

A Duty To Serve, A Duty To Provide: A Comparative Analysis Of Mental Health
Delivery In The Armed Forces Of Canada, U.K And U.S.

by

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DEDICATION

To my father, who showed me the true meaning of bravery.

“I learned that courage was not the absence of fear, but the triumph over it. The brave man is not he who does not feel afraid, but he who conquers that fear.”

- Nelson Mandela

To my mother, who taught me how to find strength in the darkest of times.

“Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen.”

- Winston Churchill

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ABSTRACT

The issue of mental trauma suffered during combat is one that has plagued militaries for as long as wars have been waged. Caring for those who have served their nations should be a top priority for the health sector of any standing army. However, the issues plaguing service personnel, specifically those within armed forces, are a difficult problem for policymakers and military superiors alike. The objective of this study is to analyze mental healthcare administrations in Canada, the U.S. and U.K. within the context of three independent variables: training initiatives, discharge policies and compensation and the role of veterans' organizations in care delivery and advocacy. Through the lens of institutional theory, this thesis will argue that some countries employ more effective tactics than others at mitigating their mental health burden. It will demonstrate that the degree to which institutions are centralized is directly related to the effectiveness with which mental health is addressed. Mental health administration in armed forces is a topic rarely, if at all, analyzed in political science and policy literature. Policymakers have a multitude of medical studies at their disposal, but few studies that suggest manners in which governance and administration can be altered to improve services. This thesis will fill that gap and provide a foundation for future research in the politics of mental healthcare in armed forces.

LIST OF ABBREVIATIONS USED

AFCS	Armed Forces Compensation Scheme
AMA	American Medical Association
BMQ	Basic Military Qualification
CAR	Canadian Airborne Regiment
CAF	Canadian Armed Forces
CFHSG	Canadian Forces Health Services Group
CIMVHR	Canadian Institute for Military and Veteran Health Research
CIR	Centre for Investigative Reporting
CISD	Critical Incident Stress Debriefing
CSF	Comprehensive Soldier Fitness
DND	Department of National Defence
DRC	Defence Recovery Capability
DRDC	Defence Research Development Canada
DVA	Department of Veterans Affairs
GAT	Global Assessment Tool
GIP	Guaranteed Income Payment
HM Forces	Her Majesty's Forces
HMS	Her Majesty's Ship
IED	Improvised Explosive Device
IRP	Individual Recovery Plan
MoD	Ministry of Defence
MRT	Master Resilience Training
NGO	Non-Governmental Organization
NHS	National Health Service

NPR	National Public Radio
NVC	New Veterans Charter
OTH	Other Than Honorable
POSM	Post-Operational Stress Management
PRCs	Personnel Recovery Centres
PRO	Personnel Recovery Officer
PRP	Personnel Recovery Plan
PRU	Personnel Recovery Unit
PTSD	Post Traumatic Stress Disorder
QR&O	Queen's Regulations and Orders
R2C	Ready and Resilient Campaign
R2MR	Road to Mental Readiness
RF	Regular Forces
RMC	Royal Military College
SCONDVA	Standing Committee on National Defence and Veterans Affairs
TBI	Traumatic Brain Injury
TRiM	Trauma Risk Management
UNOSOM	United Nations Operation in Somalia
U.K.	United Kingdom
U.S.	United States
USC	United States Code
VA	United States Department of Veterans Affairs
VAC	Veterans Affairs Canada
VCP	Veterans Choice Program
VTN	Veterans Transition Network

WIS	Wounded, Injured and Sick
WRAIR	Walter Reed Army Institute of Research
WRT	Warrior Resilience and Thriving
WWC	Wounded Warriors Canada
WWP	Wounded Warrior Project

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CHAPTER 1: INTRODUCTION

“The soldier above all other people prays for peace, for they must suffer and bear the deepest wounds and scars of war.”

- General Douglas MacArthur.

The issue of mental trauma suffered during combat is one that has plagued militaries for as long as wars have been waged. Serving those who have served their nations should be a top priority for the health sector of any military force. However, the issues plaguing service personnel, specifically those within armed forces, are a difficult problem for policymakers. It is therefore important to develop greater understandings of the politics and decision making that comes with mental healthcare in armed forces. The importance of embarking on this study is to close the gap between mental health and policy and understand how governance can be altered to improve administration of mental healthcare amongst the armed forces personnel of Canada, the United Kingdom (U.K.) and the United States (U.S.). The issue of mental health administration in armed forces is a topic not extensively analyzed in political science and policy literature. While the medical fields of psychology and sociology have covered issues like Post Traumatic Stress Disorder (PTSD) in depth, the field of political science has failed to do so.¹ Policymakers have a multitude of scientific studies at their disposal, but few studies that suggest manners in which governance and administration can be altered in order to improve services. The purpose of this thesis is to fill that gap and provide a foundation for policy development in the politics of mental healthcare.

¹ See Appendix B for definitions of PTSD.

The organization of the chapters is significant, as it resembles the stages of the life of military personnel. It commences with their training upon joining the forces and throughout their career; it is followed by the healthcare services available while they serve and upon their preparation for transition; following this, discharge policies and compensation detail the struggles facing personnel upon leaving; and finally, concludes with advocacy work, primarily undertaken by former service personnel or those with an understanding of their duties.

The primary focus of the analysis that follows is to understand the degree to which centralization plays in the delivery of mental health care in armed forces.

Across each of the jurisdictions under analysis in this study, there have been similar social forces that have influenced the shift in response to the mental health burden faced as a result of engagement in the Middle East. Primarily, an improved general social attitude towards mental health permeated the military and affected the discourse surrounding PTSD amongst personnel. For a war borne in the age of social media, there was little shielding those in civil society from the horrors of war – images of Humvees blown out by an Improvised Explosive Device (IED) and wounded soldiers being rushed to safety permeated television sets and webpages. The reality was that this exposure had both negative and positive impacts on the mental health of personnel.

It quickly became evident to those in civil society that while they may not have a personal experience with the situations personnel encounter, they had seen glimpses of the horrors of a combat zone and could understand the need for improved services to deal with the traumatic experiences faced by personnel. However, it also opened up the

military to increased scrutiny and criticism of the manner in which they conducted themselves. As Langston et al. argue, the “level of stress felt by personnel is reflected by the nation’s attitudes towards the military.”² For the armed forces under analysis, both the positive and negative reactions arguably influenced the increased focus on the mental health of personnel, particularly the emphasis on transitioning effectively into a civilian society that may have greeted them with hostility or open arms.

This transparency into the experiences of personnel was something relatively new in the age of social media. While other wars had been covered by journalists and retellings from veterans, this was one of the first conflicts in which images from the war zone were broadcast almost instantaneously to personal devices. As a result, the conversation shifted and a face was given to the conflict itself. For many, this face was of the soldier who would undoubtedly suffer some trauma as a result of the things that they had witnessed. These social changes strongly impacted the manner in which armed forces shifted their emphasis on mental health care and increased interaction with civil society on the matter.

Despite their participation in conflicts in the Middle East as allies and their exposure to similar social forces, there are interesting differences between the three jurisdictions and their armed forces. As a result each jurisdiction and its armed forces have fared differently in regards to the effectiveness with which it addressed mental health amongst personnel.

The U.S. played a much larger role and subsequently a longer commitment in the

² Langston, Victoria, Matthew Gould, and Neil Greenberg. "Culture: what is its effect on stress in the military?." *Military medicine* 172, no. 9 (2007): 931-935.

Middle East during these years, a factor which undoubtedly exacerbated the burden they faced regarding support for personnel. Enlistment in the Army following the attacks on September 11, 2001 was noticeably greater. As Major Mary Martin argues,

[j]ust after 9/11, most societies were in total support of the military with the majority supporting the actions taken by the President to reign down on terrorism. In fact, recruiting stations in most regions had people volunteering to join the military without being convinced it is the best thing to do so.³

However, the protracted conflict in Iraq resulted in hundreds of thousands of soldiers being deployed multiple times. Many of these soldiers, some who eagerly enlisted in the wake of the attacks on 9/11, left the Army in droves as the conflict died down. Nearly 886,161 veterans of the Iraq and Afghanistan conflicts have been treated by the Veterans Administration for medical conditions, a percentage much higher than in previous wars.⁴ This number will only grow in the years to come, given that many symptoms related to mental illness, and PTSD in particular, can take several years to present themselves.

The U.S. has the largest standing armed forces in comparison to the other jurisdictions under analysis, predictably resulting in the largest mental health burden. This is a factor that must be taken in to consideration throughout the analysis that follows.

Comparatively, Canada and the U.K. did not face the same rush to enlist following the attacks on September 11th and while they deployed significant numbers of troops, they were far less than the commitment made by the U.S. Army. As a result, the number of

³ <http://www.dtic.mil/dtic/tr/fulltext/u2/a489466.pdf> p13

⁴ <https://www.hks.harvard.edu/news-events/news/articles/bilmes-iraq-afghan-war-cost-wp>

individuals seeking assistance for a conflict-related injury was smaller and the burden on the system significantly less than their American counterparts.

Based on the aforementioned similarities and differences amongst the jurisdictions under analysis, it is possible to determine the degree to which centralization plays a role in the effectiveness with which mental healthcare is delivered in each jurisdiction. The results of the analysis that will follow in the forthcoming chapters will demonstrate that Britain has done the best in addressing mental health and wellbeing amongst their personnel, directly associated to the centralized nature of their armed forces and healthcare system. This determination is made on the basis of the implementation of their training programs, their commitment to personnel enshrined in legal precedent and the role external agencies and charities play in the management and provision of care. While there are flaws and controversies in every jurisdiction, the British and their armed forces possess a degree of experience that the other jurisdictions lack. Since the Second World War, attention in Britain has been given to those adversely affected by trauma as a result of conflict. This was particularly due to the bombing of major cities throughout the country, which resulted in civilians themselves being affected by mental trauma. While Canada and the U.S. participated actively in the Second World War, they were not prone to large-scale and prolonged assaults at home. The U.K. was subjected to bombing raids that resulted in the deaths of thousands of civilians and the destruction of entire livelihoods. As a result, the wars in the Middle East were not the first opportunity for the U.K. to learn how to address mental health trauma related to conflict.

Conversely, this thesis holds that Canada floats somewhere between the U.K. and the U.S. in regards to the degree to which it successfully addresses mental health amongst

personnel. In cases such as training, Canada has fared comparatively to the British in terms of the development of training programs and building on past experiences to improve initiatives. However, Canada has faced significant struggles in regards to the compensation for injured personnel. As a result, this study has found that Britain has managed to edge Canada out as the best in class example as the nation whose armed forces and associated agencies has most effectively addressed its mental health burden in the wake of engagements in the Middle East.

The analysis that follows will show that both the armed forces of Canada and the U.K. were largely more successful than their American counterparts, particularly due to the centralized nature of their military structure. Comparatively, the U.S. Army operates as its own entity within the umbrella of the United States Armed Forces. While this is necessary due to the size of the force, it undoubtedly played a role in consistency of treatment of mental health concerns. Comparatively, procedures relating to training, compensation and health are centralized within the Canadian and British forces. This analysis will also show that while Canada and the U.K. had a largely cooperative relationship with agencies responsible for the care of personnel, the U.K. managed to slightly outperform Canada. As Chapter 5 will demonstrate, the U.K. made significant efforts to build relationships with external agencies and charities responsible for providing care, so as to alleviate the burden and ensure that personnel were receiving more effective treatment. While a similar effort on cooperation was made with the Canadian Armed Forces, the U.S. lagged far behind in this regard and, despite some efforts, fell short in working with agencies, both external and internal, that are responsible for the management and delivery of care.

External variables are perhaps the most significant examples of why the U.K. Armed Forces have proven themselves to be the best in class example in comparison to their allies in Canada and the U.S. In the U.K., legal precedent has been established the responsibility for the Ministry of Defence to care for wounded and sick service personnel. The legal case, which will be discussed at length in Chapter 3, mandated that there was a requirement that the burden of care in combat must not rest on one's peers, a decision which ultimately resulted in a successful training program to address mental health amongst those serving in combat. Additionally, the British government has enshrined in law the Military Covenant and its principles, resulting in the lessening of the civil-military gap and subsequently ensuring adequate services are rendered to those in the armed forces. Comparatively, Canada and the U.S. lack a similar major legal precedent that set the groundwork for successful training initiatives or services. Neither has enshrined a duty to care for personnel within law and as a result, have lagged behind their British counterparts in doing so.

The role of charities and organizations that are not directly affiliated with the armed forces was a significant variable in determining the provision of care, particularly in the degree of cooperation between the groups and the armed forces themselves. In Britain, external forces such as charities play a significant role in easing the transition out of military life for injured personnel while also providing services to assist with the volume of personnel requiring care. There is a strong, cooperative relationship between the official branches and agencies of the armed forces and these charitable organizations, many of which were established in the wake of the World Wars. This relationship allows for an easier transition for personnel out of military life as well as ensuring that they are

receiving adequate care. While there is some degree of cooperation in both Canada and the U.S. between their armed forces and relevant external organizations, it is not comparable to the experiences in the U.K.

An analysis of three distinct variables – training and screening processes, discharge policies and compensation and the role of veterans and advocacy organizations – will provide evidence to support the superiority of the U.K. armed forces in addressing their mental health burden.

This study has included the use of metrics to provide substantive evidence of the improvement of mental health treatment. This study is the first of its kind to have collectively assembled suicide rates amongst multiple armed forces into a single analysis, which can be found in Appendix A. These rates are used to substantiate the aforementioned rank ordering of nations in this study, which found the U.K. emerging first, Canada second and the U.S. third in terms of their relative success in addressing mental health amongst their personnel.

Chapter Summaries: Research Questions

Chapter 2: Literature Review and Theoretical Framework

Chapter 2 will present an overview of the relevant policy and defence literature as it relates to the arguments presented throughout the course of this analysis. Most importantly, this chapter will discuss the absence of appropriate literature within the political science field addressing this topic. It will provide an overview of the appropriate primary sources used to understand the success of the variables analyzed in Chapters 3, 4 and 5. Finally, it will provide an overview of the literature to support the arguments in Chapter 5, including the connection of civil-military agreements to the provision of care.

Chapter 3: Training and Interventions

This chapter will conduct an analysis of the various programs that have been pioneered within each jurisdiction in attempts to stem the vast numbers of mentally ill soldiers.

Chapter 4: Discharge Policies and Compensation

This chapter relies primarily on the work of investigative journalists and primary sources to argue that the jurisdictions in this study have used discharges, both medical and otherwise, as a simple solution to the burden placed on them following the operations in Iraq and Afghanistan. This chapter exemplifies the lack of adequate scholarly analysis and theory more than any other.

Chapter 5: Advocacy and Civil-Military Relations

This chapter addresses the role that veterans' organizations and charities play in advocating for improved care, assisting in the delivery of care in conjunction with armed forces and providing care when the responsible agencies have failed to do so. It aims to build upon the overview of provision of care already presented by explaining the policy shifts of contemporary governments and how their changing relationship with veterans' agencies has impacted policy.

Methodology

The unit of analysis is incredibly important to the purpose of this study. The focus is not only on veterans, but on those who will serve and who are currently serving. Each is relevant in terms of each variable being discussed. The argument being made in this thesis is that there are specific factors that determine the relative success with which armed forces deliver mental healthcare. These factors are presented in three distinct case

studies throughout this study: training of military personnel; healthcare system; discharge policies; and advocacy and civil-military relations. These variables are then studied in depth in terms of each country.

Metrics

In order to measure this success, the development of metrics was necessary to determine how and why one country may be faring better at the mental health challenge than another. The use of incidence of suicide metrics is incredibly important in demonstrating the severity of the mental health burden facing each of the armed forces under analysis.⁵

This study faced significant difficulty in collecting data related to mental health care and treatment. Data, such as prevalence of PTSD, was available in some jurisdictions but in others, like the U.K. it was unavailable due to a number of factors. Responding to a Freedom of Information request, the MoD stated that to collate the data on veterans who were assessed for a mental disorder exceeded the appropriate limit, as it would take more than a year to search both electronic and paper records to provide a response⁶.

Additionally, the number of veterans within the U.K. population is not a figure held by the MoD and therefore neither is the number of those with PTSD.

These difficulties support the overarching claim made within this analysis, which is that centralization is directly correlated to the delivery of mental health services. The centralization of data would result in more readily accessible statistics, which would help in providing an accurate understanding of the scale of the mental health burden facing

⁵ See Appendix A: Incidence of Suicide.

⁶ Ministry of Defence. *Response to Freedom of Information Request: Veterans and PTSD*. Bristol: Defence Statistics, February 13, 2014.

armed forces. In situations where the data is not accessible because it is not centrally organized, it is difficult for researchers to attain an accurate picture of the scale of the mental health burden facing armed forces and the challenges facing personnel. In this case, the lack of centrally organized data is a detriment to the effectiveness with which mental health in the context of armed forces can be analyzed. The ability to understand the scale of the mental health crisis is imperative in order to analyze the effectiveness of current policies and the potential for improvement. The inability to obtain figures on diagnosis rates, pharmaceutical prescriptions and veteran suicides were significant limitations on this study.

Case Study Selection

This thesis relies heavily on the comparative analysis of the key variable across three separate case studies. By using case studies, it is possible to measure the problems within responsible institutions and their processes while making sweeping comparisons. In the selection of the relevant cases, it was important to place emphasis on significant similarities between them. As the purpose of this thesis is to evaluate how each case country addresses its mental health burden amongst personnel, it is important to show ways in which efforts that have succeeded in one nation may also be feasible in another. Each case study focuses on a nation that fought alongside one another in similar deployments throughout since 2001, particularly in the Middle East.

Canadian Forces and Relevant Agencies

Of the jurisdictions under examination in this study, the Canadian Armed Forces (CAF) are both the smallest and the youngest.⁷The CAF has existed in its current form

⁷ The designation that the CAF are the smallest force under examination in this study is based on the

since 1968 when the Royal Canadian Navy, Canadian Army and Royal Canadian Air Force were combined into a unified structure. Since then, they have participated in a multitude of deployments including peacekeeping operations, natural disaster response and military engagements with foreign allies and organizations. Of particular importance to this thesis is the deployment of CAF personnel in support of the Afghanistan War, beginning in late 2001.⁸ Since 2001 there has been constant deployment and presence of CAF personnel in Afghanistan and Iraq. These deployments, alongside allies that will also be the subject of this thesis, have resulted in a publically and politically scrutinized mental healthcare situation amongst returning personnel. However, this thesis will address personnel who have served in the CAF, but may not have been deployed to Afghanistan.

British Armed Forces and Relevant Agencies

Of all the jurisdictions in this study, the British Armed Forces are the oldest and second largest with strength of 140,130 full-time trained personnel.⁹ The BAF forms the military of the U.K. and participates in peacekeeping missions, international humanitarian aid and military engagements. They were established in their current model in the Acts of Union 1707 when the military forces of Scotland and England were united under the Kingdom of Great Britain.¹⁰ The modern BAF consist of the Royal Navy, the Royal

number of active military; 60,000 in Canada. See International Institute for Strategic Studies, *The Military Balance 2016: The Annual Assessment of Global Military Capabilities and Defence Economies*, (London, England, 2016), 484.

⁸ “The Canadian Armed Forces Legacy in Afghanistan,” Canadian Armed Forces, last modified September 9, 2016, <http://www.forces.gc.ca/en/operations-abroad-past/cafla.page>

⁹ This number is derived from the MoD May 2016 UK Armed Forces Monthly Service Personnel Statistics. See Ministry of Defence, “UK Armed Forces Monthly Service Personnel Statistics 1 May 2016,” Defence Statistics, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536401/Monthly_service_personnel_statistics- May_2016-s.pdf (accessed June 3, 2016), 1.

¹⁰ “Act of Union 1707,” UK Parliament, accessed June 2, 2016. <http://www.parliament.uk/about/living->

Marines, the British Army and the Royal Air Force and are headed by the Secretary of State for Defense and managed by the Defense Council of the Ministry of Defense.¹¹ The Defence Council heads the armed services and “provides the formal legal basis for the conduct of defence in the U.K. through a range of powers vested in it by statute”.¹² On the Council sit elected officials as well as senior officers of the different branches of service.

United States Army and Relevant Agencies

The U.S. Army is the largest and most senior of all branches of the U.S. Armed Forces, one of the largest standing armed forces in the world. It is the second oldest force under examination in this study, and dates itself to the formation of the Continental Army in 1775.¹³ The structure of armed forces in the U.S. differs slightly from the other cases under examination, in part due to its size. Each branch has its own distinct governance and therefore, unlike the other studies, the focus will be on the Army branch alone, rather than the entirety of the U.S. Armed Forces. This decision is based solely on the size of the U.S. Armed Forces, as well as its decentralized nature. Unlike the other jurisdictions under analysis, many of the training programs and discharge procedures are different for each branch. In addition, many organizations for veterans are specific to the branch in which the individual served.

Conclusion

The following chapters will engage in the debate on the provision of mental health amongst armed forces in the jurisdictions of Canada, U.K., and the U.S. Chapter 2 will

heritage/evolutionofparliament/legislativescrutiny/act-of-union-1707/overview/

¹¹ “Our Governance,” Ministry of Defence, accessed June 4, 2016.

<https://www.gov.uk/government/organisations/ministry-of-defence/about/our-governance>.

¹² Ibid.

¹³ “June 14th: the Birthday of the U.S. Army,” United States Army, last modified June 7, 2016, <http://www.history.army.mil/html/faq/birth.html>.

present a literature review. Chapters 3 through 5 will discuss each of the three case studies under analysis within the context of each jurisdiction under review. Finally, chapter 6 will provide a conclusion and final analysis, as well as a discussion on potential future research.

CHAPTER 2: LITERATURE REVIEW

Perhaps the most difficult challenge of this research is the state of current literature on this topic. The existing literature discussing mental healthcare in the armed forces in political science is limited. There has yet to be a study in the field of political science that addresses the issue of mental healthcare in armed forces. The issue is typically studied in academia as a medical or psychological issue. However, the topic has been at the forefront of political discourse for years and this study seeks to fill this gap. It is important that an issue of great political importance is discussed in terms of policy and administration reformation. The bureaucracy is responsible for many of the setbacks that have plagued veterans' health and until the matter is discussed in a manner that can create change in governance, it will not be appropriately resolved. The issue of mental health care for service personnel is not just a medical issue; it is a political and policy failure. By filling this gap, I aim to create a constructive discourse around policy influence and processes. Through an assessment of both the literature that exists and the gaps in literature that need to be examined, this chapter will also outline the theoretical framework that will guide this analysis.

There has been a breadth of scholarship dedicated to understanding the evolution of the recognition of PTSD within military personnel and the shifting attitudes towards it. Joanna Bourke has contributed to this scholarship through an analysis of PTSD during the First World War, when it was commonly known as shell shock. Bourke provides not only an analysis of how it was treated and identified, but also the reception of citizens within the U.K. to soldiers with mental rather than physical ailments. As Bourke recounted,

“people were described as hanging their heads in ‘inexplicable shame’”.¹⁴

Some of the most pertinent literature dedicated to understanding the psychological cost of being a soldier has come from those who have served themselves. This literature is significant in that it introduces civil society to an understanding of the cost of being a member of the armed forces. It sheds light on the expectations placed upon them. Some of this literature serves as a preface for the analysis that follows, by introducing the unique challenges that face personnel and particularly why they are unique. Lt. Col. Dave Grossman’s book *On Killing: The Psychological Cost of Learning to Kill in War and Society* has argued that over the last few generations, Western civilization has decided that killing was a private, mysterious and frightening task.¹⁵ The process has been confined to the slaughterhouse or the nursing home and advances in technology have kept people yearning for the longest life that is possible. As a result of these significant societal changes, Grossman argues that a process that was once such a part of life for nearly all citizens now “offends this new sensibility”.¹⁶ That the expectation of the soldier is to take a life or be willing to give their own is incongruent with societal attitudes that the reaction by soldiers is often psychologically damaging. To be so removed from death within society – and often seek any means to avoid it – and then to have it thrust upon you results in incredibly poor coping mechanisms amongst some personnel. Grossman’s work incorporates the experiences of personnel in their own words, which he argues “destroy the myth of warriors and war as heroic”.¹⁷ Grossman’s contribution to the

¹⁴ Joanna Bourke, “Shell Shock during World War One,” *BBC*, March 10, 2011, accessed July 22, 2016, http://www.bbc.co.uk/history/worldwars/wwone/shellshock_01.shtml

¹⁵ Lt. Col. Dave Grossman, *On Killing: the Psychological Cost of Learning to Kill in War and Society* (New York: Back Bay Books/Little, Brown and Company, 2009), xxix.

¹⁶ *Ibid.*

¹⁷ *Ibid.*, xxxiv.

literature is consequential in that it comes from lived experience, but also that it uses the words of personnel to contribute to a new rhetoric surrounding soldier identity.

Grossman is also well regarded for his wolves, sheep and sheepdogs analogy from his book *On Combat*. In the excerpt, Grossman likens citizens to sheep, as they are “kind, decent people who are not capable of hurting each other, except by accident or under extreme provocation”.¹⁸ The wolves are those who prey on the sheep and do so without any mercy and the sheepdogs are those who protect the sheep and confront the wolf. To Grossman, those who do not have capacity for violence are healthy, productive citizens, or sheep and those who have capacity for violence yet no empathy for fellow citizens are wolves. As Grossman posits, “what if you have a capacity for violence, and a deep love for your fellow citizens? What do you have then?”.¹⁹ The response is the sheepdog, the protector of the flock and a warrior. Grossman argues that sheep often tend to be wary of the sheepdog as it reminds them of the existence of wolves.

The breadth of scholarship that has been developed around a better understanding of civil-military relations has strong applicability to the arguments that are made in this thesis. Primarily, the analysis of the gap between the civilian and military societies has addressed both its implications and benefits. This thesis will apply institutional theory to understand the causal relationship between the centralization of institutions and the effectiveness with which mental health is addressed amongst armed forces personnel. A significant component of this analysis is the structure of institutions and the impact it has on mental healthcare. Civil-military relations can assist in the explanation of these

¹⁸ Dave Grossman and Loren W. Christensen, *On combat: The psychology and physiology of deadly conflict in war and peace*, (Belleville, IL: PPCT Research Publications, 2007).

¹⁹ Ibid.

structures and the manner in which they operate.

In countries in which the centralization of institutions is a defining characteristic, there exists less of a gap between civil and military society in regards to the functioning of institutions. Primarily in Canada and the U.K., the presence of a centralized national public healthcare system means that there is less of an administrative gap between civil and military society in regards to personnel receiving adequate services once they depart their respective armed forces. Both nations place a significant amount of importance on coordinating with external agencies to close this gap and ease the transition out. In this regard, it is easier for this coordination to occur because of the centralized nature of services. Conversely, the U.S. armed forces are not a centralized institution and they lack a centralized national healthcare system. As a result, the gap between civil and military society is large and essentially impossible to close. This gap has yet to be discussed extensively within the context of mental health amongst military personnel and the policies that guide the effective administration of healthcare.

Rahbek-Clemmensen et al. have produced scholarship that has elaborated on an understanding of what is meant by a gap and what the consequences of its existence are. As Rahbek-Clemmensen have argued, there has been little disagreement regarding whether there is a gap in the civil-military relationship, but there has been no succinct contextualization of this gap. Its importance and implications on military effectiveness have been heavily debated, but Rahbek-Clemmensen et al. fill the void in the scholarship by defining the specific types of gaps that occur in civil-military implications. This gap is significant in regards to an understanding of institutions and the manner in which they behave. The gap is a significant characteristic of the analysis that follows and can provide

an explanation for many of the policies and processes related to mental health care and armed forces, as well as the issues facing access to care for personnel and veterans alike.

Theoretical Framework

The analysis that follows is conducted using an institutionalist methodology. Institutional theory “considers the processes by which structures, including schemas, rules, norms and routines, become established as authoritative guidelines for social behaviour.”²⁰ This theory has been applied by scholars across a range of fields to explain a varying degree of systems. However, this analysis is unique in that it will attempt to apply institutional theory to understand the development and application of policies internal to armed forces, particularly in relation to mental health, rather than to an understanding of the role armed forces play in foreign policy. The methodological premise of this study is that the nature and structure of organizations can play a significant role in the efficacy with which mental health care is provided to personnel.

Causal Factors

Of particular interest to the focus of this study is the extent to which institutions are centralized. There exists a causal relationship between the level of centralization that exists within an institution and its success in implementing effective policies related to the mental health of personnel. While centralization does not serve as an explanation for all success and failures in this area, it can explain to an important degree the implementation of programs, initiatives and policies that have demonstrated effectiveness in addressing mental health. The degree to which an institution, whether within military

²⁰ W. Richard Scott, "Institutional theory: Contributing to a theoretical research program," *Great minds in management: The process of theory development*, no.37 (2005): 461.

or civilian society, is centralized often has a direct correlation to the effectiveness with which mental health care is provided to armed forces personnel. This study will provide evidence to demonstrate the presence and strength of this causal connection. The analysis that follows will examine the extent to which this factor is important to the overall delivery of mental health care and services to personnel.

It is important to acknowledge that centralization is not the only relevant factor. There are a multitude of other possible factors, including whether individuals have been deployed abroad in combat operations, recruitment tactics, and the presence of administrative and bureaucratic silos. There are a variety of demographic factors that have been identified by scholars as affecting the risk of traumatic exposure, such as gender, age or socioeconomic status.²¹ Therefore, this study does not attempt to claim that there is one factor determining how mental health is approached within armed forces. Rather, it attempts to study the extent to which one factor, centralization, is a determinant of care provided.

Theoretical Approach

Institutionalism is often applied to the military in the context of foreign policy or how armed forces conduct themselves vis-à-vis civilian society. Political scientist Samuel Huntington is well known for his work in the field of civil-military relations, particularly in the application of institutionalism to understand the differences between civilian and military society. While his acknowledgement of the presence of a gap between the two societies is useful in understanding some difficulties facing personnel, he primarily

²¹ Sarah L. Halligan, and Rachel Yehuda, "Risk Factors for PTSD," *National Center for Post Traumatic Stress Disorder PTSD Research Quarterly* 11, no.3 (2000), 1.

focused on using institutionalism to explain the manner in which the military and civilian societies should associate. Huntington applied institutional theory to explain the differences in structure and in values between civilian and military societies, arguing that there was a need for “objective civilian control” of the military in order to ensure more military security. While Huntington’s demand for centralization was based primarily on security, it can also be applied to the manner in which policies and initiatives are carried out within the armed forces and the impact that has on personnel themselves. This analysis will seek to apply this theory as a means of explaining the internal workings of armed forces and the policies that they generate for personnel.

The relative centralization of institutions has been used as a variable in other areas of policy analysis. Saltman, Bankauskaite and Vrangbaek analyzed the impacts that centralization has on healthcare systems, focusing on the seemingly logical benefits of decentralization, with smaller organizations being “inherently more agile and accountable than larger organizations.”²² However, the authors also contend that in healthcare, there are a wide variety of institutional forms which result in serious questions about the characteristics of decentralization, including whether these characteristics have the capacity to accommodate this variety. Policy analysis focusing on the level of centralization has thus been used in other areas, but is yet to be applied to develop an understanding of the delivery of mental health care to personnel within armed forces, including the development of relevant policies and programs.

The relative level of centralization of institutions is a variable that has not often been

²² Richard Saltman, Vaida Bankauskaite, and Karsten Vrangbaek, “Introduction: the question of decentralization,.” In *Decentralization in Health Care*, ed. Richard Saltman, Vaida Bankauskaite, and Karsten Vrangbaek (England: McGraw-Hill, 2006), 1.

applied to explain the development of policies internal to armed forces. However, the exception to this is the use of centralization to explain military procurement and management. In recent years, discussion surrounding military procurement in Canada has been rife with criticism of the handling of the processes and decision-making involved. The Canadian government relies on a “multi-departmental defence procurement model.”²³ Other countries, including the U.K. utilize a centralized organization to control the procurement process. The absence of a centralized system in Canada has been the target of great criticism, particularly given that the desire to maximize economic benefits and fuel competition sometimes conflict with the purpose of the system: to purchase the equipment that the military requires.²⁴ These interests mean that other government departments, such as Economic Development Canada and Public Services and Procurement Canada are heavily involved in the system, resulting in an abundance of bureaucratic red-tape.²⁵ In the U.K., another jurisdiction under analysis in this study, a single agency administers procurement. The agency, Defence Equipment and Support (DE&S) is defined as a “bespoke trading entity, an arm’s length body from the Ministry of Defence.”²⁶ Scholars Dimitri, Dini and Piga have argued that the centralization of procurement is increasing, trending away from a period of scepticism in which “centralized procurement was seen as a factor of monopsonization and decreased

²³ Martin Auger, *Defence Procurement Organizations: A Global Comparison*, (Ottawa:ON) Library of Parliament, 2014.

²⁴ *The Canadian Press*, “Military procurement officials hopeful years of troubles finally behind them,” July 11, 2017, <http://www.obj.ca/article/military-procurement-officials-hopeful-years-troubles-finally-behind-them>

²⁵ Ibid.

²⁶ “Defence Equipment and Support,” Ministry of Defence, <https://www.gov.uk/government/organisations/defence-equipment-and-support> (accessed June 20, 2017).

competition.”²⁷ The scholars argue that the centralization of services allows for an organization arrangement that accommodates for the swift changing of processes so as to avoid negative trends. This thinking will be applied in this study, particularly when analyzing the training and compensation provided to personnel. A streamlining of processes and initiatives in a central agency results in a standardized offering of services that can more easily be changed than a variety of different policies for the same group of personnel

The literature that exists has used centralization to conduct a policy analysis of institutions, including of the military in regards to criticisms of procurement services. However, the relative centralization of institutions has never been used to explain the development of policies internal to the armed forces that relate to mental health care, training or compensation. This thesis is novel in regards to the methodology employed because it seeks to apply centralization to describe a phenomenon – mental health delivery within armed forces – that has not yet been analyzed within the context of that variable.

As the analysis that follows will demonstrate, the effectiveness with which mental health care and services are delivered to personnel can to a certain extent be related to the degree of centralization that exists within the armed forces and related organizations.

Conclusion

The chapters that follow will provide an analysis of each jurisdiction within the context of three case studies: training and screening processes, discharge policies and

²⁷ Nicola Dimitri, Gustavo Piga and Giancarlo Spagnolo, *Handbook of Procurement*, (Cambridge, UK: Cambridge University Press, 2006), 49.

compensation and veterans' advocacy organizations. The way the following chapters proceed is significant in that it is organized in a manner that mimics the transitions of an individual into the armed forces, within the armed forces and once they have left. This experience is discussed within the context of mental health and examined through the lens of civil-military relations, particularly the cultural gap that permeates all aspects of the military experience. The next chapter (Chapter 3) will launch this inquiry by discussing the impact of training measures on the mental health concerns of personnel. The subsequent chapters (Chapters 4 and 5) will discuss discharge policies and advocacy organizations, respectively, within the lens of the Big Society approach and civil-military relations.

CHAPTER 3: TRAINING AND SCREENING PROCESSES

Building upon the theoretical framework that has been established, it is important to analyze each of the case studies in the context of the jurisdictions under analysis. At the beginning of one's career in the armed forces, they are required to undergo a period of training. This training varies in length amongst the jurisdictions under analysis in this study and specialist training is often offered at some point, depending on the vocation that they have selected. Amongst several armed forces, there is a component of initial training that addresses mental preparedness and health. However, the degree to which such training is offered varies, as some nations require the training for all new recruits, while others wait until deployment abroad to focus on mental preparation.

The training of armed forces personnel is an important variable when discussing mental healthcare delivery amongst the jurisdictions selected for this study. The manner in which personnel are prepared for deployment or debriefed following, influences the mental health status of armed forces. The psychological development of soldiers is dependent on how they are trained for deployment and how they are educated about reintegration upon return.

This chapter will demonstrate that training programs developed and implemented in both Britain and Canada have emerged as the most successful in preparing individuals mentally for combat exposure, due to their uniformity and basis within research, as well as an emphasis on professional support and training. Due to the centralized nature of the armed forces in these countries, a standardized training program is offered to all recruits. These programs are developed at the highest levels and administered similarly to all personnel. At the same time, the U.S. has not successfully developed training programs

that effectively prepare individuals due to their reliance on inexperienced trainers as well as a lack of evaluative data to substantiate the programs potential. The decentralized nature of the American armed forces has also resulted in training being delivered in an ad hoc manner, which has resulted in personnel not receiving the same preparation afforded to some of their colleagues.

This variable will address specific training initiatives, rather than provide an overview of military training in its entirety. While the manner in which basic training, or Initial Soldier Training in the U.K., is conducted is essential to the mental health of personnel, an equally important focus of inquiry is the specific nature and development of courses designed to address mental health and resilience within personnel. Training, for the purposes of this study, refers to pre-deployment preparation; training provided on reintegration following deployment; mental resilience training provided at any point of an individual's service cycle within the armed forces; and any relevant training administered to those in the field to recognize and treat mental trauma.

The focus on personnel's mental health does not begin following their exposure to combat, but should rather be of a cyclical nature, focusing on all phases of their career and deployment. This chapter will analyze training related to mental health that is provided at any stage of a personnel's career cycle and provide an analysis on the effectiveness of available training programs.

Case Study: Canada

Development of Mental Health Training in the Canadian Forces

The catalyst for change came in the late 1990s in the form of a number of difficult CAF deployments, including the 1990-1991 Gulf War and the 1992-1993 United Nations

Operation in Somalia I and II (UNOSOM I&II). In order to better understand the evolution of mental health training and why these deployments are particularly significant, it is important to provide a brief examination of the deployments themselves.

Canadian participation in the Gulf and Kuwait War of 1990-1991 involved the deployment of three Canadian vessels to a naval blockade on August 24, 1990.²⁸ The armed conflict that culminated during the months of January and February 1991 involved primarily aerial bombardment and as a result, limited involvement of ground forces. The absence of large-scale infantry combat did not mean that Canadian troops were spared the effects of conflict and upon their return, concern developed about the “potential after-effects of war” on their health and wellbeing.²⁹ As a result, the Department of National Defence (DND) commissioned a report in 1997 to examine both the physiological and psychological effects of the Gulf War on its veterans. The report contrasted the health problems reported by a control group of CAF members serving during the Gulf War, but not stationed near the Persian Gulf, with those who had been deployed to the conflict.³⁰ The results of the study revealed, as expected, that there was a higher prevalence of major depression and PTSD, amongst other ailments, in those that deployed to the Gulf.³¹

While the mid-90’s brought some of the primary research into the effects of modern warfare on soldiers, it also brought about scandal that drew even more attention to the mental health of Canadian soldiers. The Canadian Airborne Regiment (CAR), stationed in Petawawa, was sent into Somalia in 1992 as peacekeeping efforts in the

²⁸ Canada. Gulf War Veterans Cohort Study Advisory Committee. *The Canadian Persian Gulf Cohort Study: Detailed Report*, by Brian Lefrance and Maureen Carew, Ottawa: Statistics Canada, 2005, 9.

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ *Ibid.*, 3.

country increased. Despite being revered as one of Canada's most elite fighting units, the Regiment had rampant behavioural issues and inadequate leadership. Their deployment to Somalia only exacerbated these problems and there were a number of incidents that drew the attention of those at home, and the rest of the international community. The systemic abuse of Somalis and the complete lack of oversight within the ranks culminated with the beating, torture and murder of 16 year old Shidane Arone by two CAR soldiers. A Federal Public Inquiry was initiated by the Government of Canada whose mandate was to "inquire into and report on the chain of command system, leadership within the chain of command...the pre-deployment, in-theatre and post-deployment phases of the Somalia deployment."³² As Metz describes, the inquiry's findings, released in 1997, not only identified DND attempt at stifling the story, but also began the discussion about important questions surrounding the principle ethos of the military community, which was that soldiers forego the right to life in order to serve national interest, while life is a basic right of the remainder of citizens.³³ This is not a concept unique to the Canadian Forces and is applicable across the jurisdictions examined in this study. What is important to note this ethos has become a valuable tool in both advocating for better care and reforming the training of soldiers. The conclusion of the Inquiry revealed that the ethics of the CAF were questionable and there was need for an urgent visitation of training. The Somalia Affair not only revealed issues with the way Canadian soldiers were trained, but also with how they were led by commanding personnel. One commander was convicted at a court martial for "encouraging the 'Rambo-like' atmosphere that formed the context of the

³² Minutes of a Meeting of the Committee of the Privy Council, approved by His Excellency the Governor General, (March 20, 1995). Government of Canada, House of Commons, Ottawa, ON.

³³ Troy Kenneth Metz, "The Training of the Canadian Military and the Somalia Affair," (MA diss., University of Regina, 1997), 6.

killing”.³⁴ As Sherene Razack argues, the Somalia Affair was not the result of a “few bad apples” in the CAR, but rather the result of a larger systemic issues in which the failure of leaders and a culture of aggressiveness resulted in Arone’s death.³⁵

While there was very little reference to mental health within the results of the Inquiry, there was no separating the mental health of soldiers from the events that transpired in in Somalia. As this study has argued, the focus on personnel’s mental health does not begin following combat, but should rather be of a cyclical nature, focusing on all phases of their career and deployment. The issues that arose prior to deployment, of poor oversight and command, directly contribute to poor mental health and mental preparation. This is not an attempt to disregard the death of Arone as simply poor mental preparation; it is a case that exemplified the need for a military environment that prioritizes the mental health of personnel on a constant basis.

Shift in Attitudes

It was at this point that the anti-intellectual attitude of the Canadian military began to shift. As Bercuson argues, it was a shift towards re-professionalization.³⁶ The shift began with an overhaul of the Royal Military College (RMC) and included a focus on comprehensive education, including military ethics, at the same time as morale improved through the introduction of increased benefits and welfare services. Perhaps the attitude shift is most strongly summarized by Lieutenant General Sir William Francis Butler, a 19th- century British Army officer, who wrote: “The nation that will insist upon drawing

³⁴ David Bercuson, "Up From the Ashes: The Re-professionalization of the Canadian Forces After the Somalia Affair," *Canadian Military Journal* 9, no. 3 (2009), retrieved from <http://www.journal.forces.gc.ca/vo9/no3/06-bercuson-eng.asp> .

³⁵ Sherene H. Razack, *Dark Threats and White Knights: The Somalia Affair, Peacekeeping, and the New Imperialism* (Toronto: University of Toronto Press, 2004), 7.

³⁶ Bercuson, “Up from the Ashes.”

a broad line of demarcation between the fighting man and the thinking man is liable to find its fighting done by fools and its thinking by cowards.”³⁷ Many held the view that soldiers were an entirely separate group from society, but unlike the ethos presented by Butler, the view was that soldiers were purposeful insofar as they would destroy upon command, and that they knew nothing of “building up” which was left to politicians.³⁸ Butler’s arguments, while more than a century old, remain incredibly relevant today. While scholars have yet to identify the causality between the Somalia Affair and increased mental health training, there is no doubt that it exists. The emphasis on the education of soldiers that followed the Inquiry resulted in a leadership that was educated and well-versed on the subjects of military ethics. Such leadership was a change from what had been seen in the past. Military leadership not only dictates the behaviour of subordinates but also the morale, a determinant in the overall mental health of personnel. While this conclusion does not suggest that the stigma was entirely alleviated by the re-professionalization of the CAF, there is a correlation between education and improved mental health. Therefore, it is no surprise that in the years following this change, there was introduction of comprehensive mental health training and screening programs.

Road to Mental Readiness (R2MR)

The Canadian Forces program, Road to Mental Readiness (R2MR), was developed by DND as a response to the growing need for mental resiliency in soldiers coming and going from potentially traumatic deployments. Implemented in 2009, it followed the realization by the Canadian Forces Health Services Group (CFHSG) that there was not nationally standardized initiative geared towards preparing personnel for

³⁷ William Francis Butler, *Charles George Gordon*, (London; New York: Macmillan, 1891), 85.

³⁸ *Ibid.*, 84

military deployments.³⁹ As Lieutenant-Colonel Suzanne Bailey of the CFHSG argues, it was not the case that there were no programs, as the CAF had been offering its own combination of services for several years prior.⁴⁰ The program consists of multiple phases and is delivered both pre and post-deployment, including both troops and their family members. The three key objectives of R2MR as outlined by Defence and Research Development Canada (DRDC) are as follows: to teach basic mental health literacy concepts to recruits, such as understanding what is good and poor mental health; teach recruits stress management skills that can be helpful in mitigating distress; and change the attitude of recruits towards mental health and the use of appropriate services.⁴¹ The particulars of R2MR are vast and impossible to summarize in a single paragraph. These three objectives summarize the goals of the program, as well its audience. The delivery of the program is a single, 160-minute session during Basic Military Qualification (BMQ) at the recruit level, but is continually applied and carried out at different phases of one's career.⁴²

The R2MR program can be universally applied across the security sector and can be compared to the British Trauma Risk Management (TRiM) program, which will be discussed in the following case study. The Mental Health Commission of Canada has coordinated with police forces across the country to assist them in introducing a version of the program. This universal applicability speaks to the success of the program as it

³⁹ Neil Faba, "A Force to Reckon With," *BenefitsCanada*, October 2011, 15.

⁴⁰ *Ibid.*

⁴¹ Deniz Fikretoglu, Erin Beatty, and Aihua Liu, *Comparing Different Versions of Road to Mental Readiness to Determine Optimal Content: Testing Instruction Type, Homework, and Intelligence Effects at Two Timepoints*, No. DRDC-RDDC-2014-R164, Defence Research and Development Canada-Toronto Research Centre Toronto, Ontario Canada, 2014, 1

⁴² "Road to Mental Readiness," Canadian Forces, accessed September 4, 2016, <http://www.forces.gc.ca/en/caf-community-health-services-r2mr-career/index.page>

demonstrates its success in addressing the issue of mental health, particularly following PTE's. The program also attempts to improve the overall stigma surrounding mental health in the CAF, particularly by administering a questionnaire before the session that tests one's attitudes towards mental health issues, and then giving personnel the same questionnaire once the session is completed.⁴³

R2MR Results

The downfall of any analysis for R2MR is that there has been little evaluation of its success to date. This is not to insinuate that the program is failing to meet its objectives, but rather that its emphasis on continual applicability throughout the careers of personnel means that, with not even a decade passed since its implementation, there is not much room to evaluate its success quantitatively. However, a study conducted by DRDC to test the efficacy of R2MR over a two year period at BMQ. The study analyzed different versions of R2MR and found several problems in all components: delivery, receipt and enactment.⁴⁴

The problematic nature of the delivery of the program was the instructors did not adhere to the standardized material created for the session, skipped exercises and definitions. Furthermore, the largest deviation identified was in the delivery of Cognitive Restructuring part of Self-Talk.⁴⁵ At this point in the training, it was observed skipping the definitions of negative thoughts as well as the demonstration of how these negative thoughts can be replaced with positive ones. During the follow-up discussions, researchers discovered that the practitioners were not adequately instructed on this

⁴³ Neil Faba, "A Force to Reckon With."

⁴⁴ Fikretoglu, Beatty, and Aihua, *Comparing Different Versions of Road to Mental Readiness to Determine Optimal Content: Testing Instruction Type, Homework, and Intelligence Effects at Two Timepoints*, 1.

⁴⁵ Ibid.

component. This is especially problematic given that the practitioners are not medical professionals and therefore do not possess clinical training; the training they receive must be comprehensive so as to ensure the proper delivery of the program.

Case Study: United Kingdom

Trauma Risk Management Development

When Jeffrey Mitchell, a former firefighter in the U.S., developed Critical Incident Stress Debriefing (CISD), he claimed that it prevented the manifestation of PTSD.⁴⁶ However, research has showed that single session debriefings produce little positive result and can sometimes be detrimental to the mental health of clients.⁴⁷ Given these results, it is also important to note that Mitchell's intention was to deliver a program designed "exclusively for small, homogenous groups who have encountered a powerful traumatic event"⁴⁸. Therefore it was no surprise when the Surgeon General banned the use of single session debriefing programs, like CISD, within Her Majesty's Forces (HM Forces).⁴⁹ The decision was backed by a publication from the National Institute of Clinical Excellence's guidelines on the treatment of PTSD.⁵⁰ This negative understanding of CISD was counterbalanced by Greenberg et al. when they argued that while debriefings have proven to be unsuccessful in preventing psychological injury, more complex therapies that can be applied weeks after the incident "appear likely to be

⁴⁶ Neil Greenberg, Victoria Langston, and Norman Jones, "Trauma risk management (TRiM) in the UK Armed Forces," *Journal of the Royal Army Medical Corps* 154, no. 2 (2008): 123.

⁴⁷ Suzanna C. Rose et al., "Psychological Debriefing for Preventing Post Traumatic Stress Disorder (PTSD)," *The Cochrane Database of Systematic Reviews*, no. 3 (2001), 2.

⁴⁸ Jeffrey Mitchell and George S. Everly, "Critical Incident Stress Debriefing (CISD) and the Prevention of Work-Related Traumatic Stress," *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (2009): 1

⁴⁹ Victoria Langston, Matthew Gould, and Neil Greenberg, "Culture: what is its effect on stress in the military?," *Military medicine* 172, no. 9 (2007): 933.

⁵⁰ Greenberg, Langston and Jones, "Trauma Risk Management (TRiM) in the UK Armed Forces," 123.

beneficial”.⁵¹ This would be the catalyst for the creation of TRiM.

A consistent theme in this chapter is that training is often ineffective at preventing mental illness from occurring in those exposed to combat and attention should be focused on the attitude of peers, as they are a strong determinant of success when dealing with mental illness. Each case analysis will demonstrate that leaders that have an extremely negative understanding of mental illness amongst soldiers contribute to a workplace that is not conducive to healing. In the most general of terms, the TRiM program is the manifestation of the understanding that soldiers will turn to their colleagues and friends for help before strangers, such as medical professionals. It seeks to train those in the affected soldiers unit to assist in their coping process.

MoD PTSD Case

Under British law, “The Master & Servant relationship” is legislated through the Master and Servant Acts, which were laws introduced during the 18th and 19th centuries to regulate the relationship between employers and employees. The laws provided autonomy to the worker, who now had a voice, as well as the legal capacity, to address issues such as compensation for a workplace injury.⁵² This interaction, according to March & Greenberg, continues to be governed by the principle that organizations, including the military, have a “legal requirement to look after their employees both physically and psychologically as far as reasonable practicable”.⁵³ This legislation, combined with the public and political attention on mental healthcare within armed forces has resulted in a

⁵¹ Ibid.

⁵² Evelyn Atkinson, “Out of the Household: Master-Servant Relations and Employer Liability Law,” *Yale JL & Human*, 25 (2013): 236.

⁵³ Cameron March and Neil Greenberg, “The Royal Marines approach to Physiological Trauma,” in *Combat Stress Injury Theory, Research and Management*, ed. Charles R. Figley and William P. Nash (Routledge, 2011), 353.

situation in which the only viable option is recognition of a duty of care.

In the early 2000's, a number of former service personnel brought a joint legal case against the MoD based on three claims: the MoD had not prevented them from getting PTSD; the MoD had not detected their problems early on; and they had not been treated properly once they had been diagnosed with PTSD.⁵⁴ The case was the biggest legal action ever launched against the MoD, with major financial loss at risk for the MoD, in addition to major legal costs.⁵⁵ Altogether, a total of 1700 former service personnel were taking part in the action.⁵⁶ As March & Greenberg demonstrate, it is difficult to summarize complex legal proceedings and their results, but the basic result was that the judgment was found in favour of the MoD.⁵⁷ While the judge found that the MoD systems were in line with accepted practice, he did make a number of other points regarding the issue at hand. Particularly, he said that PTSD was “an organizational issue for the military to address, and that there should be sufficient training for the military personnel managers to be able to exercise their duty of care”.⁵⁸ Even though the MoD care provided to the soldiers involved was not found to be in question, the statements made by the judge were a “wake up call” for the MoD that in the future, they would need to ensure their mental health services were up to date with the most current research.⁵⁹ The Judge clearly stated that the burden of care in combat did absolutely not fall on the comrades of those affected, which undermined the traditional buddy system of suicide prevention that could

⁵⁴ Ibid, 354

⁵⁵ Clare Dyer, “The forgotten army,” *The Guardian*, January 16 2002, accessed July 17 2016, <https://www.theguardian.com/world/2002/jan/16/law.military>.

⁵⁶ “Soldiers join war trauma lawsuit,” *BBC News*, March 4 2002, accessed July 17 2016, http://news.bbc.co.uk/2/hi/uk_news/wales/1852036.stm.

⁵⁷ March and Greenberg, “The Royal Marines approach to Physiological Trauma,” 354.

⁵⁸ Ibid.

⁵⁹ Ibid.

no longer be viewed as an expectation and rather solely as a voluntary system.⁶⁰ As a result, the case led to an understanding within the MoD that military units should ensure that senior officers, particularly those responsible for the command of others, were skilled in detecting “adverse traumatic psychological issues”.⁶¹ There were no specific recommendations made on how these skills would be developed, leaving room for the introduction of TRiM.

TRiM – Background and Purpose

In 1996, the Royal Marines reviewed their stance on introducing policies and programs to manage stress amongst service personnel. The move towards change was led by the then Colonel David Wilson, an experienced Royal Marines Commando who was then employed at the Royal Marines Personnel Branch in Portsmouth. Despite there being no clear direction of what protocol should be adopted to address stress amongst personnel, Wilson was adamant that there was cause for redress. Unlike the CISD protocol that had previously been in place, TRiM was the advancement of the belief that adequate stress management needed to focus on the entirety of the deployment timeline. By embedding TRiM practitioners within units, the units were empowered to address and recognize mental trauma themselves, rather than through the intervention of unfamiliar medical personnel.

While the TRiM initiative was progressing through the Royal Marines, the remainders of HM Forces were struggling with finding appropriate ways of helping personnel cope. It was in 2000 that the catalyst came for introducing TRiM to the

⁶⁰ Nicola Fear, Dan Wood and Simon Wessely, “Health and social outcomes and health service experiences of UK military veterans,” *ACDMH/KCMHR* (2009):18.

⁶¹ March and Greenberg, “The Royal Marines approach to Physiological Trauma,” 355.

remainder of the services, when the above Surgeon General decision was handed down. At the same time, research showed that when psychological illness was identified at an early stage, more chronic forms of illness could potentially be prevented.⁶² While trying to find an appropriate stress management protocol, March & Greenberg argue that the MoD also needed to focus factors at play that would impact the implementation of the protocol including, but not limited to, readily available psychological assets and logistical constraints.⁶³ To alleviate the concerns stemming from the consideration of these factors, the emphasis was on a peer-based program delivered from within units which removed the need to parachute in outsiders.⁶⁴ Hence, the TRiM program, which had been implemented and refined by the Royal Marines for years, was the perfect fit for the remainder of HM Forces.

TRiM is a peer group delivered PTSD management strategy with the aim of keeping employees of hierarchical organizations functioning after PTE's, as well as focusing on providing support and education to those who need it and identify those who require additional, sometimes specialist, support.⁶⁵ The British Army argues that TRiM is not a medical process, nor is it therapy; it is meant to identify those at risk following a PTE.⁶⁶ It is essentially impossible, based on the nature of human reaction as well as the vast research conducted on the topic, for PTSD to be entirely preventable within service personnel, particularly those deploying to combat operations. TRiM does not intend to

⁶² N. Jones, P. Roberts and N. Greenberg, "Peer-group risk assessment: a post-traumatic management strategy for hierarchical organizations," *Occupational Medicine* 53, no.7 (2003): 469

⁶³ March and Greenberg, "The Royal Marines approach to Physiological Trauma," 357.

⁶⁴ Jones, Roberts and Greenberg, "Peer-group risk assessment: a post-traumatic management strategy for hierarchical organizations," 470.

⁶⁵ Greenberg, Langston and Jones, "Trauma Risk Management (TRiM) in the UK Armed Forces," 124.

⁶⁶ "Trauma Risk Management," British Army, accessed July 3 2016, <http://www.army.mod.uk/welfare-support/23245.aspx>.

prevent the manifestation of PTSD, or treat it, which is the responsibility of other agencies both within and outside the MoD. Instead, the TRiM practitioners are trained to “manage the psychological aftermath of a traumatic incident or series of incidents”.⁶⁷ TRiM aims to teach non-medical personnel with a basic understanding of trauma psychology and the skills to carry out a psychological assessment following an incident.⁶⁸ The practitioners consist of non-medical personnel in junior management positions who are trained over a 3-5 day period.

TRiM's Applicability in the Operational Field

A 2011 study by Greenberg et al. sought to understand the level of acceptability of TRiM within HM Forces. The results showed that the majority of subjects interviewed did not see TRiM as a replacement protocol but rather as a complement to already existing programs and services.⁶⁹ Criticisms from personnel included that there should be a very thorough and careful selection of practitioners as well as an emphasis on confidentiality.⁷⁰ The emphasis on confidentiality is an important aspect, given the risks at hand: not only does a breach of confidentiality negatively impact care, but other personnel who witness a breach would undoubtedly be more reluctant to use the same system for their own needs. The implementation of TRiM within the remaining Services of HM Forces in the early 2000's meant that there was an experienced protocol in place for the thousands of personnel that would deploy to Afghanistan over the coming decade. Frappell-Cooke et al.'s study analyzed two different units that used the TRiM protocol at several of its stages. The two groups utilized were a company of army infantry, the

⁶⁷ Greenberg, Langston and Jones, “Trauma Risk Management (TRiM) in the UK Armed Forces,” 124.

⁶⁸ N. Greenberg, V. Langston, A. C. Iversen and S. Wessely, "The acceptability of 'Trauma Risk Management' within the UK armed forces," *Occupational Medicine* 61, no.3 (2011): 184.

⁶⁹ Ibid.

⁷⁰ Ibid.

Coldstream Guards, and a company of Royal Marines. As the Marines were the original incorporators of the protocol, they were referred to as the TRiM-experienced unit, while the Coldstream Guards were the TRiM-naïve unit.⁷¹ Both of the groups were deployed to Afghanistan in the fall of 2007 for approximate deployment lengths of six months under similar conditions. The results of the study yielded major findings, the most obvious of which was that the TRiM-experienced unit reported lower levels of stress than the TRiM-naïve unit both before and after deployment.⁷² Additionally a difference remained in terms of general stress following a deployment between the units, with the naïve unit reporting higher stress than the experienced unit.

Other Issues

In 2010 Dr. Andrew Murrison, Member of Parliament, published “Fighting Fit: Mental Health plan for Servicemen and Veterans”. He had been commissioned by the Government to examine the support given to personnel suffering from mental health problems as a result of service. The recommendations he made in his report include those relating to pre-deployment and post-deployment training for coping with mental illness. Murrison acknowledged the importance of TRiM and its worth contribution to the betterment of mental health amongst personnel, while also recommending that MoD “should encourage research to develop a PTSD screening tool, ensuring that the work is capable of generating data that would be of benefit in a U.K. context.”⁷³ The mention of context is particularly important, as Murrison’s recommendation is based on comparison to other allied nations, including Canada and the U.S., who implement such screening

⁷¹ W. Frappell-Cooke et al., "Does trauma risk management reduce psychological distress in deployed troops?," *Occupational Medicine* 60, no. 8 (2010): 646.

⁷² *Ibid*, 647

⁷³ Andrew Murrison, "Fighting Fit: A Mental Health Plan for Servicemen and Veterans, 2010," *Ministry of Defence: United Kingdom* (2012), 3.

measures. However, Fertout et al. note that screening programs including questionnaires are not always as successful and the U.K. favours “organization awareness of mental health problems” and relies on programs like TRiM for early detection.⁷⁴ The study undertaken by Fertout et al. aims to answer the questions posed by Murrison in his paper: is there benefit to the implementation of post-operational stress management (POSM) policies, which “mandate that troops who are returning home from deployments have to pass through a number of stages before they can return to normal duties.”⁷⁵ The findings from their study were less than promising. Despite the increasing prevalence of POSM’s across many jurisdictions, including those in this analysis, “there is a distinct lack of robust outcome data to support its use at any stage during an individual’s military career”.⁷⁶ Most importantly, the findings of the study revealed that even if screening were to improve data on the number of sufferers of mental illness following combat, there is no evidence to suggest that the process would facilitate increased interaction with available services. Other reports have confirmed the above findings of POSM effectiveness, including a 2016 report in the New York Times which covered the work of researchers looking into the effect of combat trauma on the brain of American soldiers. The impact on the brain from bomb blasts is severe and can have long lasting mental health effects, including the development of major disorders, including PTSD. A team of researchers developed a checklist that was used to identify concussed soldiers, but were forced to rewrite it multiple times when they discovered that soldiers were memorizing

⁷⁴ Mohammed Fertout et al., "A review of United Kingdom Armed Forces' approaches to prevent post-deployment mental health problems," *International Review of Psychiatry* 23, no. 2 (2011): 136.

⁷⁵ *Ibid*, 135.

⁷⁶ *Ibid*, 141.

the correct answers in order to avoid being found unfit for duty.⁷⁷ It is not beyond the scope of possibility to assume that soldiers who are suffering from mental illness fear being discharged and as a result, will use any means necessary to remain within the ranks.

Findings

While Murrison's report addresses many other concerns relating to the mental wellbeing of HM Forces, it is important to note that the insistence on POSM policies is not always well-founded. As the studies above have revealed, there is little current data to suggest effectiveness of standardized screening processes. Conversely, the above findings have demonstrated the success of programs like TRiM in ameliorating the impacts of combat and deployment on service personnel. While the findings demonstrated more positive results amongst the Royal Marines, there were positive changes seen even in the TRiM-naïve unit. TRiM's usefulness in addressing mental illness amongst the ranks of HM Forces is not only evident in the data produced by the research conducted but also in the fact that TRiM has been applied for use in other agencies outside of HM Forces, including police organizations.

It is important to take into consideration that the attitudes surrounding PTSD and appropriate care and screening have multiplied exponentially in the past decade, particularly following high profile engagement in Afghanistan. In the case of the U.K., it is difficult to discern whether the positive implementation of TRiM can be attributed

⁷⁷ Robert Worth, "What if PTSD is more Physical than Psychological?" *The New York Times*, June 10 2016, accessed July 20 2016, http://www.nytimes.com/2016/06/12/magazine/what-if-ptsd-is-more-physical-than-psychological.html?_r=0. It is worth acknowledging that the study undertaken in this article involved Gen Peter Chiarelli, who is discussed in length in the Chapter on Discharges. Chiarelli was frustrated with the amount of soldiers discharged for misconduct behaviour that was related to brain injuries they had sustained during combat and assisted in the development of the study that was undertaken by a team called the "Gray Team", made up of almost entirely military officers with advanced education in the fields of science and medicine.

solely to the protocol itself or if the change in prevailing attitudes towards PTSD and mental illness has affected the positive reaction.

Case Study: United States

This case study will examine the pre-deployment training and reintegration efforts made by the U.S. Army. While there are different programs and initiatives implemented across the entire U.S. Armed Forces to address mental health and its relation to service, they will not be discussed in this case study. The programs under discussion include Battlemind, CSF and MRT because they were developed for and implemented within the U.S. Army.

Unsurprisingly, there is little publicly available information on the content of training programs that have been used by the U.S. Army to train personnel on how to understand and cope with any mental health issues that they may encounter as a result of their service prior to the introduction of CSF. However, there is readily available information on Battlemind, the program upon which CSF was built. Developed at the Walter Reed Army Institute of Research (WRAIR), Battlemind offers both post and pre-deployment training and targeted multiple groups including personnel, leaders and spouses.⁷⁸

The pre-deployment training module, ‘Psychological Readiness in a Deployed Environment’ (PRIDE) for soldiers focused on 6 Tough Facts about Combat. The facts presented to soldiers include: combat is difficult, deployments place a tremendous strain upon families and perhaps most significant, that soldiers are afraid to admit that they have

⁷⁸ Carl A. Castro, Charles W. Hoge, and Anthony L. Cox, *Battlemind training: Building soldier resiliency*, (Silver Spring, MD: Walter Reed Army Institute of Research, Department of Military Psychiatry, 2006), 42

a mental health problem.⁷⁹ While a breakdown of the Battlemind training syllabus is not available, a 2006 report from WRAIR explained that the PRIDE module also included a discussion regarding the findings supporting the facts and the tools soldiers can use to mitigate them.⁸⁰ The post-deployment module of Battlemind training assists personnel with transition from the battlefield and reintegration into their communities.

In 2008, then Brig. Gen. (Dr.) Rhonda Cornum, the Army's assistant surgeon general for force projection said that Battlemind is "Probably the only mental-health training that has actually been validated and shown that people who got it have less severe symptoms upon their redeployment."⁸¹ Indeed, there was evidence to show that personnel who had completed Battlemind felt more at ease seeking mental health treatment. The claims came on the heels of the 2007 revelation that suicide rate amongst Army personnel was the highest since 1980.⁸² Col. Elspeth C. Richie argued that Battlemind was proving to be particularly successful in addressing anxiety and depression. A 2008 report by the Department of the Army's Mental Health Advisory Team (MHAT), MHAT V, examined the morale and mental health of personnel deployed to Iraq and Afghanistan in 2007.⁸³ The report demonstrated that of the 1438 soldiers who reported having attended pre-deployment Battlemind training, 54.4% agreed that "The

⁷⁹ Ibid.

⁸⁰ Ibid.

⁸¹ "Healing the Invisible Wounds of War," United States Department of Defense, accessed July 5, 2016, http://archive.defense.gov/home/features/2008/1108_ptsd/stigma3.html

⁸² Elizabeth M. Lorge, "Army Continues Fight Against Soldier Suicides," *Army News Service*, May 30, 2008, <https://www.army.mil/article/9523>

⁸³ The MHAT was established by the Office of the U.S. Army Surgeon General and deployed to Iraq annually beginning in 2003. The results of the studies conducted by MHAT were used to shape policies, training programs and allocate mental health resources. The Army took the lead in executing the mission of the MHAT and it wasn't until 2010 that there was joint representation on the MHAT from all service branches; this team was J-MHAT 7. (

training in managing the stress of deployment and/or combat was adequate.”⁸⁴ This is in comparison to 30.6% among those who did not receive the training. The correlation between the administering of training and ultimate diagnosis of mental health issues among those sampled was also documented. 15.5% of those who received the training reported mental health problems, compared to 23.0% of those who didn’t attend.⁸⁵

The report also addressed post-deployment Battlemind training and provides a status update on recommendations made by the MHAT in the fourth annual report. One such recommendation was to “Mandate all Soldiers and Marine receive small group POST-deployment Battlemind Training.”⁸⁶ The update provided in MHAT V was that the Director of the Army Staff had mandated that all personnel receive the training upon return from deployment. MHAT V then recommended that the Battlemind debriefing be delivered “after 6 months in theater for high combat exposure units”.⁸⁷ The most accurate Army interpretation of the effectiveness of Battlemind comes from within the MHAT reports, particularly in evaluating whether soldiers are mentally prepared for combat and if they have been equipped with the necessary tools to mitigate any issues that might arise. While the aforementioned reports referred to Battlemind and the data supporting its efficacy, the 7th annual report, published in 2010 made only one reference to Battlemind. This is a significant observation as the suicide rate amongst Army personnel in 2010 was 147, which was not a significant decrease in numbers from the year before.⁸⁸

⁸⁴ Office of the Surgeon General, *Mental Health Advisory Team (MHAT) V: Operation Iraqi Freedom 06-08 (Iraq); Operation Enduring Freedom 8 (Afghanistan)*, (Washington, DC: US Army Medical Command, 2008), 56.

⁸⁵ Ibid.

⁸⁶ Ibid, 109.

⁸⁷ Ibid, 15.

⁸⁸ See Appendix A for documentation of suicide amongst US Army personnel.

Comprehensive Soldier Fitness

MHAT IV, published in 2009, referred to the implementation of the Army's new initiative, Comprehensive Soldier Fitness (CSF). This program was designed to "assess and provide training in five areas of fitness: Financial, Family, Spiritual, Emotional and Physical".⁸⁹ The authors of MHAT IV clearly recommended that CSF needed to be tested for efficacy and then integrated with the existing Battlemind program. CSF was established in response to the difficulties facing many personnel as the result of multiple deployments to Iraq and Afghanistan.⁹⁰ A 2013 report produced by Colonel Richard Franklin Timmons II of the U.S. Army War College, which provided a critical analysis of CSF, stated that the Army was looking to "institutionalize a program to deal with the increasing and enduring problems of psychological health."⁹¹ Then-Chief of Staff of the U.S. Army, General George W. Casey, Jr. described the program as "an integrated, proactive approach to developing psychological resilience in our soldiers".⁹² Gen. Casey recognized that the Army was operating in a state of persistent conflict and that the stress soldiers were incurring from constant rotation between home and away was impacting their performance, readiness and relationships.⁹³ There was also a need to address the concern from politicians, civilians and personnel regarding the increased rates of PTSD, substance abuse and "other mental health related issues and disturbing behavioural

⁸⁹ Office of the Surgeon General, *Mental Health Advisory Team (MHAT) V: Operation Iraqi Freedom 07-09 (Iraq); Operation Enduring Freedom 8 (Afghanistan)*, (Washington, DC: US Army Medical Command, 2009), 56.

⁹⁰ In 2012, CSF was renamed to Comprehensive Soldier and Family Fitness (CFS2) to better incorporate the entire Army Family – soldiers, their families and civilian employees – into the resilience training process. However, for the purposes of this study, CSF will be used and the majority of research and subsequent critiques are of the initial program.

⁹¹ Colonel Richard Franklin Timmons, *The United States Army Comprehensive Soldiers Fitness: A Critical Look*. (United States Army War College, 2013): 3.

⁹² George W. Casey Jr., "Comprehensive soldier fitness: a vision for psychological resilience in the US Army," *American Psychologist* 66, no. 1 (2011): 1.

⁹³ *Ibid.*

trends”.⁹⁴

However, there have been many criticisms launched against CSF. The awarding of a \$31 million sole source contract for CSF development to psychologist Martin Seligman of the University of Pennsylvania’s Positive Psychology Center, was also the attention of significant criticism. Seligman was known to psychologists and the military community as components of his research had been used in developing torture techniques for prisoners under the Bush administration.⁹⁵ An individual whose work has contributed to the development of psychological torture is inarguably a controversial choice to lead a mental health training program. A focus on positive resilience is contradictory to torture, which seeks to deteriorate such resilience.

Eidelson and Soldz have argued that the program is deeply flawed, in particular its “counter-productive history of hyping that began with the program’s initial development and roll-out”.⁹⁶ The scholars highlighted both conceptual and empirical concerns, including that CSF was a research project that soldiers are required to participate in rather than a training program.⁹⁷ Nicholas Brown argued that a fault of CSF was that there were no provisions made for long-term control groups that would allow for the outcome of the training initiatives to be properly evaluated.⁹⁸ Seligman, CSF’s architect, defended the lack of planning by citing a personal decision made by Gen. Casey to apply CSF as soon

⁹⁴ Timmons, *The United States Army Comprehensive Soldiers Fitness: A Critical Look*, 2.

⁹⁵ Scott Shane, “2 U.S. Architects of Harsh Tactics in 9/11’s Wake,” *New York Times*, August 11, 2009, http://www.nytimes.com/2009/08/12/us/12psychs.html?pagewanted=2&_r=2

⁹⁶ Roy Eidelson and Stephen Soldz. “Does comprehensive soldier fitness work: CSF research fails the test,” *Coalition for an Ethical Psychology Working Paper* 1, no. 5 (2012): 1.

⁹⁷ Roy Eidelson, Marc Pilisuk, and Stephen Soldz, “The dark side of comprehensive soldier fitness,” *American Psychologist* (2011).

⁹⁸ Nicolas L. Brown, “A Critical Examination of the U.S. Army’s Comprehensive Soldier Fitness Program,” *The Winnower*, July 22, 2014, <https://thewinnower.com/papers/49-a-critical-examination-of-the-u-s-army-s-comprehensive-soldier-fitness-program>

as possible.⁹⁹ Proponents of the program defended this decision by arguing that delaying implementation of CSF to introduce a control group would pose a moral dilemma: “how could we ethically justify withholding resilience training from soldiers slated for combat duty?”.¹⁰⁰ Such an argument allows for a presumption of success of CSF, with Brown arguing that there have been no controlled studies to support such claim.¹⁰¹

Proponents of the program have identified it as a necessary response to the rates of PTSD and suicide amongst personnel, particularly those deployed in recent conflicts to Iraq and Afghanistan. Supporters have hypothesized that the learned skills from CSF would “enhance soldiers’ ability to handle adversity, prevent depression and anxiety, prevent PTSD, and enhance overall well-being and performance”.¹⁰² However Timmons argues that none of these claims have materialized and the aforementioned hypothesis has not been accompanied with quantifiable evidence.¹⁰³

CSF has been marred by a lack of evidence and results to support its claims regarding the success of CSF. There exists a disconnect between expectations outlined by supporters and architects and the program administrators’ experiences. As Timmons demonstrates, the Army personnel responsible for ensuring the program’s implementation do not see it as a tool to mitigate suicide amongst personnel and “therefore...should not be used as a metric.”¹⁰⁴ This stands in contrast with comments made in 2012 by Chief of Staff of the Army, General Ray Odierno, who stated that the Army would increase its use

⁹⁹ Martin EP. Seligman, *Flourish: A visionary new understanding of happiness and well-being*, (New York: Simon and Schuster, 2012), 163.

¹⁰⁰ Paul B. Lester, Sharon McBride, Paul D. Bliese, and Amy B. Adler, "Bringing science to bear: an empirical assessment of the Comprehensive Soldier Fitness program," *American Psychologist* 66, no. 1 (2011): 78.

¹⁰¹ Brown, “A Critical Examination of the U.S. Army’s Comprehensive Soldier Fitness Program.”

¹⁰² Roy Eidelson, Marc Pilisuk, and Stephen Soldz, "The dark side of comprehensive soldier fitness.”

¹⁰³ Timmons, *The United States Army Comprehensive Soldiers Fitness: A Critical Look*, 21.

¹⁰⁴ Ibid.

of CSF as a method of suicide prevention.¹⁰⁵ It is evident that there is a misunderstanding between those who are the programs' creators and those responsible for putting it into practice.

Master Resilience Trainer (MRT)

One of the pillars of CSF is the Master Resilience Trainer (MRT) course, a 10-day program offered to non-commissioned officers (NCO's). MRT not only teaches resilience skills to NCOs, but also teaches them how to teach the skills to the soldiers under their command.¹⁰⁶ The "train the trainers" model has consistently appeared across multiple training programs examined in the aforementioned case studies.

MRT was born in 2009 from a collaborative effort between Army personnel from CSF and the University of Pennsylvania.¹⁰⁷ The partnership sought to modify the Penn Resilience Program (PRP) for a military audience through modifications including adversities particular to soldiers and using these as case studies in training sessions. In summer 2009, two pilot courses were conducted and the curriculum was completed in fall 2009 which would serve as the foundation for the first complete MRT course offering in late 2009.¹⁰⁸ There are three components to MRT: preparation, sustainment and enhancement. Each component teaches foundational skills necessary for resilience as well as the skills necessary to teach resilience to subordinates.¹⁰⁹ The length of the course is

¹⁰⁵ Ibid.

¹⁰⁶ Karen J. Reivich, Martin EP Seligman, and Sharon McBride, "Master resilience training in the US Army," *American Psychologist* 66, no. 1 (2011): 25.

¹⁰⁷ The collaboration was an attempt to modify the Penn Resilience Program (PRP) for a military audience. PRP was developed at the University of Pennsylvania and focused on factors including self-regulation, emotional awareness, empathy and strong relationships. (Reivich, Seligman and McBride, "Master resilience training in the US Army," 25).

¹⁰⁸ Reivich, Seligman and McBride, "Master resilience training in the US Army," 26.

¹⁰⁹ Martha Yoshida "Master Resilience Training Preps Leaders for Success," *U.S. Army*, April 30, 2015, https://www.army.mil/article/147614/Master_Resilience_Training_preps_leaders_for_success

approximately ten days with skills and techniques being the focus of the first eight days; this is the Preparation Component. On the ninth day, the sustainment component teaches “reinforcing resilience skills over the course of a military career and applying these skills in the military-specific context.”¹¹⁰ The final day is the Enhancement Component, which is based on sports psychology and focuses on skills such as goal setting, building confidence and attention control.¹¹¹ The preparation component is the product of the aforementioned University of Pennsylvania’s Positive Psychology Centre, run by Seligman.¹¹² The sustainment component was developed at WRAIR and is primarily focused on the deployment cycle. The third and final component was developed at the U.S. Military Academy at West Point by sports psychologists and teaches skills to maximize performance.¹¹³

The intention of MRT was that NCOs selected for the course would “take the skills and training taught in the MRT course to the junior soldiers they instruct and lead”.¹¹⁴ There is value in the decision to place emphasis on a training program that instructs the trainers on how to approach and identify mental health and resiliency amongst their troops. As will be discussed in Chapter 5, the role that stigma plays in the relationship between higher ranking personnel and their subordinates directly impacts mental health, its stigma and that attitude towards seeking assistance. This is similar to the TRiM program used by the British Armed Forces.

Critiques of MRT have focused on the ability to measure and determine the

¹¹⁰ Reivich, Seligman and McBride, “Master resilience training in the US Army,” 31.

¹¹¹ Ibid.

¹¹² Ibid, 25.

¹¹³ Ibid.

¹¹⁴ Ibid.

program's effectiveness. In the third Army study on the CSF, Lester et al. state that "it is impossible to determine the mechanisms through which the presence of the MRT training impacts the self-reported resiliency and psychological health of soldiers and we do not know which of the 12 MRT skills influenced the resiliency and psychological health scores most or least."¹¹⁵ Another criticism, levelled by Timmons, is whether or not the appropriate individuals are being selected to undergo MRT training and eventually serve as trainers to their subordinates. Army selection criteria do not identify any specific requirements, leaving the commanding officers with sole discretion in the selection process. Eidelson and Timmons have both scrutinized the length of the training and questioned whether it is an adequate period of time to prepare personnel to teach the material, given that they have "virtually no experience in the field of positive psychology."¹¹⁶ It is worth noting that this criticism could also be levelled against the programs implemented in the other jurisdictions under examination in this study. The British TRiM program has a much shorter period instruction and also relied on non-medical personnel from all ranks. However, the major difference is that the TRiM program teaches these individual to support their peers through an understanding of psychological risk assessments which can help identify those who may need extra support. Unlike MRT, it does not charge personnel with instructing their subordinates and serves as a complement to other training programs, rather than as a replacement. It is also imperative to note, that unlike MRT and CSF, there are solid, evidence-backed studies that support the effectiveness of TRiM.

¹¹⁵ Paul B Lester et al., "The Comprehensive Soldier Fitness Program Evaluation. Report #3: Longitudinal Analysis of the Impact of Master Resilience Training on Self-Reported Resilience and Psychological Health Data," (2011), Publications of Affiliated Faculty: Nebraska Public Policy Center, Paper 32, 26.

¹¹⁶ Timmons, *The United States Army Comprehensive Soldiers Fitness: A Critical Look*, 17.

Ready and Resilient

In 2013, Secretary of the Army John McHugh issued a directive instructing that all programs in the fields of resilience training and suicide prevention would fall under the purview of a much larger initiative, called the Ready and Resilient Campaign (R2C). The decision was influenced in part by the recommendations from an Army-wide Behavioral Task Force which was led by McHugh the previous year. McHugh revealed that one of the recommendations was “that all programs dealing with resilience come under a single command authority, the G-1 or Office of the Deputy Chief of Staff for Personnel.”¹¹⁷ This recommendation was the result of the abundance of programs that often led to a redundancy of services. This undoubtedly made it difficult for personnel to be aware of how and where to access care if they required it.

At its core, R2C sought to “institutionalize education to promote resilience and built it into professional military instruction at various levels of a Soldier’s career.”¹¹⁸ It was implemented in March 2013 to public praise, particular in response to its dedication to addressing the stigma surrounding mental health and the often related suicides amongst personnel. R2C was designed to be rolled out in three phases, with some phases being implemented concurrently. The first of the three phases was Immediate Actions, focused on the “issuance of the campaign plan” and short-term objectives that were necessary to reverse problematic trends.¹¹⁹ Activities in this phase included the implementation of the Army’s Global Assessment Tool (GAT), an online confidential, self-assessment tool that

¹¹⁷ Gary Sheftick, “SecArmy orders ‘Ready and Resilient Campaign,’” *U.S. Army*, February 5, 2013, <https://www.army.mil/article/95793>

¹¹⁸ Ibid.

¹¹⁹ U.S. Army, *The United States Army’s Ready and Resilient Campaign* (Washington, DC, 2013), 6, <https://www.army.mil/e2/c/downloads/285588.pdf>

allows personnel to assess physical and psychological health.¹²⁰ The entire first phase is focused on improving awareness of and support for R2C and communicating the significance of quality training.

Phase II, *Change The Force*, is mandated in the R2C plan to have begun no later than March 31st, 2014.¹²¹ At this phase, attention is given to restructuring of systems and processes so as to better address the importance of resiliency within personnel. Finally, phase III, Sustain, focused efforts to ensure that support to personnel is constant and “continually reassessed and improved” so as to ensure that the change is permanent.¹²²

Summary

Similar to TRiM, the training programs that are employed by the U.S. Army focus on the training of a small group of individuals, who would then pass along that training to their subordinates. However, the programs employed by the U.S. attempted to entrust personnel with no psychology background with the instruction of advanced concepts to their subordinates. TRiM’s effectiveness lies in its emphasis on detection and subsequent referral to appropriate medical professionals. This system builds a level of unit cohesion and solidarity that would not otherwise exist in the American systems. Additionally, the mentioned absence of scientific studies backing the American training programs are particularly problematic in that there is no measure of success of the programs beyond individual perception.

Variable Analysis

What is perhaps one of the most important takeaways of this analysis is that the

¹²⁰Ibid.

¹²¹ U.S. Army, *The United States Army’s Ready and Resilient Campaign*, 8.

¹²² Ibid, 9.

British have rooted their obligation to preventing PTSD amongst the ranks through training in centuries-old law. Unlike Canada and the U.S., TRiM was implemented following legal cases against the MoD. Most significant about the finding of this legal case was that the judge ruled that while the care provided was not in question, it was the burden of care in combat that could not be rested on the laurels of one's peers. As the evidence shows, this ruling was a factor in the introduction of the TRiM program. The TRiM program stands out in terms of its measurable outcomes as well as its innovative approach. Within the military, camaraderie amongst peers is not only a highly-touted recruiting appeal, but also often a healing mechanism for those who have suffered as the result of their service. The ruling by the judge in the British case study clearly departed from this emphasis on peer-support alone and demanded evidence based-interventions. In contrast, the programs implemented by the U.S. Army relies often solely on peers who possess no medical background or experience, to instruct their subordinates on mental health awareness. Additionally, R2MR faced criticism regarding program delivery when instructors failed to adhere to standardized materials, skipping sections and definitions. Like the MRT program, R2MR trained individuals who were not medical practitioners. To skip materials or provide incomplete instruction would put their ability to properly train others in jeopardy.

It is clear that there are two common trends amongst training programs in the jurisdictions under analysis: an emphasis on a "train the trainer" model or a focus on recognizing and managing personnel who have been exposed to trauma. Arguably, the evidence shows that the latter has proven to be less problematic. As was evident in both R2MR and MRT, "train the trainer" models often result in medical and psychological

responsibilities being given to those with no professional background or experience. The training itself can also be problematic if the information is not provided in its entirety, leaving the trainees with gaps in skill development that is necessary for them to effectively address mental health issues. While there are a variety of factors at play in TRiM's success, it is their use of the management approach that sets them apart from other jurisdictions. The deviation from an emphasis on medical management of stress by unqualified personnel towards peer personnel management is unique. Each initiative has a peer element to its execution, an important characteristic given that it is known that personnel are more likely to speak about their experiences to their peers.¹²³ However, TRiM practitioners serve as accompaniments to available health supports, and assist in mentoring personnel as they cope with the stress of their experiences. TRiM is in part successful because it focuses on developing an ability to recognize signs of mental illness amongst their peers, and emphasizes cohesion and trust amongst peers, two imperative factors when attempting to mitigate stigma surrounding mental illness.

Another important observation from this analysis is the length since implementation of each training initiative under review. While it is possible to identify predictive factors for mental illness, it is not entirely possible to determine the reaction that individuals will have to exposure to combat. Therefore, training programs to address mental health must be tailored using the best possible evidence-based research and not rushed implementation as a result of political demands or public opinion. Of all the initiative examined, TRiM is the oldest, having been in place in the early 2000's, prior to mass deployment to Iraq and Afghanistan. Comparatively, R2MR, CSF and MRT were

¹²³ N Greenberg et al., "Perceived psychological support of UK military Peacekeepers on return from deployment. *Journal of Mental Health*," *Journal of Mental Health* 6 (2003): 564.

not implemented until 2009, the height of engagement in the Iraq and Afghanistan wars. As the majority of veterans examined in this study are personnel who have participated in these conflicts, it is not possible to determine whether the training initiatives offered in Canada and U.S. have had significant impact on the mental health of the cohort under study. This is not to say that these programs are without fault; significant issues have been raised about the utilization of the “train the trainer” model as well as the lack of evidence to support the training structure. However, there was an established TRiM protocol by the time that personnel began deploying to Iraq and Afghanistan. They were able to benefit from the evidence-based program and there are therefore measurable outcomes amongst the cohort following the conflict. Training programs established in the CAF and U.S. Army are less than a decade old and therefore there has been little to no opportunity to effectively study the outcome of these programs amongst the cohort under analysis. The majority of Canadian and American personnel who have drawn attention to their struggles with PTSD in recent years are veterans of the conflicts in the Middle East. Many of these individuals did not gain the potential benefits afforded through the use of any available training programs. While their experiences would most likely not have been any different, it is not possible to measure the impact these programs had on their mental health. With the maturation of these program, it is expected that more comprehensive reviews will be conducted that can provide evidence-based research to improve existing flaws in the programs.

In large part, centralization played a significant role in the success of the training programs implemented in both Canada and the U.K. The nature of both of these jurisdictions and their respective armed forces meant that much of the training for the

entirety of their personnel was developed in a central institution within the armed forces body and then uniformly applied to all who required it. The same does not exist within the U.S. Army, meaning that the training was delivered unevenly, in an ad hoc manner. This undoubtedly resulted in the problematic nature of the training and subsequent impacts that it had on the mental health of personnel.

The analysis of civil-military relations played an important role in the success of the TRiM program in comparison to the other jurisdictions. Whilst civil-military relations do not always result in favorable outcomes and can be contentious, the legal case and subsequent finding that was brought forward were instrumental in the implementation TRiM. It is Cohen's conceptualization of the civil-military gap that is relevant here, particularly in his attempt to understand who influences military policy. While he was focused primarily on policy that concerned the use of force, his questioning of whether civilian values influence military policy is key here. In the U.S. and Canada, the training programs were not the result of any civilian institutional interference or influence. However, the role that the government and court plays in the introduction of training programs in Britain is difficult to ignore. While they are not entirely responsible for the development of the programs, the role they played at the beginning potentially increased the level of external oversight in the creation of the program which may have contributed to TRiM's success.

It is not appropriate to make absolute judgements of whether a training initiative is successful in addressing and ultimately mitigating mental health issues amongst personnel. However, it is appropriate to make judgements on relative success and make suggestions for potential changes or adaptations to training programs. This analysis has

demonstrated that due to a number of factors, the British TRiM program has emerged as one of the most successful to date in addressing mental health amongst personnel. It is difficult to measure the alleviation of stigma, the development of mental health and whether or not training played a decisive role in the mitigation of mental illness.

However, TRiM was based on evidence-based research and its approach is rooted in legal decisions and advice. Perhaps most significantly, TRiM was equally applied to all incoming and current personnel, resulting in equal training across the board. This is directly related to the centralized nature of services within the British armed forces, and results in all personnel receiving the same preparation. It has also meant that those who conduct the training have received the same degree of education on the subject and are all equally qualified to instruct the program.

Comparatively, MRT has been critiqued by those who question whether the appropriate individuals are being selected as trainers and by those who question whether the structure of the program allows for any measurable outcomes. The decentralized nature of their system means that training was not uniform in nature: it was not provided to all personnel and was provided differently at different bases. TRiM also does not rely on peers to instruct their subordinates, which moves away from the emphasis on the superior-subordinate relationship which so strongly permeates almost every aspect of the military. Likewise, R2MR has also been critiqued for the questionable instruction provided to those undergoing the training. The instructional emphasis that exists within both the CAF and U.S. Army does not do much to alleviate stigma as individuals would most likely have difficulty reaching out to their superiors for assistance. The TRiM approach moves away from a medical intervention approach, focuses on establishing trust

and support amongst peers and research on the program has produced positive results. It is difficult to make comprehensive changes during the height of a conflict. During such times, attention is focused elsewhere and filling ranks with personnel often takes priority over developing evidence-based training programs. Both Canada and U.S. undertook training programs during the height of deployments to the Middle East and it will take time before individuals who have underwent these training initiatives and programs can attest to their effectiveness. Therefore, the criticisms of their training programs must be approached with the understanding that the maturation of these programs could result in measureable impacts if research conducted over time is considered by those working on these initiatives.

This chapter argued that training programs succeeded most effectively in the U.K. because they were based heavily on scientific data and their method of delivery worked to avoid exacerbating the stigma that exists surrounding mental health, particularly between superiors and subordinates. The engagement of professionals from civil society in the development of training programs in the U.K. contributed to their success in that civil society values, such as the emphasis on seeking professional help rather than assistance solely from peers, was incorporated into their training methods. Finally, and perhaps most importantly, was the degree to which the institution in which training is developed and implemented is centralized. While Canada and the U.K. both have more centralized systems than the U.S., Canadian training efforts succumbed to a greater number of causal factors and fell short of what the U.K. managed to achieve. The U.K.'s effectiveness in training their personnel and providing adequate, research-based initiatives is directly related to the degree to which processes are centralized within their armed forces.

CHAPTER 4: DISCHARGE POLICIES AND COMPENSATION

Undoubtedly the most controversial aspect of mental health delivery - or lack thereof - in the jurisdictions discussed, is the discharge policies and procedures. These policies not only dictate the justification for medical discharge for personnel, but often the benefits and continuation of treatment following discharge. In recent years, the increase in deployment to combat operations has led to an increase in publicity surround personnel experiencing mental trauma. While some argue that the numbers of those rendered unable to perform their duties has rapidly increased, such a claim is difficult to make given the lack of discussion and research on which to gauge increases and decreases. However, it is difficult to disagree with the notion that the publicity and social awareness of the mental health issues facing those within armed forces has increased exponentially. This heightened criticism means that armed forces are now faced with the difficult task of providing care in a time of financial and public scrutiny and diminished ranks.

This chapter will analyze the case study of discharge policies and compensation, particularly in their relation to the increase in mental trauma during operations in Iraq and Afghanistan. It will argue that within the U.S. and – to a lesser degree – Canada, personnel with mental illness have been forcibly removed from the ranks for reasons that include limited resources, inappropriate understanding of mental health and a desire to ensure a prepared and healthy force, capable of deployment. This case study will also examine the degree to which institutions are centralized and discuss the related issues of oversight that have a direct impact on the manner in which discharge policies and compensation are applied. However, this chapter will also discuss the causal factors of operational readiness and financial scrutiny, which are of equal importance to

centralization in this case study.

For the purposes of this analysis, the term discharge will be used in the U.S. and U.K. studies where applicable, while the Canadian analysis will refer to the process as release. This difference in use of language is key to understanding the attitudes of armed forces towards the process itself. This study argues that the mistreatment of soldiers who are experiencing mental illness because of their service is not always deliberate or malicious and often arises from a lack of resources and poor planning. The conclusions of each jurisdictional analysis carried out in this chapter and subsequent conclusion will address this lack of resources, while also explaining the negative attitudes towards ill and injured within the ranks.

Case Study: Canada

Much like the analysis previously conducted on the American Army, the resources used in this case study are mainly from investigative journalists and primary sources. In recent years, there has been discord within Canada about the treatment of veterans once they have been medically released from service. While there is not widespread evidence of dismissal on ground of misconduct for soldiers with mental illness, there have been excessive medical releases of soldiers in the years since the Afghan conflict.

In 2008, then General Rick Hillier, the Chief of Defence staff, ordered his subordinates that no soldier wounded in Afghanistan was going to be released without his review. As *Macleans* journalist Michael Friscolanti wrote, there is a strong desire to avoid any potential public relations issues when it comes to the release of soldiers with mental

illness.¹²⁴ The avoidance of public scandal would not last long, as systemic issues surrounding the compensation for mentally ill veterans were brought to light, as well as a controversial principle dictating soldier fitness.

This case study will analyze the release policies for Canadian soldiers, the politicization surrounding compensation schemes and the impact of the universality of service principle on personnel mental health.

Types of Dismissal and Release

The Queen's Regulations and Orders (QR&O) for the CAF is the primary document of military law in Canada.¹²⁵ Chapter 15 outlines the laws governing release of CAF personnel and, unlike the American process, prefer to use the terms dismissal or release rather than discharge. There are five types of releases: misconduct, unsatisfactory service, medical, voluntary and service completed.¹²⁶ Within each of those categories, there are subcategories which are more specific to the nature of release. Most important for the purposes of this study is medical release, which can be under one of two reasons: "on medical grounds, being disabled and unfit to perform duties as a member of the Service"; or "on medical grounds, being disabled and unfit to perform his duties in his present trade or employment, and not otherwise advantageously employable under existing service policy".¹²⁷ In addition, the regulation states that there can be discretion allotted to any member of the Regular Force (RF) whose injury necessitates medical

¹²⁴ Michael Friscolanti, "Fighting to Serve," *Maclean's* 121, no. 11 (2008): 21.

¹²⁵ This is aside from the National Defence Act is the enabling legislation for the organization and funding of the CAF, while the QR&O allows for the governance of the CAF and outlines the regulations determining military law.

¹²⁶ Canada. Department of National Defence, and Canada. *The Queen's Regulations and Orders for the Canadian Forces: Issued under the Authority of the National Defence Act*. Ottawa: R. Duhamel, Queen's Printer, 1965.

¹²⁷ *Ibid.*

release by the Chief of Defence Staff, who may request that the individual be retained for up to six months for treatment.¹²⁸ After this 6 month period has passed, the individual will be released unless otherwise directed by the Minister. Furthermore, those who are to be released as medically unfit are referred to Veterans Affairs Canada (VAC) if they require further treatment and the release is completed as soon as possible following the referral.¹²⁹

There are not significant instances of CAF personnel being released on any other grounds than medically unfit once they have been diagnosed with a mental illness. However voluntary release can be potentially problematic when addressing mental health as there is little time for transition counselling, with only 30 days' notice required by personnel.

Medical Release Process

Unlike the U.S., the process for release is much more centralized and is coordinated by case managers at the CAF and DVA. As outlined by the National Defence and Canadian Forces Ombudsman, there are three phases to the transition to civilian life which are, in order, the period between the injury or diagnosis and when a decision is made for a medical release; the period between the receipt of medical release decision and the actual date of release; and finally the date of release and approximately two years after the release date.¹³⁰

According to a report issued by Lynda Manser, an official in the CAF, a total of

¹²⁸ Ibid.

¹²⁹ <http://www.forces.gc.ca/en/about-policies-standards-queens-regulations-orders-vol-01/ch-15.page>

¹³⁰ "Your Transition to Civilian Life – The Three Phases of Medical Release," National Defence and Canadian Forces Ombudsman, accessed July 4 2016, <http://www.ombudsman.forces.gc.ca/en/ombudsman-questions-complaints-helpful-information/transition-phases-index.page>

8026 personnel were released on medical reasons between 2006 and 2011.¹³¹ From 2008 to 2013, she has collected the data per year of medical release, approximately 1000 per year. However, the 2012 Auditor General's reports stated that the CAF "does not maintain consolidated information on ill and injured Forces members, including...those who will be released for medical reasons, and those receiving transition support services".¹³² Therefore, it is not possible to discern the exact number of discharges each year as the data does not simply exist. There is data related to the reason for medical releases and while limited, does provide some insight into the scope of mental illness diagnoses in the CAF. The 2014 CAF Surgeon General's Report, 13.2% of serving CAF personnel were diagnosed a mental or psychological illness within 4.5 years of deployment to Afghanistan.¹³³ However, the limitation in the data is that not all of these individuals were medically released. Robert Poisson, with data from the Canadian Forces Health Services Group (CFHSG) revealed that in 2013, 1217 personnel were released from the CAF for inability to meet the Universality of Service criteria, of which 41.3% were mental health injury or illness.¹³⁴ He also argues that this is a rather consistent number for each of the years for which data is provided, 2009 to 2013. The unfortunate conclusion that this leads to is that there are many personnel whose mental illness and trauma has gone unnoticed. The lack of reliable data has been regularly addressed in CAF

¹³¹Lynda Manser, *The Needs of Medically Releasing Canadian Armed Forces Personnel and Their Families – A Literature Review* (Ottawa, ON: Military Family Services, 2015), 35.

¹³² Canada, Office of the Auditor General of Canada, *Report of the Auditor General of Canada to the House of Commons: Chapter 4 Transition of Injured and Ill Military Personnel to Civilian Life*, (Ottawa, ON, 2012), http://www.oag-bvg.gc.ca/internet/docs/parl_oag_201210_04_e.pdf, 23.

http://www.oag-bvg.gc.ca/internet/English/parl_oag_201210_04_e_37348.html#hd5j section 4.55

¹³³ Canadian Forces Health Services Group. *Surgeon General's Report 2014*. Ottawa, ON: National Defence, 2014.

¹³⁴ Robert Poisson, "The imperative of military medical research and the duty to protect, preserve, and provide advanced evidence-informed care," *Journal of Military, Veteran and Family Health* 1, no. 1 (2015): 12.

reports, including the 2009 *Report on the Evaluation of Support to Injured CAF Members and their Families* which states “The extent to which statistics are kept is uneven at best”.¹³⁵ It is important to maintain accurate data to measure the effectiveness of programs administered. The Auditor General has consistently addressed these faults in reports, and has recommended a consolidation of information on the medically released personnel within the CAF. There have yet to be tangible results as the issue is ongoing but the urging of accountability is conducive to change.

Problematic Nature of Benefits

Access to benefits has been the most controversial aspect of addressing mental health within the CAF ranks since the beginning of the Afghan conflict. The New Veterans Charter promised to ease the transition for injured and ill personnel to civilian life and introduced the disability reward, career transition services and rehabilitation services among others.¹³⁶ The benefits that the NVC offers have been harshly criticized by those affected as well as by government officials. One area of contention was the introduction of lump sum payments for disability, which replaced the monthly lifetime benefits, and maxed out at \$285,000.¹³⁷ The payments did not financially measure up to those offered by their allies, demonstrated in the case analysis of the U.K. Moreover, the new lump-sum payment under the NVC was significantly less than the previous offering of a lifetime monthly pension for disabled veterans. It was journalist Sean Bruyey who became one of the first to draw public attention to the “shortfalls of the lump-sum

¹³⁵ Chief Review Services. *Evaluation of Support to Injured CF Members and Their Families*. Ottawa, ON: National Defence, 2009, 69.

¹³⁶ Jean-Rodrigue Pare, *The New Veterans Charter: Background Paper*, (Ottawa: ON) Library of Parliament, 2011.

¹³⁷ Laura Stone, “Invisible Wounds: Is the New Veterans Charter Working?” *Global News*, accessed July 21 2016, <http://globalnews.ca/invisible-wounds/1255407/invisible-wounds-recommendations-to-new-veterans-charter-expected-this-spring>

program” in 2005.¹³⁸ With the introduction of the 2005 NVC came an outpouring of anger from veterans and their families over the payment cuts. It was not until 2011 that the *Enhanced New Veterans Charter Act* brought about change in payment schemes, allowing veterans to choose between a lump-sum payment and an annual payment. In 2013, Mary Chaput, Deputy Minister of Veterans Affairs Canada (VAC), argued that the majority of veterans continued to opt for the lump-sum payment: “The fact is that most of them are not choosing to take periodic payments. It’s been 2% or 1%. They are typically choosing to take it in a lump sum. I can only assume that the independent financial advice they are getting is suggesting that in their particular circumstance that’s the best way to go.”¹³⁹

While Chaput’s stats may have been correct, her statements did nothing to curb the continued uproar from veterans, their families and politicians. As is described in the 2014 Report of the Standing Committee on Veterans Affairs (SCONDVA), one of Canada’s most well-known and revered veterans, Senator Romeo Dallaire, continued to press that the lump sum measure was “detrimental”.¹⁴⁰ SCONDVA emphasized that the opposition to the new payment scheme was based its relation the behaviour of people suffering from mental illness and its failure to ensure financial security for the injured and ill.

The primary opposition to the lump sum payment is that those who receive it are

¹³⁸ Sean Bruyey, “Disabled soldiers angry over lump-sum payments,” *The Toronto Star*, August 26 2010, accessed July 20 2016, www.thestar.com/opinion/editorialopinion/2010/08/26/disabled_soldiers_angry_over_lumpsum_payments.html.

¹³⁹ *Standing Committee on Veterans Affairs (ACVA)*, November 19 (2013) (statement of Mary Chaput, Deputy Minister of Veterans Affairs Canada).

¹⁴⁰ *Standing Committee on Veterans Affairs (ACVA)*, April 3 (2014) (statement of Romeo Dallaire).

undergoing a tumultuous period in their lives, often suffering from severe injury or illness and abandoning career expectations by being forced to leave the CAF. Handing an individual in this state a large sum of money is an incredibly high risk that can have disastrous effects. The decision to switch to a lump sum payment system reflects an assumption by the bureaucracy that all veterans are financially savvy, which represents a gross misunderstanding when factoring in that many of the veterans receiving these payments are suffering from severe mental illness. Furthermore, the switch to lump sum payments denotes a rush to be rid of personnel who are ill and injured, whereas the use of a lifetime disability pension conveys a continued commitment to those whose ailments are the result of service to Canada. The lack of awareness in this decision is only a part of the systemic problems in VAC, particularly in the understanding of mental illness and its characteristics. Those in opposition to the lump sum program also believe that the care it provides to veterans with serious injuries in the short term, but moderate permanent disabilities, is inadequate for meeting their needs. Advocates like Jim Scott of the Equitas Society says it is undoubtedly crucial to address the most seriously injured veterans first, it doesn't mean that there is reason to neglect veterans who do not face serious long term disability.¹⁴¹

For years, CAF veterans and political officials have expressed concern that the current benefits system prevents soldiers from coming forward and addressing their mental health concerns in fear of losing benefits and pension. Unlike in the U.S., the fear is not fueled by fear of being receiving a misconduct discharge, an often-automatic loss of benefits, but rather of failing to meet the pensionable service criteria outlined by the CAF.

¹⁴¹ Greg Kerr, "The New Veterans Charter: Moving Forward," *Report of the Standing Committee on Veterans Affairs, 41st Parliament, 2nd session, House of Commons, Canada* (2014), 19.

To receive an immediate pension upon medical release, both Reserve and Regular Force personnel must have at least 10 years of pensionable service.¹⁴² If they fail to meet the ten years of service, they are simply paid out the contributions they made during their years of service, with no coverage for long-term costs.

What is most important about this protocol is the impact that it has on veterans who are suffering from mental illness. In fear of losing benefits and economic security, personnel who have not yet reached ten years of service are incredibly unlikely to come forward with any concerns over the state of their own mental health. While it is more evident that those who face medical release before ten years will often receive a disability compensation, it is more important to recognize that the limitation of ten years of service particularly targets those who are not clinically diagnosed. Most troubling is that the protocol remained in place during a period in which there was a strong recognition of the depth of mental illness within the ranks.

Universality of Service Principle

The process of release from the CAF, in particular medical release, is influenced by the universality of service principle, also referred to as the “soldier first” principle. It holds that CAF members are “liable to perform general military duties and common defence and security duties, not just the duties of their military occupation...this may include but is not limited to the requirement to be...employable and deployable for general operational duties”.¹⁴³ Echoing the sentiments of former U.S. Army chief of staff Chiarelli, this principle provides justification for the dismissal of personnel from the ranks if they are found unfit to deploy. The CAF has consistently justified the principle,

¹⁴² <http://www.forces.gc.ca/en/caf-community-pension/contributor.page>

¹⁴³ <http://www.forces.gc.ca/en/about-policies-standards-defence-admin-orders-directives-5000/5023-0.page>

arguing that while they are committed to assisting ill and injured personnel through the recovery process, they “are required to take those measures necessary to field a ready, operationally effective force in the defence of the nation”.¹⁴⁴

It is important to understand why this is problematic given that the purpose of standing armies is to protect the nation and serve in operations abroad. In 2014, then ombudsman of national defence and CAF Pierre Daigle appeared before a Senate committee and blamed the universality of service rule for contributing to a culture of fear within the CAF.¹⁴⁵ Several months later, then Defence Minister Rob Nicholson informed the House of Commons that a working group had been established to review the principle in question. Nicholson acknowledge the precarious relationship between a duty to care for injured and ill service personnel while also having enough troops fit to deploy when necessary.¹⁴⁶

Two years later, in May of 2016, the Chief of Defence Staff General Jonathan Vance told Gloria Galloway of the Globe and Mail that there was not likely going to be a change of the principle, stating: “We are a small armed forces; everybody’s got to be able to pitch in all the way.”¹⁴⁷ While he agreed that there needed to be an improvement of the discharging processes, he said that it would not be feasible to retain injured and ill

¹⁴⁴ “Fit to Serve: Universality of Service and Related Support Programs,” National Defence and the Canadian Armed Forces, March 5 2011, <http://www.forces.gc.ca/en/news/article.page?doc=fit-to-serve-universality-of-service-and-related-support-programs/hnps1vfl>

¹⁴⁵ Bruce Campion-Smith, “Soldiers suffering from stress risk being kicked out of the forces, watchdog says,” *Toronto Star*, February 5 2016, accessed July 22 2016, https://www.thestar.com/news/canada/2014/02/05/soldiers_suffering_from_stress_risk_being_kicked_out_of_forces_watchdog_says.html

¹⁴⁶ David Pugliese, “DND reviewing policy of kicking injured soldiers out of the military,” *Ottawa Citizen*, October 14 2014, accessed July 20 2016, <http://ottawacitizen.com/news/national/defence-watch/dnd-reviewing-policy-of-kicking-injured-soldiers-out-of-the-military>.

¹⁴⁷ Gloria Galloway, “Discharge rule for disabled soldiers must stay in place, general says,” *The Globe and Mail*, May 10 2016, accessed June 20 2016, <http://www.theglobeandmail.com/news/politics/discharge-rule-for-disabled-soldiers-must-stay-in-place-general-says/article29970146/>

personnel within the ranks.

Case Study: United Kingdom

The problematic nature of discharges in the U.S. is not mirrored within HM Forces in terms of the questionable justification for removal. The issues that will be discussed in this jurisdictional analysis do represent the differences in delivery of care and how that can impact discharge policies and attitudes. As will be discussed in this section, soldiers in the U.K. are often assured of the security of their position within HM Forces, regardless of the severity of their injuries. Additionally, the care for injured and ill soldiers is the responsibility of the MoD while they remain soldiers, but transfers to the National Health Service (NHS) once they are discharged. This downgrading in care is one area of contention that will be discussed further.

Exit Options and Definitions

As in all the standing armed forces discussed in this study, there are multiple options for exiting HM Forces as well as a difference in the terminology applied to the options. Unlike in the U.S., there is not strong evidence of personnel with mental illness diagnoses being wrongfully dismissed or discharged. Subsequently, the only focus of this case study will be on understanding the medical discharge process and the compensation associated.

A factor considered in the British Armed Forces, which is not mirrored in the U.S. and Canadian analyses, is that there is a clear differentiation in retention standards in each of the service branches. This division amongst the services offers incredible oversight and likely leads to the avoidance of wrongful dismissals on the scale that they occur in the U.S.

In the U.K., the term ‘discharge’ is applied to personnel who have permanently left HM Forces while ‘dismissal’ is applied to those who have been compelled to leave as the result of a court martial.¹⁴⁸ In the U.K., there are a variety of codes used for administrative purposes when dealing with medical discharges, including: P7-fit for limited or restricted duties in the U.K. only; and P8-medically unfit for any form of military service.¹⁴⁹ When an individual is deemed to have psychological or physical ailments that place them below the required standards, they are referred to a medical board for examination.¹⁵⁰ If the medical status of the service member is found to be so severe that they are entirely unable, currently or in the foreseeable future, to meet retention standards, they will be recommended for a medical discharge. In many cases, the service member is first downgraded “to allow for treatment, recovery and rehabilitation”.¹⁵¹ If there is progress in the recovery, but not a total recovery, personnel will be permanently downgraded and retained or subsequently referred for a medical discharge.

Defence Recovery Capability Initiative

For those facing departure from HM Forces because of mental illness, an important area of focus is on recovery. The Defence Recovery Capability (DRC) was developed to “deliver a conducive military environment within which all serving Wounded, Injured and Sick (WIS) personnel get the appropriate support to enable an

¹⁴⁸HM Forces, “HM Forces: applications on discharge,” British Home Office, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488255/Armed_Forces_apps_discharge_V3.0.pdf

¹⁴⁹ Ibid, 15.

¹⁵⁰ Ministry of Defence, “Annual Medical Discharges in the UK Regular Armed Forces 2009/10 - 2013/14,” Defence Statistics, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445326/20140708-medical_discharges_1_apr_09_31_mar_14_Final-O.pdf (accessed June 8, 2016), 2.

¹⁵¹ Ibid, 2.

effective return to duty or transition to a properly supported and appropriately skilled for civilian life.”¹⁵² The MoD and all Service branches insist that personnel are entitled to welfare support until their final day of Service and that their support is appropriately tailored for either their return to duty or their life after an approaching discharge.¹⁵³ While each Service has their own approach to recovery, but operate under the same umbrella of services.

The DRC, introduced in 2010, is an initiative led by the MoD put delivered in conjunction with service charities including Help for Heroes and the British Legion.¹⁵⁴ This multi-agency approach to service delivery further represents the finding in this study that to meet demands for care, the British emphasize coordinated support. The multi-million pound commitment made by the charities and MoD to HM Forces is “the largest single charitable contribution to the Armed Forces in British history.”¹⁵⁵ The DRC is delivered through multiple avenues including an Individual Recovery Plan (IRP), Recovery Units, Personnel Recovery Centres (PRCs), Battle Back, Recovery Courses and CTP-assist (formally Recovery Career Services).¹⁵⁶ After a WIS soldier is absent from duty for 7 days, their Unit Welfare Office will commence a IRP which considers all the aspects of a soldier’s recovery. If it is determined that a soldier will take more than 56 days to recover, they are transferred to a PRU and assigned a Personnel Recovery Officer

¹⁵² Ministry of Defence, Directorate Service Personnel Policy, “Tri Service Operational and Non Operational Welfare Policy,” https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/436113/20141215-JSP_770_Final_v10-U.PDF (accessed June 8, 2016), 84.

¹⁵³ Ibid.

¹⁵⁴ Government of the United Kingdom, “Background Quality Report UK Armed Forces Recovery Capability: Wounded, Injured and Sick in the recovery pathway: 1 October 2010 to 1st October 2015,” Defence Statistics https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512087/20160331_-_Background_Quality_Report_WIS_Official_Statistic-Oct_2015_O.pdf (accessed June 9, 2016), 1.

¹⁵⁵ Ibid, 2.

¹⁵⁶ Ibid, 2.

(PRO). It is at this point, normally within a 12-month period, the service member will be referred to the medical board for an evaluation of status. Once recommended for a medical discharge, the Veterans Welfare Service will prepare to provide a continuation of support for the member upon discharge so that they are prepared for the transition to civilian life. Appropriate staff will also refine the member's IRP to plan accordingly for the discharge deadlines.

The benefit of the IRP is that it is a multi-faceted approach to recovery and involves all relevant areas of recovery, including welfare, education, housing, work placement and medical.¹⁵⁷ Additionally, the cooperation with outside agencies allows for an alleviation of responsibility for care off the MoD while also maintaining a smooth transition and cooperation.

Benefits and Compensation

To ease the transition for an individual with mental illness who is facing medical discharge, it is important that they are provided with adequate information prior to discharge about the benefits that they can expect to receive. The financial impact of leaving one's career is significant and when combining that impact with the debilitating symptoms of a mental illness, the prospects are challenging. The Tri Service Operations and Non-Operational Welfare Policy issued by the MoD states that all service personnel who are facing discharge will receive "an automatic forecast, of any ill-health pension benefits they are entitled to normally no later than 6 weeks prior to their date of

¹⁵⁷ Ministry of Defence, Directorate Service Personnel Policy, "Tri Service Operational and Non Operational Welfare Policy," 85.

discharge”.¹⁵⁸

Within HM Armed Forces, Veterans U.K. is responsible for administering the armed forces pension schemes and compensation payments for those that have been injured or suffered illness through their service. Under the Armed Forces Compensation Scheme (AFCS), a claim can be made if the illness or injury was made on or after April 6 2005 and includes ‘mental disorders’.¹⁵⁹ The claim can be made for any injury or illness incurred while participating in a service related activity and is therefore does not necessarily need to be related to combat or deployment experience. Much like within Canada, there are different payment options for successful AFCS claims. Both lump sum payment options and Guaranteed Income Payments (GIPs) are available, with lump sum payments strongly outweighing those offered to their Canadian allies, with a maximum compensation of £570,000.¹⁶⁰ The GIPs are for those with the most serious injuries and illnesses and provide a tax-free income stream beginning the day after service ends.¹⁶¹ This award takes into consideration the impact that one’s injury has on their ability to become employed while also considering the pension that you may have lost because of time you could have served if you had not been medically discharged.¹⁶²

Under the Freedom of Information Act 2000, the MoD has released data on the compensation awarded to those with mental illness under the AFCS. Between 6 April

¹⁵⁸ Ibid, 106.

¹⁵⁹ “Armed Forces Compensation: what you need to know,” Ministry of Defence, accessed June 8, 2016, <https://www.gov.uk/government/publications/armed-forces-compensation/armed-forces-compensation-what-you-need-to-know>

¹⁶⁰ This sentiment has also been expressed in a Canadian Standing committee on Veterans Affairs Report and by other Canadian veteran advocates. However, it has been dismissed by several Canadian military personnel who argue that the financial value of other services available to Canadian personnel that are not available to British personnel close that financial gap.

¹⁶¹ “Armed Forces Compensation: what you need to know,” Ministry of Defence.

¹⁶² Ibid.

2005 and 30 September 2014, 130 individuals were awarded compensation for a mental disorder and a total of 135 compensation awards were made to these individuals.¹⁶³ This data reflects the argument that many sufferers of mental illness within armed forces suffer from a multitude of injuries, both physical and psychological. While the data mentioned above failed to specify whether the awards were provided to veterans of the Afghanistan conflict, the dates provided coincide with the Afghanistan conflict. Given the time of processing compensation, it is logical to interpret that some of the individuals who received compensation during this time served in Afghanistan.

The benefits and compensation schemes awarded to those within HM Forces by the MoD and other veterans charities are often lauded by advocates in other jurisdictions, including the two analyzed within this study. While it is not without faults, which will be discussed in the forthcoming section, they are few and far between when contrasted with their allies. The plan for medical discharge and the continuation of service through veterans' charities is an innovative way of addressing an onslaught of mental injuries following conflict.

Political and Veteran Backlash

Perhaps one of the most unique findings of this study is that the negative response from veterans who have been medically discharged from HM Forces is primarily fueled by a desire to remain within the ranks, not by a belief that they were wrongly discharged.

When Lance Bombardier Ben Parkinson was injured in a Taliban bomb attack in 2006, he lost both of his legs and suffered more than 40 other injuries resulting in severe

¹⁶³ Defence Statistics Letter, April 8 2015, *Ministry of Defence*, Bristol, UK. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/423112/FOI201502584_O_R_edacted.pdf

brain damage that impacted his memory and speech. Many medical professionals and military officials hail him as the most badly injured surviving soldier in the U.K. In 2007, his injuries were assessed under the compensation scheme that awarded him £115,000 for the loss of his legs at 100%, £34,500 for his brain injury at 30% and £2,650 pounds for an elbow fracture at 15%.¹⁶⁴ His other 34 injuries were not assessed, a decision overturned with the help of his legal counsel. Ben's case was reassessed so that the traumatic injuries he sustained as well as his fractured vertebrae were considered as his third injury, rather than his elbow.¹⁶⁵ The compensation received by Parkinson was called 'insulting' by many at the time, who also called for a change to maximum payout offered to personnel, which stood at £285,000 as of 2007.¹⁶⁶ Parkinson's legal counsel issued a letter of intent to then Defence Minister, Derek Twigg, outlining their plans to push for a judicial review of the compensation scheme.¹⁶⁷ In late 2007, the MoD responded and said that "changes that could lead to higher compensation for Parkinson and other similarly injured soldiers were now being considered".¹⁶⁸ The high-profile case resulted in a government ruling that soldiers must be compensated for all the injuries they receive in a single incident and not just the three most serious, which raised Parkinson's compensation to £540,000.¹⁶⁹ This award came after multiple court battles for a soldier and his family already facing the stress and trauma of his service overseas.

¹⁶⁴ Paul Stokes, "Ben Parkinson assured of full compensation," *The Telegraph*, October 11, 2007,

<http://www.telegraph.co.uk/news/uknews/1565789/Ben-Parkinson-assured-of-full-compensation.html>

¹⁶⁵ At the time, only a maximum of three separate injuries could be considered, with a scale of seriousness determining the payout for each one. This was particularly detrimental for veterans like Parkinson, who had suffered a multitude of injuries during service.

¹⁶⁶ Ned Temko, "Disabled soldier's pay-out victory," *The Guardian*, September 2, 2007,

<https://www.theguardian.com/uk/2007/sep/02/military.politics>

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

¹⁶⁹ Richard Norton-Taylor, "MoD challenges payments for injured soldiers," *The Guardian*, July 28, 2009, <https://www.theguardian.com/uk/2009/jul/28/veterans-injured-soldiers-compensation>

Parkinson's battle would not end there. As was discussed in the previous section, personnel who are injured during service are often retained and downgraded to allow for recovery and treatment to take place before they are recommended for medical release. In 2011, Parkinson faced "forced" medical discharge from HM Forces.¹⁷⁰ The extent of injuries and his long road to recovery would leave few doubts in the minds of many that Parkinson should be medically discharged as he is unable to fulfill his responsibilities as a soldier. However, the structure of the compensation and treatment scheme in HM Forces means that while Parkinson is retained, his treatment is covered. To be discharged would mean a scale back in his treatments as well as being forced to finance many of his own treatments. Additionally, Parkinson was making incredible progress that defied the odds of medical professionals by learning to walk with the help of crutches and improving speech through therapy. He was also placed in a computer job with his regiment in 2010, allowing him to remain a contributing member of HM Forces while also receiving the necessary care.¹⁷¹ Per his parents, this would have resulted in Parkinson being transferred from the care of the MoD to the NHS, reducing the amount of therapy he receives each week to just two hours. His high-profile case generated more attention and resulted in a promise by the MoD that he would remain a soldier if his recovery necessitated it by then Minister Andrew Robathan who was responsible for Welfare and Veterans.¹⁷²

Despite the decision to allow Parkinson to remain within the ranks, high-ranking military personnel have been publicly criticized for their attitudes towards medical

¹⁷⁰ "Soldier injured in Afghanistan faces 'forced discharge'," *BBC News*, September 28, 2011, <http://www.bbc.com/news/uk-15096301>

¹⁷¹ Martin Wainwright, "Double-amputee soldier gets new army job," *The Guardian*, December 28, 2009, <https://www.theguardian.com/uk/2009/dec/28/soldier-ben-parkinson-army-job>

¹⁷² "Injured Para Ben Parkinson wins battle to stay in Army," *The Yorkshire Post*, October 24, 2011, <http://www.yorkshirepost.co.uk/news/injured-para-ben-parkinson-wins-battle-to-stay-in-army-1-3901076>

discharging soldiers like Parkinson. A 2011 report by Steven Swinford of *The Daily Telegraph* revealed that the MoD had the intention of fast tracking discharges of those who were medically unfit. There are battalion limits for the number of injured soldiers that can be retained before a battalion is deemed unfit for deployment. At the time of the report, 6% of the British Army's forces had been classified as unfit for operational deployment.¹⁷³ In a briefing note obtained by Swinford, the director general of Army personnel, wrote that the retention of injured personnel was not in the "best interest of either the individual or the Army".¹⁷⁴ The note was sent to divisional commanders and angered many when it echoed sentiments expressed both in the Canadian and U.S. case studies by stating: "The number of non-deployable personnel serving in the Army remains a concern in an Army that is focused on operational capability. It is harsh reality that we must look critically at how we manage our wounded, injured and sick, regardless of cause."¹⁷⁵ The primary issue with many impacted by such a statement was that it was contradictory to a statement made by Lord Dannatt, the former head of the Army, who said that soldiers who have been injured in operations should be retained within the Services.¹⁷⁶

Such a public disconnect in the discourse on a contentious issue is undoubtedly going to make an already difficult situation more volatile. It is important to note that Swinford's report came months prior to the decision to retain Parkinson within the ranks. Much like the evidence presented in the Canadian analysis, there was undoubtedly a

¹⁷³ Steven Swinford, "Wounded soldiers to be forced out of the Army," *The Telegraph*, February 18, 2011, <http://www.telegraph.co.uk/news/uknews/defence/8335021/Wounded-soldiers-to-be-forced-out-of-the-Army.html>

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

desire to avoid any potential public relations scandals. Parkinson's case was already widely known and he, along with his supporters, were influential for many injured veterans in drawing attention to their plight, both physical and psychological, and influencing real change in compensation and adequate care.

For many, the problematic nature of these discharges is that while there is a continuance of care and soldiers will not go untreated, the cost of that care is often more than what is affordable for personnel, particularly any care required from a specialist. Additionally, the frequencies of services that can be delivered from within the NHS are drastically less than those from within the MoD.

Case Study: United States

In the U.S. Army, the political climate surrounding the discharge of soldiers diagnosed with PTSD or other related mental illness has been particularly volatile in recent years. This conflict was fuelled by research that came from investigative journalism at several high-profile media institutions, particularly The New York Times and National Public Radio (NPR). While many of these reports touch on the poor access to services, this case study will focus specifically on the widespread and often qualitative evidence of discharging soldiers who are suffering from mental illness. It will begin by describing the types of discharge and releases that soldiers with mental illness have received and an analysis of the difficulties of accessing benefits and compensation.¹⁷⁷ The importance of this case study is to identify the causation of thousands of discharges of American soldiers with mental illness: costs saving measures and an often a negative

¹⁷⁷ Any use of the term benefits in this study is referencing the benefits and/or compensation that are awarded to soldiers or veterans who have been diagnosed with a mental illness and require assistance. While the term 'benefits' is broadly applied by the VA that encompasses home loans, life insurance and pension, these types of benefits are not within the scope of this analysis.

attitude towards mental illness by superiors.¹⁷⁸

Definition of discharge and separation categories

When an individual experiences the characteristics of a mental illness, the priority should undoubtedly be ensuring the receipt of proper medical attention so that they may receive proper treatment. This idealistic approach is not well-founded in many cases of mental illness in armed forces. The reality is that many personnel will not be able to return to service and therefore their departure needs to be handled accordingly. However, many soldiers who experience mental trauma in combat exhibit behaviour that, while directly associated with mental illness, is contradictory to the structure of the military environment.

Across the jurisdictions under analysis in this study, military discharges from service vary in terms of types and qualifications. In the U.S., the category of discharge administered also impacts the compensation provided by the U.S. Department of Veterans Affairs (VA). Under title 38 of the United States Code (USC), the VA determines, based on the “character of discharge”, whether an individual meets the requirements for benefits.¹⁷⁹ The categories of discharge are: Honorable, General (under honorable conditions), Other Than Honorable (OTH), Bad Conduct (adjudicated by a general court-martial or a special court-martial), and Dishonorable Discharge.¹⁸⁰ The most important categories of focus for this study are OTH and General Discharges.¹⁸¹ The requirements

¹⁷⁸ For the purposes of this study, any reference to those who have been discharged is to those who have been discharged, separated or retired from the Army following diagnosis or in the process of diagnosing a mental health related illness, including, but not limited to, PTSD.

¹⁷⁹ *Veterans' Benefits, U.S. Code 38* (1997), § 3.12.

¹⁸⁰ U.S. Library of Congress, Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, by Umar Moulta-Ali and Sidath Viranga Panangala, R43928 (2015), 5.

¹⁸¹ These categories of discharge are important to the study because they are commonly administered discharges to individuals whose behavior for which they were reprimanded is in line with their diagnosis of

of an OTH discharge are “a pattern of behaviour that constitutes a significant departure from the conduct expected of service members”.¹⁸² The administering of a General Discharge is “warranted when the negative aspects of the service member’s conduct or performance of duty outweigh positive aspects of the service member’s conduct”.¹⁸³ A misconduct discharge, the focus of much of this case study, falls under the OTH classification and is deemed an involuntary discharge.

In addition to discharges, USC authorizes Secretaries of Military Departments to retire or separate personnel when they are found to be unfit for service, whether the result of injury or illness.¹⁸⁴ To be medically retired, the individual must meet a variety of criteria including having 20 years of experience or having a 30 percent on the VA schedule of disability rating and must have been injured in the line of duty during war or while performing active duty.¹⁸⁵ The criteria for a medical separation are that the individual must have less than 20 years of service; the disability is or may be permanent; and the disability is less than 30 percent on the VA schedule of disability rating and is a result of active duty or incurred in the line of duty in time of war.¹⁸⁶ These types of removal from the Army are administered when the individual is found to be “unfit to perform the duties of the member’s office, grade, rank or rating.”¹⁸⁷ These cases are not often as contentious or politicized as cases in which veterans diagnosed with mental

PTSD or other mental health illnesses.

¹⁸² U.S. Library of Congress, *Veterans’ Benefits*, 18.

¹⁸³ *Ibid.*

¹⁸⁴ *Retirement or Separation for Physical Disability, U.S. Code 10* (2015) § 1201.

¹⁸⁵ *Ibid.*

¹⁸⁶ *Ibid.* For the purposes of this study, medical separation or medical retirement will refer to those who have experienced combat or deployment and subsequently met the requirements for these categories. While the code makes reference to those personnel who have not experienced deployment or combat and are able to qualify for these categories, they are not within the scope of this study and will be omitted for the purposes of clarity.

¹⁸⁷ Department of Defense, *Disability Evaluation System (DES)*. DoD Instruction 1332.18. Washington, DC: Department of Defense, August 5 2015.

illness face general or OTH discharge.

Access to Disability Compensation

This study focuses on the provision of mental healthcare and the determinants of success in that field. Undoubtedly, the U.S. Army has failed its service members by discharging them for issues aligned with their mental illness diagnosis. Furthermore, the failure is manifested in the lack of compensation, if any, that is available to those who have been discharged and not medically separated/retired. However, what this study has revealed is that veterans who have been medically separated or retired also face major difficulties and bureaucratic red-tape when attempting to secure compensation to assist with their illness.

To assume that those who have been medically separated or retired are secure in their access to benefits would be incorrect. The VA has a storied history of backlogs and mismanagement. It is not difficult to ascertain that the U.S. and VA bureaucracies were ill-prepared for the onslaught of mental trauma in Iraq and Afghanistan veterans. This neglect posed a significant dilemma to those who were medically retired or separated, eligible for disability compensation and seeking access to care. Those who have been medically separated and are found to have a medical condition that did not exist prior to service are eligible for separation with severance pay.¹⁸⁸ If the member is found to have a disability that is service-oriented, such as PTSD, they are eligible to apply for disability compensation from the VA. The same applies to those who have been medically retired, although their retirement pay compensation is greater. The VA disability compensation is available to those who have had illnesses or injuries occurred or aggravated during active

¹⁸⁸ “Disabilities Evaluation System (DES),” Soldier and Family Assistance Center – IMCOM, accessed December 16 2016, <http://www.imcom-europe.army.mil/sfac/compensation/des.htm>

military service.¹⁸⁹ The amount afforded is dependent on the degree of the disability on a scale from 10 percent to 100 percent.¹⁹⁰

While the eligibility may appear to be relatively straightforward, accessing the compensation is often anything but. Like many government bureaucracies, the VA is not immune to harsh criticism. Their response in recent years has been to rush the processing of claims and expansion of coverage. A 2016 article in the Wall Street Journal revealed that one Iraq veteran, Brian Jacobson, who was being treated for PTSD and Traumatic Brain Injury (TBI), was coached into getting more benefits by a VA staffer by being told to act “like you have a screw loose in your head”.¹⁹¹ The criticism launched against the VA in recent years over work appears to have caused them to create a system in which more claims are being processed with less evidence. This has resulted in veterans like Jacobson being forced to exaggerate the truth of their injuries to be prioritized for care over other veterans who have entered the system with less evidence of injury. Daniel Bertoni, a director at the U.S. Government Accountability Office said, “Much of what [the VA] is trying to do is built around quickly processing claims...there’s always a danger to cut corners.”¹⁹² The Centre for Investigative Reporting (CIR) has conducted extensive research on disability compensation backlogs. A review they conducted revealed that there were chronic errors in VA performance data and that an emphasis on

¹⁸⁹ “Types of Compensation,” Department of Veterans Affairs, accessed January 18, 2016, <http://www.benefits.va.gov/COMPENSATION/types-compensation.asp>.

¹⁹⁰ “Disability Compensation,” Department of Veterans Affairs, accessed January 23, 2016, <http://www.benefits.va.gov/COMPENSATION/types-disability.asp>.

¹⁹¹ Daniel Huang, “Trying to Serve More Veterans Faster, VA Opens Door to Disability Fraud,” *The Wall Street Journal*, July 14 2016, accessed July 20th 2016, <http://www.wsj.com/articles/trying-to-serve-more-veterans-faster-va-opens-door-to-disability-fraud-1468511504>.

¹⁹² Ibid.

speed of processing applications has led to widespread delays.¹⁹³

In addition to the overload of individuals in the system due to this lack of oversight, there has been a scarred history of the VA taking exceptionally long to process claims. Huang's Wall Street Journal article spoke to VA spokeswoman Meagan Heup, who acknowledged the decrease in average days a veteran needed to wait for a disability claim decision which fell to 94 in early 2016.¹⁹⁴ The VA's service-connected disability compensation scheme is not subject to any statutory or regulated timelines for making decisions eligibility.¹⁹⁵ As Nagin describes, in January 2014 the wait time for an initial disability compensation decision was approximately six months, which is much longer than other public programs.¹⁹⁶ For veterans in major population centres, this wait time can be as high as 642 days.¹⁹⁷ These wait times also encapsulate only the veterans who are making an initial disability claim. As of late 2012, 45% of veterans of the Afghanistan and Iraq conflict had applied for psychiatric and non-psychiatric medical problems.¹⁹⁸ The sheer volume of individuals is unprecedented, as demonstrated by McNally et al., in comparison to much lower percentiles from previous conflict. Furthermore, McNally et al., correlate the increased survivability of wounds in combat with the sharp rise in

¹⁹³ Aaron Glantz, "Accuracy isn't priority as VA battles disability claims backlog," *The Center for Investigative Reporting*, November 9 2012, accessed July 19th 2016, <http://cironline.org/reports/accuracy-isnt-priority-va-battles-disability-claims-backlog-3983>.

¹⁹⁴ Huang, "Trying to Serve More Veterans." This was a significant development following the 2014 VA scandal that revealed the excessive and sometimes deadly wait times veterans were facing when seeking care.

¹⁹⁵ *Vietnam Veterans of America v. Shinseki*, 599 F.3d 654, 657 (D.C. Cir. 2010).

¹⁹⁶ Daniel L Nagin, "Goals v. Deadlines: Notes on the VA Disability Claims Backlog," *U. Mass. L. Rev.* 10 (2015): 55.

¹⁹⁷ Aaron Glantz and Lauren Rabaino, "Infographic: Veterans waiting longer," *The Center for Investigative Reporting*, March 11 2013, accessed July 20 2016, <http://cironline.org/reports/infographic-veterans-waiting-longer-4255>.

¹⁹⁸ Marilynn Marchione, "Almost half of new vets seek disability," *Associated Press*, 27 May 2012, accessed July 17, 2016, <http://news.yahoo.com/ap-impact-almost-half-vetsseek-disability-160656481.html>.

compensation claims.¹⁹⁹ The CIR revealed that veterans who appeal a rejected disability claim can wait up to three and a half years.²⁰⁰ These wait times are not only detrimental to the well-being of individuals suffering from mental illness, but are also demonstrative of a systemic issue within the bureaucracies responsible for caring for military personnel and veterans.

Soldiers who face a discharge that was not under honorable conditions are subject to a VA determination as to whether the “discharge was under conditions other than dishonorable”.²⁰¹ This determination will define the compensation that is available to individuals discharged. Under the USC, a release or discharge under any conditions other than honorable results in a bar to compensation. However, the caveat provided by the VA is that this ban can be alleviated if the individual is found to have been “insane at the time he/she committed the offense”.²⁰² The use of the term insanity has been controversial in the history of the VA. In 2009, the VA compensation benefits case, *Henry Gardner v Shinseki* at the U.S. Court of Appeals for Veterans Claim, found that the VA erred in its use of insanity to deny the veteran benefits.²⁰³ The veteran was dishonorably discharged and thus, lost his status as a “veteran”.²⁰⁴ The aforementioned caveat of insanity which

¹⁹⁹ Richard J. McNally, and B. Christopher Frueh, "Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates?," *Journal of anxiety disorders* 27, no. 5 (2013): 521.

²⁰⁰ Glantz, “Accuracy isn’t priority.” The oldest of these cases is Ivan Figueroa Clausell who filed a claim in 1985 for injuries stemming from a car accident while on duty with the National Guard. (Alan Zarembo, “VA is buried in a backlog of never-ending veterans disability appeals,” *Los Angeles Times*, November 23, 2015, accessed July 21 2016, <http://www.latimes.com/nation/la-na-veterans-appeals-backlog-20151123-story.html>.)

²⁰¹ “Claims for VA Benefits and Character of Discharge,” Department of Veterans Affairs, accessed July 13 2016 http://www.benefits.va.gov/benefits/docs/cod_factsheet.pdf.

²⁰² Ibid.

²⁰³ “Insanity for Purposes of the Department of Veterans Affairs,” Legal Help for Veterans, PLLC, last modified October 10 2009, <http://www.legalhelpforveterans.com/2009/10/30/insanity-for-purposes-of-the-department-of-veterans-affairs>.

²⁰⁴ Under U.S.C. the term “veteran” is reserved for those who have served in the active military and who has been discharged under conditions other than dishonorable (*Definitions* 38 USC § 101(2)).

may allow for benefits under less than honorable conditions was the central focus of this case. The VA Board denied benefits to Gardner because there was “no indication that the veteran’s behaviour at the time of his offenses resulted from any disease which placed the appellant’s mental health capacity beyond his control.”²⁰⁵ There is no need to find a causal connection between the offenses and the individual’s insanity and rather “the condition of insanity need only exist at the time of the commission of the offense leading to the person’s discharge”.²⁰⁶ The VA Board overturned this ruling and the individual was available to access VA compensation.

While the case of *Gardner v Shinseki* set a precedent for access to compensation for veterans facing discharge, the reality is that many veterans suffering from mental illness who have been discharged for offenses do not necessarily meet the definition of insanity under VA.²⁰⁷ For such veterans, their patterns of misconduct, often the result of behaviors symptomatic of their diagnoses, leave them ineligible for military-provided medical care. The cost of providing benefits is enormous and while the research is minimal, it is evident that discharges are an easy way to disassociate individuals’ mental illness from their unacceptable military conduct to be financially stringent. The anecdotal evidence of this has grown in the past decade, mainly in part to the work of investigative journalists.

While it is evident that the regulations and legislations that govern access to

²⁰⁵ “Insanity for Purposes of Department of Veterans Affairs.”

²⁰⁶ *Struck v. Brown*, 9 Vet. App. 145, 154 (1996).

²⁰⁷ Per VA regulations, an "insane" person is one who: (a) while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basic condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or (b) interferes with the peace of society; or (c) has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustment to the social customs of the community in which he resides. *See Definition of Insanity* 38 C.F.R. § 3.354(a).

benefits and compensation are adhered to by the VA, it is impossible to refute that their structure enables the VA to ignore mental trauma if necessary. While the motivations to ignore these illnesses are not always clear, the following section will address military personnel who directly admit that one motivating factor was cost-saving. The VA has a history of necessitating a causal connection between insanity and commission of offenses to deny benefits. While the legal case was overturned, and set precedence in this regard, it is not out of reach to interpret their reasoning as a combination of financial scrutiny and a lack of understanding of mental illness.

Purged from the ranks

In 2006, an article by Daniel Zwerdling of NPR revealed the experiences of several soldiers at U.S. Army Installation Fort Carson in Colorado in their encounters with mental illness. These stories shed light on the difficulty those in need face when trying to find assistance for mental health illness after deployment. Most troubling was that the same article also revealed cases in which soldiers were forced out of the Army upon diagnosis with mental illness. Many soldiers received misconduct discharges for infractions that are associated with the presence of a mental illness. Yochi Dreazen's book *The Invisible Front* addressed the story of Private Alex Orum, also interviewed in Zwerdling's piece, who was diagnosed with PTSD upon return to Ft. Carson following a tour in Iraq.²⁰⁸ He was cited for infractions that included "coming to work dishevelled, missing rent payments and otherwise mishandling personal finances".²⁰⁹ Each of these failings could have been associated with Orum's diagnosis. Poor physical appearance is

²⁰⁸ Yochi Dreazen, *The Invisible Front: Love and loss in an era of endless war* (New York: Broadway Books, 2015), 189.

²⁰⁹ *Ibid.*

identified by T Allen Gore et al. as one of the many manifestations of PTSD.²¹⁰ Additionally, a National Financial Capability Study revealed that money mismanagement is a “significant problem for military service members”.²¹¹ It is not plausible to differentiate between Orum’s behaviour and his PTSD diagnosis. The reprimands Orum received for his actions, which may not be acceptable within the military environment, are a detriment to his mental health. Shortly thereafter, Orum was discharged for misconduct.²¹² There was another aspect of Orum’s case which demonstrated the lack of adequate understanding amongst superiors, which was the response from his sergeant, Nathan Towsley. When interviewed by Zwerdling, Towsley said: “When I’m dealing with Alex Orum’s personal problems on a daily basis, I don’t have time to train soldiers to fight in Iraq. I have to get rid of him, because he is a detriment to the rest of the soldiers.”²¹³ Towsley’s attitude may seem to some as archaic, particularly in our contemporary society in which emphasis is placed on mental health and wellness, but it is not unique to the military community.

Zwerdling also interviewed Richard Travis, the Army’s former senior prosecutor at Ft. Carson, who said that soldiers discharged for mental illness receive special benefits, while soldiers discharged for misconduct receive much less.²¹⁴ For a nation in the throes of large scale conflict overseas, financial scrutiny is imperative. To argue that cost saving measures came at the expense of mental health care is a well-founded claim, which the

²¹⁰ Kay Jankowski, “PTSD and Physical Health,” National Center for PTSD – U.S. Department of Veterans Affairs, last modified February 23, 2016, accessed December 17 2016, <http://www.ptsd.va.gov/professional/co-occurring/ptsd-physical-health.asp>

²¹¹ Eric B. Elbogen, et al. "Homelessness and money mismanagement in Iraq and Afghanistan veterans," *American journal of public health* 103, no. S2 (2013): 248.

²¹² Dreazen, *The Invisible Front*, 189.

²¹³ Daniel Zwerdling, “Soldiers Say Army Ignores, Punishes Mental Anguish,” *National Public Radio*, December 4 2006, accessed July 16 2016, <http://www.npr.org/2006/12/04/6576505/soldiers-say-army-ignores-punishes-mental-anguish>.

²¹⁴ Ibid.

Army itself investigated in 2012.²¹⁵ As was discussed in the previous section, the benefits provided to ex-personnel are dependent on the nature of their discharge. Therefore, those who are discharged for misconduct, or medical reasons less severe than PTSD, are not afforded the benefits of someone with a PTSD diagnosis. Discharging soldiers for misconduct based on behaviour that is undoubtedly fuelled by mental trauma because of deployment is a simple way to prevent having to pay long-term and expensive benefits packages.

In October of 2015, two articles released by Daniel Zwerdling of NPR and Colorado Public Radio (CPR) revealed another group of casualties of the Iraq and Afghanistan campaigns: thousands of soldiers discharged for “misconduct” after returning with mental health problems or TBI.²¹⁶ The investigation was conducted with help from Army Staff Sgt. Eric James who secretly recorded conversations with his therapist. James discussed his contemplation of suicide following two tours in Iraq as a sniper. The Army attempted to discharge him in 2013 for driving while intoxicated in 2011 which, Zwerdling notes came years after a 2009 congressional edict that promised to ensure misconduct is not the result of mental trauma suffered during deployment.²¹⁷ The recordings that James produced – more than 20 hours – revealed that his therapists paid little attention to his suicidal ideations and denied that his behaviour was a result of the trauma he experienced during service overseas. Upon learning of the recordings, senior Army officials launched an investigation and reprimanded both therapists. While

²¹⁵ An investigation conducted into the Madigan Army Medical Centre screening team found that more than 40% of PTSD diagnosis had been reversed for patients being considered for medical discharge (Hal Bernton, “40% of PTSD diagnoses at Madigan were reversed,” *Seattle Times*, March 20, 2012, <http://www.seattletimes.com/seattle-news/40-of-ptsd-diagnoses-at-madigan-were-reversed/>)

²¹⁶ Zwerdling, “Missed Treatment.”

²¹⁷ *Review of Discharge or Dismissal, U.S. Code 10* (2014) § 1553.

James was then honorably retired and given full benefits, a more troubling revelation came when the Army revealed that the problems at Fort Carson, where James was stationed, were not systemic.

The NPR investigation that followed James experience involved “hundreds of pages of confidential documents from Fort Carson, and interviews with dozens of sources both inside and outside the base”.²¹⁸ Figures obtained under the Freedom of Information Act revealed that the Army has been “pushing out” soldiers who had been diagnosed with a mental health illness at bases across the U.S. Since January of 2009, 22,000 Iraq and Afghanistan veterans who had been diagnosed with mental health problems upon return home had been discharged for misconduct.²¹⁹ In addition to facing limited or no access to benefits and compensation, veterans who have been discharged for misconduct are more likely to become homeless. Researchers with the VA Salt Lake City Health Care System analyzed VA records of 448,290 veterans who met the following criteria: had been active-duty service members; were discharged between 2001 and 2011; and were eligible for VA services.²²⁰ Gundlapalli et al. also found that homelessness increased in the years following discharge with the overall incidence of homeless at 0.3% at the time of the first encounter and 2.1% within five years.²²¹

The importance of the study conducted by Gundlapalli et al. is that it draws necessary attention to the risks of misconduct discharges for vulnerable personnel. While the study makes no reference to the mental health diagnosis, if any, of the individuals that

²¹⁸ Zwerdling, “Missed Treatment.”

²¹⁹ Ibid.

²²⁰ A. V. Gundlapalli et al., “Military Misconduct and Homelessness Among US Veterans Separated From Active Duty, 2001-2012,” *Journal of the American Medical Association* 314, no.8 (2015): 832.

²²¹ Ibid.

participated, it does support the reports of veterans facing a difficulty transitioning to civilian life. The study also makes note of the concerning rise of incidences of misconduct discharges, substantiated by the work of Zwerdling and Dreazen.²²² While there is little evidence that links the 22,000 veterans with mental health diagnosis discharged for misconduct with a rise in homelessness, Gundlapalli et al. provide strong evidence of the consequences that could face many of these veterans.²²³ The discharge of 22,000 veterans with mental health issues for misconduct cannot be simplified to a shocking coincidence.

Political and Military Response to Discharges

The investigations and research conducted in the field of misconduct discharges and mental healthcare has not gone unnoticed in the political community. In 2006, a letter was authored by three U.S. Senators, including former U.S. President Barack Obama, which addressed Zwerdling's 2006 NPR article. It was addressed to the Honorable William Winkenwerder, Jr., the Assistant Secretary of Defense for Health Affairs and requested an investigation be conducted into the allegations in Ft. Carson, following inflammatory comments made by sergeants in the article, admitting they refuse soldiers under their command access to treatment sessions for PTSD.²²⁴

Three years following Zwerdling's first piece on the purge of mentally ill soldiers on charges of misconduct, a federal law was passed that intended to address the very issue.

²²² Lolita Baldor, "Misconduct forces more soldiers out," *Associated Press*, February 16 2014, accessed June 27 2016, <http://bigstory.ap.org/article/ap-exclusive-misconduct-forces-more-soldiers-out>.

²²³ A. V. Gundlapalli et al., "Military Misconduct and Homelessness Among US Veterans Separated From Active Duty, 2001-2012," 832.

²²⁴ Barbara Boxer, Christopher Bond and Barack Obama to Honourable William Winkenwerder, Jr., Assistant Secretary of Defense of Health Affairs, December 7 2006, *United States Senate*, Washington, DC.

In 2009, 10 USC § 1553(d) (1)-(2) was passed mandating:

In the case of a former member of the armed forces who, while serving on active duty as a member of the armed forces...was diagnosed by a physician, clinical psychologist, or psychiatrist as experiencing post-traumatic stress disorder or traumatic brain injury as a consequence of that deployment, a board established under this section to review the former member's discharge or dismissal shall include a member who is a clinical psychologist or psychiatrist, or a physician with training on mental health issues connected with post-traumatic stress disorder or traumatic brain injury.²²⁵

The law was enacted as a means of protecting soldiers whose mental illness might be linked to the conflicts in which they served. It also stipulated that members were not to be separated or discharged under any condition other than honorable until the "results of the medical examination have been reviewed by appropriate authorities".²²⁶ This law was quickly lauded as a major advancement in the veteran welfare. Not only would it advance their right to access appropriate benefits, but it would assist in the removal of the stigma surrounding mental health in the armed forces. Soldiers would no longer be deemed at fault for actions spurred by mental illness they had experienced because of combat.

However, this positive development was short-lived. Zwerdling's 2009 piece, *Missed Treatment*, which revealed that thousands of soldiers with mental illness had been discharged for misconduct, fueled a political uproar. Despite the 2009 law, it appeared that soldiers were being systemically punished for misconduct stemming from injuries sustained in combat. Lt. Col. Chris Ivany told Zwerdling that the army was not violating the law because the "functional impairment was not severe enough" in some soldiers to legitimately affect their judgment.²²⁷ Ivany also argued that in several cases, the initial mental diagnosis might have been severe, but had significantly improved prior to any

²²⁵ *Review of Discharge or Dismissal, U.S. Code 10 (2014) § 1553.*

²²⁶ *National Defense Authorizations Act for Fiscal Year 2010*, Pub. L. No. 11-84, 123 Stat. 2281 (2009).

²²⁷ Zwerdling, "Missed Treatment."

misconduct and they could not therefore justify their actions on their experience overseas. Per Ivany, all of this “clearly shows that there is no systemic attempt” to discharge soldiers with mental illness.²²⁸

Despite Ivany’s claims, the revelation drew the ire of politicians. In November of 2015, U.S. Senator Chris Murphy led a group of Senators in calling for an investigation into the allegations of wrongful discharges. The concerns expressed in the letter addressed to Acting Under Secretary of the Army, Eric Fanning, and Chief of Staff of the U.S. Army, General Mark A. Milley, included access to benefits and compensation, treatments and a perpetuation of the negative stigma surrounding mental illness.²²⁹ In response, Fanning ordered a review of the issues addressed in the letter and committed to producing a final report on the matter.²³⁰ Fanning’s letter also referred to the 2009 law, 10 USC § 1553(d) (1)-(2), and assured that “the entire Senior Army Leadership, our commanders in the field, and every Army leader are committed to soldiers getting the care they need.”²³¹ The response, issued in December 2015, has yet to produce any tangible results and thus there is little to date known about this matter.

Despite the Army’s commitment to reviewing and reporting on the issue, Murphy and three other Senators, including Barbara Boxer who co-authored the 2006 letter to Winkenwerder, called for a moratorium on discharges of soldiers who have mental health diagnosis or TBI’s.²³² Their demand was not unwarranted: Debra Wada, the Army

²²⁸ Zwerdling, “Missed Treatment.”

²²⁹ Christopher Murphy et al., to the Honourable Eric Fanning and General Mark A. Milley, November 4, 2015, *United States Senate*, Washington, DC.

²³⁰ Eric K. Fanning to Honourable Christopher Murphy, November 30, 2015, *Department of Defense*, Washington, DC.

²³¹ Ibid.

²³² Michael De Yoanna, “Four U.S. Senators Demand Army Stop Discharging Troubled Combat Soldiers,” *Colorado Public Radio*, February 1 2016, accessed June 27 2016, <http://www.cpr.org/news/story/four-us->

assistant secretary responsible for the review, signed a document two weeks after she was named to dismiss a highly-decorated soldier with 20 years of service who had been diagnosed with PTSD.²³³ Former military prosecutor David Sonenshine said it was a particularly troubling move because “the person who’s in charge of the investigation is also the same person who ultimately reviews some of these administrative separations”.²³⁴ This lack of objectivity and clear conflict of interest was enough to outrage Murphy and his Senators. The response from the Army was predictably vague and said that they would be unable to provide any further information, citing the ongoing investigation.²³⁵

Murphy subsequently led eleven of his colleagues in demanding an investigation into the discharges of soldier. In March 2016, before a Military Construction, VA and the Related Agencies Appropriations Subcommittee hearing, Murphy questioned VA officials about what was being done to restore compensation and benefits to soldiers improperly discharged.²³⁶ The political outcry led by Christopher Murphy was an effective response to a longstanding maltreatment of those whose injuries are a result of their service to their country.

Case Summary

The nature of discharge and medical separation policies will always remain contentious, particularly when there are diagnoses of mental illness related to combat

[senators-demand-army-stop-discharging-troubled-combat-soldiers.](#)

²³³ Ibid.

²³⁴ Ibid.

²³⁵ Michelle Tan, “Senators to Army: Stop misconduct discharges until review is completed,” *Army Times*, February 3 2016, accessed June 30 2016, <http://www.armytimes.com/story/military/capitol-hill/2016/02/03/senators-army-stop-misconduct-discharges-until-review-completed/79716118/>.

²³⁶ Senator Chris Murphy, “In Hearing with VA Officials, Murphy draws attention to Soldiers with TBI, PTSD who are ineligible for VA Services,” press release, March 3 2016, <https://www.murphy.senate.gov/newsroom/press-releases/in-hearing-with-va-officials-murphy-draws-attention-to-soldiers-with-tbi-ptsd-who-are-ineligible-for-va-services>

exposure. However, while U.S. Senators call for change and an increase in bureaucratic oversight, there needs to be a dramatic shift in the rhetoric amongst senior military officials. The continual reassurance that the status quo is adequate for dealing with mental illness amongst soldiers is not conducive to improvement. The Army's vice chief of staff from 2008 to 2012, Peter Chiarelli, has accused those who cover the stories of the wrongfully discharged of simplifying the matter. Furthermore, he has argued that it often makes sense for personnel with mental health issues who commit misconduct to be pushed out, given the "uncertainties and enormous pressure on the Army".²³⁷ Chiarelli's attitude is not uncommon, and was echoed by Sgt. Towsley when addressing Pvt. Orum's mental health illness. The attitude amongst senior personnel is imperative to the improvement of inappropriate discharges. However, the prevailing attitude is that soldiers are meant to fight wars and if they are not deployable, they are unable to do their job and dismissal is warranted. This is not a sentiment exclusive to the U.S. and is exemplified in the Universality of Service principle within the CAF and the urging of senior officers in HM Forces to dismiss injured and ill personnel to make room for new recruits.

Analysis

It is difficult to find a more contentious area of mental health amongst armed forces than discharge policies and compensation. Not only are the grounds that personnel with mental illness discharges often questionable, but the compensation received by many, even those who have left on their own accord, is inadequate for seeking assistance. While this analysis revealed some startling truths about the manner in which individuals are handled following a mental illness diagnosis, it also revealed a need to balance the

²³⁷ Zwerdling, "Missed Treatment."

criticism of discharges with the understanding of the purpose of armed forces. As the primary duty of armed forces are to defend the nation abroad and serve a broad range of other interests, it is essential to have a force that is capable of doing so. Retaining individuals within the ranks whose illness prevents them from doing their jobs would potentially pose financial and security risks.

Attempts to fill the ranks during a time of war is not a concept new to armed forces, including those of the nations under analysis; Canada experienced conscription during the First World War, the U.S. Federal Government implemented the draft during the Vietnam War and the U.K. had periods of mandatory service, otherwise known as Military or National Service, twice during the 21st century. While such requirements were not implemented during the Iraq and Afghanistan conflicts, there was a surge in recruitment and retention efforts. In the height of the Iraq and Afghanistan wars, CAF recruitment surged, with 25,738 applications in 2009-10 compared to 13,504 in 2001-02.²³⁸ The U.S. Army faced a recruiting shortage in 2005, failing to meet recruiting targets by tens of thousands and subsequently refusing to dismiss new recruits for factors that previously would have disqualified them for service.²³⁹ However, these efforts are not without consequence; when a nation is engaged in conflict abroad, their numbers must be adjusted so as to account for cycles of deployment and extensive deployments. When the conflict comes to a close, nations reevaluate and often make budget and personnel cuts. The HM Armed Forces underwent massive personnel and budget cuts in the wake of Afghanistan, with plans in place to increase reservists but slash nearly 20,000

²³⁸ “Afghan mission saw Canadian Forces Recruitment surge,” *CTV NEWS*, June 25 2011, accessed January 6 2017, <http://www.ctvnews.ca/afghan-mission-saw-canadian-forces-recruitment-surge-1.662006>

²³⁹ Jamie Wilson, “US lowers standards in army numbers crisis,” *The Guardian*, June 4 2005, accessed January 6 2017, <https://www.theguardian.com/world/2005/jun/04/usa.jamiewilson>

full-time service personnel.²⁴⁰ Such measures are unarguably necessary and part of the cyclical nature of peace and conflict, for each nation under analysis, this is a consistent reality: not one is exempt from needing to make changes during a transition from conflict to peace. However, it is essential that they must be executed in an ethical manner and the research revealed that some countries fail to do so.

While in each nation, there are incidents of discharges whose justification borders unethical reasoning, some were guiltier than others. Research revealed that the U.S. has disproportionately been accused of systemic discharges on questionable grounds in part due to the evidence of systemic discharging of personnel with a mental illness attributed to their service. Evidence showed that the cuts were intrinsically linked to cost-saving measures as well as to stigmatized attitudes towards mental illness amongst the U.S. Army. It is not an easy task to determine why the U.S. was so disproportionately guilty of bad discharges when compared to their allies. What is inarguable is that the U.S. led both Canada and the U.K. in regards to financial and personnel contribution to the conflicts in Iraq and Afghanistan. Therefore, it was inevitable that they would be required to find the means of offloading more personnel than the other nations. However, not all of the individuals who were given discharges following admission or diagnosis of mental illness had been deployed to Iraq. The explanation can be explained through the voice of senior officials, including Chiarelli, who argue that it makes sense to remove those whose misconduct or behaviour is the result of a mental illness. The belief, held consistently across all three jurisdictions, is that if an individual does not have the discipline and

²⁴⁰ Emma Atkinson, "Armed Forces job cuts reach target three years early," *BBC News*, July 29 2015, accessed January 10 2017, <http://www.bbc.com/news/uk-33638492>

ability to fight a war, they are no longer of use to their job and the role must be filled by an individual who does possess the capability.

While an individual's discharge can be attributed to their mental illness, a better understanding of trauma is needed so as to avoid discharging individuals for offences beyond their control. Neither Canada nor the U.K. executed en masse discharges of individuals with a mental illness diagnosis, yet there are similarities amongst all three jurisdictions. The reasoning provided by senior officials in the U.S. Army for the discharges are echoed in the CAF universality of service principle and in HM Forces Army personnel, urging that it was not in their interest to retain those unfit to serve within the ranks. A need to balance operational capability and soldier welfare is a consistent theme in this analysis. Normative expectations significantly come into play here, as while many in civil society do not believe that it is ethical to discharge personnel with a mental illness diagnosis, they do not possess the understanding of operational necessity that senior officials do. Additionally, they are often not familiar with principles such as universality of service, and make arguments influenced by individual experiences and stories, rather than taking into account the cost of keeping such individuals in the forces, while also recruiting personnel to replace them.

However, none of this analysis contradicts the facts that comparatively, there is evidence to support that not all discharges in the U.S. Army discussed in this chapter can be attributed solely to the need to improve operational capability. Compared to Canada and the U.K., it was the nature of the discharge, not the discharge itself, that was significant in the U.S. Army. There is evidence that cost-saving influences may have impacted many of the discharge decisions, a completely unethical approach when the care

of personnel is at stake. While this analysis demonstrated that in Canada and the U.K., there is a need to balance the competing narratives and understand that operational capability must be maintained while also maintaining care for personnel, it did not reach the same result in the U.S. Army. The calculated decision to release individuals with mental illness for misconduct demonstrates that the U.S. Army has significantly erred in ensuring that discharge and compensation processes account for mental illness that has manifested as the result of service.

The theoretical framework employed in this study has significant merit in the evaluation of transfer of care upon discharge as well as compensation as well as the difficulty facing the continuum of care. The gap that exists between civilian and military societies is a result of the difference in institutions, particularly in their understanding of the unique impact that is had on personnel as a result of their service. This gap is a defining characteristic of the mental health crisis facing those who are exiting their respective armed forces. The U.K. analysis revealed that for injured or ill personnel, their care is transferred to the NHS For personnel that are being transitioned out of HM Forces. This is often seen as a downgrading in care as the level of treatment is often less while a civilian than while a member of HM Forces. More individuals within the system coupled with a lack of understanding by those in civil society of the experiences of military personnel makes it difficult to get adequate treatment. This is particularly where Rahbek-Clemmensen et al.'s conceptualization of the civil-military culture gap is relevant; a gap in the understanding of the cultural differences between the military and civil society can have a profound impact on care provision. Therefore, there is no question as to why personnel would wish to remain within the ranks, particularly in the case of HM Forces,

while receiving care for an illness or injury. Evidence has been presented consistently throughout this thesis that demonstrates personnel prefer to confide in peers or those who can understand their experiences firsthand. This belief is the foundation of the training initiatives addressed in Chapter 3, particularly the TRiM program. The belief that peer support most adequately addresses mental health is built into the process in which a soldier is trained, but is often not incorporated when treatment and discharge are being considered. The culture gap can explain the problems facing those upon discharge or release and their opposition to their departure. This analysis showed that across all jurisdictions, there must be considerable thought given to how to possibly incorporate the elements of peer support throughout the entirety of one's career in the armed forces, including the transition out of it, a point at which arguably they require the support the most.

In this chapter, it was argued that cost-saving incentives and operational capability were factors that affected the circumstances under which individuals with mental illness leave the armed forces. However, the degree of centralization in each jurisdiction has once again appeared as a causal factor. It is evident that in Canada and the U.K., centralization within the armed forces institutions allowed for a level of oversight that prevented an illegal, en masse discharge of personnel suffering from mental illness. Due to the decentralized nature in which the U.S. Army operates, there was a lack of both oversight and preparation when it came to discharging personnel. As the case study demonstrated, there is no even application of discharge policies throughout the armed forces, meaning that personnel in one branch cannot be discharged for behaviour that personnel in a different branch are discharged for. The analysis presented in this chapter

has one again confirmed that the degree to which armed forces institutions are centralized has a causal relationship with the level of mental healthcare and treatment afforded to personnel.

CHAPTER 5: THE ROLE OF VETERANS CHARITIES AND ADVOCACY GROUPS IN CARE DELIVERY

The experience with mental health issues that have stemmed from service do not disappear once personnel have been discharged. Many individuals choose to pursue advocacy work with organizations related to the armed forces. However, there are many that continue to suffer as a result of their illness and are unable to obtain timely and efficient care once being injected back into civil society. As a result, they turn to many of these organizations for social or health assistance. These organizations are therefore not only a component of the life cycle of armed forces personnel, but it is not possible to discuss the provision of care without discussing these organizations.

The analysis that follows will argue that many organizations have played a significant role in the delivery of care as well as the advocacy of improved health-related services for personnel, due to the existence of a divide between civilian and military societies and a subsequent overburdening of the military health system in the years following engagement in the Middle East. The research has demonstrated that the degree of centralization in both armed forces and external agencies is correlated to the effectiveness with which personnel transition out of the military as well as the degree of cooperation and collaboration that exists with agencies to fill the healthcare gap.

This chapter will examine the role of military and veteran-focused non-government organizations (NGOs) in each jurisdiction. This will be followed by an analysis of the differentiation in roles between each country and an explanation of. Furthermore, this chapter will illustrate how NGOs have not only served as advocates for mental health reform in the military, but how they have also begun to fill a service gap for

personnel seeking treatment. As argued by Joshua Jones, “any individual or communal responsibility for the treatment of an afflicted veteran appears to be deflected and redirected into the realms of politics and philanthropy.”²⁴¹

The purpose of this chapter is to analyze the role of NGOs and charities in delivering mental healthcare to personnel as well as the degree to which they advocate for improved services. While it is not unreasonable to expect that these organizations will assist in providing care or alternative therapies, they should complement rather than replace government services. This chapter will also determine the relative success of each case based on an evaluation of the level of cooperation between governments, defence agencies and organizations within both the public and private sector. How these organizations have advocated on behalf of veterans within the context of the civil-military relationship is also an integral component to the analysis that will be provided in the coming pages.

Definitions and Explanation of Advocacy Groups

This variable explores the roles of organizations and advocacy networks in mental healthcare provision. Of primary importance is the analysis of the effect of lobbying efforts on policies and service delivery. Charities pertaining to the welfare of service personnel, both active and veteran, are not unfamiliar. In recent years, the heightened awareness of the importance of mental healthcare within the military has resulted in rapid growth within this niche of the non-profit sector. There is often a flooding of the system and veterans have no clear understanding on where to turn to when the state, the armed

²⁴¹ Joshua A. Jones, "From Nostalgia to Post-Traumatic Stress Disorder: A Mass Society Theory of Psychological Reactions to Combat," *Inquiries Journal* 5, no. 02 (2013): 1.

forces or their health agencies are unable to provide care.

For the purposes of each case study, there will be a discussion of organizations that define themselves as ex-service (U.K.) or veteran (U.S., Canada) organizations as well as organizations that assist current service personnel. Each case will also look at the role such agencies have played in advocacy work.

Case Study: Canada

Veterans' organizations in Canada are much younger and smaller than those of their allies. In Canada, the era of stagnation ended with the Afghanistan conflict, from which a multitude of charities were born. While many of these charities provide services to veterans, they also create scholarship programs for family members, advocate for improved services and push for regulation of alternative forms of therapy, such as the use of service dogs. This study will demonstrate that Canadian organizations offer a diversity of services, but also face a fair share of criticism.

Advocacy and Civil-Military Relations

In Canada, the role of advocate for improved mental health services for current and former CAF personnel has been filled by many politicians, civilians and organizations. It is incredibly important to examine the advocacy and its impact on civil-military relations within the context of veterans charities as these groups have often taken the lead in pressing federal governments for improved services, training and the infrastructure required to address mental health amongst former and current service personnel.

Wounded Warriors Canada

One of the most prominent veterans' agencies in Canada is Wounded Warriors Canada (WWC). Incorporated in 2006 as the Sapper Mike McTeague Wounded Warrior Fund in honour of a seriously wounded Canadian soldier. The original intent was the support of personnel wounded on operations and to improve the morale of injured soldiers.²⁴² Over a decade, the program as evolved and it is now regarded as “the nation’s leading, wholly independent veterans charity focusing on mental health.”²⁴³ Wounded Warriors offers a breadth of direct programming and scholarships, exceeding a \$1,000,000 in 2014.

One of the WWC initiatives is the Doctoral Scholarship, announced in 2013 as a 10 year \$400,000 commitment in partnership with the Canadian Institute for Military and Veteran Health Research (CIMVHR).²⁴⁴ The fund was established to provide support to students conducting research at a doctoral level on an issue relevant to the lives of military personnel, veterans and families. The program is regarded as a means of developing a greater foundation of research into the mental health of military personnel. As has been consistently demonstrated throughout this study, the absence of academic research in this field, particularly from a social science perspective, is damaging to policy and decision makers who need to establish policy regimes that can best address endemic issues of mental health within militaries.

Wounded Warriors Canada has also stepped in to provide care in the absence of

²⁴² Wounded Warriors Canada, “Our Story,” accessed October 6, 2016, <http://woundedwarriors.ca/about-wwc/our-story/>

²⁴³ Ibid.

²⁴⁴ Wounded Warriors Canada, “How We Help,” accessed October 7, 2016, <http://woundedwarriors.ca/how-we-help/wounded-warriors-canada-doctoral-scholarship/>

available supports from VAC or national health programs. There is also an inadequate level of available compensation for veterans and personnel who seek to heal from mental trauma through alternative forms of therapy. One of these forms of assistance comes in the form of therapy or service dogs. WWC is Canada's largest funder of Animal Assisted Therapy for PTSD and makes a commitment to work with a person's mental health team to determine whether a PTSD service dog is appropriate. The costs of purchasing, training and maintaining a PTSD service dog are exceptional, often more than \$10,000. WWC has partnered with several service dog agencies across Canada and commits to providing the animals free of charge with funding to veterans.²⁴⁵ WWC has also played a significant role in advocacy for veterans through their commitment to establishing national standards for service dog providers and trainers. The standardization regulation surrounding service dogs, particularly for PTSD, has been a contentious issue within Canada. Other organizations, including the Royal Canadian Legion, have spoken about the need for standards and the incredible benefit such services can bring to veterans with mental health needs.

WWC has also financially supported programs that aim to ease the transition of veterans with mental illness into civilian society. Veterans Transition Network (VTN) is based at the University of British Columbia and uses a model developed by medical professionals and psychologists over 15 years. VTN identifies that those who have "spent their adult lives working in disciplined teams with delicate equipment suddenly find themselves in a job market where military skills are often not recognized."²⁴⁶ VTN

²⁴⁵ Wounded Warriors Canada, "PTSD Service Dogs," accessed October 6, 2016, <http://woundedwarriors.ca/how-we-help/ptsd-service-dogs/service-dog-information/>

²⁴⁶ Veterans Transition Network, "What is transition?" accessed October 4, 2016, <http://vtncanada.org/what-is-transition/>

focuses on developing these skills and helping veterans' make a healthy transition into civilian life and potentially a new career.

Controversy

There have been several significant concerns raised about veteran's organizations in Canada in recent years. Particular attention was given Canada Company, who refused scholarships to children of soldiers who had committed suicide as a result of mental illness undoubtedly attributed to their service. In early 2016, Renata D'Aliesio of the *Globe and Mail* covered the story of widow Sherri Elms and her two children. Captain Brad Elms of the Royal Canadian Regiment had died in November 2014 after battling with a depressive disorder for close to a decade. His family were adamant that he had suffered from PTSD but like so many others, "he never sought a diagnosis because he worried it would destroy his army career."²⁴⁷ Canada Company said that Elms' death did not meet the scholarship criteria. However, Elm's death was found to be attributed to his service by both a military board of inquiry and Veterans Affairs.²⁴⁸

Elms was a respected figure within the Canadian Armed Forces and served multiple tours abroad, including to Kandahar, over 33 years of service. However, his death by his own hand rather than at the hands of an enemy combatant meant that his legacy and ultimately his family were treated differently. For Elms widow, the significance of Canada Company's rejection was that it was not in line with the trend of the CAF to pay more attention to their personnel's mental health needs. Perhaps nothing summarizes the issue more than D'Aliesio's statement: "It was a harsh reminder of the

²⁴⁷ Renata D'aliesio, "Left Behind," *The Globe and Mail*, May 3 2016, accessed September 20 2016, <http://www.theglobeandmail.com/news/investigations/investigation-canada-company-scholarships/article29808916/>

²⁴⁸ Ibid.

discord between the ideal of military strength and the reality of mental illness.”²⁴⁹

Canada Company president Angela Mondou defended the committee’s decision in a statement by stating that when the fund was created it was specifically for the children of those killed whilst on military operations. Mondou’s statement also read: “We have a commitment to our donors to support the children of Canadian soldiers who...have been killed serving in an active role in a military mission, and we take that very seriously.”²⁵⁰ However, it is important to note that the scholarship committee had made previous exceptions for the children of personnel who had been killed on training accidents. D’Aleisio conducted a survey of 21 private and government education-assistance programs to determine eligibility for children of soldiers who had committed suicide and found that only the Northern Alberta Institute of Technology’s Fallen Heroes Scholarship does not determine such children eligible. The remaining do not exclude these children or have no policy that would deem them ineligible.²⁵¹ Prominent veteran and advocate retired lieutenant-general Romeo Dallaire, himself a member of Canada Company, chastised the organization for their decision. “The children of those who are suffering from PTSD are living in hell, and there is next to no support for them... You have an organization that could, in fact, pull them out of that and give them a breath of hope.”²⁵²

The decision made by the organization is a perpetuation of the stigma surrounding mental illness in the military. For the Elms’ family, the decision that the children of Capt. Elms were ineligible because he took his own life sends a message that the sacrifices he made for Canada were not enough because the battle itself was not what killed him, but

²⁴⁹ Ibid.

²⁵⁰ Ibid.

²⁵¹ Ibid.

²⁵² Ibid.

rather the lasting effects of that battle. Retired General and Former Chief of the Defence Staff Rick Hillier has also been affiliated with Canada Company, and told D’Alaseio, “In my view, those who commit suicide and it is deemed caused or contributed to by service to Canada, their children must be treated like one of those casualties that are caused by direct physical action. Mental injuries are every bit as devastating as physical ones and we [should] look after their survivors in an appropriate manner.”²⁵³ This attitude shows a disconnect between those who have served in the military and had responsibility over the wellbeing of personnel, and those who share no similar experience, yet make determinations about the eligibility of a sacrifice.

Case Study: United Kingdom

History and Development of Charities in the U.K.

As has been illustrated throughout the entirety of this study, governments, until recently, have for the most part neglected their service personnel once they have left the armed forces. As Dandeker et al. describe, the history of the British armed forces as a long –standing professional, rather than conscripted army, had contributed to a “culture of neglect”.²⁵⁴ The attitude is deep rooted in the development of the British armed forces as a means to reinforce government manpower at home and abroad before protecting and reinforcing citizen rights.²⁵⁵ This paradoxical relationship historically resulted in a citizenry that, while proud of their soldiers, viewed them as separate from society and regarded their welfare as not the responsibility of the government. Therefore, the central components of the British state have not often been the providers of assistance to

²⁵³ Ibid.

²⁵⁴ Christopher Dandeker et al., "What's in a Name? Defining and Caring for “Veterans” The United Kingdom in International Perspective," *Armed Forces & Society* 32, no. 2 (2006): 164.

²⁵⁵ See H. Strachan, *Politics of the British Army* (Oxford, UK: Clarendon, 1997), 195-233; and H. Strachan, “The Civil-Military ‘Gap’ in Britain,” *Journal of Strategic Studies* 26 (2003): 43-63.

veterans. Beginning in the early nineteenth century, assistance rendered to soldiers and veterans came from regimental and corps associations, such as the Ex-Servicemen's Welfare Society, now Combat Stress. On the heels of these associations came the civilian charities, of which the most well-known is The Royal British Legion, formed in 1921 as a voice for the ex-service community.²⁵⁶ It was following the Second World War that the creation of the national welfare system resulted in consistent treatment for military and civilian personnel alike.²⁵⁷

While this progression might have seemed promising in regards to the development of centralized assistance for current and ex-service personnel, it contributed to the lack of research on British personnel after the Second World War. With the centralization of services in the national system came a decline in medical services within the British Armed Forces, which resulted in a comparable neglect of academic research. Until the end of the Gulf War, there had been scarce social and psychological research into the effects of a specific deployment on personnel during the inter-war years. It was not until 2001 that a U.K.-funded study was conducted to assess the health of Gulf War veterans within the U.K. for the purposes of comparing "their health to that of similar personnel not deployed, to describe patterns of ill health in both groups, and to estimate their extent."²⁵⁸

A constant theme within this study is that this inter-war period is plagued with stagnation, both in the undertaking of new research in this field but also in the creation of

²⁵⁶ "Our History," Royal British Legion, accessed July 7 2016, <http://www.britishlegion.org.uk/about-us/our-history/>

²⁵⁷ Dandeker et al, "What's in a Name?," 164.

²⁵⁸ N. Cherry, et al., "Health and Exposures of United Kingdom Gulf War Veterans. Part 1: The Pattern and Extent of Ill Health," *Occupational and Environmental Medicine* 58 (2001): 291.

new charities and advocacy groups. The conflict in Afghanistan and the vast numbers of returning wounded meant that there was an increased social response to assist service personnel.

Current Charities and their Roles

In the post-Afghanistan years, there has been a surplus of charities aimed at addressing the mental health needs of current and ex-service personnel. The scope of each organization varies greatly and their target audiences are often different, although there is often overlap. The academic literature in this field is not extensive, and that which has been completed is primarily historical recounting of the development of charities. Such work does not lend itself well to the scope of the analysis presented here: to understand the role these charities play in both providing and advocating for mental healthcare for ex-service personnel.

Combat Stress

Hailing themselves as ‘The Veterans’ Mental Health Charity’, Combat Stress is one of the oldest charities in the world whose focus is directly on improving the mental health resources available to service personnel. The creation of the charity in 1919 was ambitious for the time period, given the attitudes towards mental welfare which were “primitive, even barbaric.”²⁵⁹ The reasoning behind the creation of Combat Stress most strongly exemplifies the necessity of the research being undertaken in this study. When soldiers returned from the First World War, thousands were suffering from shell-shock.²⁶⁰ Under Martial Law, these ex-service personnel were confined to Mental War Hospitals.

²⁵⁹ “History of Combat Stress,” Combat Stress, accessed August 20, 2016, <http://www.combatstress.org.uk/about-us/history-of-combat-stress/>

²⁶⁰ See Appendix B for definitions.

Craiglockhart, a hospital for officers with war neuroses, was the subject of British war poet Siegfried Sassoon's 1917 piece 'Survivors', in which he writes "These boys with old, scared faces, learning to walk./They'll soon forget their haunted nights".²⁶¹ Dr. Joanna Bourke wrote that the hospitals were not places focused on improving the mental trauma of servicemen, but rather places of shame, where soldiers "were greeted in silence".²⁶² In response to these conditions, a small group of women, the 'founding mothers of Combat Stress', created the charity in order to assist the veterans to cope with their condition through a rehabilitation programme, centred around employment schemes in keeping with the connection of work to masculine identity.²⁶³

Nearly a century later, Combat Stress has emerged as one of the largest advocates for and provider of mental health services for ex-service personnel within the U.K. They provide residential and community treatment programmes for nearly 6000 veterans, free of charge.²⁶⁴ In their 2014-2015 Annual Report, they revealed that of the veterans they are currently supporting, 971 served in the Afghanistan conflict and 1185 in the Iraq conflict.²⁶⁵ These numbers alone, making up 36% of the total veterans seeking their services that fiscal year.

The Royal British Legion

Formed in 1921, the Royal British Legion, hereafter referred to as the British Legion, brought together four organizations established by ex-Serviceman in the wake of

²⁶¹ Daniel Hipp, *The Poetry of Shell Shock: Wartime Trauma and Healing in Wilfred Owen, Ivor Gurney and Siegfried Sassoon* (Jefferson, NC: McFarland, 2005), 168.

²⁶² Bourke, "Shell Shock during World War One."

²⁶³ "History of Combat Stress."

²⁶⁴ Ibid.

²⁶⁵ Combat Stress, *2014-15 Annual Report and Financial Statements*, 3, <https://issuu.com/combatstress/docs/cs.reportaccounts.v9>

the First World War. The Legion's main purpose is "to care for those who had suffered as a result of service in the Armed Forces during the war, whether through their own service or through that of a husband, father or son."²⁶⁶ In 1981, membership in the Legion was extended to all serving members of Her Majesty's Armed Forces as well as ex-service personnel.

The Legion has dedicated resources to supporting the mental wellbeing of both active and former service personnel within the U.K. As part of the MoD's DRC program that was discussed in Chapter 4, the Legion provided £27 million to establish the Battle Back Centre.²⁶⁷ The Centre's goal is to assist those with both physical and psychological challenges to recover and ultimately return to service or transition into civilian life.

The Legion has played an integral role in advocacy work on behalf of veterans and is a key organization in British civil-military relations. In 2007, the Legion launched the *Honour the Covenant* campaign, calling on the Government to honour the Military Covenant, an acknowledgement of the unique responsibilities shared between the civilian and military societies in the U.K.

Military Covenant

The acknowledgment of a unique bond between civilian society or the state and its armed forces in the U.K. extends back to the era of Elizabeth I²⁶⁸. While recognized as

²⁶⁶ "Our History," The Royal British Legion, accessed September 6, 2016, <http://www.britishlegion.org.uk/about-us/our-history/>

²⁶⁷ "The Battle Back Centre," Royal British Legion, accessed September 6, 2016, <http://www.britishlegion.org.uk/get-support/physical-health/the-battle-back-centre/>

²⁶⁸ In 1593, a statute issued by Queen Elizabeth I, "An Acte for Reliefe of Souldiours" recited that those soldiers who are disabled as a result of service to "Her Majesty and the state, should at their return be relieved and rewarded to the end that they may reap the fruit of their good deservings", creating the first legal provision for disabled soldiers in British history. (Hutt, George, ed. *Papers Illustrative of the Origin and Early History of the Royal Hospital at Chelsea*. GE Eyre and W. Spottiswoode, 1872, 6).

the first codified example of formal support for disabled veterans, it fell “well short of a comprehensive commitment to those willing to lay down their lives on behalf of the state”.²⁶⁹

In 2000, *Soldiering – the Military Covenant* was published by the Army, detailing the unique responsibilities of the soldier to “share the legal right and duty to fight and if necessary kill, according to their orders, and an unlimited liability to give their lives in doing so.”²⁷⁰ While this is not an expectation unique to British soldiers, the creation of the Military Covenant is unique in its formal recognition of the obligation the nation has to sustain the military. While the term was heavily endorsed by members of the military, including Chief of the General Staff General Sir Richard Dannatt, it was not until a 2007 speech that Prime Minister Tony Blair accepted the existence of these mutual obligations.²⁷¹ Blair not only acknowledged that soldiers were working harder and longer than was originally intended, but at a time when service personnel were asked to give so much, their grievances were particularly important. This was essentially a formal recognition of the key proponent of the Military Covenant: that a specific obligation from the state was warranted to those that were asked to go above and beyond in service to the nation.

Before an examination of the controversy and political rhetoric that has emerged around the Military Covenant, it is first important to examine the relevant literature.

²⁶⁹ Anthony Forster, “The Military Covenant and British civil-military relations: Letting the genie out of the bottle,” *Armed Forces & Society* 38, no. 2 (2012): 274.

²⁷⁰ *British Army, Soldiering: The Military Covenant* (Upavon: Ministry of Defence, 2000), http://www.army.mod.uk/servingsoldier/usefulinfo/valuesgeneral/adp5milcov/ss_hrpers_values_adp5_I_W.html#milcov (accessed October 20, 2016).

²⁷¹ George Jones, “We need to spend more on Armed Forces, admits Blair,” *The Telegraph*, January 13 2007, accessed October 2, 2016, <http://www.telegraph.co.uk/news/uknews/1539340/We-need-to-spend-more-on-armed-forces-admits-Blair.html>

Unlike many of the accounts provided within this study, the Military Covenant has been interpreted within the theoretical framework of civil-military relations scholarships to better understand the provision of healthcare and welfare provisions for discharged or retired personnel. As soldiers surrender their personal liberties for the purposes of serving the state, there is an inherent expectation that they will receive a level of care that is unique to the expectations set upon them. Mumford argues that health provisions and welfare are now the “primary manifestations” of how the state fulfills its obligations towards personnel.²⁷² The emergence of debates surrounding mental healthcare in the post-Gulf War intensified the “focus on veteran care as a source of policy, academic and public interest”.²⁷³

Mumford’s assertion that the historical tensions that have existed between the British Armed Forces and the public over conscription, amongst other things, is a manifestation of the culture gap theory that permeates civil-military relations. In addition, Mumford argues that the “bonds of solidarity that the wider public feels for the armed forces seems to have diminished” as the result of the end of mandatory service in the 1960’s.²⁷⁴ While this is a not a commentary on the success of efforts of civilian charities and organizations that seek to assist veterans, it is a significant commentary on the state of civil-military relations in the U.K. Mumford argues that an insertion of ‘Big Society’ ideals into the understanding of the Military Covenant has resulted in a decentralization of veteran care and an emphasis on community efforts in caring for personnel in need. This would, in part, provide an explanation for the emergence and popularity of agencies

²⁷² Andrew Mumford, “Veteran care in the United Kingdom and the sustainability of the ‘Military Covenant’,” *The Political Quarterly* 83, no. 4 (2012): 820.

²⁷³ Ibid.

²⁷⁴ Ibid, 822.

such as the Legion and Combat Stress. The efforts are made to “absent the state from certain provisions...developing a tangible narrative that realigns particular services or functions as the problem of society and not the government”.²⁷⁵ This manifestation of the civil-military gap is further demonstrated by the fact that anywhere from 161 to just below 2000 agencies working with or on the behalf of veterans within the U.K..²⁷⁶ While those numbers seem alarming, the other jurisdictions examined in this chapter face the same problem of excessive organizations and a distancing of government from provision of care.

Political Reaction

The Honour the Covenant campaign was launched in 2007, as a means of holding the U.K. Government accountable to the responsibilities it owed to the nations service personnel. According to the Legion, the objectives of the campaign included improved compensation, a cross-departmental strategy on improving welfare for personnel and enshrining the principles of the Covenant into law.²⁷⁷ That October, then-Conservative Party leader David Cameron addressed the Covenant, telling then-Prime Minister Gordon Brown, “I believe your government has broken it.”²⁷⁸ The response from Brown’s government came a month later, when then-Secretary of State for Health Alan Johnson announced that veterans would receive priority through the NHS and any charges for prescription medication would be waived.²⁷⁹ After nearly four years of campaigning and

²⁷⁵ Ibid, 824.

²⁷⁶ Ministry of Defence, *Report of the Task Force on the Military Covenant*, London: Ministry of Defence, 2010, 25.

²⁷⁷ “Previous Campaigns,” The Royal British Legion, accessed October 2, 2016, http://support.britishlegion.org.uk/app/answers/detail/a_id/196/~the-royal-british-legions-previous-campaigns

²⁷⁸ “Cameron speech in full,” *BBC News*, October 3 2007, http://news.bbc.co.uk/2/hi/uk_news/politics/7026435.stm.

²⁷⁹ Matthew Taylor and Richard Norton-Taylor, "Priority NHS treatment promised to war

political debate over the issue, it was announced in 2010 that Prime Minister David Cameron had made arrangements to enshrine the Covenant into law, which would allow personnel to sue the Government if they felt as though they had been victims of a breach of the Covenant. During a visit to aircraft carrier Her Majesty's Ship (HMS) Ark Royal, Cameron stated:

It's time for us to rewrite the Military Covenant to make sure we are doing everything we can... Whether it's the schools you send your children to, whether it's the healthcare you expect, whether it's the fact that there should be a decent military war for anyone who gets injured. I want all these things refreshed and renewed and written down in a new Military Covenant that's written into the law of the land.²⁸⁰

In the Armed Forces Act of 2011, a provision was made for the Defence Secretary to make an annual report on progress towards the rebuilding of the Covenant, with reference to healthcare. After receiving Royal Assent, the principles of the Military Covenant were enshrined into law within the Armed Forces Act in November of 2011.

Summary

The role that charities have played in the U.K. is significant, as they have not only participated actively in the provision of care, but they have also served as staunch advocates for reform in veteran healthcare. The Legion proved to be a key factor in the reform of the Armed Forces Act and their efforts ensured that the obligation the U.K. has to its personnel is protected within law. Given the difficult nature of transition after conflict and the publicity surrounding PTSD amongst soldiers, this protection is imperative to ensuring that those who have suffered physically or psychologically

veterans", November 23 2007, *The Guardian*,
<https://www.theguardian.com/society/2007/nov/23/nhs.publicservices>.

²⁸⁰ "Military Covenant to be enshrined in law," Ministry of Defence, accessed September 19 2016,
<https://www.gov.uk/government/news/military-covenant-to-be-enshrined-in-law>.

because of their service are awarded the proper care and benefits. The enshrining of the principles of the Covenant into law is representative of an attempt to close the gap that has permeated civil-military relations for decades in the U.K.

Case Study: United States

The U.S. case studies from Chapter 3 and 4 demonstrated that compared to the other jurisdictions, the U.S. is the largest in terms of size of the armed forces as well as numbers of injured personnel. However, the U.S. also dwarfs both Canada and the U.K in terms of the number of veteran organizations, with an astonishing 45,000 non-profits registered as of 2015 that are devoted to military veterans and their families.²⁸¹ Some cater to specific branches of the armed forces, or veterans of specific conflicts, whereas others offer services to all veterans. As each organization has unique objectives, it is not possible to provide a comprehensive analysis of veterans' organizations in the U.S. Therefore, this chapter will examine organizations who work with veterans that are within the scope of this thesis, as well as have a focus on mental health.

According to journalist Dave Phillips, many of the organizations are reflective of the era in which they were created. In the years following the First World War, the organizations resembled fraternal orders, whereas following the Vietnam War, they were more representative of advocacy organizations. This study will argue that organizations founded amongst the most recent conflicts in the Middle East resemble corporations and operate on a similar model.

It is important to acknowledge that this study does not possess the capacity to

²⁸¹ "U.S. Veterans Organizations by the Numbers," Guidestar, 2015, <http://www.guidestar.org/downloadable-files/us-veterans-organizations.pdf>

provide a taxonomy of all 45, 000 organizations that exist within the U.S. However, the case study selected was chosen based on the interesting differences in public political culture when compared to its British and Canadian counterparts. It is difficult to conduct a comprehensive overview that would provide an accurate representation of all organizations and therefore, attention is given to one organization whose attitudes and decisions have contributed to an interesting and often contentious discourse when compared with their allies. The following case study should not be interpreted as a representation of all 45,000 organizations but rather as a representation of the stark differences between the U.S. and its allies.

Wounded Warrior Project

Founded in 2003 by a group of friends, Wounded Warrior Project (WWP) works to address the needs of physically and mentally wounded veterans and fill gaps in government care. What is most relevant to this analysis is that the charity caters only to veterans whose injuries are attributed to service on or after September 11, 2001.²⁸² It is rare amongst all of the jurisdictions under analysis to find organizations that cater specifically to the younger generation of veterans, particularly those who served in Afghanistan and Iraq. WWP offers a variety of programs and supports, ranging from health and wellness to employment and education. Of relevance to this analysis are the mental health supports offered by the organization, which include long-term supports as well as Project Odyssey, a retreat that utilizes nature, recreation and peer support to rehabilitate personnel.²⁸³ Another initiative is the Warrior Care Network, a partnership

²⁸² “General WWP FAQs,” Wounded Warriors Project, accessed January 21 2017, <https://www.woundedwarriorproject.org/general-wwp-faqs>

²⁸³ “Project Odyssey,” Wounded Warriors Project, accessed January 21 2017, <https://www.woundedwarriorproject.org/programs/combat-stress-recovery-program/project-odyssey>

between WWP and four medical centres to fill in gaps in government care, free of charge, to veterans in need of assistance. While the charities in Canada and the U.S. attempt to fill these gaps in a manner of ways, WWP is the first in this study to explicitly state that this is key priority. While Canada and the U.K. offer national healthcare, the U.S. does not have a similar system. Therefore, many veterans are left on their own to find assistance once they have left the armed forces, especially those who have been released for misconduct, an issue discussed in depth in Chapter 4. Perhaps no country in this analysis is more in need of organizations to fill the gap in care than the U.S., which is why WWP is an important organization to examine.

However, WWP has also dealt with a significant amount of controversy in the years since its inception. Identified as the neighbourhood bully of veterans organizations, WWP has launched several lawsuits for defamation and similarities in branding material.²⁸⁴ They have also initiated lawsuits against several veterans critics for articles that were critical of WWP policies. In 2015, Alex Graham was on the receiving end of a lawsuit after he was openly critical on a blog about the salaries being paid to WWP executives.²⁸⁵ Graham later removed the articles and issued a retraction. However, in January 2016 Dave Phillips of *The New York Times* reported that only 60% of WWP revenue was being funneled back into services for veterans, and that the remaining 40% was spent on its overhead, compared to 8% among other veterans organizations.²⁸⁶ WWP

²⁸⁴ Mike Mather, "Small veterans' charity sued for "unfair competition" by Wounded Warrior Project," *WTKR*, April 29 2015, <http://wtkr.com/2015/04/29/small-veterans-charity-sued-for-unfair-competition-by-wounded-warrior-project/>

²⁸⁵ Adam Ashton, "Wounded Warrior Project sues a veteran critic in Gig Harbor," *The News Tribune*, February 9 2015, <http://www.thenewstribune.com/news/local/military/article26253748.html>

²⁸⁶ Dave Phillips, "Wounded Warrior Project Spends Lavishly on Itself, Insiders Say," *The New York Times*, January 27 2016, <https://www.nytimes.com/2016/01/28/us/wounded-warrior-project-spends-lavishly-on->

was shown to have spent thousands of dollars a year on lavish trips, hotel rooms, team-building and other expenses that were deemed unnecessary by many watchdogs as well as by former employees. William Chick, a former supervisor at WWP, claimed that he was let go following a dispute with a supervisor and that there were a number of individuals let go for seemingly minor infractions, as well as for raising questions about spending decisions that they believed were questionable.²⁸⁷ Then-CEO Steve Nardizzi did not necessarily rebuke the criticisms that the organization was operating on a for-profit model and staunchly believed that organizations should be able to spend what they like on travel and trips. As Philips notes, Nardizzi earned a compensation of \$473,000 in 2014.²⁸⁸ While this is shocking in comparison to many of the charities under analysis in this chapter, it is also unsettling when contrasted to the humble beginning of WWP.

Founder John Melia was a Marine veteran who was wounded in a helicopter crash of the coast of Somalia in 1992. In 2003, wounded troops began arriving back in the U.S. and Melia was reminded of how he arrived with only a hospital gown. He began compiling backpacks stuffed with items like CD players, toothpaste and socks. The backpack project became the foundation upon which WWP is built. Melia eventually hired several fellow veterans to assist him with the project, as well as Nardizzi who was then a lawyer for a non-profit but who possessed no military background.²⁸⁹ As they expanded both fundraising efforts and services provided, there was contention between Nardizzi and Melia about the direction that WWP was headed. Unsurprisingly, Nardizzi was pushing for more aggressive expansion, something that did not settle well with

[itself-ex-employees-say.html](#)

²⁸⁷ Ibid.

²⁸⁸ Ibid.

²⁸⁹ Ibid.

Melia. In 2009, Melia resigned from the company and although he has never spoken publicly about the resignation or Nardizzi, but his ex-wife who also was an employee of WWP claimed that her husband felt as though something had been “stolen from him.”²⁹⁰ The direction that Nardizzi took WWP was not one that sat well with many former employees, particularly those who were former veterans themselves. Dave Ward, a vice president who left in 2015, claimed that WWP “put warriors on a pedestal and the nation wrapped its arms around that concept.”²⁹¹ While the branding was flashy and emotional, many felt that executives were wasteful and misdirected. Employees revealed that staff members flying overseas were booked first class, costing thousands of dollars a ticket.²⁹² According to tax forms, in 2014 the company spent \$7.5 million on travel.

While many of the organizations in this chapter have lobbied governments and politicians to improve mental health services and close the gap in provision of care, WWP has lobbied to fight proposals that would increase non-profit transparency.²⁹³ Nardizzi told Phillips that bills in both California and Florida passed in amended formats that would not have significant impact on WWP.²⁹⁴ However, it is evident that the advocacy taken by WWP is self-serving rather than focused on improving the lives of the veterans they state they are committed to serving.

As of January 2015, there was evidence of widespread firing of employees, many of whom were wounded and ill veterans for disloyalty or opposition to controversial spending. Despite having hired a top public relations firm in 2014 who has represented

²⁹⁰ Ibid.

²⁹¹ Ibid.

²⁹² Ibid.

²⁹³ Ibid.

²⁹⁴ Ibid.

corporate giants such as Starbucks, public perception and media coverage of WWP increased. Two months later, in March 2015, WWP board of directors fired Nardizzi and Al Giordano, Chief Operating Officer. Their firing came amidst evidence that the executives had become intolerant of criticism and were guilty of inappropriate allocation of funds. It also came a month after WWP had hired independent law firm Simpson Thacher & Bartlett to do an independent review, the results of which confirmed many of the accusations leveled by watchdogs and former employees.²⁹⁵ After the terminations, board chairman Anthony Odierno took control of WWP. Odierno is a retired Army captain who was wounded in Iraq and is the son of Gen. Raymond Odierno, a former chief of staff of the army.²⁹⁶ The focus of WWP immediately turned to gaining the trust of the veteran community and as Odierno stated, “to put the organization’s focus directly back on the men and women who have so bravely fought for our country and who need our support”.²⁹⁷ As of October 2016, WWP had been dropped from watchdog Charity Navigators “watch list” and received commendation on both accountability and transparency.²⁹⁸ In February of 2017, WWP was cleared by the Better Business Bureau of “lavish spending” and given a seal of approval.²⁹⁹

Advocacy

While there are potentially hundreds of veterans organizations that also work to alleviate

²⁹⁵ Dave Phillips, “Wounded Warrior Project’s Board Fires Top Two Executives,” March 10 2016, https://www.nytimes.com/2016/03/11/us/wounded-warrior-board-ousts-top-two-executives.html?_r=0

²⁹⁶ Ibid.

²⁹⁷ Ibid.

²⁹⁸ Lynnsay Gardner, “Charity watchdog drops Wounded Warrior Project from watch list,” October 3 2016, <http://www.news4jax.com/news/wounded-warrior-project/charity-watchdog-drop-wounded-warrior-project-from-watch-list>

²⁹⁹ Emily Wax-Thibodeaux, “Wounded Warrior Project cleared of ‘spending lavishly,’ report finds,” *The Washington Post*, February 8 2017, https://www.washingtonpost.com/news/checkpoint/wp/2017/02/08/wounded-warrior-project-cleared-of-spending-lavishly-report-finds/?utm_term=.50d9cb6d6b8f

the mental health burden facing the U.S. armed forces, the advocacy work undertaken by individuals and organizations alike is of particular usefulness to this analysis.

Under the Obama administration, the Joining Forces initiative sought to build bridges between the private and public sectors to ensure that personnel and their families receive adequate care in order to live a healthy and successful life. The initiative worked to address wellness, education and employment amongst veterans.³⁰⁰ There are a number of research organizations that have partnered with the federal government to undertake policies that focus on veteran mental health and how best to treat personnel in need. The American Medical Association (AMA) is a voluntary association of physicians in the U.S. that sets standards for care. The organization worked with the Obama administration and Congress to improve access to care outside of the VA, until the system could provide timely and adequate assistance.³⁰¹ In 2014, AMA supported the passage of the Veterans Access, Choice, and Accountability Act of 2014, which created the Veterans Choice Program (VCP).³⁰² VCP allowed veterans to seek assistance from a non-VA physician in the case that the veteran was unable to receive care with less than a 30-day wait or lived more than 40 miles from a VA facility.³⁰³ VCP was intended to end in August 2017, as the VA worked to alleviate the wait times and barriers that necessitated the programs creation. However, AMA has been pushing for a bipartisan effort to make VCP a permanent program. AMA also works with the Committees on Veterans' Affairs of the Senate and the House of Representatives to "streamline programs, improve access to care

³⁰⁰ "Joining Forces," The Obama White House, accessed January 7 2017, <https://obamawhitehouse.archives.gov/joiningforces>

³⁰¹ "Advocating for Veterans' Health," The American Medical Association, accessed January 8 2017 <https://www.ama-assn.org/delivering-care/advocating-veterans%E2%80%99-health>

³⁰² Ibid.

³⁰³ Ibid.

and to encourage participation by non-VA physicians and other providers”.³⁰⁴

AMA is not the only organization that has strongly worked to advocate for improved veterans’ health services, but they are significant in that they are an organization formed by physicians, most of whom possess no familiarity with the military experience. However, they have managed to advocate for services that would alleviate the majority of the concerns address in chapter 4 and continue to push for bipartisan efforts to improve health services for personnel.

Conclusion

What is perhaps most interesting about this case study is that the civil-military culture gap framework can be applied to explain both the internal and external issues that arose within the charity under analysis, WWP.

The founder of WWP was heavily influenced by his own personal experiences as a wounded veteran and as a result, he was driven to help those facing a difficult and long journey upon returning home. Conversely, Nardizzi was driven to operate WWP on a for-profit model and faced no difficulty taking large compensations or spending lavishly on trips. It can be argued that Nardizzi lost sight of the purpose of WWP, or that he perhaps never possessed such an understanding. This lack of understanding is indicative of Rahbek-Clemmensen’s culture gap, in that Melia, who possessed military experience, wanted the central focus to be on veterans in need whereas Nardizzi wanted to operate WWP as a for-profit organization, and was heavily focused on marketing and expensive team-building. WWP was chosen for this case study because it is not often that the civil-military gap can be examined within the context of the organization’s own decisions. The

³⁰⁴ Ibid.

framework also explains the public reaction to WWP prior to the termination of Nardizzi and Giordano. The normative expectations of civil society led to a backlash when it became evident that one of the largest veteran organizations in the country was being run as a for-profit corporation, with lavish trips and expensive travel just some of the expensive. As a result, the culture gap was increased between the organization and those in society who could not separate the organization from the veterans and armed forces that it claimed to represent.

Additionally, this case study was interesting in that the role that the AMA played in the development of improved policies and services is not something that appeared in the other jurisdictions under analysis. The fact that one of the most important influencers of improved policy in recent years was an organization that consisted of care providers is significant in that it closes the civil-military gap. By intersecting the public health organizations and the VA, the changes led to options for veterans who face increased wait times and difficult travelling for assistance. This intersection is integral to improving policies, particularly in the U.S., where there are not readily available public healthcare services to personnel.

Variable Analysis

The role that veterans' organizations play in both the provision of care and advocacy is integral to the overall health and wellbeing of personnel. While both training and compensation processes have been discussed in academic relating to military mental health, it can be argued that this chapter is the first time that there was strong evidence presented to support the importance of these organizations in the overall care received by those in the armed forces.

Through the lens of civil-military relations, this chapter demonstrated that many organizations seek to appeal to both civil society and the military community. The culture gap discussed by Rahbek-Clemmensen is effectively minimized by organizations that seek to assist those facing difficulty reintegrating into civil society. When an increased number of charities seek to assist personnel and veterans, it can be argued that those with civil society see it as an opportunity to scale back services offered at the expense of governments. Rather than organizations stepping into to fill gaps in care that exist, they often find that they are increasingly becoming responsible for providing services that should be rendered by armed forces and governments alike. However, as the U.K. case study demonstrated, this can be alleviated by increased coordination between the public and private sector. This coordination is eased by the centrally organized nature of the organizations both within civil and military society in the U.K. The cooperation between Combat Stress and the MoD resulted in an improved continuum of care for personnel transitioning out of HM Forces. This cooperation between organizations and governments is arguably a solution faced by each jurisdiction under analysis, who continue to deal with the heavy burden of mental healthcare following combat operations.

Of uniqueness to this case study was the manner in which the civil-military framework could be used to describe the faults that exist within organizations themselves, such as WWP in the U.S. In this instance, the organization found itself at odds internally, fueled by competing executives who saw different visions for WWP: one saw an organization focused on small expansion and remaining committed to the veteran-focused initiatives it was built on; and one, backed by no military experience, who based his ideas on a for-profit model and wanted to see WWP ran similar to a large scale corporation.

This demonstrates the disconnect between those with military experience and those without, which is not always a detriment to effective care, but aptly explains problem when they do arise.

Finally, the importance of advocacy from those within civil society is of particular importance in this analysis. At times, there is need for a well-informed and proactive civil-society to hold the armed forces and governments to account, particularly when they are failing to address problems amongst their ranks. These external forces can be crucial to improved services, increased awareness and better communication between the military and society. There is no doubt as to whether there is a gap between civil and military societies; however this gap should not be regarded as impermeable. As this chapter demonstrated, there are opportunities for this gap to be bridged when serious issues necessitate it. The role of the AMA in the development of the VCP is incredibly important, given that the program seeks to alleviate many of the barriers to care discussed throughout this study. In the Canadian case study, retired lieutenant-general and former Senator Romeo Dallaire was shown as an example of an individual who has tried to use both of his experiences to appeal to superiors in each community and advocate for improved services.

In this chapter, it was argued that veterans' organizations have provided care and advocated for improved services in the absence of formal supports from both civilian and military society and that both Canada and the U.K. emerged above their American counterparts. This was largely due to the fact both Canada and the U.K. had organizations that were actively engaging with their respective armed forces and developing partnerships to ensure a continuum of care, an action that was not thoroughly undertaken

within the U.S. The ability for this cooperation to take place in Canada and the U.K. can be directly attributed to the degree of centralization that exists. As the study demonstrated, it is not worthwhile to argue that the U.S. does not wish to have a similar level of cooperation in attempts to alleviate the burden being placed entirely on the armed forces and relevant bodies. However, it is the ease with which this cooperation is achieved that is directly related to the degree of centralization that exists. In Canada and the U.K., the centralized nature of both civil and military organizations means that the cooperation is easier to achieve than it is in the state. This has a significant impact on the level of care that is received by veterans as well as the capacity of American non-profits to enact meaningful reforms and provide sufficient care.

There is no question that the role of veterans' organization in providing care and advocating for improved services is incredibly important to the wellbeing of personnel and the effectiveness of nations addressing their mental health burden amongst military personnel. Therefore, there is a need for greater research into the role that these organizations can play in delivering care and the opportunity for collaboration with both federal and armed forces agencies responsible.

CHAPTER 6: CONCLUSION

It is evident that there are few things less contentious in the field of military health than the handling of mental illness amongst personnel in the years since the initial deployments to Iraq and Afghanistan. In Canada, the U.K. and the U.S., there are no shortages of difficulties in coping with the overwhelming numbers of individuals requiring care. However, this thesis demonstrated that it is not just the volume of individuals requiring care that impacts health administration, but also the manner in which individuals are trained, the discharge processes and the role of organizations once personnel have transitioned out of the armed forces. Each variable was analyzed in this study in the order that they occur in an individual's career into, during and after the armed forces. This thesis sought to determine the degree to which centralization played a role in the effectiveness with which mental healthcare was provided in each jurisdiction. The judgements, made on both qualitative evidence and the use of suicide rates, demonstrated that the U.K. has most effectively addressed mental health amongst its armed forces when compared to its allied in Canada and the U.S.

While the majority of literature has focused on the types of medical treatment and therapy available, mental health amongst armed forces is marred by a lack of understanding as to the influences, both social and political, that impact health administration. By framing this subject in the lens of institutional theory, it is evident that while a gap exists between civil society and the armed forces, normative expectations heavily influence changes made by armed forces and responses within civil society have led to significant adjustments in each variable under analysis. Civil society often holds the military to the same standards that it holds itself, which has heavily influenced the outcry

over suicides amongst veterans and the state of mental healthcare. While this outrage is often warranted, this thesis revealed an important competing narrative. This narrative analyzes the importance of maintaining healthy, deployable armed forces, which often means the necessary discharge of individuals with mental illness diagnoses. A primary conclusion drawn from this thesis is that this narrative guides the attitudes and policies related to mental illness in the armed forces. While armed forces make concerted efforts to ensure personnel wellbeing and mental health, they do so with the understanding that their primary responsibility is to protect the nation at home and abroad. Therefore, the need to address mental health is often secondary to the need to fulfill their obligation as an armed force.

This study demonstrated that in each case study, the degree to which institutions are centralized is directly correlated with the effectiveness with which mental healthcare and related initiatives are delivered. The metrics that were collected supported this argument, in that the U.S. has seen a steady increase in the number of suicides amongst their personnel as the conflicts in the Middle East continued. However, towards the ends of these conflicts, the suicide rates in both Canada and the U.K. steadied and eventually began to decline. In comparison to the constant rise of suicide facing their American allies, it was clear the manner in which mental health was addressed in Canada and the U.K had significant impacts on personnel's wellbeing in the long term. As the case studies demonstrated, the centralization of relevant institutions in these jurisdictions was intrinsically connected to the manner in which mental healthcare was addressed. The metrics demonstrate that this centralization was most effective in Canada and the U.K. and the decentralized nature of institutions in the U.S. did not have a positive impact on

suicide rates and outcomes of mental health.

This thesis sought to first understand how mental health is addressed in the beginning of one's career with the armed forces, specifically through training initiatives. The case studies of each jurisdiction in Chapter 3 revealed the difficulties in evaluating training programs and their relation to wellbeing. It was evident that for U.K. and the U.S., training for mental health is more often relegated to deployments, rather than initial entry in to the forces. Conversely, Canada has implemented a training program that begins with BMQ but has components that are implemented throughout one's career. However, the evidence showed that this difference did not necessarily have a strong impact on the impact and reception of the program's effectiveness. Canada and the U.S. implemented many of their initiatives during the height of the Iraq and Afghanistan conflicts, allowing very few individuals who experienced combat in that theatre to benefit from the training. Comparatively, the U.K. TRiM program was implemented much earlier, prior to the height of deployments to the Middle East. Additionally, TRiM was based on readily available research and has been in place for nearly two decades, which has allowed for a number of studies to measure outcomes and performance of individuals who have used this program.

This thesis sought to understand the degree to which centralization played a role in the effectiveness of training programs. Therefore, it is evident that the TRiM program implemented by HM Forces has demonstrated the most success compared to those implemented in Canada and the U.S. In part, this is due to the focus on evidence-based interventions, rather than peer-based ones. However, the uniform nature of the training program and the even implementation across all personnel also resulted in its efficacy. In

a more centralized system, training programs are delivered in a standardized manner, both in their delivery and in the education of those providing the training itself. Centralization was evidently more prominent in the U.K., which significantly impacted their effective delivery of training programs. In both Canada and the U.S., non-medical personnel are trained to carry out mental health interventions and train subordinates. By transitioning away from relying on peers, there is an increased emphasis on the responsibility of the armed forces for personnel wellbeing, rather than the responsibility being placed on personnel themselves. Additionally, neither Canada or the U.S. have training programs that have been in place long enough to produce measurable outcomes amongst veterans of the most recent conflicts in the Middle East. Therefore, while evidence supports the success of the U.K. model, there is an opportunity for further research in this field to accurately determine the impact of R2MR, MRT and CSF on personnel. While the CF is a more centralized institution than the U.S. armed forces, they faced difficulty in the training of personnel. This case study reiterated the premise of this analysis: centralization can be a decisive factor in the effective delivery of mental health care, but it does not serve as the only factor.

Chapter 4 conducted an analysis on the discharge processes and compensation available to personnel exiting the armed forces as a result of mental illness. Undoubtedly the most controversial of all variables under examination revealed the difficulty of balancing competing narratives between armed forces and veterans regarding the manner in which individuals with mental illness are treated within armed forces. Given the difficulty of discerning the degree to which discharge and compensation policies for personnel contribute to the stigmatized attitude surrounding mental illness, it was

incredibly valuable to incorporate personal experiences and voices into this chapter. The voices of superiors within the armed forces adhered to the narrative that their purpose is to field an able-bodied, deployable fighting force. To achieve this, they are often required to discharge individuals with psychological and physical injuries. In Canada, this narrative is enshrined in the universality of service principle. However, there is narrative amongst veterans that discharges are handled inappropriately, particularly for personnel who have been diagnosed with a mental illness. As was discussed in the U.S. case study, there is ample evidence to suggest that in certain jurisdictions, personnel are forced out of the armed forces due to their mental illness. However, with the exception of the U.S., there is not widespread evidence to suggest that in Canada and the U.K., discharges for personnel with mental illness are handled inappropriately.

The culture-gap as conceptualized by Rahbek-Clemmensen et al. provides an explanation as to why there is a hostile reaction to those being discharged; they wish to continue receiving care amongst their peers and from those who are familiar with the institutional structure to which personnel have belonged. It also demonstrated the power balance between the two societies, in that the military alone has the power to impact the transition of individuals out of the armed forces. The relevance of institutional theory and centralization as a causal variable cannot be overstated, particularly when discussing discharges and transitioning out of armed forces. A common thread across all jurisdictions was a difficulty by many in their transition out of the armed forces and back into civilian society. This transition is made difficult by the change in structure, as the institutional structures within forces are designed to establish a superior-subordinate relationship. It is not possible to simply equate the difficulty in transition to a culture-gap.

Rather, it is important to acknowledge that individuals going through a difficult period of transition do not react to sudden change in a way that is conducive to healing. Rather, it is imperative to slowly ease the transition so as to adjust to differing institutional structures within civilian society.

It is evident that there was a causal relationship between the degree of centralization and the poor application of discharge policies and compensation in the case of the U.S. The lack of a centralized institutional framework has resulted in an uneven application of discharge policies which has itself resulted in personnel being discharged for reasons that did not apply to their colleagues.

In making relative judgements of the manner in which armed forces handle discharge and compensation policies, it is clear that Canada and the U.K. are similar in both their challenges and successes. However, it is without question that the U.S. has many improvements to make to their processes. Not only was the manner in which tens of thousands of personnel discharged unethical, but it also resulted in them having little to no access to benefits, which prevents individuals from getting the care that they need. It is difficult to deny the causality between these discharges and the rise in veteran suicides in the U.S.³⁰⁵

Finally, the analysis of organizations that was presented in Chapter 5 demonstrated the decentralized nature of institutions in the U.S. resulted in a great number of smaller organizations with the absence of an oversight body to prevent scandals such as those presented in the U.S. case study. Additionally, due to the centralized nature of armed forces institutions in Canada and the U.K., the ability to

³⁰⁵ See Appendix A for Incidence of Suicide.

coordinate and cooperate with external agencies to provide services where there was shortfall was much greater. As has been evidenced throughout this study, the burden of mental healthcare facing armed forces often overwhelms available services. This has resulted in a growth of non-profit organizations who often step in to provide services and programs to assist injured and ill personnel. While many of these organizations can provide services in the fields of health, recreations, education and employment, it is inarguable that cooperation between these agencies and their military counterparts would improve the continuum of care for individuals transitioning out of the armed forces. In Canada and the U.K., the centralization of institutions resulted in a strong emphasis on the importance of the continuum of care.

The case study of the U.K. demonstrated that greater cooperation and collaboration between agencies in military and civilian society results in improved care. A productive working relationship between the two sectors has led to a distribution of responsibilities and services. Not only does this work to alleviate the burden on armed forces, but it also ensures an easier transition into civil society for personnel. While the chapter did not seek to make absolute judgements about the success of organizations in providing care, it was evident that the collaborative relationship built in the U.K. between the MoD and the Royal British Legion in funding the DRC program discussed in Chapter 4 is extremely effective in assisting personnel.

The most important causal variable that presented itself within this analysis was the degree to which institutions were centralized, which effectively determined the manner in which all aspects of mental health relating to armed forces were handled. This causal variable affected each of the three independent variables to a degree that

significantly impacted the wellbeing of service personnel. Centralization was a factor in all discussions surrounding mental health, from the manner in which training was delivered to the potential exacerbation of stigma by superiors, as was demonstrated in several case studies. However, this thesis also demonstrated that this was not the only causal factor, particularly in relation to the second variable of discharge policies and compensation. In this chapter, it was evident that there were other factors that played an equally important role: operational readiness and financial scrutiny both offered adequate explanations for the manner in which discharge and compensation policies were inappropriately applied within the U.S. However, these policies provided an explanation for why the U.S. were guilty of unethical en masses discharges but did not necessarily explain why the U.S. fared much worse than their allies. This was explained by the degree of centralization in both institutions and their relevant policies pertaining to this variable.

The conclusions drawn from these chapters that there is a direct correlation between the degree of centralization between armed forces institutions and the effectiveness with which they address mental health. This was an argument that was reflected in both the case studies as well as the outcomes of incidence of suicide. The study of institutions, including both their degree of centralization as well as the gap that exists between civil and military societies is integral to the understanding of mental healthcare delivery in armed forces.

Future Research

The primary motivation behind this analysis was that there is a severe lack of research into military mental health from a policy and social science perspective. While there are an abundance of studies that can provide scientific data on suicide, development

of mental illness and measurable outcomes of interventions among armed forces, there are only a handful that intersect social and health sciences to better approach mental illness in the armed forces. Further research would include this intersection in order to better understand administration of care. Military and civilian cultures are distinct.

A future extension of this project would be to conduct interviews with care providers responsible for military mental health, as well as with policymakers responsible for drafting many of the policies discussed. These interviews would assist in an understanding of the actors' perspective on civil-military relations and the role the relationship plays in healthcare. A limitation to this thesis was that, due to an inability to conduct interviews, it was difficult to discern the degree to which a relationship with civil society impacts care provided by armed forces for mental health. While the framework helps to guide an explanation of why mental health amongst armed forces is in its current state, there is room for an involvement of these actors' experiences to understand the degree to which this relationship influences policies.

Finally, another area of future study would be an analysis of the role of veteran organizations in care provision and advocacy. It is evident that they play a significant role in the provision of care as well as in advocating for improved policies. Without these organizations, there would arguably be a much larger gap in the provision of services which would ultimately have a negative impact on health outcomes for personnel. However, the limited research in this area results in a difficult understanding of the way in which these organizations interact with military society regarding policy and program delivery.

Conclusion

Overall, an examination of competing narratives and multiple variables revealed the connection that centralization of institutions has to the effectiveness with which armed forces administer mental healthcare and relevant policies in the years during and following conflicts in Iraq and Afghanistan. Canada, the U.S. and the U.K. face respective difficulties in approaching the mental health burden following years of conflict in the Middle East. Given that armed forces will always be required to participate in combat abroad, it is important to understand the manner in which the mental health of personnel is addressed. This thesis was able to provide a comprehensive analysis of the most important variables related to mental health amongst armed forces personnel and the manner in which Canada, the U.S. and the U.K. approaches these variables. It was evident throughout this analysis the U.K. had the most success in each variable, while the U.S. struggled more than each nation to cope with addressing mental health in the U.S. Army.

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APPENDIX A: INCIDENCE OF SUICIDE

Year	Canada		U.S.		U.K.	
	In Service Personnel	Active Duty Personnel	In Service Personnel	Active Duty Personnel	In Service Personnel	Active Duty Personnel
2001	10	66,100	52	482,655	16	205,650
2002	10	61,600	70	488,631	15	204,690
2003	11	61,600	79	497,770	25	206,920
2004	10	61,394	67	498,428	20	207,020
2005	10	61,460	87	490,632	22	201,100
2006	8	62,703	102	507,131	12	195,850
2007	10	63,716	115	522,190	10	190,400
2008	14	64,397	139	544,150	10	187,060
2009	12	65,890	161	553,579	15	188,370
2010	12	68,136	147	566,045	7	191,660
2011	21	68,250	167	565,463	15	186,360
2012	10	67,700	161	550,063	15	179,800
2013	9	70,000	115	532,043	5	170,710
2014	16	66,000	122	508,210	9	159,630
Total	157		1584	N/A	196	N/A

Sources: Data from National Defence, Surgeon General Health Research Program (2016); Ministry of Defence, Defence Statistics (2016); Ramchand, Acosta and Burns (2011); National Centre for Telehealth & Technology, DoDser (2009); National Centre for Telehealth & Technology, DoDser (2010); National Centre for Telehealth & Technology, DoDser (2011); National Centre for Telehealth & Technology, DoDser (2012); National Centre for Telehealth & Technology, DoDser (2013); National Centre for Telehealth & Technology, DoDser (2014), Department of Defence (2017), National Defence and the Canadian Armed Forces (2014), Schenck (2013).

APPENDIX B: DEFINITIONS

Post-Traumatic Stress Disorder

Post-traumatic stress disorder is defined by the American Psychiatric Association as the development of characteristic symptoms following the exposure to a traumatic event. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria include recurrent and involuntary memories associated with the event, distressing reactions such as flashbacks and marked reactions to internal or external cues that are reminders of the event among others. Of most relevance to this study is the criteria that “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.”³⁰⁶

Shell Shock

Shell-shock was a term coined during the First World War to describe the reactions of soldiers to traumatic events and combat before PTSD had been defined. It described reactions to intense bombardment and fighting which resulted in a variation of symptoms, including panic and fear as well as an inability to sleep, walk or talk.³⁰⁷ However, shell-shock was often used to describe both physical and psychological reactions to combat, as well as employed to negatively label those who lacked bravery. It is used almost exclusively for veterans of WW1 and upon identification of PTSD, is no longer used to describe reactions to combat.

³⁰⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-5*, 5th ed., (Arlington, VA: American Psychiatric Association, 2013), 272.

³⁰⁷ Adam Hochschild, *To End All Wars: A Story of Loyalty and Rebellion, 1914-1918*, (Boston: Houghton Mifflin Harcourt, 2011), 242.