beliefs and actions from peers and leaders, and physical and organizational barriers to care. Social support from family, military co-workers, and unit leaders facilitated care.

Conclusions: Notwithstanding efforts to facilitate access to mental health care, some soldiers still perceive significant barriers to care.

Keywords: military culture, military identity, post traumatic stress disorder, stigma, veterans.

Acknowledgements

While the name on the front page of this thesis may be mine, it would have never been possible without my thesis committee, my family and friends, and most importantly the brave men and women of the Canadian Armed Forces who came forward and shared their experiences in order to help their fellow soldiers.

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realized with his extensive research experience he knew exactly when to challenge me, ensuring I was learning along the way.

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My Mom and Dad have been my biggest supporters from day one. The mission in Afghanistan was not an easy one. Leaving a child behind is the hardest thing for a parent to do. Thank you for always being there to fill whatever role was needed to support Danny and I so we could go with peace of mind, knowing Brighton was in the very best hands. I could never put into words how truly grateful I am.

My husband Danny, truly is my better half. Deployments, taskings, courses, shift-work, and a THESIS and he still loves me. No matter which one of us is packing a barracks box, or how many tears are in my eyes he is always the voice of reason and pillar of strength. He has pushed me to be brave when I need to be brave and is always there with a shoulder to cry on when the world gives me just a little too much to handle.

The official flower of the military child is the dandelion. It puts down roots almost anywhere, and it’s almost impossible to destroy. It’s a survivor in the harshest of environments. Just like the dandelion, military children bloom wherever the winds carry them. Their roots are strong, cultivated deeply in the culture of the military. They stand

tall, proud and upright. Every day as a military child, without ever donning a uniform or earning a rank, my son Brighton serves his country. The first time I deployed he was only a toddler. He gently wiped away my tears telling me “it’s okay” as I headed off to “Canada-har.” Leaving him was always the hardest thing I had to do, but I always told myself that every soldier we cared for at the Role 3 was somebody’s ‘Brighton.’ Now many years have passed and I couldn’t be any prouder of the young man he is becoming. He is my greatest pride and joy, and my greatest accomplishment.

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List of Abbreviations

CAF	Canadian Armed Forces
CAF CWO	Canadian Armed Forces Chief Warrant Officer
CDS	Chief of Defence Staff
CDU	Care Delivery Unit
CF	Canadian Forces
CFHSG	Canadian Forces Health Services Group
CO	Commanding Officer
IBTS	Individual Battle Test Standards
IED	Improvised Explosive Device
IPSC	Integrated Personnel Support Centre
JPSU	Joint Personnel Support Unit
JTTS	Joint Theater Trauma System
MPTSR	Medical Professional Technical Suicide Review
NATO	North Atlantic Treaty Organization
OSI	Operational Stress Injury
OSISS	Operational Stress Injuries Social Support
PTSD	Post Traumatic Stress Disorder
Role 3	Role 3 Multinational Medical Unit
R2MR	Road to Mental Readiness
RSM	Regimental Sergeant Major
RSO	Range Safety Officer
U.S.	United States

U.K. United Kingdom

WRAIR Walter Reed Army Institute of Research

Chapter 1

Introduction

Introduction

Relevance

The issue of suicides in the Canadian Armed Forces (CAF) and the mental welfare of soldiers continues to dominate defense news in Canada (CBC News, 2014). In the fall of 2014 the media announced that suicide claimed the lives of more soldiers than those killed by combat in Afghanistan (Gwiazda, 2014). While the number of suicides are heartbreaking and gain significant media attention, it is even more alarming that more than half of the soldiers with mental health problems do not seek help (Iversen et al., 2011; Fikretoglu, Guay, Pedlar, & Brunet, 2008). Review of CAF and Ombudsman reports indicate that while the CAF has improved its mental health system, several problem areas remain (Collier, 2010; National Defence and the Canadian Forces, 2001). These problem areas are compounded by a lack of progress and continuity in gathering information about mental health concerns of currently serving CAF members and veterans (Collier, 2010; CBC News, 2014).

Recent CAF and allied operations have involved multiple deployments coupled with high intensity guerilla insurgent type warfare, resulting in increased exposure to traumatic events such as direct fire, bombings, handling human remains, killing an enemy, and seeing dead comrades and victims of war including women and children (Di Leone et al., 2013). This type of continued combat exposure is associated with a high risk of developing mental health problems, such as post-traumatic stress disorder (PTSD), depression and substance abuse (Hoge et al., 2004). Despite high rates of mental health challenges, soldiers do not readily get the help they need. As a CAF Nursing Officer, I feel a professional and moral obligation to care for and improve the health of our soldiers. It is essential that we find out why our soldiers are not accessing the care they need.

The military environment may exacerbate mental health problems by creating barriers to care. Two major categories of barriers have been identified: (1) stigma and (2) treatment perceptions and their consequences (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). Throughout the literature, stigma was described as the greatest barrier to mental health care for soldiers. The military environment may also reinforce barriers to accessing mental care because of its 'soldier on' culture, its emphasis on group loyalty and its individual heroism, which militate against admitting vulnerability (Fikretoglu et al., 2008). The generalized military view focuses on conformity as positive and stigma generally denotes a trait that marks a soldier as different from others in a negative way. A negatively regarded trait, or stigma, is often a precursor to discrimination or unfair treatment (Goffman, 1963). Stigma is not only what is perceived by others; those requiring help will also stigmatize themselves as they are aware of the attitudes of their peers and the beliefs of the culture to which they belong (Goffman, 1963; & Greene-Shortage, Britt, & Castro, 2007). This process is referred to as self-stigma. Soldiers with anxiety, depression and PTSD are twice as likely to report a series of stigmatizing beliefs when compared to soldiers without these mental health issues (Fikretoglu et al., 2008; Hoge et al., 2004, Iversen et al., 2011).

The military has done much to try to reduce the stigma surrounding mental health issues and several high-ranking officers have disclosed suffering from mental health conditions to aid in de-stigmatization (Collier, 2010). Despite these efforts, a substantial proportion of military personnel still anticipate stigma and believe any help-seeking behavior is likely to negatively impact their career (Iversen et al., 2011). Military members operate within a culture that fosters self-sufficiency and are required to be fit to

serve; the daily mantra of supervisors and Commanding Officers is ‘if you are not deployable, you are not employable’ (National Defence and the Canadian Forces, 2006). This fear of being considered unfit to deploy and thus unfit for employment may make it less likely for soldiers to obtain mental health care (Fikretoglu et al., 2008). When asked, 85% of British soldiers indicated that they believed a diagnosis of a psychiatric disorder would be detrimental to their careers (Greenberg, Langston, & Gould, 2007). In the United States, evidence suggests that mental health problems are the leading cause of medical release of service members; 47% of those hospitalized for the first time for a mental disorder were discharged from military service within six months, compared with an attrition rate of 12% for those with non-mental health related illness or injury (Hogue, 2002).

Successful mental health services typically require a trusting relationship between patients and mental health care providers. Research has identified that a lack of trust and confidence in mental health providers was a significant concern among soldiers. Confidentiality is a particular concern and a deterrent to help seeking in the close-knit military environment (Iversen et al., 2011; Fikretoglu et al., 2008).

Mental disorders constitute a substantial public health and operational readiness problem in the CAF (Fikretoglu et al., 2008). Mental disorders pose a significant threat to operational effectiveness and given that the number one reason for premature release from military service has been identified as having an untreated mental disorder, mental disorders also constitute a significant force sustainability problem for the CAF (Hoge et al., 2002).

Thesis Objective

The objective of this thesis is to explore perceived barriers and facilitators to accessing mental health care by CAF members who have accessed mental health care in the CAF. By understanding the pathway to care for those who seek care, we will gain new insight into the attitudes and beliefs of those who do not seek mental health care.

Epistemological Standpoint

As a Canadian, CAF Nursing Officer, comrade, military spouse, and mother of a military child, knowing that over half of the CAF members who need mental health care do not access it is professionally and personally disturbing, troublesome and heartbreaking (Iversen et al., 2011; Fikretoglu, Guay, Pedlar, & Brunet, 2008). As a CAF Nursing Officer I am in no place to argue the politics. My job is to defend our country and take care of my fellow soldiers. As a nurse, I am ethically, professionally and morally obligated to “do no harm” and to advocate for the best care possible for my patients. As a CAF Nursing Officer, these obligations take on an additional dimension when my work to care for and improve the health of our soldiers has the potential to improve the lives of individual soldiers, their families, units, and the readiness of the CAF to carry out its duties to the Canadian people.

Prior to starting this academic journey I could not have imagined undertaking a research project outside of my comfort zone of trauma care. However upon starting my Advanced Practice Nursing course I came to realize that an advanced practice nurse focuses on the needs for her patients and their families and this brought me to reflect on the current needs of our CAF soldiers, particularly in the area of mental health care. Upon consultation with the CAF Chief of Nursing Services and senior members of the CAF

Health Services Directorate of Mental Health my research on mental health care in the CAF began.

Although this insider perspective is advantageous, it is a double edged sword which requires me to remain vigilant in conducting qualitative research with my fellow soldiers. The qualitative approach employed in this study (qualitative description) allowed me to distance myself from interpreting the data beyond the manifest level of analysis and ensured findings were grounded in the data (Sandelowski, 2000). Journaling throughout the research process and debriefing with my thesis supervisor allowed me to reflect on the process and the data with a focus of remaining objective. Additionally, including research team members without military backgrounds was especially important during the data analysis and interpretation phases of the study.

This research is grounded in the interpretivist/constructivist paradigm. By employing these views I was able to rely upon the soldiers' views of accessing mental health care while acknowledging my own background and experience (Creswell, 2003; Mackenzie & Knipe, 2006). Research within the interpretivist/constructivist paradigm is not initiated based on theory (Creswell, 2003; Mackenzie & Knipe, 2006) thus allowing categories and sub-categories to be inductively developed. This approach facilitated capturing the experiences of CAF members who sought mental health care.

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Chapter 2
Literature Review

Literature Review

A review of the current literature on barriers and facilitators to mental health care in military environments is presented in this chapter.

Search Strategy

The objective of this literature review was to discover the scope of existing literature on barriers and facilitators of mental health care in the CAF. As a result of the paucity of Canadian and qualitative research on barriers and facilitators to mental health care in the CAF, I included all allied nations research as well as literature reviews on the focus area. A literature search was undertaken at the University of Ottawa Library using the following keywords: mental health, psychological health, emotional health, soldier, suicide, Canadian Armed Forces, Army, Veteran, military, barriers, and facilitators. Articles were selected from 2001 to present in order to keep focus on more current combat operations, specifically Afghanistan and Iraq. The following databases were searched: CINAHL, EBSCO Host, PubMed, AMED, and PsycINFO. A total of 121 relevant publications were identified. Duplicate and irrelevant articles were removed. Further screening removed those articles published after 2001 in which the content focused on earlier combat situations. Articles that included non-allied forces or civilians in the study group were also removed. The remaining 66 publications were reviewed in their entirety. Articles and reports were identified by reviewing the reference lists of cited references, through searches of Google and Google Scholar, and discussion with military mental health experts.

Synthesis of Literature

The need for mental health care in military settings is not new. The impact of battle and war on the mental health of soldiers was described by the Greeks and Romans dating back to 490 BC (Hampson, 2014). During World War I the French used psychiatric care to treat combat stress close to the front lines. British soldiers who were evacuated back to hospitals in the United Kingdom were less likely to return to combat than those treated close to the front lines (Jones & Wessely, 2001). Roughly 10,000 Canadians were treated for shell shock during the Great War (Hampson, 2014). As a result of these experiences it became standard practice to treat psychiatric casualties as close to the front lines as possible with the intent that soldiers could return to duty.

The CAF serves Canada by supporting freedom, democracy, the rule of law and human rights around the world, and by defending Canada's values, interests and sovereignty at home and abroad. The CAF is comprised of the Canadian Army, the Royal Canadian Navy, and the Royal Canadian Air Force. The CAF includes 63,365 regular force members, 27,135 primary reserve force members, and 5,000 Rangers (Government of Canada, Canadian Armed Forces, 2013).

Recent CAF and allied operations have included missions in Afghanistan, Bosnia, Rwanda, Haiti and East Timor that have involved multiple deployments coupled with high intensity guerilla insurgent type warfare, resulting in increased exposure to traumatic events such as direct fire, bombings, handling human remains, killing an enemy, and seeing dead comrades and victims of war including women and children (Di Leone et al., 2013). This type of combat exposure can cause severe physical injuries (Palm et al., 2012) and is associated with a high risk of developing mental health problems, such as post-traumatic stress disorder (PTSD), depression, anxiety and substance abuse problems

(Fiedler et al. 2006; Hogue et al., 2004; Smith et al. 2008). In addition, there is evidence that the increased length of deployments, multiple deployments, and increased combat exposure substantially increase the likelihood of the development of mental health problems for military personnel (Department of Defense Task Force on Mental Health, 2007; Hoge et al., 2004; Kang, Natelson, Mahan, Lee, & Murphy, 2003). CAF suicide rates have remained stable over the last 10 years (Zamorski et al. 2015). However, U.S. Army suicide rates have increased in recent years (Government of Canada, Department of National Defence, 2010a; Kennedy, 2008; Tan 2009).

Despite high rates of mental health disorders, soldiers do not readily get the help they need. Several studies have indicated that half of the soldiers with mental health problems do not seek help or avail themselves of available mental health services, (Iversen et al., 2011; Fikretoglu, Guay, Pedlar & Brunet, 2008) and one third of CAF personnel with PTSD did not obtain any form of treatment in their lifetime and therefore suffered in silence (Fikretoglu et al, 2008). Strong associations between soldiers diagnosed with PTSD and compromised physical health, decreased psychosocial and occupational functioning, and decreased quality of life have been documented. According to Corrigan (2004) individuals who are diagnosed with a mental disorder or perceived as mentally ill are at an increased risk of losing their jobs, experiencing homelessness, and being incarcerated. Mental health conditions are leading causes of reduction in productivity including absenteeism and turnover (Hogue, Auchterlonie, & Milliken, 2006; Rost, Smith, & Dickson, 2004). Untreated mental health conditions have a significant economic impact on both civilian and military populations (Fikretoglu et al., 2007; Hoge et al., 2002).

Barriers to Mental Health Care

Soldier on. Military environments may increase barriers to care thus exacerbating mental health problems because of a ‘soldier on’ culture, with its emphasis on group loyalty and individual heroism, which militate against admitting vulnerability (Fikretoglu et al., 2008; Richardson, Thompson, Boswell & Jetly, 2010; Sudom, Zamorski, & Garber, 2012). According to Visco (2009) an explanation for this is that the fundamental beliefs of duty, honor, and country are paramount for a soldier. This generalized military view focuses on the positive aspects of conformity and defying weakness. The belief that soldiers should always push through any obstacle, putting mission first was also evident in several studies (Fikretoglu et al., 2008; Murphy et al., 2014; Olden et al., 2010; Sudom, Zamorski, & Garber, 2012). Among British soldiers this phenomenon was described as “cracking on despite a problem” (Murphy et al., 2014). For American soldiers the ethos of pride in inner strength was observed to be persistent across ranks (Olden et al., 2010).

Self-reliance. To examine barriers to care the CAF 2008/2009 Health and Lifestyle Survey used a list of barriers from a civilian survey and augmented with barriers that applied more specifically to a military environment. The results of this survey showed that the most prevalent barrier to accessing care (observed in 64%) was that respondents preferred to manage their problems on their own (Government of Canada, Department of National Defence, 2010b; Zamorski, 2011).

Military identity. The war on terror in Iraq and Afghanistan since 9/11 has changed the face of veterans in Canada and for our coalition partners. Veterans today no longer fit the image of the elderly man sitting quietly with his family or with his fellow

veterans at the Legion Hall; veterans of today are young men and women who have families to support. Many of today's veterans have suffered egregious injuries both visible and non-visible that affect their identities in a myriad of ways (Martone, 2008). For today's young veterans the linkage between their career and their self-identity is particularly salient, pervasive, and essential for survival on the battlefield (Lande, 2007).

Tajfel (1972) defined social identity as an individual's awareness that he or she belongs to specific social groups or subcultures combined with some personal value and emotional significance related to group membership. Tyler and Blader (2001) have conducted extensive work in the area of identity. They explored how the group to which an individual belongs creates his or her self-concept, and how these reflections relate to an individual's behavior within the group. They discovered that people search for groups to join and while in them, exercise discretionary cooperative behavior; looking to preserve the groups status and promote their own personal status by choosing to participate in group activities and behaviors. People were noted to express and maintain their individual feelings of respect and pride by representing their group and, in so doing, maintain a favorable self-image while also continuing to promote the group (Tyler & Blader, 2001).

Review of the literature revealed insight as to why soldiers have a unique experience of trading their self-identity for military identity or intertwining the two in such a way that the self-identity becomes only a small part of the military identity. One argument for this stems from the unique characteristics of a career where it is imperative to risk one's own life or take the life of others, and order others to do the same (Danker, Wessely, Iverson, & Ross, 2003). In military culture, the soldier's body is both an

instrument and symbolic mechanism for the battle. Through expert organizational practices and training, the otherwise ‘civilian’ body is reconstructed as an appropriate tool for the military mission (Godfrey, Lilley & Brewis, 2012). Operating in erratic weather conditions, inhospitable landscapes, and fighting guerilla forces become common physical tasks of the trained soldier. Tasks, that without a strong military mind would be impossible to accomplish (Ewalt & Ohl, 2013). A military identity is associated with one’s individual determination (Woodward & Jennings, 2011).

While an established military identity may be essential for a successful military career, the loss or hibernation of ones self-identity throughout their years of service contributes to the great struggles they face when leaving the Armed Forces; this is true even when soldiers are planning a well-timed retirement (Walker, 2012). The sense of esprit de corps in the military is an important cultural aspect for soldiers that is painfully missed in their lives when they retire or are forced to leave the military (Westwood, McLean, Cave, Borgen, & Slakon, 2010). The military identity that allows survival in battle, and comfort and belonging in garrison causes distress and maladjustment upon release from the military (Haynie & Sheppard, 2011). It is not uncommon that even several years after leaving the military, veterans still identify themselves as military, unable to reconcile military and civilian selves (Yanos, 2004). Problems among homeless veterans including free-floating anxiety, depression and psychosomatic difficulties, are associated with persisting military identities (Higate, 2001).

Stigma. The word “stigma,” stemming from the Greek word stigmat, means a sign or a branding mark. Erving Goffman, a Canadian-born sociologist and writer, who is considered one of the most influential American sociologists of the twentieth century

defined stigma as “the process by which the reaction of other spoils normal identity” (Goffman, 1963). He identified both public stigma; the reaction of others in the community at-large toward people with symptoms of mental illness, and self-stigma; the self-blame and self-derogatory attitudes that people with mental illness may harbor about themselves (Goffman, 1963; Sharfstein, 2012). It is not uncommon for individuals with mental illness to be perceived as dangerous and unpredictable with limited social skills (Britt, et al., 2008; Corrigan, 2004). In response people with mental illness often internalize stigma, decreasing their self-esteem and retreating socially rather than seeking support (Corrigan, 2004). Despite research efforts and numerous initiatives to combat stigma surrounding mental health, stigma remains to be one of the central mental health related issues, and is cited as the most formidable obstacle to the receipt of mental health care (Hinshaw & Cicchetti, 2000, & Lebowitz & Ahn, 2012). These findings extend to the military environment, stigma has been recognized as the greatest barrier to accessing mental health care for military personnel (Hogue et al., 2004; Britt et. al., 2008; Gould et al. 2010; Greene-Shortridge, Britt, & Castro, 2007).

Stigma associated with mental health problems is a significant barrier to care and can be attributed to the gap in mental health care service utilization (Britt, et al., 2008; Corrigan, 2000, 2004). Soldiers with anxiety, depression and PTSD are twice as likely to report a series of stigmatizing beliefs when compared to soldiers without mental health disorders (Fikretoglu et al., 2008; Hoge et al., 2004, Iversen et al., 2011). Murphy et al. (2014) studied U.K. Armed Forces members and observed that participants acknowledged their own self-stigmatizing beliefs and progressed through them in order to access care. The U.S. Department of Defence has made efforts to decrease stigma

associated with seeking mental health care, but stigma remains a significant barrier for U.S. soldiers (Adler & Castro, 2013). The CAF has focused anti-stigma efforts on destigmatizing the development of a mental disorder or accessing mental health care after a deployment by focusing on operational stress injuries with the strategy that society will act more compassionately and have more understanding because the mental illness is not the affected service member's fault (Zamorski, 2011).

Loss of or damage to career. Military personnel operate within a culture that fosters self-sufficiency and they are required to be fit to serve, which is commonly summarized in the statement 'if you are not deployable, you are not employable' (National Defence and the Canadian Forces, 2006). This fear of being considered unfit to deploy and thus unfit for employment may make it less likely for soldiers to obtain mental health care (Fikretoglu et al., 2008). In Greenberg, Langston, & Gould's (2007) study, when surveyed most British soldiers (85%) believed a diagnosis of a psychiatric disorder would be detrimental to their careers. In the United States, mental health problems have been linked to ending military careers. Hogue et al. (2002) found that 47% of those with first time hospitalization for a mental disorder were discharged from military service within six months, compared to a 12% attrition rate for those with non-mental health related illness or injury. Cawkill (2004) found that concern for damage to one's career was not isolated to lower ranks and even U.K. Armed Forces Commanders were fearful that mental health issues would cause them to be looked over for promotion. Untreated mental disorders remain the number one reason for premature release from military service (Hoge et al., 2002).

Lack of trust in the mental health system. The literature indicated a lack of trust and confidence in mental health systems as a barrier to accessing mental health care. This included concerns about confidentiality, treatments and medications. There was concern that providers would not understand the service member's problems and fear of possible medication side effects (Kim et al. 2011). Confidentiality has been documented as a particular concern and deterrent to help seeking in the close-knit military environment (Hoge et al. 2004; Iversen et al., 2011; Fikretoglu et al., 2008).

Physical barriers. Findings related to physical barriers to mental health care were mixed. Canadian studies reported that excluding deployed operations structural barriers are not obstacles to mental health care. Costs for care are covered, time off work is guaranteed, specialists are abundant, care is available in both official languages and if required transportation is available and it was concluded that barriers to care are attitudinal not physical (Sudom, Zamorski, & Garber, 2012; Zamorski, 2011). Conversely, studies with American veteran populations (Elnitsky et al. 2013; Burnam et al. 2009) identified physical barriers to mental health care that were due to the long-standing geographic disparity of having the greatest concentration of mental health professionals in urban areas.

Facilitators to Mental Health Care

Leadership as a facilitator. There was a paucity of studies on facilitators to care. When facilitators were mentioned they were used in reference to a civilian mental health care context where income and availability of care were related. This was not pertinent in this review as all Canadian military service members access medical and mental health care that is provided through the military health care system (Fikretoglu et al., 2008). Two

qualitative studies identified positive leadership as a facilitator to care (Britt et al., 2012; Wright et al., 2009). Wright et al. (2009) observed that soldiers reported higher morale and unit cohesion and less stigma toward mental health care in units with positive leadership. Britt, Wright and Moore (2012) examined both positive and negative leadership behaviors. Negative leadership behaviors were associated with increased perceived stigma and positive leadership showed decreased stigma and fewer barriers to mental health care. Excluding leadership, limited information was available addressing the role that facilitators play in increasing access to care in the military environment. This confirms that there is a gap in the literature surrounding existing and achievable facilitators to mental health care in the CAF.

It is clear that despite the acknowledged barriers and attempts to improve soldiers' access to mental health care obstacles remain as more than half of the soldiers who are in need of mental health care do not to access it. Positive attitudes of leadership towards mental health care is the only identified facilitator in terms of soldiers' being more likely to access mental health care. The research in this area is limited to quantitative studies, which make use of standardized measures and available data (e.g. number of mental health visits, wait times visits). Although quantitative approaches contribute to our understanding of barriers and facilitators for soldiers as they access mental health care, they may preclude an understanding of how the perception of these barriers and facilitators impede or encourage CAF soldiers to access mental health care. Therefore, by employing a qualitative descriptive approach we can understand how known barriers and facilitators effect soldiers mental health seeking behaviors as well as uncover unidentified barriers and facilitators to care.

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Chapter 3

Methods and Methodology

Methodology

Paradigms are sets of beliefs and practices shared by communities of researchers, which regulate inquiry within disciplines (Weaver & Olson, 2006). A paradigm is defined as a set of basic beliefs that represent a worldview, defines the nature of the world and the individual's place within it and guides action (Plack, 2005). Paradigms offer different insights for explaining, predicting and discovering knowledge (Weaver & Olson, 2006). Ontology (how to view the world), epistemology (how knowledge is acquired) and methodology (the process of knowledge and inquiry) serve as the fundamental philosophical assumptions upon which each paradigm is established (Thomas, 2006).

This research is grounded in the interpretivist/constructivist paradigm. This paradigm allowed the research to progress with the intention of understanding “the world of human experience” (Cohen & Manion, 1995, p.36) proposing that “reality is socially constructed” (Mertens, 2005, p.12). By employing these views I was able to rely upon the “participants’ views of the situation being studied” (Crestwell, 2003, p.8) while recognizing my own background and experiences (Mackenzie & Knipe, 2006). Research within the interpretivist/constructivist paradigm is not initiated based on theory thus allowing categories and sub-categories to be inductively developed. Thereby capturing the experiences of CAF members who sought mental health care.

Study Design

This study used a fundamental qualitative descriptive approach as described by Sandelowski (2000). The goal of qualitative descriptive studies is to complete a comprehensive summary of events in everyday terms of those events (Sandelowski, 2000). When straight description of a phenomenon is desired and there is little previous

research on the phenomenon a qualitative description is the method of choice (Sandelowski, 2000; & Elo & Kyngas, 2007).

As a fellow CAF soldier and nurse with extensive combat experience I am well positioned and suited to capture the experience of my comrades. When conducting qualitative descriptive studies researchers stay close to their data and to the surface of words and events. As a CAF Nursing Officer and military spouse I have the advantage of being seen by participants as one of their own, and I am also able to speak their language. This includes the military jargon soldiers use every day, as well as the realities of combat as both a soldier in a war zone and a military spouse maintaining the home front.

Methods

Primary Research Question

What is the lived experience of CAF soldiers on their path to accessing mental health service?

Secondary Research Questions

What were the barriers they encountered and how did they perceive these barriers?

What were the facilitators they encountered and how did they perceive these facilitators?

Participants

Recruitment. Recruitment posters outlining the study and presenting the researchers contact information were placed in the CAF medical and mental health clinics. Study information packages containing a letter from the researcher that included contact details and information about the study as well as a letter from the mental health

team were also given to potential participants by the mental health team. This letter outlined that while the team considered the potential participant an eligible candidate for the study, they would not know if the person decided to participate in the study, and it would have no effect in any way the care the potential participant would receive at the clinic.

Inclusion Criteria. Prospective participants were selected using the following inclusion criteria: 1) being a current English speaking member of the CAF, 2) between the age of 18 and 60, 3) regular force non-commissioned member or officer, and 4) currently accessing mental health care. Participants who did not meet these inclusion criteria were excluded from the study. These criteria were chosen due to logistical necessity; the age range is the age of those eligible to serve in the CAF and English was chosen, because the researcher is English speaking. The criterion of having accessed mental health care was chosen, because this is important when examining facilitators to care and examining participants' pathways to care. The study included two CAF locations. Participants included non-commissioned members as well as officers in order to obtain data that provided multiple perspectives on the phenomenon of CAF members' experiences seeking mental health care services.

Sampling. CAF members were selected to participate using purposeful sampling. While it was expected, based on civilian qualitative design literature, that 8 to 10 participants would be required (Smith & Osborn, 2003; Smith, 2004; Polit & Beck, 2012; Caelli, Ray, & Mill, 2003). I obtained expanded approval for a sample size of up to 15 to account for the high tempo and transient requirements of CAF members which could disrupt a member's availability for participation in the study (National Defence and the

Canadian Armed Forces, 2013). Qualitative research sample size is based on informational needs and it is recommended that sampling continue until the point is reached where no new information is revealed (Polit & Beck, 2012). Twelve participants volunteered for the study and 12 interviews were conducted. Prior to transcription or any analysis of interview data one participant withdrew from the study. This participant was concerned that he may have been seen leaving the building where the interviews took place and was worried that his chain of command would know about his participation in the study. In qualitative content analysis an adequate amount of data is collected to ensure that data is rich and of sufficient depth (Elo & Kyngas, 2007; Hsieh & Shannon, 2005), which was the case in this study.

Data Collection and Analysis. Preliminary analysis after six participants was conducted to ensure interview questions were yielding data of sufficient depth. It was determined that interview questions were yielding rich data and additional participants were recruited and interviewed from the second CAF location.

Ethical Considerations

Ethical approval for this study was granted by the University of Ottawa and has received full endorsement and approval from the CAF Surgeon General's Health Research Board. Participants were informed that their participation was voluntary and each participant was provided with information about the study and a copy consent forms for their records.

Data Collection

Data was collected through semi-structured, face-to-face interviews using a pre-prepared interview guide (Appendix D). Participants were encouraged to talk freely and

to tell their story using their own words. Interviews were scheduled for 45 to 60 minutes, and I conducted all interviews. Interviews took place at CAF health services and support facilities. These locations were chosen to minimize anxiety and make it easier for participants as they are familiar with the locations and could schedule interviews at a convenient time. Interviews were scheduled to ensure no participant was kept waiting and that participants did not see each other arriving to or departing from the interviews and away from their health care team. While the intent was not to distress the participants in any way, it was essential to recognize speaking of and recalling mental health experiences could result in distress for participants. Therefore interviews only occurred during operating hours of the clinics to ensure that participants could access the mental health care services they may need as a result of their interview without delay. Participants were also given contact telephone numbers for the CAF 24 hour Member Assistance Program. The interviews were audio recorded for subsequent transcription and coding.

Data Analysis

Inductive qualitative content analysis was utilized to analyze interview data and is the strategy of choice in qualitative descriptive studies (Sandelowski, 2000; Hsieh & Shannon, 2005; Elo & Kyngas, 2007). The advantage of using this approach for this study is that due to the limited previous research literature on the perceived barriers and facilitators to mental health care in the CAF the researcher was able to utilize qualitative content analysis to gain insight into the phenomenon of the participants' experiences accessing mental health care in the CAF without imposing preconceived categories or perspectives. The knowledge generated from the qualitative content analysis is based on

the participants' unique perspectives and grounded in the actual data (Elo & Kyngas, 2007). Authentic citations from participants were used to ensure participants' voices were heard and to provide readers with a glimpse into the richness of the original data (Sandelowski, 1993; Elo & Kyngas, 2007).

Each interview was transcribed verbatim. Each interview was read numerous times to ensure that prior to any analysis I was completely immersed in the data. Throughout this process notes were made of first thoughts and impressions. Once it was felt that I had a true sense of all of the data, analysis began with open coding and then categories were generated from these codes. Dendrograms (treelike diagrams) were used to assist with organizing data as it evolved from codes, to sub-categories and categories. I conducted initial data analysis and then the data were subsequently reviewed by the other research team members who were able to look at the data from a non-military lens as well as ensure that codes, categories and descriptors were grounded in the data.

Rigor

Rigor is essential to maintain the value, utility and credibility of research; without it qualitative research could be compared to mere stories or works of fiction (Morse, Barret, Mayan, Olson, & Spiers, 2002). In order to ensure that rigor or trustworthiness as it is referred to by Lincon & Guba (Lincon & Guba, 1985; Morse et al., 2002) was established throughout this research the following four constructs/criteria were addressed: 1) credibility, 2) transferability, 3) dependability, and 4) conformity (Guba, 1981; Lincoln & Guba, 1985; Morse et al., 2002).

Credibility. According to Lincoln and Guba (1985) ensuring credibility is one of the most important factors in establishing trustworthiness. This criteria can be addressed

through the use of research methods that are well established both in the qualitative research field and in research inquiry in general (Shenton, 2004). The research method of qualitative description is frequently employed methodological approach in the practice disciplines when there is little previous research on the phenomenon and straight description is desired (Elo & Kyngas, 2007; Sandelowski, 2000).

Credibility is also enhanced with the development of an early familiarity with the culture of organizations participating in the research before any data collection takes place (Shenton, 2004). Despite not being currently posted to either of the two CAF bases where recruitment and participant interviews were conducted, as a CAF Nursing Officer with 15 years of service and deployment experience I was familiar with the culture of military environments. While this is a strength for achieving credibility it was also essential that I remain conscious of this connection to ensure it did not dominate my interpretation of the data (Shenton, 2004).

In order to address the requirement for triangulation two different locations for participant recruitment were used. These CAF bases were not only geographically different; one was a large Army base with a high operational tempo in a rural area, while the other was a large support/logistical base in a large urban centre. Triangulation was also achieved via data sources (Lincon & Guba, 1985). The literature review was conducted using academic and grey literature and yielded results produced by the CAF, external organizations, media and allied nations.

Tactics were employed to help ensure honesty from participants (Shenton, 2004). Participants were given the opportunity to withdraw from the study at any time without reason or consequence. Participants were informed they would remain anonymous at all

times in any study data and reports. Each participant was encouraged to speak freely. The status of the researcher was also emphasized. While it was disclosed that I am a CAF Nursing Officer it was reinforced that I was conducting interviews for my thesis research as a student in the University of Ottawa's Master of Science in Nursing program.

Throughout data collection and analysis frequent debriefing sessions occurred between myself, my thesis supervisor (JCP) and methodological advisor (PF). This communication helped to ensure that the interpretations (main and sub categories) were grounded in the data and these communications helped to develop new ideas and interpretations (Shenton, 2004). Additional insights into the analysis were obtained from the external thesis committee member (MZ). MZ is recognized as an expert in mental health research in the CAF. As a professional peer and physician, he provided fresh perspectives and valuable insights into the research (Shenton, 2004).

Transferability. It is not the goal of qualitative description to generate results that are used to generalize but rather to provide access to experiences that can inform understanding of phenomena that are not attainable by other methods. According to Bassey (1981) practitioners may relate findings to their own situation or practice if they believe their situations to be similar to those described in the study. Readers must determine how far results can be transferred to their practice setting (Shenton, 2004). According to Lincon and Guba (1985) the investigator is only responsible to provide sufficient information about the fieldwork and research subjects to allow readers to use their own judgments or make inferences about the findings. In this study as much contextual information about the fieldwork and participants as possible was provided without putting participant anonymity at risk.

Dependability. In order to address the construct of dependability the steps and processes followed to conduct the study were described in detail. Thus enabling a future researcher to repeat the study in the same way, acknowledging that with different participants there may be different results. This also allows the reader to evaluate the research process (Shenton, 2004).

Confirmability. While my role as a fellow CAF soldier and a military spouse was beneficial in establishing rapport and trust with participants, it also made it vitally important that the construct of confirmability was addressed throughout the research process. While I was aware of my own predispositions (Miles & Huberman, 1994). Maintaining detailed notes and using dendrograms during data analysis were valuable tools to ensure analysis was directly developed from interview data. Interview transcripts were reviewed by the other research team members who were able to view the data from a non-military lens and an additional military lens which ensured that codes, categories and descriptors were grounded in the data.

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Chapter 4

Accessing Mental Health Care in the Canadian Armed Forces: Soldiers' Stories

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Abstract

Background: Recent Canadian Armed Forces operations involved multiple deployments and exposure to traumatic events that are associated with post-traumatic stress disorder, depression and substance abuse. Despite efforts to facilitate mental health care, some soldiers do not get the help they need.

Objective: To understand soldiers' experiences and explore barriers and facilitators they encountered accessing mental health care.

Results: Qualitative descriptive interviews with 11 Canadian Armed Forces members revealed six major categories that provide insights into their experiences accessing mental health care. Participants' revealed significant barriers to care including fear of damaging their career or being released, stigma beliefs and actions from peers and leaders, and physical and organizational barriers to care. Social support from family, military co-workers, and unit leaders facilitated care.

Conclusions: Notwithstanding efforts to facilitate access to mental health care, some soldiers still perceive significant barriers to care.

Keywords: military culture, military identity, post traumatic stress disorder, stigma, veterans.

Accessing Mental Health Care in the Canadian Armed Forces: Soldiers' Stories

In 2014 media across Canada announced that suicide claimed the lives of more soldiers than those killed by combat in Afghanistan (Gwiazda, 2014). It is not uncommon to see such headlines in the media. Suicide is an important public health problem linked to mental health, and public interest in military suicides increases when there is a perception that the suicide was related to deployment or military duties (Government of Canada, Department of National Defence, 2010). Suicide rates in the Canadian Armed Forces (CAF) have nevertheless remained stable over the last 10 years and are not higher than the general population (Zamorski et al. 2015). This has not been the case for our American allies who have seen the U.S. Army suicide rate double in the past decade (Government of Canada, Department of National Defence, 2010). The phrase “one suicide is too many” has been used to reinforce the significance of suicide in military and civilian communities. Evidence has shown that while almost all suicide victims struggle with mental health problems, the majority are not receiving care (Mann et al. 2005). Recognizing that mental health problems are significant precursors to suicide, the CAF has acknowledged its role in suicide prevention (Government of Canada, Department of National Defence, 2010).

Recent CAF and allied operations have involved multiple deployments with high intensity, guerilla-insurgent type warfare, resulting in substantial exposure to traumatic events such as direct fire, bombings, handling human remains, killing an enemy, and seeing dead comrades and victims of war (Di Leone et al., 2013). Exposure to this type of combat is associated with a high risk of developing mental health problems, such as post-traumatic stress disorder (PTSD), depression and substance abuse (Hoge et al., 2004).

Conceptual and empirical links among deployment-related trauma, mental disorders, and suicide have been substantiated (Zamorski, et al., 2015).

CAF medical and mental health care is provided by the Canadian Forces Health Services Group (CFHSG). The responsibility of CAF healthcare does not fall under the jurisdiction of provincial or territorial health authorities as it does for other Canadians. The CFHSG provides location-dependent care through the use of primary care clinics, field ambulances, and field hospitals. Each CAF base has a primary care clinic (Government of Canada, Department of National Defence, 2014). The main providers of mental health services for serving CAF members are located within CF Health Services. The first point of contact for many CAF members who are experiencing mental health difficulties is their primary care clinician at their local base primary care clinic. Mental health care is also available through CAF mental health services, staffed by mental health nurses, psychiatrists, psychologists, social workers, and addiction counselors. CAF members may self-refer on a walk-in basis to the mental health program or be referred by a physician or others such as their supervisor. In addition to mental health services provided within the primary care clinics, operational trauma and stress support centres were established to meet the needs of CAF members returning from overseas deployments and suffering from tour-related psychological problems (Government of Canada, Department of National Defence, 2014).

Mental health disorders are medical and public health concerns for the CAF, which directly impact operational effectiveness and force sustainability (Fikretoglu et al., 2008). Despite the influence of mental health conditions on members and operational capabilities and the effectiveness of recent mental health treatments, mental disorders

remains a leading contributor to premature release from military service (Hoge et al., 2002).

The CAF has acknowledged the increased demands for care and support and has strived to improve its mental health and personnel support systems. The Road to Mental Readiness (R2MR) resilience and mental health training program is embedded throughout the career of CAF members (National Defence and the Canadian Armed Forces, 2015b). In 2014 The Surgeon General's Mental Health Strategy was released. It is grounded in having accessible, high quality, evidence-based mental health system trusted by CAF members.

The Joint Personnel Support Unit (JPSU), which encompasses the Integrated Personnel Support Centres (IPSCs), was established with the goal of providing CAF members and their families coordinated integrated care when they are ill or injured and through rehabilitation, recovery and reintegration back into military duty or civilian life (National Defence and the Canadian Armed Forces, 2015a). The Operational Stress Injuries Social Support (OSISS) program was designed to support CAF members, veterans and their families affected by an operational stress injury (National Defence and the Canadian Armed Forces, 2013). While these programs and policies have resulted in improvements in care there are still public concerns that the system remains overburdened and programs are difficult to access (Cobb, 2013), and there is a perceived lack of progress and continuity in gathering information about the mental health of current CAF members and veterans (CBC News, 2014; Collier, 2010; National Defence and the Canadian Forces, 2001).

Thus, despite high rates of mental health disorders and the purposeful reinforcement of military mental health systems over the past decade, not all soldiers readily get the help they need. Several studies observed that more than half of the soldiers with mental health problems do not seek help or avail themselves of available mental health services (Iversen et al., 2011; Fikretoglu et al, 2008). Indeed, military environments may exacerbate mental health problems by creating barriers to care, including stigma and treatment perceptions, and their consequences (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012).

Stigma is often viewed as the most formidable obstacle to the receipt of mental health care within society and the military (Hinshaw & Cicchetti, 2000; Hoge et al, 2004; Lebowitz & Ahn, 2012). The military's 'soldier on' culture, where conformity is positive and the emphasis is on group loyalty and individual heroism, militate against admitting vulnerability (Fikretoglu et al., 2008; Sudom, Zamorski, & Garber, 2012). From this perspective stigma marks a soldier as different from others in a negative way and may be a precursor to discrimination or unfair treatment (Goffman, 1963). Soldiers may internalize the attitudes of their peers and the beliefs of the culture to which they belong thus experiencing self stigma in addition to social stigma (Goffman 1963; Greene-Shortage, Britt, & Castro, 2007). Soldiers with anxiety, depression and PTSD are twice as likely to report stigmatizing beliefs compared to soldiers without mental health disorders (Fikretoglu et al., 2008; Hoge et al., 2004; Iversen et al., 2011). Studies have indeed found stigma to be a significant barrier yet strategies to overcome this obstacle have not eliminated the often substantial fraction of military personnel who fail to seek mental health care (Greene-Shortage, Britt, & Castro, 2007). Qualitative studies with British

(Murphy et al. 2014) and American (Elnitsky et al. 2013, Zinzow et al. 2013) soldiers highlighted that military culture may further impede access to care.

While findings from Canada's allies provide insight into this phenomenon, these findings may not apply to CAF personnel because mental health beliefs and perceived barriers are rooted in both the sociocultural context and the mental health system (Zamorski, 2011). In addition, most research to date has been quantitative. Unlike qualitative studies these quantitative studies are unable to capture the richness, complexity, and individuality of the experience of mental illness and the decision to seek care. While stigma was identified as a leading barrier to care in other qualitative work (Elnitsky et al. 2013; Greene-Shortage, Britt, & Castro, 2007; Murphy et al. 2014), survey data has not shown this same result and more importantly stigma does not have the expected relationship with care seeking propensity (Sudom, Zamorski, & Garber, 2012). In addition, previous research has predominately focused on barriers to care. By interviewing CAF members who have been successful in accessing care, it is possible to gain a better understanding, not only of the barriers they overcame in order to obtain care, but the facilitators that enabled them to access care more readily.

The purpose of this study was to understand the personal experiences of CAF soldiers who have accessed mental health care. Through their experiences, new insights can be gained that may inform strategies to help soldiers access mental health care. Effective interventions to facilitate use of mental health services in the CAF require a full understanding of both barriers and facilitators, which may be best explained by soldiers who have journeyed to mental health care.

Methodology and Methods

This study used a qualitative descriptive study design (Sandelowski, 2000) to capture the experiences of CAF members who sought mental health care. This study design provided a comprehensive summary of events in everyday terms that facilitated understanding of the pathway to mental health care for those who seek care. Through this approach, it may be possible to gain new insights into the attitudes and beliefs of those who do not seek mental health care (Sandelowski, 2000).

Participants and Recruitment

Eleven CAF members who accessed mental health care were recruited from two military centres using purposeful sampling, through posters placed at CAF medical and mental health services and/or the provision of invitation letters describing the study. Inclusion criteria for this study were CAF members who are English speaking, regular force non-commissioned member or officer, and currently accessing mental health care. The study was approved by the Research Ethics Board at the University of Ottawa. Participation was voluntary, and all participants provided written informed consent.

Participants included both non-commissioned members and officers, combat arms and support trades, male and female members, a wide age range, and collectively the group had between 5 -35 years of service. Members were currently posted to one of the two locations, with one being a large Army base that contributed many personnel to the mission in Afghanistan and the other a large administrative base. In practice, participants' journey to mental health care spanned several additional CAF bases. Participants self-reported diagnoses of operational stress injuries (including PTSD, anxiety and depression) and other chronic mental health disorders (including bipolar and autism spectrum disorders). The diverse group provided multiple perspectives on the

phenomenon of CAF members’ experiences seeking mental health care services. Please see table 1 for demographic details.

Table 1. Participant Demographics

Alias	Sex	Age Range	Rank	Intimate Relationship Status
Clark	M	31-45	SNCM	Married
Bruce	M	31-45	JNCM	Divorced
Selina	F	46 +	JNCM	Separated
Anthony	M	18-30	JNCM	Single
Diana	F	46+	JO	Separated
Tom	M	31-45	SNCM	Married
Donald	M	31-45	JNCM	Separated
Steve	M	31-45	SO	Married
Sam	M	46+	SNCM	Separated
Linda	F	31-45	JO	Single
Peter	M	31-45	JNCM	Married

Note. Sex: = male; F = female; Rank: JNCM = Junior Non-Commissioned Member, SNCM = Senior Non-Commissioned Member, JO = Junior Officer, SO = Senior Officer.

Data Collection

Data were collected during semi-structured face-to-face interviews that lasted between 45 and 60 minutes. Sample interview guide items included “Please tell me about your journey to getting mental health care. Tell me your story,” “Was there anyone/anything that made it easier or harder to access care?” and “What advice do you have for other soldiers who are thinking about or trying to access mental health care?”

Probes were used to clarify and obtain more details of their experiences. Interviews were conducted by the first author, a CAF Nursing Officer with deployment experience, who is also a military spouse. This proved advantageous in terms of understanding their language and experiences, including military jargon and the realities of combat as both a soldier in a war zone and a military spouse maintaining the home front. Interviews took place in a private room at CAF health services and support facilities. The interviews were audio recorded for transcription and subsequent analysis.

Data Analysis

Data were analyzed using qualitative content analysis (Elo & Kyngas, 2007; Hsieh & Shannon, 2005; Sandelowski, 2000). Inductive qualitative content analysis facilitated interpretation of the data through a systematic classification process to identify themes (or categories) and patterns (Elo & Kyngas, 2007). It is a dynamic and flexible form of analyzing text data collected through open-ended interview questions (Cavanagh, 1997; Hsieh & Shannon, 2005). By not imposing a coding schema, inductive content analysis allows for novel insights and understanding from the experiences of CAF members that are grounded in the data (Elo & Kyngas, 2007). Citations from participants were used to ensure that their voices were heard and to provide readers with a glimpse into the richness of the original data (Elo & Kyngas, 2007; Sandelowski, 1993).

Analysis began with a thorough reading of each interview transcript. Throughout this process, notes of first thoughts and impressions were made. The next step of the analysis began with open coding to generate categories. Dendrograms (treelike diagrams) were used to organize data as it evolved from codes, to sub-categories and categories. The first author conducted initial data analysis, then the other research team members

who were not military members reviewed the data to ensure that codes, categories, and descriptors were grounded in the data.

Findings

The data mapped almost completely into six categories. The six main categories are: Fear of Consequences; Denial; Crisis: Hitting rock bottom; Stigma; Unit and Chain of Command Support; Medical System; and Making it Through, Getting Better. Each of these categories includes a range of subcategories that reflect the variation within the main category. Although these categories are derived from the data and have been inductively identified from the data, an absolute delineation of the participants' experiences into discrete parts is impossible. As a result, there are overlaps between and among the main categories.

Fear of Consequences

All participants feared the consequences of seeking mental health care. Severity and type of feared consequences and losses experienced accessing mental health through CAF differed among participants, but each described a tension between fear of not seeking help and consequences to their careers and relationships as a direct result of seeking mental health care. Fears were embedded in what they had heard others experienced, how they perceived messaging received from commanding officers and others in the military, messaging within the news, and what they themselves experienced through seeking care. For some, these fears remained a deterrent to seeking mental health care and they would advise peers to carefully consider consequences before accessing mental health services in the CAF system. This fear of consequences is succinctly identified by Peter, "That's—number one I can guarantee you it runs through everyone's

minds is being kicked out. Being tossed to the side like a piece of garbage.” The following subcategories provide further insights into their fear of consequences.

Fear of damage or loss of military career. To remain in the CAF, all members must be fit to serve and meet the Universality of Service requirements that all personnel must be capable at all times of performing a broad range of general military tasks, common defence and security duties, in addition to the specific duties associated with their occupations. If a member cannot meet the requirements due to medical reasons they are placed on either a Temporary or Permanent (Medical) Category (TCAT and PCAT, respectively) that captures the restrictions in their duties due to their medical condition. If a member cannot recover during the TCAT, a PCAT is issued. If the member has restrictions that are persistently in violation of Universality of Service policy, they will eventually be medically released from the CAF (National Defence and the Canadian Forces, 2006). These policies and procedures are designed with the intent that medical restrictions or categories have an individualized approach that considers the specifics of an individual’s symptoms, functioning, and treatment requirements. While most participants agreed with the CAF’s requirement for Universality of Service in order to maintain operational readiness they felt in their personal experiences TCATs , PCATs and release policies were overly rigid.

These considerations prevented or delayed seeking mental health care for most participants. Anthony explained how his desire to remain fit for duty acted as a barrier to care because he presented himself as doing better than he felt due to his fear of being discharged:

I pretty much stopped, ah, seeing, ah, Mental Health, ... I even [told] them ... I was doing better to get better assessment outcomes to put in my file to stay in. Which wasn't necessarily true, but they put me in the position where I'm like what am I going to do with myself? I'm going to lose my job. So, my overall opinion of my experience is it's there to help you to a degree but it's—like, yeah they help you, but it doesn't really matter the outcome because you're still going to lose your job ... this isn't just me, the people that they do release with PTSD are fucking wicked soldiers and they still want to stay.

Donald described his frustration with being released from the military because of his mental health diagnosis, not his ability to do his job:

Because of my diagnosis, I'm to be ejected from the military, which is truthfully completely archaic. I'm a [trained,] fully functioning soldier. It cost millions of dollars to train me to be and do what I am ... think of the concept of just throwing a perfectly useful human being in the garbage, that's like ... you see posters of, ah, physically disabled people and ... they'll take a guy with no fucking leg over a guy who's got bipolar ... I can't fucking stand that concept. I can still take a fucking hill...[or] machine gun.

Despite doing his job in an office setting for the past three years, Peter is being released because PTSD prevents him from firing a weapon. He stated, "I'm employable, I'm not deployable, but I'm still getting booted ... I haven't had [or]... caused any issues, why can't I work, why can't I stay? Because I can't fire a weapon."

Loss of identity. For many military members their self-identity is deeply entrenched in their military identity and is inseparable from it. This is the norm for

soldiers and is often necessary for survival on the battlefield. Trading self-identity for military identity or intertwining the two in such a way that one identifies as being a soldier above all else can make seeing a life outside the military seem all but impossible, as identified by Diana:

It's been a huge issue for me to decide what I want to be when I grow up and I still don't know. It's made me very anxious that once they boot you out the door ... [you're] not ready.

It is common for military recruits to join immediately after high school, Linda described the military as the only life she has known as an adult "[After] 14 years in the military it's my whole life since I was 17 ... I'm kind of feeling like oh well now you're medically useless...[sigh] how do I explain it?" Many participants described always wanting to be a soldier and not being able to even imagine life outside the military, Anthony stated, "It took me a long time to give up the fact that I can't be a super-soldier anymore."

Loss of military family. It is not uncommon to hear military members refer to their unit as their family. Even in garrison close bonds are formed, and these become even closer on deployment. The hierarchy in a military environment is similar to what is seen in families with the patriarchal father figure, older brother, and loyalty between siblings. Many join the military at a young age, leaving biological families to join their military family. Throughout history soldiers have been referred to a band of brothers or brothers and sisters in arms. Leaving the military for some of these participants is like losing their entire family at once. Despite stating that he has accepted the fact that he is being released from the CAF it was difficult for Peter to talk about:

Ah, I think that's ... a lot of [the] issues with people seeking help because they have that need to belong, that sense...[clears throat] excuse me ... of family, right, and you don't want to give that up and it's hard. Ah, it took a while for me to accept the fact that, ah, I'm getting out. Like, you can say that you're getting out ... sorry [teary eyed]...but, you don't really get it until that paperwork comes.

Loss of family. These above concerns and fears about loss of a military career were in time counterbalanced by other concerns about loss, especially those related to loss of intimate partners and family. Therefore avoiding mental health care was no longer an option. Initially spouses' encouragement to seek help was ignored by many of these participants or minimized due to fears of identity loss, loss of military families, and fears about their careers. Almost all of the participants described that ignoring the encouragement of spouses to seek care created harmful tension within the family. Clark described how difficult things had to get at home before the fear of losing his family ultimately superseded his fear of losing his identity, peers, and career. His wife and daughter had left for the weekend and he was not sure if she would return:

My wife [and daughter] left for a weekend, umm, I was just sitting on the front porch in misery ...her and my daughter and, umm, sending me texts ... "we're okay and we love you" ... [she asked] "did you like that," and I'm like, 'no', like and I was livid, It was not an environment to raise a kid. She was at her wits' end, you know, it choked me out...If it wasn't for her I wouldn't have been getting help.

Denial

While the magnitude and duration of denial was different for each participant, it was something expressed by all. For most it started with explaining a ‘wash out’ period after deployments, during which they waited for trauma-related symptoms to disappear without care. Sadly, for most, denial continued until they reached complete crisis including (for some) attempted suicide. These soldiers talked of how they tried to give it more time, denying a need for help, because they were trying to maintain the image of a strong and capable soldier. However, in trying to protect themselves from being different, many self-medicated with alcohol or other substances to cope with their symptoms instead of seeking mental health care. The reality of denial and its role in preventing help seeking was clearly explained by Sam, who said “it’s awareness. If somebody is in denial ... I have no problem, blah, blah, blah ... as long as they have no problem they will never seek help.” Denial manifested itself in multiple ways in different participants as described in the following subcategories.

Time heals all wounds or does it? Participants recognized things were “not quite right” or having “difficulties” but they expressed feeling it was something they could or should be able to take care of on their own; they equated it to completing a military mission. Tom discussed his acknowledgement that things weren’t right but felt it was something he needed to deal with, “I guess that’s the only difficulty... is that I guess sort of the back of your head, you know, you should be able to cope with these things and, ah, overcome.”

Many of the participants used vacation time to try and provide distance from work, thinking this would make their symptoms go away. They expressed a desire to not let others know about their symptoms and did not want to be viewed as different. Bruce

shared thinking all he needed was some time away from work to fix everything, he said “I was trying to use my Christmas leave to get better and I’m just going to cartwheel into work and everything is going to be okay and nobody has to know about any of this shit.”

Even when participants started to recognize they were having “issues” they all still expressed feeling that if they gave it time it would get better. Clark described:

That was a fucking hard tour, a lot of shit [*clears throat*] went down. Umm, and, umm, when I got home I was done—pew... So, ah, same thing, you know, back to work [*sigh*], things really going sideways for me, but I just thought if I just gave it more time, more time, more time. Just, you know, yeah, it was a hard tour and you need time to just sort yourself out, but it was just—it was getting worse, it wasn’t getting better.

The ways in which participants dealt with trying to deny their symptoms varied. Many, but not all, used alcohol and other substances to cope. Steve described:

I wasn’t drinking, wasn’t beating my wife—I was doing well at work. Just maybe a bit less patient per se. Obviously for the first six months returning from tour my wife was terrified to drive with me...but, ah, yeah. Maybe that should have been the indication, but anyway regardless I was able to carry on at work fine.

The period of denial varied between participants, Clark discussed being in care after one deployment but ending care because his psychologist quit; “I thought I was good and ... and [I] went back on tour rocking the Ativan the whole way there and the whole way home, but, ah, [*smirk*] other than that, no, no issues.”

Soldier on. Numerous participants talked about their need to continue on without seeking help despite the difficulties they experienced. This is characterized in the military

phrase “soldier on,” which means to push forward and is grounded in group loyalty and individual heroism. The mission always comes first and in deployed environments the ability to ‘soldier on’ is essential for mission success and battlefield survival. Linda shared her perception of what the CAF expected of her:

I feel in the military, umm, we’re expected to be strong and we’re expected to persevere under any staffing shortage or burning building, right? Like, that’s kind of the environment [sigh] you know, umm, and then you know here I am complaining about staffing shortages ... people are dying overseas, right, so you think about this kind of stuff and you don’t access care.

Most participants reported that there was a time when they viewed their mental health struggles as a ‘failure’. Peter describes it as an obstacle to get over:

I can’t fail ... that’s drilled into you right from day one. You suck it up, buttercup. Push on, be the man, right, so to speak. There’s nothing wrong, you can deal with this, it’s just another hurdle, right, just get over it.

Participants found themselves between a rock and a hard place, they felt that once they accessed mental health care they would be given medical restrictions and no longer permitted to continue with their normal duties. Bruce described how he struggled between getting help and being an effective soldier because he did not see them as co-existing, “Well, yeah, there’s this duality of like hey I need help and hey I need to fucking go to work and put my uniform on be a soldier.”

Maladaptive behaviors. More than half of the participants used alcohol or drugs as a way to cope with their mental illness symptoms. For some it was the first time they had drunk or used drugs. Initially participants described using alcohol and drugs to help

‘numb the pain’ and denied the need for help but for several this strategy quickly turned to addiction. Clark described being sober at work, but turning to alcohol at night to deal with PTSD symptoms, he said, “I wasn’t piss-tanked during the day but when night time come around I would just get as drunk ... as fast as I could to just pass out and not have any nightmares.” Diana shared that a time came when her nighttime drinking progressed to drinking to go to work and thinking she was holding it all together despite warnings from a co-worker:

At that point in time I was working with a clerk who used to be a medic Sergeant ... and he said the liquor is going to get you by the ass [clears throat], so at that point in time I was drinking in the morning to go to work and I was drinking after work and holding it all together at work.

Anthony explained that he used marijuana to hide his symptoms and avoid care and prescription medication, he said, “I started smoking weed again, ah, to stay away from the drugs because ... I didn’t want to go to therapy. I wanted to just keep doing my job [and] be left alone.”

Crisis: Hitting rock bottom. All participants reached a crisis point before accessing mental health care. Two participants attempted to access mental health care, but were unsuccessful navigating the system and reached crisis before getting care. Others only sought care after they were in crisis. Suicide and suicidal ideation was a reality for all but one participant. Anthony shared, “Ah, there was a time when I attempted to commit suicide with not enough painkillers, I guess.”

Clark described how hard he had to fall before he sought help:

I made the decision to [*Frustrated sigh*]*—*how would you explain it—I don't want to say I made *the* decision to kill myself, but I made *a* decision to kill myself. I wasn't—it was there and, ah, phew, I think I just went out that night, but I woke up that morning and I was like, oh my God ... I could [have] killed myself ... and I came here and something has to change soon.

The crisis point for some participants was recognized as an unconscious cry for help that was heard by others. Donald explained that his supervisor asked if he was suicidal:

I was getting worse and starting to say things that ... that led people to believe that I was going to cause harm to myself ... [my supervisor] took me aside and ... just hit me with it, you know, point blank. It was like, '*listen man, is this a reality?*' [clears throat], I was like, '*yeah, well you know what, yeah.*'

Stigma

Two forms of stigma, self (not wanting to identify with stigmatized groups) and social (severe disapproval of a person based on trait considered deviant from the norm), deterred participants from seeking mental health care. Although the stigma (self and social) they experienced is similar to persons with mental health conditions in civilian society, participants talked mostly about the significant stigma within the military society in which they were embedded.

Self-stigma. Self-stigma contributed to delays in seeking mental health care because participants fought their own stereotypes of military personnel with mental health conditions, which negatively affected their identity as a soldier. Self-stigma was not of being seen as 'ill' but as weak and less of a soldier. Self-stigma is closely linked to

the category fear and their struggles to maintain their identity. However it was distinctly different because of their own negative attitudes, beliefs, and misunderstandings of mental health. “[T]hat’s the hardest thing to fucking do is ... breaking that stigma ... in your own head, let alone everybody else’s.” (Peter)

Clark described a repatriation ceremony in Kandahar for a soldier who committed suicide while on tour, highlighting his personal stigma surrounding suicide:

Well, I remember ... I was fucking livid that I was on the ramp ceremony. I [recently] put one of my boys on that plane and then here’s a person that took her own life. It just shows you people’s ignorance, right. At the time I was mad... I was, ‘How could you fucking do that?’

This experience stayed with Clark and he shared how his views have changed, he described thinking back to the suicide of his fellow soldier in Kandahar after coming close to suicide himself:

I remember thinking about that poor woman and now I just felt awful for how I reacted, right. I ... still don’t understand her completely, but I got to peek over that edge [sigh], ... I don’t want to go back there; I don’t want anybody else to go back there.

Social stigma: Military peers and chain of command. Participants reported it was the potential for and experience with stigma from their peers, chain of command and even family that was an added burden—not the stigma that they experienced from civilian society. Selina described the fear and stigma surrounding the location of mental health services. On the base there is a building where only mental health services are located, making it impossible to hide why one is there. She described the lengths that

fellow soldiers go through to ensure that when they have to go for deployment screening they are not identified as being there to seek mental health care. By wearing their deployment uniform ('tans') it is clear to everyone that they are there for deployment screening, not mental health care:

Just going in is tough ... people know you're going in for mental health and it's funny because people who are going on deployment now they'll go in their tans and you know they are there because 'oh I'm on deployment', not because they need mental health. So, yeah, just the stigma.

Bruce described the degree of stigma (dismissal and disapproval) he experienced from his peers, the same comrades he fought with and would have died for. Now he was no longer one of them:

So, even though I was out of my unit and in JPSU... I'd walk around the base and I'd see these guys that I used to be on tour with who used to be my buddies ... like I'd die for all these guys ... but now they're walking by me and they're judging me and you can see it. You walk into the room and you know some are judging you ... like well how come he got PTSD and I don't have PTSD? I was in the same situation, how come he had it and I don't. He must be a liar ... fuck him.

So that was the biggest thing that was just—contributing to the isolation.

Even after soldiers received treatment they described continuing to experience social stigma when they reintegrated into their workplace. They felt as though this would not have occurred for soldiers who had a reduction in work to accommodate continued treatment for physical injuries.

Linda expressed feeling judged not only by strangers but also her peers, “I would leave at 2:00 and [hear], ‘oh, must be nice’ ... no, ...It’s actually awful. ...because I’m still injured. So, that’s from the peers and people that don’t know you, I feel, are very quick to judge.” Despite his outstanding performance and promotions prior to his mental health diagnosis Steve believed he now had a black mark that would never go away, “... there’s definitely a stigma and from conversations I had with the regimental mentor I know darn well that it’s on my file somewhere ... it will always be a consideration in whatever they consider me for, it’s detrimental.”

Unit and Chain of Command Support

Within the military, chain of command is the hierarchical structure through which higher ranking superiors are responsible not only for the performance of their subordinates but also for their wellbeing. Unit and chain of command support was instrumental in facilitating access to mental health care for some participants. This support came from someone in their unit recognizing that they were suicidal and taking steps that helped them access care. When others within units were not supportive participants voiced a decreased inclination to seek care and described greater isolation, which resulted in further deterioration in their mental health status before seeking care.

Half of the participants described being seen as ‘no longer wanted’ or ‘no longer useful’ to their units due to their mental health symptoms. In these units the participants described being less likely to access care. Half of the participants were seen as ‘salvageable’ by their unit. Tom used the analogy of maintaining a car to illustrate his perspective of soldiers using mental health care:

If your car breaks down and it's a relatively good car but it just needs a new set of brakes, you know, you need to take the time to put the new set of brakes on because you know you're going to get an awful lot of use out of it again in the future. You're not just going to say this car is a piece of shit, but if the car needs new brakes and you don't put new brakes on and then the muffler goes and then the tires all blow out of it and the engine quits, eventually you're just going to be like I got to get a new car. You're just going to take that one to junk yard, so I think that, you know, I think that maybe the unit kind of thinks that way... I think ... I'm just going to go talk to somebody about this...get the brake pads changed and put me back on the highway and I'll be good to go for another 100,000 miles, right.

Punishment. Following orders and maintaining proper discipline are cornerstones of military life. This lifestyle is something all participants were accustomed too. However, once their mental health problems impeded their ability to uphold military decorum they expressed fear of discipline. For some the fear of being charged for maladaptive coping (use of drugs and alcohol) and going to jail kept them from seeking help. This fear was not unfounded among this group of soldiers because several of them were charged and punished and one participant received help for maladaptive behaviors and addiction only after being sent to military prison.

Bruce shared that he divulged his addiction to illicit drugs and alcohol to his chain of command with the intent of getting help. As a result of disclosing to his chain of command as opposed to his medical provider where his privacy would have been protected Bruce was sent to military prison first then to addictions rehabilitation:

I told them what kind of situation I was in, so they're better able to help; ... So they sent me to jail and that's a really bad idea to send somebody with PTSD ... there should be a better way to deal with people like that [chuckle]. That was [a] really horrible, horrible, horrible HORRIBLE experience.

Diana described feeling that she was unfairly charged, let down by her chain of command, and unable to access mental health care. Her experience was one of having to suffer in silence because of an order not to speak of anything relating to her tour and the charges against her. Without being permitted to speak of the events of her tour experiences she was unable to seek the type of care her symptoms required:

Umm, it was really stressful because I didn't have really anyone to go to. Ah, I took a charge. I wouldn't let people do ... unethical things ... Because I took a charge [clears throat] I was sent home ... I started to have a lot of irritability, I had a flashback that dropped me to the floor. I was falling apart at home...

Because I was charged I didn't get help ... it didn't happen until ... after a court martial, ah ... they waited out almost six months. The CO (Commanding Officer) gave me a gag order that if I spoke about anything on tour to anybody it would be worse ... so I had nobody.

Physical and geographic challenges. Participants described varying degrees of support from their units. Some participants raised concerns about driving long distances when they were experiencing PTSD symptoms or recovering from injuries; they felt obstructed from accessing care by the unit not authorizing help with transportation to appointments when their injury prevented them from driving themselves. For example, due to his injury Anthony's physical challenges prevented him from driving and he

missed appointments because he had to walk in winter conditions. This experience left him feeling demoralized because he asked for help and was turned down by his chain of command:

I [felt] pretty detached. A lot of my friends were still overseas ... I was in an apartment all by myself with a back brace on, not able to really do anything, with painkillers and all that stuff, and [tried] to do things on my own. Ah, so I couldn't drive or anything like that I had to walk a lot of places in the winter ... across the snow ... sports fields and all that stuff in the snow with a back brace [it] was brutal ... I asked the RSM (Regimental Sergeant Major) like, 'can the duty guy come pick me up like all my buddies are gone kind of thing.' And, he's like 'the duty van is not a taxi' that's what the fucking guy said ... So, after that I started to feel a lot of like, ah, what the fuck is going on kind of thing. Ah, they told me they were going to take care of me. I'm in this apartment by myself, like my family is not here. I was already in a pretty good depression.

Leadership. Every soldier has a leadership role and exemplary leadership is embedded in CAF culture. Leaders are expected to inspire, protect, teach and encourage. Not all participants experienced leadership in the same way. Some participants felt that leadership supported and facilitated access to care and contributed to overall unit morale. Supportive leadership was equated with a better work environment, where participants felt 'safe' and knew help was available. Some described commanding officers and other unit members who provided the same degree of support they had been trained to do while in combat, they ensured that they were protected to the best of their abilities. Donald described how his Sergeant Major took responsibility to ensure he received the care he

needed. “My Sergeant Major drove me to the hospital and hung out with me until 2:00 in the morning.”

Leadership within a unit was described as responsible for providing units with a formal peer support program. These units had dedicated peer support positions that were staffed by CAF members who had been through the mental health system themselves and were formally trained in peer support. Participants who were members of units with formal peer support programs were grateful for these programs and described “never having to feel alone” and “always knowing there was someone to talk to.” These participants directly viewed this as a result of leadership; understanding the needs of soldiers. Anthony shared his experience of positive change in his unit:

I think the CO we have right now is awesome and he understands. He’s getting people that do care and putting them in the right places. We have peer support positions, directing people to the right places or talking to people. I’m happy to see people get help because I don’t want people to get in the same situation I got in where you didn’t know what to do.

Not all participants experienced leadership in the same way. Negative variations of leadership impeded soldiers from accessing mental health care. Negative leadership made participants question the foundations of the organization to which they had dedicated their lives to and placed themselves in harm’s way to protect. Participants felt their verbal concerns about their own mental health were dismissed by leadership, which resulted in worsening symptoms. Peter described how he was not ready for a change in his role after a nine-month deployment, yet his concerns were dismissed:

I came back to Canada and it was a nine-month tour ... they sent me right away to [a training] course without any, ah, medical review or anything. Like, I hadn't even gotten back to work at that point, which kind of started the process of the medical issues, right. It was a dark time in that unit we were deployed every six months ... yet they didn't care ... I think, ah, some of the senior staff just wanted that, ah, tick in the box and that's all...even when I talked to the RSM and said 'look, I don't think I'm ready to go there, I don't think I can go there.' My entire training command they're like, no you're fine, go.

Peter's requests to postpone the course were denied and he went as ordered. He described how he felt he had done everything that was asked of him but no one noticed that he was on the verge of taking his own life:

I did everything the military had asked me. I cancelled Christmases with my family. I've cancelled vacations for courses or exercises because they said it and so that's fine. I'll do what you ask. So, yes, I had a complete mental breakdown. I could have killed myself. I mean, I was that close and nobody would have known.

Medical System

The CAF is responsible for providing medical services including mental health care to its members. Some participants received excellent care from specific providers. However, they all discussed system and clinician obstacles that affected their ability to access and utilize mental health care.

Accessibility of care, falling through the cracks. Previous categories have highlighted the obstacles soldiers overcame on their journey to access care, however this was not their only battle. Once they decided to access mental health care, all participants

felt it was not readily accessible. It was not uncommon to wait weeks or months for care.

Selina illustrated her inability to access care by saying:

They sent me over to Warrior Support [facility where mental health care is located], they said ‘you’re in the orange and you’re heading towards the red and, ah, yeah, you definitely need to see somebody ... we will be in touch.’ Ah, three months later I call Warrior Support back, [and was told] that’s not the process, go in to the CDU (Care Delivery Unit) and the CDU will call me in. Umm, three months after that I get an email from Warrior Support telling me I have to report to the CDU within 14 days to see mental health... I got back on the waiting list for Warrior Support and waited about four weeks and I just had an absolute crash at work. They took me to see whoever’s at Warrior Support, his concern that day was, was I suicidal ... probably took about another four weeks to see somebody at Warrior Support and it was on the psychosocial side, not on the mental health side ... If they offered me access to mental health when I asked it never would have gotten as bad as it did.

Peter described seeking help while at another base, but despite telling them he was depressed he was instructed to return to his unit and it took another month before he was assessed. Peter described what he perceived was a gap in care:

I was severely depressed and [it] was not a good thing for me to be driving 18 hours on my own. There should be something in place that says, hey you know what, you’re pretty friggin’ on the edge. Maybe you should stay here for a day or two so we can do assessments or something or transport you back home some other way than let you drive your own vehicle, right. Like, what would have

happened in that meantime? That two days of driving I could have killed myself... Umm, so being close to suicide was bad [sigh] and not being able to receive the help for almost two months was not a good thing.

Although participants all described significant gaps in care many realized that the burden to provide care may be contributing to their negative experiences. For example, Clark identified that there was "...not enough help. If they could get more [qualified and culturally aware] people, mental health professionals, more people that truly understand, relate to [you] as opposed to just spending a month just explaining acronyms and things like that."

All but one participant reported 'getting worse' during this waiting period. Steve was able to 'keep things together' while waiting to get in for a mental health assessment because he had access to an interim mental health professional. While he did not get a diagnosis or treatment during that time Steve shared that he was not sure what would have happened if he did not have someone 'just to talk to' while he waited to get into the mental health program:

I went to see [clinician's name], he's in the position that he sees walk-ins, helps people, you know, from doing something stupid... helps them cope with some of the stress and some of the issues. He fills in the interim between you walking in and being formally placed in the mental health program. Part way through the third month I saw one of the psychiatrists it was found that I have an OSI... I no longer went to [clinician's name] because like I said, I think he just does the stopgap measures. [He] did a very good job. He was excellent. I would say he's

exactly the right person to be where he is, doing what he's doing... it is what I needed at that point in time.

Lack of continuity. Many participants described lack of continuity of care as another medical system challenge. Lack of continuity left them frustrated and 'feeling passed around,' like 'nobody cares' and exhausted from telling their story over and over again. Diana described her challenges with continuity of care:

I was without a caregiver for nine months... in the last six months I've seen three doctors. I was told you can't pick and choose your doctors... I don't need to re-start over, to re-tell history, to start things from scratch... there's not even a choice because you waited eight months to see somebody. You don't click with that person then you just say fuck it ... [you're] back on the same track.

Policy. Participants who received mental health care expressed feeling like a 'victim' of policies that limited their ability to work if they admitted to experiencing mental health symptoms. The placement of TCAT's and PCAT's was an area of concern. While these policies contribute to these participants' fear of career loss, they also noted these policies contributed to the frustration they experienced with the medical system.

A clear example of how time stipulation policies affected medical care was described by Donald:

Now, realize that I was on temporary category from this. It took that initial six months, that's an entire category thrown right out the window because I was taking the wrong medication. Category is supposed to be spent getting better. I spent an entire category getting absolutely nothing... except to find out that I was taking the wrong medication... You've only got two of those before they put you

on a permanent one. So, the next one I spent kind of adjusting my medication which is really what you should be doing with the first one. And, then, eventually I ended up on a third category which comes time for a permanent. Which means that I'm going to get switched out [released from the military].

When a soldier is placed on medical restrictions it means that they are no longer permitted to do certain elements of their job due to their medical diagnosis. Clark discussed the need for medical restrictions (captured in a form referred colloquially to as a 'sick chit') to be individually tailored rather than giving everyone the same restrictions:

Guys all get the exact same chit...unfit [for] military operational environment, unfit [for] weapons handling, unfit [for] vehicles, and all that stuff. They need to case-by-case it... not take a guy that, you know, has problems or issues or whatever, but he's not gun-shy, you know, loves the army stuff, it's the dealing with the other shit, you know, and you take all that way from them and that's hard too. Umm, [smirk], I was actually RSOing (Range Safety Officer) an M72 range, the next day they're like, 'here's your category unfit weapons.' I'm like I just RSO'd a rocket range for you fuckers. No, I didn't turn one on myself or anybody else... Come on, you know what I mean, the chits need to be tailored to the person.

Making it Through, Getting Better

These participant's stories all differed, but they all shared a narrative of loss and suffering. They experienced loss of family, career, and financial stability and most had been close to losing their life. Despite all of this, participants shared messages of hope, determination, recovery and optimism.

Get Help. When asked what advice they would give other soldiers going through similar experiences they unanimously said ‘get help.’ While their opinions of how to access help varied, the message was clear ‘you must find help,’ there is no other way. Clark succinctly summed this up when he said:

The most important thing is just get better and if that lands you on your ass then so be it, that’s frustrating, but you’re still taken care of, but, yeah, and that is the overall thing... If you think you have a mental problem—you do. Go talk to somebody, get the help. Life will carry on. Life will get better. This too shall pass. Just stick to it, swallow your pride... [there are] services available.

What’s really important. Despite experiencing the most desperate situations each participant found something to cling to and recognized what was truly important in their life. For most it was their family, particularly their children. Peter explained the importance of seeing the big picture and realizing what is truly important. “You do have something. You have your life ... your family. You have everything you need. The military is just the military. It will go on without you. It took me two years to realize this.”

Donald shared the progress he has made and the satisfaction of being in control and having his life back. He credits this to his decision to get help because he realized he was not the person he used to be around his friends and family. “I’m a totally different person than I was... I used to completely lose my shit; instigate conflicts. I’m completely level-headed [now]; it’s a world of change.”

Lost some battles, but I won the war. Every participant described a journey and ‘battles’ they had to go through to get where they are today. The losses they experienced

along the way were great but with almost everyone having contemplated or attempted suicide at some point in time, being around to tell their story was a victory. Tom shared the struggles he experienced including a time when he was medically restricted from doing his job but he pushed through, found the help he needed, returned to work and has since been promoted:

I'd been through all this stuff, you know, I was in the fog, I came out of the fog and things advanced and things are doing great. I got promoted and I got the courses that I wanted to get my Warrants and everything is good to go...I'm telling you, for a while there I was in pretty bad shape. I was Lithium pills, I was Ativan pills, I couldn't go to the field for six months and hold a weapon. I was dealing with people at the Warrior Support Centre, they couldn't figure out what the problem was. They diagnosed me. I got the help. I told my chain of command...they said, well as long as you have it sorted out, it's not going to hold you back. You're good to go.

Many participants recalled being told they were 'broken' by leadership, peers and the medical system, at the time it was hurtful and damaging for most participants. However for some it inspired them to push forward and prove people wrong. Clark shared how he used his anger to fuel his determination. "Somebody told me... 'you're broken.' I don't [know] whether it was her demeanor or whatever. [I] was like, you know what, fuck you, I'll show you broken and I'm going to beat this ... watch me." Bruce not only wanted to show he was not 'broken' he wanted others struggling to see there doesn't have to be an unhappy ending:

All they're telling you right now by getting help is Humpty-Dumpty sat on the wall, Humpty-Dumpty had a great fall and nobody could put him back together again. That's all people know right now, but they don't tell you what fucking happened after Humpty-Dumpty fell. He, like, put himself back together and then he got himself back on the fucking wall. And, that's what I did and they don't know...people aren't telling you the fucking end of the story. You have to paint a new narrative for people to believe in.

Discussion

Our study is the first qualitative descriptive study to explore the experiences of soldiers as they accessed mental health care in the CAF. It provides insights into the barriers and facilitators they faced in their journey. The six main categories: Fear of Consequences; Denial; Crisis: Hitting rock bottom; Stigma; Unit and Chain of Command Support; Medical System; and Making it Through, Getting Better succinctly described the internal and external tensions that each of the participants faced. However, there was commonality and variation in how these categories were experienced by the participants, which speaks to the individuality of mental health seeking behaviors. The findings of this study will contribute to strategies to decrease barriers and strengthen facilitators that can be tailored to the present challenges faced by soldiers needing mental health care. Additionally, the mental health struggles of soldiers and the increase in observed rates of PTSD and other mental health disorders including anxiety and depression after challenging operations in Afghanistan is not unique to Canada (Fikretoglu et al., 2008; Sudom, Zamorski, & Garber, 2012) and remains a concern for our allies (Hoge et al.

2004; Murphy et al. 2014). Therefore our study findings may have meaning for our coalition partners as well.

Barriers

Loss of career. Participants expressed fear of losing their career as the paramount reason for not accessing care. CAF members, similar to their British and American coalition partners (Greenberg, Langston, & Gould, 2007; Hoge et al., 2002; Walker, 2010; & Burnam, 2009), were afraid of damaging or losing their careers and this fear caused them to delay seeking help. Greenberg, Langston, & Gould's (2007) study revealed that 85% of British soldiers felt that a mental health diagnosis would be detrimental to their career. This fear was present in all ranks in our study, which is similar to Cawkill's (2004) findings that even U.K. Armed Forces Commanders' were fearful that mental health issues would cause them to be looked over for promotion. When participants shared their fear of loss of career they also expanded on what this meant to them as soldiers. Similar to civilian samples, fear of loss of financial stability was a cause for distress (Hindshaw & Cicchetti, 2000) but fear of losing their identity as a soldier was more disconcerting to the participants in this study. They perceived that they would no longer be a 'soldier' and that their families would no longer be 'military families.' They perceived that their entire world was about to change. Many of today's veterans have suffered egregious injuries both visible and non-visible that affect their identity in a myriad of ways (Ray & Heaslip, 2010; Martone, 2008). Their strong military identity is what made them excellent soldiers. It is what kept them alive on the battlefield. However, now this fear of losing of their military identity may prevent them from accessing mental health care (Lande, 2007).

Denial. In our study CAF members described their reluctance or denial to seek care by expressing they must “soldier on”. While this exact phrase seems to have been unique to our Canadian participants (Fikretoglu et al., 2008; Sudom, Zamorski, & Garber, 2012), the belief that soldiers should always push through any obstacle always putting mission first was also evident in other studies. British soldiers described it as “cracking on despite a problem” (Murphy et al., 2014). Among American soldiers the ethos of pride in inner strength appeared persistent across ranks (Olden et al., 2010). Similar to the findings of Zinzow et al. (2013) and Murphy et al. (2014) all participants in this study described reaching a crisis point—suicidal ideation or attempted suicide. This crisis point became in essence their permission for not soldiering on and making it acceptable to seek care.

In some studies, this period of denial is also attributed to members failing to recognize they have a problem (Sareen et al. 2007). Fikretoglu et al. (2008) found that only a small minority of people identified an unmet need for care in the face of a mental disorder. Therefore their leading barrier to care was that most people did not recognize that they had a problem requiring professional help. This was not found in our study. During the period of denial participants did not deny that they had a problem and they acknowledged ‘things were not right’; their denial was focused on their need for mental health care. They first wanted to try to fix things themselves before seeking help. Several participants described symptoms such as flashbacks, nightmares and severe anxiety in public places as acceptable during a ‘wash out’ period after deployment but recognized they were symptoms of potential problems when they continued.

Physical barriers. All study participants reached a crisis point before accessing mental health care. While the reaching of a crisis point was not a finding unique to our study, the physical and geographical barriers participants encountered prior to and after this crisis point were novel findings for the CAF. Treatment and transportation costs are covered, time off work is guaranteed, and specialists are abundant, therefore structural barriers are presumed not to be pertinent to CAF members (Sudom, Zamorski, & Garber, 2012; Zamorski, 2011). This did not hold true for our study: Two participants reached a crisis point not because they denied needing care—it occurred after their repeated failed attempts to access the system. Even when soldiers overcame reluctance to seek help, they felt care was not readily accessible. It was common for participants to describe waiting weeks and months for mental health care appointments despite revealing to primary care clinicians that they were ‘severely depressed’ and ‘suicidal.’ Along with the long wait times geographic barriers to accessing care were identified. Studies with American veteran populations (Elnitsky et al. 2013; Burnam et al. 2009) recognized similar barriers to care acknowledging that the geographic disparity of having the greatest concentration of mental health professionals in urban areas was problematic. This was echoed in our study by soldiers posted to rural areas who had to travel long distances for their care, many times on their own. However, soldiers also offered insights into innovative strategies to improve access including telemedicine and access to trained peer support workers through Skype or video conferencing. The value of optimizing the use of technology to improve access to care is also recognized by CAF Health Services and was identified as a strategic priority in the Surgeon General’s Mental Health Strategy (2014).

However, at least in the case of some of the respondents in this study, those approaches were not used to overcome physical barriers to care.

Policy. Participants expressed extreme frustration with policies in place related to their medical restrictions, TCAT, PCAT, and medical releases, which were perceived as overly restrictive policies that drove mental health problems underground (Gould et al., 2010). While these policies and procedures are designed with the intent that medical restriction or categories have an individualized approach (National Defence and the Canadian Armed Forces, 2015c), participants shared that in their experiences these were implemented in an overly rigid way and felt that every person and every mental health diagnosis was ‘painted with the same brush.’ They expressed that policies and their timelines needed to reflect the realities of wait times, availability of care and an individual’s symptoms and diagnoses. In short, based upon their personal experiences the participants called for a tailored approach based on individual mental health needs.

Stigma. While stigma may no longer be the most prevalent barrier to mental health care in military environments, it remains a significant barrier (Adler & Castro, 2013). Stigma (both social and self) while identified as its own specific category remained intertwined within other categories of our study. Similar to the findings of Murphy et al. (2014) participants acknowledged their own self-stigmatizing beliefs and progressed through them in order to access care. A notable difference between our findings and that of Murphy et al. (2014) was that their study found that once participants addressed their own self-stigma they were able to overcome external or social stigma because their fears of rejection were not actualized. This was not the case in our study.

Social stigma continued to be experienced by all but one participant and it came from both leadership and peers.

Participants acknowledged the importance of attempts to reduce stigma through messages delivered from the highest ranking members of the CAF as well as famous celebrities. However, participants expressed that these efforts have little effect if their immediate supervisor or local chain of command verbally expressed stigmatizing beliefs. These local leaders can make it difficult to access care and can formally or informally punish soldiers because of the soldiers known mental health challenges.

Stigmatizing labels and common military language that reinforced stigma emerged throughout the interviews. Participants reported soldiers were labeled weak, crazy, or malingerers because of their need for mental health care, these labels are not unique to the military and have been documented in civilian literature on stigma (Goffman, 1963). Several participants experienced being labeled as 'broken' by health care providers. Peers and unit leadership were the support system the participants should have been able to turn to in their time of need. However, the stigmatization they experienced compounded their feelings of isolation and made it more difficult for them to access help.

Facilitators

Leadership. Participants in our study described CAF leadership and more specifically their local chain of command as both facilitators and barriers to care. Our findings that leadership can act as a facilitator to care is similar to the findings of previous studies which reported that increasing unit support not only helps decrease barriers to mental health care it can also improve the psychological health of the entire

unit. (Britt, Wright & Moore, 2012; Pietrzak et al. 2009; Wright et al. 2009). These findings reinforce the importance of ensuring all CAF leaders understand the role they play in facilitating mental health care for their soldiers as well as the psychological health and morale of their units (Adler et al. 2014).

Social Support. The finding of social support as a facilitator to care in our study was similar to that of Murphy et al. (2014) for British soldiers and by Briones et al. (1990) in civilian populations. In our study, social support included family and friends, particularly military family. Formal peer support programs that had soldiers who were not only trained in peer support but who had been through the system were highly praised by participants. This type of program was seen as successful in keeping a watchful eye out for those who may need help, providing structured guidance and advice, and provided a trusted person who could be counted on to ‘listen and not judge’ when a soldier is navigating mental health challenges.

Implications

Leadership. In a military environment leaders act as gate keepers and have the ability to facilitate (or impede) care for their subordinates. Recognizing the impact that leadership has on soldiers’ mental health and expanding beyond the recognized influence leadership has on cultural attitudes within units our American allies at the Walter Reed Army Institute of Research (WRAIR) have begun to examine the concept of domain-specific mental health leadership. Domain-specific leadership recognizes the link between specific leader behaviours and the well-being of their subordinates, which in turn leads to outcomes that are important to an organization. Based on work done with health-oriented leadership, they have expanded to include mental health-specific

leadership. Leadership skills within the mental health domain are defined as behaviors that target mental health outcomes in subordinates. This includes such examples as stress management and healthy sleep (Adler et al. 2014). Recognizing that while CAF experiences in mental health have not been identical to our allies, the CAF Expert Panel on Suicide Prevention identified the role leaders play in reducing work-related stress (Government of Canada, Department of National Defence, 2010). Domain-specific leadership, particularly health-oriented leadership and mental health-specific leadership, is an area of new research that could positively influence leadership strategies and skills used to improve mental health care of Canadian soldiers (Adler et al. 2014).

Medical System. Mental health care resources should not be limited to mental health experts (psychiatric/mental health nurses, psychiatrists, psychologists and social workers). Nurses and other primary care service providers have a key role in addressing stigma as well as in preventing and treating mental illness and injury. The involvement of primary caregivers is instrumental to the success of getting CAF members the mental health care they require. Primary care providers care for the members at CAF clinics and many are embedded within units and deploy and work side by side within the units. This privileged position puts primary care providers in the perfect place to open doors, screen for mental health issues, and put an end to stigma surrounding mental health in the CAF.

The military environment offers opportunities for nurses and all health care providers (as well as leadership) to expand their care domain outside of a typical clinic or even work setting. Military members, particularly while on training exercise or deployment, spend all of their time together, this includes eating meals together, partaking in sports and recreation together, and sharing living quarters. This experience

of living and working together gives health care providers and leaders an opportunity to know their comrades well. Such environments allow for providers and leaders to make themselves available outside of a traditional clinical or work setting providing greater opportunities to provide help and support, and gain more holistic insights into the mental health of their soldiers. This privileged opportunity reinforces the need for health care providers to maintain strong mental health clinical skills and for leaders to utilize leadership skills that focus on mental health. It is crucial for care providers and leaders to stay up to date with knowledge of services and programs available to CAF members. (Government of Canada, Department of National Defence, 2014).

Participants in our study described ‘getting lost in the cracks’ or being ‘passed around.’ These descriptions echo the importance of continuity of care for those seeking mental health care. In response to similar findings and in recognition of the crucial role that primary care holds in the care of soldiers with mental disorders, the U.S. Army has implemented a program, RESPECT-Mil (Re-Engineering Systems for the Primary Care Treatment of Depression and PTSD in the Military). This program was modeled after a civilian program that confirmed through randomized controlled trials that the use of systems-level approaches was effective in primary care settings for treating depressed patients (Engel et al. 2008). The key elements of RESPECT-Mil consist of preparing and educating providers for its implementation, universal primary care screening for PTSD and depression, follow up brief standardized primary care diagnostics for soldiers who screen positive, and, notably, the use of a nurse care facilitator to ensure continuity of care for those who need treatment, by enhancing the interface between primary care and mental health care. The nurse care facilitator role is key to the program’s success and

includes ensuring primary care follow up, monitoring of symptoms to include treatment adjustment and facilitates communication between primary care and specialty mental health services (Engel et al. 2008). These principles of increased primary care screening and follow-up align with recommendations of the CAF Expert Panel on Suicide Prevention (Government of Canada, Department of National Defence, 2010). The reported anecdotal and empirical evidence-based reported success of the RESPECT-Mil program (Engel et al. 2008) provides clear evidence of the importance of mental health delivery in primary care as well as the vital role that nurses can play in clinical assessment, patient advocacy, education, collaboration and leadership to achieve optimal care for military members requiring mental health care. Future research should focus on the possible benefits of implementing a systems-level approach, such as RESPECT-Mil into the CAF primary health care delivery model.

Soldiers' Advice

Every participant expressed that the reason that they came forward as a volunteer for this study was to help others. Most shared feeling that, for them, it was too late, but they wanted to help improve things for the future. For those who were at a point in their journey where they felt they had survived and come out better than they expected, they wanted to share their story as an inspiration to others. They were forthcoming with their personal experiences and provided suggestions they felt would help those coming behind them. With the mission intent that every soldier gets the help they need, this study's participants suggested implementing the following recommendations for reducing barriers and increasing facilitators to mental health care: 1) mandatory annual mental health screening, 2) mandatory critical incident debriefing, 3) mandatory realistic mental

health training, which provides accounts from front-line soldiers who struggled with accessing care and have been through the system, 4) expansion of formal peer support programs within units, and 5) review CAF release policies with particular attention to the reality of wait times and accessibility of care issues and imposed time restrictions.

Several of the above recommendations are in line with the strategic priorities outlined in the Surgeon General's Mental Health Strategy (2014). They include the involvement of CAF leadership and training establishments as well as CFHSG Directorate of Mental Health. These findings require further investigation and additional research using mixed-methods approaches with representative populations.

Strengths and Limitations

There are strengths and limitations to this study. The purpose of qualitative descriptive research is not to generalize but rather to provide access to experiences that can inform understanding of phenomenon that are not attainable by other methods. The use of semi-structured interviews with open-ended questions allowed participants to express their thoughts and experiences, resulting in rich data. Participants were recruited from two CAF locations and their journeys to mental health care spanned several additional CAF bases, thereby adding to the transferability of these findings to members across CAF locations. Participants were representative of both combat arms and support trades and displayed a multitude of demographic characteristics, which is a strength of the study because diverse perspectives from these categories were represented. Medical records were not accessed to confirm participants' mental health diagnoses', however, as determined through self-report, the participants had diagnoses of operational stress injuries (including PTSD, anxiety and depression) and other chronic mental health

disorders (including bipolar and autism spectrum disorders). Thus their experiences may represent those of CAF members accessing mental health care for all forms of mental health symptoms. While this study looked particularly at CAF members who had accessed mental health care while in the CAF. Participants spent a significant amount of time either avoiding or denying they needed care, or were unable to access care. When asked about their journey to mental health care, each participant gave accounts of their various life experiences both military and non-military that brought them to where they are today. Therefore it is feasible to assume our findings could transfer to CAF members who had not sought mental health care because our participants shared their experiences during both their time seeking care and the care they received after they accessed care.

Conclusion

The CAF has made strides in attempting to reduce stigma and address the mental health needs of CAF members and their families (Collier, 2010; Government of Canada, Department of National Defence, 2014). The programs in place have been developed by military and civilian mental health experts with the unique needs of CAF members and their families in mind (Government of Canada, Department of National Defence, 2014). Despite these efforts there are still some members suffering in relative silence. This qualitative study has produced some novel findings that are not currently supported by quantitative research, however the evidence from these soldiers' experiences warrant the judicious attention of CAF Health Services and CAF leadership. Many of the study findings and recommendations made by participants when asked about ways to improve access to mental health care in the CAF echoed recommendations made by the CAF Expert Panel on Suicide Prevention (Government of Canada, Department of National

Defence, 2010) or are encompassed in the strategic priorities in the Surgeon General's Mental Health Strategy (2014). Our study's findings reinforce the need for timely implementation of these programs and initiatives along with investment in the identified current facilitators to care.

There is variation in how soldier's access care and how they are affected by the programs designed to help them. Innovative delivery methods, flexibility in policy and programing for prevention and treatment of mental health conditions are essential. Engaging soldiers with the lived experience of accessing mental health services provided us with a wealth of information about their journey to care seeking. Examining their experiences with current and future mental health programs would be a positive step forward in developing and improving ways to meet their needs, thereby improving the mental health of CAF members which will enhance operational effectiveness and force sustainability.

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Chapter 5
Integrated Discussion

Thesis Summary

Introduction

The overall aim of this thesis was to gain a better understanding of the personal experiences of CAF soldiers who have accessed mental health care. A literature review was conducted (Chapter 2), followed by a qualitative descriptive study (Chapter 4). This chapter will summarize the findings, provide an integrated discussion of issues and considerations generated by the thesis, bring into focus implications for nursing practice, and highlight opportunities for future research.

Summary of Thesis Findings

Through the process of conducting the literature review and qualitative descriptive study, three considerations became apparent. First, there was a lack of published research about mental health care in the CAF. Second, while there are more studies done by coalition partners, particularly the U.K. and U.S., their findings may not be transferrable because mental health beliefs and perceived barriers are rooted in both the sociocultural context and the mental health system (Zamorski, 2011). Each country's approach to how it deploys fighting forces is different and previous findings from other countries may not directly apply to the CAF. The greatest contributions to the literature is from the U.S. The CAF and our allies provide very similar medical care and support to soldiers on deployed operations but their delivery of medical care has notable difference in the domestic environment. In the U.S. these differences include a system that treats not only military members but also includes their dependent family members (Herold, 2011) and a Veterans Affairs integrated health system (U.S. Department of Veterans Affairs, 2015). CAF dependent family member's access health care through the Canadian health care system and once a member is released from the military they also access health care

through this same system and are dependent upon the medical system in the province or territory where they live (CF Morale and Welfare Services, 2015a). Third, substantial barriers and facilitators to care were found in the qualitative descriptive study (Chapter 4). Although some of this study's findings were similar to those found in several other studies (Britt, Wright & Moore, 2012; Elnitsky et al., 2013; Hoge et al., 2004; Pietrzak et al., 2009; Richardson, Thompson, Boswell & Jetly, 2010), other findings from this study concurred with findings previously reported by a few studies (Adler et al. 2014; Burnam et al. 2009; Elnitsky et al. 2013) and this study produced unique findings.

Combat exposure is associated with a high risk of developing mental health problems, such as PTSD, depression and substance abuse, and greater than half of the soldiers with mental health problems do not access the help they need (Iversen et al., 2011; Fikretoglu et al, 2008). Mental illness is a significant public health and operational concern for the CAF. Considering the gravity of this situation and the dearth of research on accessing mental health in the CAF there is an abundance of opportunities for future research and subsequent interventions in this area. With such a wealth of valuable and noteworthy areas to pursue it is necessary to prioritize areas of focus. Based on the findings of this thesis there are implications for research, practice, policy and education for nurses and other clinicians. The following will discuss and present suggestions in each of these areas and situate these within the literature.

Implications for Nursing

Research. As researchers, nurses have the opportunity to engender and translate knowledge related to nursing that will advance the profession and influence best practices in health care (CNO, 2009). Nurses play key roles in advancing health care research both

as independent researchers and as members of collaborative research teams. This study has documented that there is a lack of research about the experiences of military personnel accessing mental health care in the CAF and provides direction for future research to addressing barriers and facilitators to mental health care in the CAF as well as guide development and/or implementation of programs to improve access to mental health care.

Sentinel events. The review of sentinel events in a trauma or medical acute care setting follow institutional and even national policies and guidelines for a timely structured review (Accreditation Canada, 2013). This type of review is more difficult in mental health care outpatient settings. The experiences of participants in our study revealed that sentinel events—attempted suicide—occurred at different times during participants’ journey to mental health care. For most it occurred prior to them accessing care. Medical Professional Technical Suicide Reviews (MPTSR) were instituted by CAF Health Services Group in April 2010 (National Defence, 2013) in an effort to understand factors contributing to suicides among CAF members. These reviews examine factors that may have contributed to a member’s suicide and makes recommendations that may reduce the risk of suicides in future cases. While MPTSR examine factors that may have contributed to a member’s suicide with the intent of improving care, sadly, it is too late for those members’ voices to be truly heard. However it is not too late for the survivors of attempted suicide to add value to these reviews. The review of mental health sentinel events in the CAF should include the perspectives of these soldiers. Nurse researchers need to explore how best to include suicide survivors voices into the MPTSR process.

Further review of reported suicide attempts would provide insight into what could

be done to prevent similar experiences for others and bring to light what barriers were paramount for CAF members during that point in their journey to mental health care. This would not only be an area for further research but also a valuable performance improvement initiative. Perhaps through the review of medical records and qualitative interviews CAF members who committed or attempted suicide could provide invaluable insights into what brought them to turn to suicide and has the potential to improve access to and delivery of mental health care in the CAF.

Contrary findings. Previous research on accessing mental health care in the CAF focused more on attitudinal barriers to care rather than physical barriers to mental health care. Canadian studies identified resources that have been put into place to improve the mental health care of CAF members, because treatment and transportation costs are covered, time of work is guaranteed, and specialists are abundant, and structural barriers are presumed not to be pertinent to CAF members (Sudom, Zamorski, & Garber, 2012; Zamorski, 2011). However this research study revealed evidence of physical and structural barriers such as long wait times for mental health care appointments, transportation issues and CAF members getting lost in the medical system or ‘falling through the cracks’.

The first point of contact for many CAF members who are experiencing mental health difficulties is their primary care clinician at their local base primary care clinic. (Government of Canada, Department of National Defence, 2014). Several participants reported that accessing mental health care through primary care was a significant challenge. They described experiencing a lack of continuity of care, long wait times, and lack of follow up from primary care clinics. Previous research did not identify any

program or systems in place to directly address this barrier and there were no accounts from participants to indicate that any type of system existed during their encounters with primary care to help them navigate access to mental health services. With this barrier resonating so strongly in the current research and the accounts that participants attempted suicide after unsuccessful efforts to access mental health care, system/structural barriers require immediate attention and further research.

The U.S. Army has recognized system/structural barriers, especially in the form of continuity of care and follow up to facilitate accessing mental health care and implemented a mental health care component within their primary care system. RESPECT-Mil addresses barriers to accessing care in the primary care environment (Engel, 2008). While such a program recognizes the significance of all health care providers in mental health care delivery it provides nursing a unique opportunity to influence change and ensure quality care. The nurse care facilitator role is key to the program's success and includes ensuring primary care follow up for mental health symptoms and conditions, monitoring of symptoms to include treatment adjustment and facilitates communication between primary care and specialty mental health services (Engel et al. 2008). However, due to system differences between the US military health care system and CAF adopting such a program will require modifications and evaluation.

Despite not being identified in previous Canadian research physical and structural barriers to care were evident in the current study's results. Participants described challenges with accessing local transportation as well as having to travel to large urban centres for specialist care. As a result of large CAF bases being located outside of urban centres it is not unrealistic to think that the mental health care delivered at these bases

could experience geographic disparity. Geographical disparity in accessing mental health care has been identified in studies of veterans in the U.S. (Burnam et al. 2009; Elnitsky et al. 2013). Living outside an urban centre impeded access to mental health care because the greatest concentrations of mental health professionals were in urban areas (Burnam et al. 2009; Elnitsky et al. 2013). The use of technology to access mental health care was a recommendation by the current study's participants and was identified as a strategic priority in the Surgeon General's Mental Health Strategy (2014). Telehealth has been successful in a variety of health care settings and has been used in many rural areas across Canada (Gagnon, Duplantie, Fortin & Landry, 2006). A range of clinicians, including nurses, can provide care via telehealth. Therefore, the use of telehealth for mental health care delivery in the CAF should be implemented and evaluated for effectiveness in an attempt to address geographical barriers to accessing mental health care in the CAF.

New findings. This study focused on both barriers and facilitators to accessing mental health care and participants were asked specifically about who or what made it easier or helped them access mental health care. This study identified that local leader's support, in particular peer support, was a facilitator to accessing mental health care in the CAF. Units that had dedicated peer support mentors were viewed as committed to facilitating access to mental health care for their members. Peer support mentors are CAF members who had been through the mental health system themselves and were formally trained to provide peer support for mental health issues. Participants who were members of units with formal peer support programs were grateful for these programs and described "never having to feel alone" and "always knowing there was someone to talk

to.” These participants directly viewed this as a result of leadership understanding the needs of soldiers. Similar to telemedicine, peer support is not a new concept in a variety of health care fields, including mental health (Mental Health Commission of Canada, 2010). However, peer support mentors embedded in the CAF is relatively new and there are currently limited numbers of formal peer support mentors in CAF units. Despite perceived success, formal evaluation of the peer support mentor program has not been conducted. A review of the peer support program needs to be conducted to determine the most salient components of the program so that expansion of the program throughout the CAF can occur as warranted. Additionally, nurses can play a key role in training, supporting, and collaborating with peer mentors to ensure their continued health and that of those they mentor. This form of collaboration has the potential to strengthen this type of program and warrants further study.

While it was not clear from this study whether intimate partners and family acted as a facilitators to accessing mental health care in the CAF, fear of loss of these relationships due to mental health symptoms, such as aggressive behavior or substance abuse, was reported. When describing the influence that friends and loved ones had on a soldier’s decision to access mental health care, it was more often described as a fear of losing these relationships that promoted participants’ decisions to seek mental health care, rather than following advice or pleas from significant persons to seek care. Therefore the presence of intimate partners or family was not found to be a facilitator to care in this study and has not been identified in previous military studies. Civilian literature however has recognized that family is a strong facilitator to mental health care (Mental Health Commission of Canada, 2013; Action on Mental Illness Quebec, 2015).

Military families are recognized as a component of CAF operational readiness and military families manage unique stresses associated with military life (CF Morale and Welfare Services, 2015b). Recognizing that as nurses we do not treat patients in isolation; the care of soldiers not only involves themselves but also must include the soldier's family (Calkin, 1984; Wands, 2011). There is a paucity of research on the experiences of soldiers' families as their loved one accesses mental health care. Knowledge generated from such research would provide additional perspectives on this phenomenon.

The findings of our allies. Both American and British studies revealed findings similar to those of our study, indicating that leadership can be both a barrier and facilitator to care (Britt, Wright & Moore, 2012; Elnitsky et al., 2013; Hoge et al., 2004; Pietrzak et al., 2009). Stigma is multidimensional. Social stigma is the disapproval of an individual or group, based on a social characteristic, by others in a society (Goffman, 1963). Self-stigma is a negative view of self due to a belief in the negative stereotypes associated with mental health (Goffman, 1963). Most previous studies emphasized the role of leaders in reducing social stigma and facilitating a cultural climate that does not perpetuate stigma for those who seek care (Zamorski, 2011). Fears of stigmatization have been identified as barriers to seeking treatment in the CAF (Richardson, Thompson, Boswell & Jetly, 2010) and attempts have been made to address this using a top down approach. The Chief of Defence Staff, Chief of Military Personnel, and the Surgeon General (Government of Canada, Department of National Defence, 2014) have all made their stance on stigma and mental health clear. This study's findings identified self-stigma and social stigma as continued barriers to accessing mental health care. In a study of British Armed Forces personnel, Murphy et al. (2014) found that once participants

addressed their own self-stigma they were able to overcome external or social stigma because their fears of rejection were not actualized. This was not the case in the current study. Despite attempts such as those mentioned above to address stigma in the CAF social stigma continued to be experienced by all but one participant and participants felt stigmatized from both leaders and peers. A novel finding of the current study was that participants reported that social stigma remained a barrier to care despite their perception that they had addressed their self-stigma. This requires further investigation to determine how unit leadership may continue to play a significant role in how and why stigma remains a barrier to care for some military personnel.

Our allies have also taken steps similar to those of the CAF to reduce the stigma associated with mental health and while stigma may no longer be the most prevalent barrier to mental health care in military environments, it remains a substantial barrier to care (Adler & Castro, 2013). Recognizing that current initiatives have not eliminated stigma as a barrier to mental health care and acknowledging that in a military environment leaders act as gate keepers and have the ability to facilitate (or impede) mental health care for their subordinates the Walter Reed Army Institute of Research (WRAIR) examined the concept of domain-specific mental health leadership. Based on work done with health-oriented leadership, they have expanded to include mental health-specific leadership. Leadership skills within the mental health domain are defined as behaviors that target mental health outcomes among subordinates, including stress management and healthy sleep (Adler et al. 2014). Thus far the WRAIR has produced positive results with using health-specific leadership (Adler et al. 2014). The findings that link leadership to improved mental health care need to be examined by CAF Health

Services Group and those responsible for CAF leadership doctrine. Programs that support mental health specific leadership behaviors need to be designed and tested to determine if they translate to the CAF context and improve access to mental health care among CAF members.

In addition to the findings that emerged from the categories in this study, participants offered recommendations to improve the current experience of soldiers accessing mental health care in the CAF. Every participant expressed that the reason they came forward as a volunteer for this study was to help others. Most shared feeling that for them it was too late but they wanted to help improve things for the future. For those who were at a point in their journey where they felt they had survived and come out better than they expected, they wanted to share their story as an inspiration to others. They were forthcoming with their personal experiences and provided suggestions they felt would help those coming behind them. “If I were going to [give] advice I’d say strap in because you’re in for a fucking ride, man, and it’s not going to happen overnight. You fucked your life up ... and need a couple of years to figure it out, but there is a light at the end of the tunnel.”

Participant recommendations. Participants with the intent that every soldier gets the help they need, suggested implementing the following recommendations for reducing barriers and increasing facilitators to mental health care, 1) mandatory annual mental health screening, 2) mandatory critical incident debriefing, 3) mandatory realistic mental health training, 4) expansion of formal peer support programs within units, and 5) review CAF release policies. Although some of these are areas require further research some could be implemented as education initiatives or policy changes.

Mandatory mental health screening. Recognizing the difficulty that they had accessing mental health care many participants suggested that annual mental health screening should be mandatory; they compared it to dental DAG (pre-deployment and annual screening), IBTS (Individual Battle Task Standards) training, the annual fitness test and other mandatory annual training every CAF member must complete. The success of mandatory mental health screening could be tracked to determine if this practice is helpful in decreasing suicide or attempted suicide by alerting nurses and other clinicians early that a soldier needs follow up or referral to mental health care.

Mandatory debriefing. It was also suggested that mandatory critical incident debriefing occur after all major incidents both in training and deployed environments. Mental health screening and critical incident debriefing in the CAF could be adapted from best practice and successful models used in law enforcement and emergency response communities (Tuckey & Scott, 2014). Nurses would have a critical role in these debriefing exercises to discuss the impact of critical incidents on physical and mental well-being.

Mandatory mental health education. It was recommended that everyone complete annual mental health training. It was specified that this education needs to be current and realistic (Zinzow et al., 2013) not just ‘sunny happy’ success stories of higher-ranking personnel. It must reflect ‘the good the bad and the ugly’ so members who are struggling can see that other soldiers have been in similar situations and went through very difficult times, but it is possible to get through it. Participants expressed that sharing candid truths and examples of how they were treated by their peers and leaders as they tried to get help may be useful. This education would not only help those struggling with

the decision to seek help, the intent would be to reach out to those who hold stigmatizing beliefs about people with mental health issues. This training may increase awareness among leaders and peers, helping them realize that their actions have a damaging effect on others, including preventing their subordinates and peers from getting help, destroying their careers and families and pushing them toward suicide. CAF Nursing Officers are uniquely positioned to provide this form of education program, which could be evaluated for effectiveness.

Peer support programs. As noted previously peer support programs require further evaluation but are valued by soldiers. The participants in this study specifically recommended that there be a review of current programs in place, identifying those that ‘work’ and expanding successful programs were perceived as an essential for improving the mental health of CAF members. Formal peer support programs that had soldiers who were not only trained in peer support, but who had been through the system were highly praised by participants. This type of program was seen as successful in keeping a watchful eye out for those who may need help, providing structured guidance and advice, and provided a trusted person who could be counted on to ‘listen and not judge’ when a soldier is navigating mental health challenges. As mentioned previously, the involvement of nurses as ‘behind the scenes’ trainers and supports for peer mentor programs should be considered and studied.

Policy review. Participants recommended that policies surrounding medical categories and release be reviewed and updated. As a result of their experience with release policies many participants expressed feeling that they were not valued by the CAF as a person and they perceived that they were treated as a ‘piece of garbage’ or

‘junk.’ Rather than appealing to the ‘human cost’ of current policies it was suggested that those who make ‘the policies’ look at things from a financial and force sustainability perspective. Participants questioned whether it was more financially advantageous or beneficial to recruiting images, to throw away trained soldiers rather than invest in soldier’s recovery. Nurses have a role in advocacy and as commissioned officers are strategically aligned to make health related policy recommendations.

Each one of these recommendations from participants warrant further examination. They provide expansive opportunities for future research, which may result in new interventions or policies to improve access to mental health care in the CAF. . In addition, future research can inform further improvements to guide nurses’ clinical practice, education, and leadership.

Nursing Clinical Practice. Prior to 2001, the average age of veterans was 60 years of age or older. The new generation of Canadian veterans returning from the mission in Afghanistan is providing new challenges to both the medical services of the Canadian Armed Forces and the Canadian Health Care System. These soldiers are returning from war and trying to reintegrate themselves back into Canadian society. Some have made the transition successfully however this is not the case for many. Our wounded warriors are facing the challenges of returning home with severe physical and mental injuries (Boulos & Zamorski, 2013). For these wounded warriors and their families the challenge may seem insurmountable. One only needs to participate in a single ramp ceremony (parade at an airfield to welcome home and honor our fallen soldiers) or witness an inconsolable child pulled from the arms of a soldier as they board a plane headed to war to understand that the military is not simply a career, it is a way of

life. This way of life has taken its toll on CAF members and their families (Fikretoglu et al, 2008; Morrison, 2014). “Due to the operational tempo of the CAF over the last 20 or so years military personnel and their families have been facing battles on the home front with conflicts being waged at work, in dark basements and at dinner tables across the country” (Morrison, 2014, p. 43).

As a nurse it is essential to assess each patient in a holistic manner. Comprehensive health care includes not only physical assessment and procedures it must also consider the untreated mental health comorbidities in all patients in both acute and primary care settings (Singer, Das-Munshi, & Brahler, 2009). Holistic assessment is unlike physical assessment. It is not possible to obtain information about the complex needs of a patient and their family in the same way you can listen for lung sounds or obtain a temperature (Wands, 2011). In order to glean this invaluable information nurses must have true presence with patients and families (Flinn, 2007).

Nurses can provide support for reintegration and transition for soldiers and their families (Wands, 2011). The ability of nurses to use knowledge and theory to inform practice enables them to address the all-encompassing experience of the soldier and the soldier’s family (Calkin, 1984). The struggles of veterans are complex and multi-dimensional. Their care not only involves themselves but also must include their family. Their care does not fit within the margins of any one healthcare discipline (Wands, 2011). This provides an excellent opportunity for RNs caring for soldiers and their families to utilize their skills of collaboration and consultation. Recognizing that over half of the soldiers who are suffering from mental health symptoms have not accessed mental health care (Fikretoglu et. al, 2008; Hoge et al., 2004) nurses can use patient encounters in acute

and primary care settings to assess for signs and symptoms of mental health disorders prevalent in this patient population such as depression, anxiety, and PTSD (Fikretoglu et al., 2008; Hoge et al., 2004). Nurses outside of the military also need to be aware of the uniqueness of military life as these nurses will encounter soldier's family members and the soldiers themselves who have been released from military service.

Nursing Education. Nurses (both inside and outside of the military) need to understand that soldiers and their families may be struggling with the loss of their military identity if they are released from the military as a result of their illness or injury (Ray & Heaslip, 2010; Martone, 2008). While also recognizing that in many cases military families are posted all over Canada and around the world, far from their immediate and extended family and as a result their social supports are closely tied to the military community. Nurses working in military environments and those working in settings with proximity to military communities can play a meaningful role in patient education for this population. By making themselves well informed on resources and services available to military members and their families nurses can better educate their patients on resources available to strengthen their social supports such as contacts with relocation services, veterans affairs, financial services, the military family resource center, and community supports outside of the military.

Leadership. Leadership is a responsibility of all nurses. Leadership roles can be both formal and informal. Regardless of position all nurses will have opportunities to incorporate leadership skills such as role modeling, advocacy, and support into their practice (CNO, 2009). It is imperative that Nursing Officers demonstrate leadership skills that promote the mental health of their subordinates, recognizing that as CAF leaders they

play an instrumental role in facilitating mental health care for their soldiers as well as the psychological health and morale of their units (Adler et al. 2014).

Conclusion

Despite being unable to identify the original source, there is a noteworthy statement that resonates about the actions of our soldiers. “A service member writes a blank cheque—payable in blood—in service to their country.” When a nation, any nation, draws on that fund of patriotism, an explicit and implicit contract is formed. The contract says: “We will not forget your sacrifice” (Daly, 2014). It is Canada’s duty to provide the support and health care and financial infrastructure to care for our CAF members and veterans. For many soldiers the battle is not over, they are fighting an invisible enemy. The sand, the insurgents, and the explosives, have been replaced with a fear of stigma, bureaucracy, loneliness, alienation, and a loss of self-identity. There is a new battlefield; it’s the hometown battlefield. It is the duty of those who care for them to help them remember who they are; they are Canadians, and they are heroes. They were willing to sacrifice everything to protect us and we must help them find their way home.

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Chapter 6

Co-Authorship Contributions

Contribution of Collaborators

Co-Authorship

Several authors contributed to the various aspects this thesis. Lisa Ann Compton RN, BN, CD (LC) conceived, participated in, and directed all aspects of this research project in partial fulfillment of the requirements for a Master's Degree in Nursing at the University of Ottawa. LC is a registered nurse and Canadian Armed Forces Nursing Officer.

Three thesis committee members, Dr. J. Craig Phillips, PhD, LLM, RN, ARNP, PMHCBNS-BC, ACRN, FAAN (JCP) (supervisor), Dr. Paula Forgeron, PhD, RN (PF), and Dr. Mark Zamorski, MD, PhD (MZ) also were involved in several stages of the thesis including guiding me in developing the thesis proposal, regular consultation throughout the research process, editing and revising the thesis for important intellectual content, and approving the final thesis (see Table 2).

JCP is associate professor of nursing at the University of Ottawa. His nursing and human rights legal training and experience guide his practices as a nurse, nurse practitioner, nurse educator, and researcher. He has more than 2 decades experience as a nurse or nurse practitioner working with persons living with HIV and/or mental illnesses in the United States and Canada. He has been a nurse educator since 1999; teaching in (brick-and-mortar and technology mediated–online) classroom and clinical environments. He co-led the development of the Scope and Standards of HIV Nursing Practice for the United States and was instrumental in the development of Best Practice Guidelines for the Care of Persons Living with HIV in Canada. His program of research is titled *the ecosocial context of health as a human right*. He has research expertise in documenting social factors influencing health outcomes among vulnerable populations, primarily

persons living with HIV, in Botswana, Canada and the United States. He has held intramural research funds from the University of British Columbia and the University of Ottawa and extramural research funds from the Canadian Institutes of Health Research (CIHR), professional organizations (American Nurses Foundation), and philanthropic foundations (Elton John AIDS Foundation) to carry out his research work to design a tailored smoking cessation intervention with HIV+ gay men and document nurses' knowledge of HIV-related criminal laws and how those laws influence nurses' clinical practices across Canada and the United States. He has been selected for induction as a Fellow of the American Academy of Nursing and will be inducted in October, 2015. He has authored more than 30 articles in peer-reviewed journals, 10 book chapters, and has presented more than 68 posters and papers at local, national, and international conferences.

PF is an assistant professor at the School of Nursing, University of Ottawa. Prior to joining the faculty she had a diverse clinical career including being a clinical nurse specialist on a pediatric complex pain team. She has been a principal investigator and co-investigator on several national and international research grants and has been an invited lecturer nationally and internationally. Her program of research has two main foci using both qualitative and quantitative methodologies. One is to examine the social functioning of adolescents with chronic pain, particularly their friendships, to better understand these relationships and define the issues, with the goal being to develop and test social strategies to improve function and friendships for adolescents with pain. The other is to examine the processes and strategies needed to improve pain care for hospitalized children and their families globally. She has received several awards including a

Canadian Institutes of Health Research Doctoral Fellowship and Canadian Pain Society Early Career Research Grant.

Mark A. Zamorski received his MD degree from Michigan State University in 1989 and completed a family practice residency at the University of Michigan in 1992. He spent 9 years as a Clinical Instructor and Clinical Assistant Professor in the Department of Family Medicine at the University of Michigan, completing a Master of Health Services Administration at its School of Public Health in 1996. He joined the Department of National Defence in 2002 and currently serves as Senior Medical Epidemiologist in its Directorate of Mental Health. His research interests include the epidemiology of trauma-related disorders in military populations, occupational mental health, and mental health services research. He has published more than 40 peer reviewed papers, 3 book chapters, and more than 100 other articles and abstracts.

Summary of collaborator contributions

Table 2

	Chapter 1 General Introduction	Chapter 2 Literature Review	Chapter 3 Methods and Methodology	Chapter 4 Qualitative Descriptive Study	Chapter 5 Integrated Discussion
Conception and Study Design	LC	LC	LC PF	LC PF MZ JCP	LC
Collect Data	LC	LC	LC	LC	LC
Analyze and Interpret Data	LC	LC	LC	LC PF MZ JCP	LC
Draft Manuscript	LC	LC	LC	LC	LC
Edit and Revise for Important Intellectual Content	LC PF MZ JCP	LC PF MZ JCP	LC PF MZ JCP	LC PF MZ JCP	LC PF MZ JCP
Approve Final Version to be Published	LC PF MZ JCP	LC PF MZ JCP	LC PF MZ JCP	LC PF MZ JCP	LC PF MZ JCP
Responsible for Overall Content	LC	LC	LC	LC	LC

Appendices

Appendix A Recruitment Poster



Who:

Canadian Armed Forces Regular Force English speaking members between the age of 18 and 60, whom are currently participating in mental health services.

What:

A study is being conducted to better understand the pathway to mental health care for CAF members. The goal of the study is to gain information that can be used to improve access to mental health care in the CAF. You can help by sharing your story.

Your participation will consist of an interview that will take approximately 45 – 60 minutes. During the interview you will be asked about your thoughts and experiences concerning barriers and facilitators to mental health care in the CAF and your personal experience accessing mental health care in the CAF.

When & Where:

Interviews will be conducted at CAF mental health services clinic based on a time convenient to volunteer participants.

Why:

Lisa Compton, a Nursing Officer and a University of Ottawa student in the Master of Nursing program is researching Facilitators and Barriers to Mental Health Care in the Canadian Armed Forces.

This research will gather information that could be used to improve the mental health care of CAF members.

How:

Selection of participants will be on a first-come, first-served basis. If you are interested in volunteering for this study please contact:

Lisa Compton, RN BN. [REDACTED]

Appendix B

Information/Recruitment Letter to Possible Volunteers

Good Day,

My name is Lisa Compton, I am a Nursing Officer and a student in the University of Ottawa, Master of Science in Nursing Program. I am conducting a research project about accessing mental health care in the CAF. The title of this research project is, *Perceived facilitators and barriers to mental health care in the Canadian Armed Forces*.

This research project is part of my final research paper (Thesis).

I am looking for Canadian Armed Forces Regular Force English speaking members between the age of 18 and 60, whom are currently participating in mental health services to volunteer to share their experiences with me.

I know that connecting to mental health services is not easy for many people and I want to look at how you accessed care and what that journey was like for you. By looking at things that made it easier or difficult for people that have accessed services it can help gain a better understanding what needs to be done to improve access to care for all CAF members.

Your information is completely confidential. This study has received full endorsement and approval from the Canadian Forces Surgeon General Health Research Board and has received ethics approval from the University of Ottawa Research Ethics Board.

If you choose to take part you will be asked to meet with me for a face-to-face interview that will last 45- 60 minutes. Interviews will be conducted at CAF mental health services clinic at a time that is convenient for volunteer participants.

If you were given an information package about this study from your CAF mental health care clinic they **will not** know if you choose to take part or do not take part in this study. The CAF mental health care clinic or the CAF chain of command **will not** have any knowledge of your participation and they **will not** receive any information about the study participants or information from the interviews. This study is separate from any care you receive at the mental health clinic and **will not** have any impact on the care and services you receive.

During the interview you will be asked about your thoughts and experiences concerning barriers and facilitators to mental health care in the CAF and your personal experience accessing mental health care in the CAF.

Selection of participants will be on a first-come, first-served basis.

If you would like to volunteer for this study or have any questions please contact:

Lisa Compton
[REDACTED]
[REDACTED]

Appendix C
Letter to Possible Volunteers from CAF Health Services Clinic Chain of Command

Letter to Possible Volunteers from
CF Mental Health Care Clinic Senior Representative of Chain of Command

Good Day,

You have been given this information package about the research study, *Perceived facilitators and barriers to mental health care in the Canadian Armed Forces*, because this study is taking place at our clinic and you may be interested in volunteering for the study. This project is being conducted by Lisa Compton, a Nursing Officer whom is a student in the University of Ottawa, Master of Science in Nursing Program. This study is a part of her schooling and is being conducted independently from the CAF.

This study has received full endorsement and approval from the Canadian Forces Surgeon General Health Research Board and has received ethics approval from the University of Ottawa Research Ethics Board. The clinic is providing the researcher with administrative support in the form of distributing volunteer information packages, displaying volunteer recruitment posters and providing office space for interviews.

All scheduling for interviews and any questions related to the research project will be through the researcher, Lisa Compton.

While we are aware of this research project and are agreeable to giving out information packages it is important for you to understand that the (Name of Clinic) staff or any members of the CAF chain of command **will not** have any knowledge of your participation. We **will not** know if you choose or do not choose to participate in the study, or if you chose to participate and then change you mind. We **will not** receive any information about the study participants or information from the interviews. This study is separate from any care you receive at the mental health clinic and **will not** have any impact on the care and services you receive.

The letter from the researcher Lisa Compton is included in the information package and it will give you further information about the study. Please contact the researcher Lisa Compton [REDACTED]; [REDACTED] if you are interested in volunteering or with any questions you may have about the study.

Thank You,

Senior Representative of Chain of Command (or designate)
Name of CF Mental Heath Clinic
Contact Information

Appendix D

Interview Questions and Discussion Guide

Interview Questions and Discussion Guide

The interview will commence with grand tour questions. These broad questions will be related to the research question (Polit & Beck, 2012).

Examples:

Please tell me about your journey to getting mental health care. Tell me your story.

Please tell me about what you think facilitated or helped you get mental health care.

Please tell me about what you think prevented or made it more difficult for you to get mental health care.

Please tell me about how and when you knew that you needed to get help and access mental health care. Was it something very specific or a bunch of things?

Was there anything that caused you to feel worried or afraid of seeking help?

Please tell me about anything that made it difficult for you to access mental health care.

Were there someone or a group of people who made it easier or harder for you to access mental care?

Were there something or several things that made it easier or harder for you to access mental health care?

Did you notice things with your physical health?

Once the grand tour questions are complete or if the participant did not elaborate other probing questions can be asked.

Examples:

Did you know that according to the literature and research that not even half of the members that need help get help?

Why do you think soldiers do not get mental health care help even if they know they have a problem?

What do you think would make it easier for soldiers to get mental health care help?

What things need to change in the CAF to ensure soldiers get the help they need?

What do you see as problems with the CAF mental health care system?

What advice do you have for other soldiers who are thinking about or trying to access mental health care? What would you tell a buddy who comes to you and tells you they think they need help...

If you could go back in time are there things you wish you could tell yourself / advice you would give yourself?

Anything else you would like to share...

!

Appendix E
Demographic Collection Form

Demographic Information

Interview # _____

First Name _____

Last Name Initial _____

Age:
(Please Circle)

18-25 26-30 31-45 46-50 51-55 56-60

Years of Service:
(Please Circle)

0-5 6-10 11-15 16-20 21-25 26-30 30+

Rank Classification:
(Please Circle)

Junior Non-Commissioned Member

Senior Non-Commissioned Member

Junior Officer

Senior Officer

Relationship Status: _____

Operational Stress Injury (OSI) Status: _____

Appendix F Information and Consent Form

!

Information and Consent Form

Title of the Study: Perceived facilitators and barriers to mental health care in the Canadian Armed Forces.

Name of researcher: Lisa Compton, RN, BN, University of Ottawa, Master of Science in Nursing Student. Telephone: [REDACTED]. Email: [REDACTED]

Supervisor: J. Craig Phillips, PhD, LLM, RN, ARNP, PMHCNS-BC, ACRN. Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa. Telephone: [REDACTED]. Email: [REDACTED]

Invitation to Participate: You are invited to take part if you want in the above mentioned research study conducted by the research student Lisa Compton and her research supervisor J. Craig Phillips. You are being asked to take part because you are a member of the Canadian Armed Forces (CAF) and you are currently seeking and undergoing mental health care. This study has received full endorsement and approval from the Canadian Forces (CF) Surgeon General Health Research Board.

Purpose of the Study: The purpose of this research study is to understand the experiences of soldiers who seek care for mental health. Hearing more about your experiences will help us understand more about what things help a soldier to seek care and what things are barriers to soldiers seeking care. This study will include 8 to 15 participants. The goal of the study is to gain information that can be used to improve access to mental health care in the CAF. You can help us by sharing your story.

Participation: If you choose to take part you will be asked to meet with Lisa Compton for a face-to-face interview that will last 45- 60 minutes. This interview will be audio-tape recorded and transcribed so that an in-depth analysis of your experiences can be done by Lisa Compton and her research supervisor Dr. Craig Phillips. During the interview you will be asked about your thoughts and experiences concerning barriers and facilitators to mental health care in the CAF and your personal experience accessing mental health care in the CAF. Your interview will be conducted at the CAF health services clinic at a time that is most convenient to you.

Risks: As part of your participation, you will be asked to voluntarily share personal information and recall your experiences with the CAF mental health care system. This may cause you to feel uncomfortable. You have been assured by the researcher, Lisa Compton, that every effort will be made to minimize these risks. You will be offered a debriefing session after the interview session to allow for any questions or to express any concerns you may have. Your interview will take place during operating hours of the local CAF medical and mental health clinic so you may access their services if you need to do so. As a CAF member you and



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your family can access the **CAF Member Assistance Program**, 24 hours a day, 365 days a year at **1-800-268-7708**.

During silent hours, the Duty officer is available for emergent administrative & medical assistance only (ie. death of a family member, hospitalization, crisis intervention).

CF Health Services Centre Ottawa Duty Officer can be reached at 613-355-3498.

CFB Petawawa Garrison Duty Centre (24-hour) at (613) 687-5511 ext. 5611

For Medical Emergencies call 911

Benefits: If you take part in this study you will not benefit directly. However, the information you share could assist in developing programs and policies that would improve the mental health care of CAF members.

Confidentiality and anonymity: The researcher, Lisa Compton, will keep the information you share strictly confidential. She will not share your individual information with anyone outside of the research team. All members of the research team are bound by the policies of the University of Ottawa to keep study participant information confidential. Even when the research team sees information from your interview your name will be removed. The information will be used only to provide an improved understanding of the perceived barriers and facilitators to mental health care by CAF members, with the aim of improving the mental health of soldiers.

The information you provide will be used in scholarly publications (health science journals) or health science presentations. In addition the information will also be used in the final paper (Thesis) of the researcher, Lisa Compton, as a part of her studies at the University of Ottawa. Your confidentiality will be protected in the following ways; all information collected will be coded with no identifying personal information (for example, your name will be removed). Audio-recordings will be transcribed verbatim (word-by-word) and the researcher Lisa Compton will listen to the recordings while reading the transcripts to ensure transcript accuracy. After data analysis is complete, all audio-recordings will be destroyed. Any direct quotes used will not contain any identifying information. Your identity and that of other participants will not be revealed in any publications, presentations or reports.

Your responses to the questions asked in each interview will be kept confidential and will not be shared with your unit leaders/supervisors or health care providers. Your decision to take part or not to take part will have no impact on your career or health care services. Although your base commander or commanding officer and health care providers may be aware that this study is taking place, he or she will not be given a list of names of people who take part or who do not take part.

If you were given an information package about this study from your CAF mental health care clinic they will not know if you take part or do not take part in this study.

Conservation of data: Throughout the study your data (audio recordings and transcripts of your interview) will be kept secure. Electronic files will be saved as password protected encrypted files on a password-protected

server. At the end of the study the original materials, with personal identifying information removed, will be kept in a securely locked file cabinet located within the University of Ottawa, School of Nursing in the locked office of the research supervisor, Dr. J. Craig Phillips, for 5 years and then destroyed by the researcher in accordance with University of Ottawa guidelines.

Voluntary Participation: You do not have to take part in this study. No one will be informed that you decided not to take part. Your decision to take part or not to take part will have no impact on your career or health care services. Even if you decide to take part, you can withdraw from the study at any time. If you choose to withdraw, your data will be destroyed, unless you grant permission for its use. If you take part you can refuse to answer any questions without suffering any negative consequences. If you choose to withdraw you must notify the researcher, Lisa Compton verbally or in writing.

Consent: I, _____ agree to participate in the above research study conducted by Lisa Compton, of the University of Ottawa, Master of Nursing program, under the supervision of Dr. J. Craig Phillips.

My signature on this consent form means the following:

- The study has been fully explained to me, I have been given the chance to discuss it and ask questions. All of my questions have been answered to my satisfaction,
- I have read each page of this consent form,
- I am aware of what is required of me as a participant in the study,
- I am aware of the risks to me of participating in the study,
- I allow access to any information shared during the interview and study data as explained in this consent form, and
- I allow destruction of all audio recordings upon completion of data analysis.
- I understand that by signing this consent form I have not waived any legal rights I may have as a result of any harm to me occasioned by my participation in this research project beyond the risks I have assumed.
- I voluntarily consent to take part in this study.

If I have any questions about the study, I may contact the researcher or her supervisor at the phone numbers or email addresses provided above.

1. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5 telephone: (613) 562-5387 or email: ethics@uottawa.ca.
2. There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

**Appendix G
Ethics Approval Notice**

File Number: H02-15-10

Date (mm/dd/yyyy): 03/23/2015



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

**Ethics Approval Notice
Health Sciences and Science REB**

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Craig	Phillips	Health Sciences / Nursing	Supervisor
Lisa Ann	Compton	Health Sciences / Nursing	Student Researcher

File Number: H02-15-10

Type of Project: Master's Thesis

Title: Facilitators and Barriers to Mental Health Care in the Canadian Armed Forces

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
03/23/2015	03/22/2016	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

File Number: H02-15-10

Date (mm/dd/yyyy): 03/23/2015



Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Kim Thompson
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB

Appendix H Surgeon General's Health Research Board Endorsement Letter

Surgeon General's Health Research Board Endorsement Letter



Défense nationale National Defence

Canadian Forces Health Services Group Headquarters
1745 Alta Vista Drive
Ottawa, ON
K1A 0K6

1000-3 (Science & Technology Manager)

27 January 2015

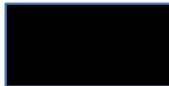
Major Lisa Compton
University of Ottawa
75 Laurier Ave E
Ottawa, Ontario K1N 6N5

Dear Major Compton,

On behalf of the Surgeon General, I am pleased to inform you that your research proposal entitled, "*Perceived Facilitators and Barriers to Accessing Mental Health Care in The Canadian Armed Forces*" has been endorsed by the Surgeon General's Health Research Board. I understand you will be submitting your proposal to the University of Ottawa research ethics board. Please ensure to provide evidence of ethics approval to Captain MacEachern once received.

This is a challenging topic, and the information gleaned from your study could usefully inform our training and policies. I wish you the best of luck with your research and look forward to seeing the results.

Sincerely,



R.M. Poisson
Lieutenant Colonel
Science & Technology Manager

Canada

Appendix I Journal of the American Psychiatric Nurses Association: Authors' Guidelines

Retrieved August 22, 2015, from <https://us.sagepub.com/en-us/nam/journal-of-the-american-psychiatric-nurses-association/journal201684#submission-guidelines>



Journal of the American Psychiatric Nurses Association

2014 Impact Factor: 0.977
 2014 Ranking: 111/140 in Psychiatry (SCI) | 99/133 in Psychiatry (SSCI) | 56/110 in Nursing (SCI) | 53/108 in Nursing (SSCI)
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[Official Journal of the American Psychiatric Nurses Association](#)



Editor [Karen F. Stein, Ph.D., RN, FAAN](#) University of Rochester School of Nursing, USA

eISSN: 15325725 | ISSN: 10783903 | Current volume: 21 | Current issue: 4 | Frequency: Bi-monthly

Print flyer Recommend to Library

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