

Combining Clinical Treatment and Peer Support: A Unique Approach to Overcoming Stigma and Delivering Care

Alexandra Heber, MD, FRCPC

Psychiatrist and Program Leader
Operational Trauma and Stress Support Centre
Canadian Forces Health Services Centre
1745 Alta Vista Drive
Ottawa, Ontario K1A 0K6
CANADA

Heber.as@forces.gc.ca

LCol Stephane Grenier, CD

Program Manager
Operational Stress Injury Social Support
Department of National Defence of Canada
Directorate of Casualty Support Administration
National Defence Headquarters
101 Colonel By Drive
Ottawa, Ontario K1A 0K2
CANADA

Grenier.SG@forces.gc.ca

Donald Richardson, MD, FRCPC

Consultant Psychiatrist
Veterans Affairs Canada
55 Bay Street North
Hamilton, Ontario L8R 3P7
CANADA

Don.Richardson@vac-acc.gc.ca

Kathy Darte, MN

Program Co-Manager
Operational Stress Injury Social Support
Veterans Affairs Canada
P.O. Box 7700, Charlottetown
Prince Edward Island C1A-8M9
CANADA

Kathy.darte@vac-acc.gc.ca

ABSTRACT

Operational Stress Injury (OSI) is the term used in the Canadian military to describe psychological illnesses resulting from traumatic events experienced by soldiers during operational duties. These include post-traumatic stress disorder, depression and substance abuse. The Canadian Forces and Veterans Affairs Canada have established mental health clinics, called Operational Trauma and Stress Support Centres (OTSSC's), and Operational Stress Injury (OSI) Clinics across Canada to facilitate early diagnosis and treatment of members and veterans suffering from OSI's. Yet it often takes years for traumatized soldiers to present for care. There are many reasons for this. Shame, isolation, and institutional stigmatizing of mental illness are compelling counter-forces to the urge to seek help. Recent research has shown that the fear of stigma is one of the principal reasons why soldiers do not seek treatment, even when they recognize that they are suffering from psychological problems. In contrast to this, the literature tells us that early intervention is a critical factor in decreasing the sequelae of PTSD and other mental disorders.

In an attempt to address the issue of stigma and other barriers to treatment, the OTSSC developed a partnership with the Operational Stress Injury Social Support (OSISS) program, a peer support program funded by the Canadian Forces and Veterans Affairs Canada. This program uses volunteers and paid employees as peer support workers and co-ordinators, who are either currently-serving military members or veterans who have suffered from deployment-related psychological injuries themselves. The rationale for the OSISS program is based on research showing that social support is an important factor in

Heber, A.; Grenier, S.; Richardson, D.; Darte, K. (2006) Combining Clinical Treatment and Peer Support: A Unique Approach to Overcoming Stigma and Delivering Care. In *Human Dimensions in Military Operations – Military Leaders' Strategies for Addressing Stress and Psychological Support* (pp. 23-1 – 23-14). Meeting Proceedings RTO-MP-HFM-134, Paper 23. Neuilly-sur-Seine, France: RTO. Available from: <http://www.rto.nato.int/abstracts.asp>.

Report Documentation Page

Form Approved
OMB No. 0704-0188

Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

1. REPORT DATE 01 APR 2006		2. REPORT TYPE N/A		3. DATES COVERED -	
4. TITLE AND SUBTITLE Combining Clinical Treatment and Peer Support: A Unique Approach to Overcoming Stigma and Delivering Care				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Psychiatrist and Program Leader Operational Trauma and Stress Support Centre Canadian Forces Health Services Centre 1745 Alta Vista Drive Ottawa, Ontario K1A 0K6 CANADA				8. PERFORMING ORGANIZATION REPORT NUMBER	
				10. SPONSOR/MONITOR'S ACRONYM(S)	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
				12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release, distribution unlimited	
13. SUPPLEMENTARY NOTES See also ADM001955.					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT UU	18. NUMBER OF PAGES 14	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

ameliorating the effects of psychological trauma, and preventing or decreasing the severity of PTSD. Powerful aspects of peer support include the ability to identify with the suffering member, the credibility of the peer in the eyes of the soldier, and the interpersonal acceptance which the peer conveys.

This paper outlines how clinicians and peer support co-ordinators (PSC's) work together to reduce stigma through educational outreach to the troops and the chain of command. It describes how PSC's are often instrumental in getting soldiers into treatment, helping them maintain compliance with treatment, and providing support to military members and their families through difficult emotional times.

Case examples will be used to illustrate the effectiveness of this partnership. Challenges to the success of this partnership will be addressed. Issues of maintaining appropriate professional boundaries, and self-care for the peer support worker, will be discussed. Practical guidelines to help military organizations integrate peer support services will be outlined. The relevant literature will be reviewed.

This partnership of clinicians with expertise in psychological trauma, and military members and veterans who have coped with PTSD and other psychological problems themselves, is an innovative endeavor supported by the Canadian Forces and Veterans Affairs Canada.

INTRODUCTION

This paper will describe the collaboration between military clinics set up to treat soldiers with operationally-related psychological problems, and a national peer support program that is jointly funded by the Canadian Forces (CF) and Veterans Affairs Canada (VAC). These two entities, one staffed by mental health professionals, and the other by military members and veterans who have themselves suffered from deployment-related mental health conditions, are developing a partnership to serve the psychological and social support needs of current and former CF members who suffer from operational stress injuries, as well as their families.

An operational stress injury (OSI) is defined as any persistent psychological difficulty resulting from operational duties performed by a Canadian Forces member. The term is used to describe a broad range of problems, which usually result in impairment in functioning. The term OSI was created by the peer support program OSISS, to focus on the idea of "injury" rather than illness, in an attempt to destigmatize the mental health problems experienced by CF members and veterans. Although not a diagnostic term, OSI is a useful one, and is now commonly used by clinicians working within the CF and VAC, to encompass all operationally-related psychiatric problems. Common OSI's include: Post Traumatic Stress Disorder (PTSD), Major Depression, Substance Abuse, Anxiety Disorder NOS (Subsyndromal PTSD) and Panic Disorder. There is a high incidence of co-morbidity between PTSD and other psychiatric diagnoses, especially Major Depression and Substance Abuse [1,2].

THE OPERATIONAL TRAUMA AND STRESS SUPPORT CENTRES

In 1999, the Operational Trauma and Stress Support Centres (OTSSC's) were stood up across Canada, to meet the needs of Canadian Forces members returning from overseas deployments and suffering from tour-related psychological problems. The OTSSC's were followed a few years later by the creation of Operational Stress Injury (OSI) clinics by Veterans Affairs Canada.

There are five OTSSC's across Canada, located within the base mental health or medical clinics. They are staffed by multidisciplinary teams of psychiatrists, psychologists, mental health nurses, social workers, chaplains and addiction specialists. The OTSSC's are responsible for providing assessment and treatment of CF members who present with psychiatric symptoms related to military operations. The OTSSC's were established to be centres of excellence where the staff would develop expertise in assessing and treating

those with OSI's, as well as functioning as special resources to the other bases in their catchment area. Therefore, each OTSSC has a regional mandate.

The OSI clinics sponsored by Veterans Affairs, have a similar structure and mandate. There is work ongoing towards amalgamation of resources and patient populations between the VAC and CF clinics. In some areas of the country, this has already happened [3].

A confluence of events preceded the creation of these specialized clinics.

Over the past fifteen years, Canada, like many NATO and UN member countries, experienced a significant increase in operational tempo. The end of the cold war changed peacekeeping forever. With the fall of the Soviet Union, there was a new world "disorder" among ethnic tribes, in which Serbs and Croats, Hutus and Tutsis, and dozens of others sought revenge for historical slights. Troops were now employed in the middle of conflicts, trying to enforce peace rather than keeping an existing peace that had been politically brokered. The UN shoulder flash and the white jeep were no longer enough to maintain the peace. Peacekeeping rapidly turned into a combination of peace enforcement and peacemaking, and soon became just another synonym for war [4].

Soldiers returned home from very active deployments, and tried to reintegrate into their families and worklives back in Canada. Some of them were ordered by their commanding officers to report to their medical officers because of disruptive and aggressive behaviour in the workplace. Others were given ultimatums by their spouses to get help or get out, as their angry and reclusive behaviour was creating havoc in the home. The military medical clinics, and the Canadian Forces flagship hospital, the National Defence Medical Centre (NDMC), started to see soldiers presenting with classic symptoms of PTSD, and other mental disorders, which had begun during or following their deployments. By the late 1990's, it was clear that the services for treating operational stress disorders were inadequate [5].

Then, Lieutenant General Romeo Dallaire, who had been Force Commander of the United Nations Assistance Mission in Rwanda during that nation's genocide, became Assistant Deputy Minister, Human Resources-Military in the Ministry of National Defence. He identified that something was broken in the mental health care system, and he assigned the task of developing a working group to create what would become the OTSSC's [5]. Not long after this, General Dallaire was diagnosed with PTSD, as a result of his experiences in Rwanda [6]. He went public with his diagnosis, and in this way, he became a powerful role model and advocate for military members suffering from deployment-related psychological trauma [7].

Despite the creation of the OTSSC's six years ago, it is still common for members of the Canadian Forces to first present for treatment a number of years after their traumatic deployment. In some cases, although already secretly suffering from PTSD, these soldiers have gone on to complete several more tours of duty to very active and war-torn parts of the world.

This raises the question of why military members wait so long to get help for these very debilitating and distressing symptoms.

When Canadian soldiers who present for care are asked why they didn't seek treatment earlier, they often give the following reasons: Fear of being considered weak or a burden by the chain of command, fear of harming one's career, feelings of failure and shame, and a lack of faith in the mental health system. Hoge et al found that American soldiers returning from active duty in Afghanistan and Iraq, cited similar barriers to seeking care [8].

These reasons are all rooted in the issue of stigma.

STIGMA AND OPERATIONAL STRESS INJURIES

Citizens in ancient Greece would prick the skin of their slaves with a sharp instrument, to demonstrate ownership and to signify that those so marked were unfit for full citizenship. The Greek word for prick is “stig”, and the resulting mark is a “stigma” [9]. Today, a stigma is a symbolic mark of social disapproval or disgrace [10,11]. Those who are stigmatized are viewed as inferior, weak or damaged. Mental illness is highly stigmatized in our society [10,12]. Some authors have pointed out that stigma alone “adds a dimension of suffering to the primary illness – a second condition that may be more devastating, life-limiting and long-lasting than the first” [9,13]. According to the Canadian Mental Health Association, our society “feels uncomfortable about mental illness. It is not seen like other illnesses such as heart disease or cancer...People (may)...believe that an individual with a mental illness has a weak character or is inevitably dangerous. Mental illness can be called the invisible illness. Often, the only way to know whether someone has ...a mental illness is if they tell you. The majority of the public is unaware of how many mentally ill people they know and encounter every day”[14].

The invisibility of mental illness is a double-edged sword. It allows those suffering to do so in private, and to maintain their confidentiality. Often early on in treatment, this invisibility is called on as a positive coping strategy, to help decrease the patient’s sense of being exposed and vulnerable. However, the atmosphere of disapproval, and often disgust, that surrounds mental illness, serves to encourage the person to keep his suffering a secret. By doing so, the person’s sense of shame is reinforced. And the stigmatizing and erroneous attitudes of those around him go unchallenged, and therefore do not change. Stigmatized views of mental illness are shared by everyone in our society. This includes the person suffering from such a disorder, as well as those who are treating him.

The Canadian Mental Health Association and Health Canada report that while one in five Canadians will suffer from a mental illness at some point in their life, almost fifty percent will never receive treatment, because of the stigma attached to their condition [15].

Within certain social groups or workplaces, such as the military, stigmatization of mental illness can be profound. This has been well documented in the Canadian Forces Ombudsman’s report on the systemic treatment of CF members with PTSD [16] and the Ombudsman’s report entitled, “Off the Rails: Crazy Train Mocks Operational Stress Injury Sufferers” [17]. It would be hard to overestimate the effects on a military member of having a stigmatized condition. There are few activities in a person’s life that convey a greater sense of self or self worth, than one’s career. “Work influences how and where one lives, it promotes social contact and social support, and it confers title and social identity” [9].

The military members’ identity is closely tied to their work. For them, living in a closed and controlled environment, where neighbours, friends, and work colleagues are often the same people, the effects of stigma in the workplace can rapidly become universal. In addition to this reality, the military organization is one of the last remaining institutions that operates its own health care system. As a result, members are often fearful of seeing the “corporate doctor”, as they worry that their career may be put at risk.

Because of the importance of factors such as team cohesion, a willingness to follow orders and a preparedness to put oneself in harm’s way, military training tends to discourage attitudes and behaviors seen as rebellious, unstable, or morally feeble. If behaviors associated with mental illness are considered signs of rebellion, instability and moral weakness, the stigma attached to these disorders can be expected to permeate the views held by the troops and the chain of command.

In the early stages of implementation of the Operational Stress Injury Social Support (OSISS) national peer support program, one of the newly hired Peer Support Coordinators (PSC’s) heard through the grapevine of a veteran who had voluntarily released from the military and disappeared. He heard that the man had been severely symptomatic, had moved out into the

bush in the northern parts of western Canada, and was living alone. The PSC decided to track down the veteran and offer assistance. After several weeks of trying to find this man, he heard from a contact that the veteran in question had changed his name. The PSC, having no idea what this veteran's new name was, continued with his search. He eventually contacted the veteran and found a severely distressed and isolated man. During his first encounter with the veteran, the OSISS PSC mustered the courage to tell him of the difficulty he had had finding him, and asked the veteran why he had changed his name. The veteran, who had served in Bosnia and had been decorated with a medal for bravery, stated that since he had developed PTSD, he could no longer function at work, and so he decided to take his voluntary release from the military, move as far away as possible, and change his name so that he would not dishonour his regiment.

PEER SUPPORT AND THE OSISS MODEL

A history of the peer support model

Over the past 20 years, community mental health has expanded the traditional medical model, to mobilize community resources for the benefit of patients. This has meant that the highly specialized skills of a few professionals treating those with mental health problems, while still critical in the care of the mentally ill, is no longer the pivotal activity. What has emerged is a patient-centered approach, where the needs identified by the patient become a central focus of care [18-20].

A vital part of this expansion of mental health philosophy has been the inclusion of peers or consumers, who have themselves suffered a mental illness, as part of the front line care team, and as active participants in overall mental health program planning and development [21-23]. “Self-help”, “consumer-driven services”, “social support”, and “recovery model”, are all terms used to describe this growing peer support movement. The inclusion of peers in the continuum of care has not come without some struggle. There has been scepticism and distrust on both sides. Peers, often angry and disillusioned with the gaps in the mental health care system, and resentful of the role they were often expected to play as the passive recipients of the doctor's or therapist's treatment, wanted a voice in the care they received, and in how the priorities for that care were decided. Clinicians, on the other hand, were concerned about the boundaries between themselves and the peers they might work with. They were unsure what they could expect from the self-help model, and how resilient a peer who had formerly been a patient, could be in working with other patients. They had trouble with the relationship shift from being the caregiver to becoming a colleague. It was likely that boundaries would become blurred, and it was not always clear what to do when this happened.

The concerns and reluctance of professionals was sometimes seen as resistance, and as an expression of negative attitudes toward the self-help movement [19,24]. Professionals were criticized for not being interested or motivated to build a cohesive service system that included self help or peer support services [24-25].

At the same time, clinicians who were open to trying this model began to write about the unique benefits of peer support to their patients, and to treatment outcomes [21,23,26,27]. Benefits of peer support which they described included:

- First-hand knowledge of systems in which professionals have had no experience. A good example of this in the military mental health clinics is experience with military life, the chain of command and the process of releasing from the military. Most providers of mental health services in the Canadian Forces are now civilians, who can find themselves at a disadvantage when trying to understand and empathize with the particular work-related situations facing their patients. One phone call to a peer support colleague often quickly clears up their confusion.

- Another benefit of peer support workers is engagement of patients into care. Soldiers suffering from OSI's are often suspicious of the system and reluctant to seek help. However, many clients who do not trust the military system or mental health professionals will trust a fellow injured soldier.
- The experiences which the peer support worker shares with the clients, such as suffering debilitating symptoms, encountering the stigma of mental illness, having ambivalence about accepting therapy, and experiencing both the benefits and side effects of medication, makes the peer support worker an invaluable teacher for the mental health team. He or she can sensitize clinicians to these experiences, and thereby influence how they provide care.
- Peer support workers can serve as role models to their peers and provide a powerful sense of hope. As well, they can be role models to the professional team, providing clinicians with a potent example of how patients can succeed despite having suffered from severe and debilitating symptoms.

The mental health self-help movement is built on the assumption that one does not need to rely solely on professionals to overcome one's afflictions or injuries. Self-help groups "emphasize self- definition of needs, voluntary participation, and autonomy," and tend to be non-hierarchical in structure [21]. The importance of those with mental health problems being active participants in both their individual recovery, and in organizing the services delivered to them, is integral to this model. The shared decision-making between the consumers and providers of mental health services, parallels the trends occurring in other areas of modern medical care [21].

There are generally four models of formalized peer support described in the literature. They are:

- **Mutual Support Groups.** These are voluntary, informal groups, often conducted on a drop-in basis, which are led by peers and focus on a particular condition or life stage. Bereavement groups, and groups for cancer survivors are two examples. These groups aim to help people overcome stigma, to feel supported and accepted by others with similar challenges, and to gain self-acceptance. Another goal of mutual support groups is to engage in advocacy. Through these endeavours, rather than through professional interventions, the group strives to help its members. Structure and governance vary widely, and often, as these groups mature, their focus evolves from one of individual and family support to action-oriented advocacy [28-30].
- **Consumer or Peer-Run Services.** Peers are paid employees of the program and do not expect, and are not allowed to receive support or other assistance from those served by the program. They usually aim to provide a supportive setting, and to engage in more formal interactions with the peers they serve. The fiduciary responsibility of the peer support workers towards the peers they serve, becomes an increasing factor in this model, compared to mutual support [22,28].
- **Peers as Part of the Mental Health Team.** Peers are paid employees, and work as providers of support within the professional setting. The peer support workers (PSW's) are usually hired and trained by mental health professionals, and work alongside them as colleagues. The advantages of this model are that it can provide more opportunity for the PSW to be a visible role model for the peers being served, and the PSW can reach a larger number of clients. As well, it offers the PSW greater potential to influence reforms in the way clinical and support services are designed and delivered. Therapeutic boundaries are less ambiguous as the PSW's behaviour is more likely to be guided by conventional professional practices [28]. Disadvantages include the potential value of peer support being diminished by the prevailing medical or clinical philosophy [22]. Peers can be "absorbed" into the clinical culture, thereby neutralizing their greatest effect.
- **Workplace Embedded Peers.** This model is often used in workplaces where the normal demands of the job can put an employee at increased risk of developing a physical or psychological injury. Careers in firefighting, policing, and the military are examples of such professions. Certain

employees receive special training to provide support and counselling to their colleagues when a job-related traumatic incident occurs. These peer support workers provide this service in addition to carrying out their regular (non-support) duties. This model is distinct from the previous three. Here, one is a “peer”, not because of a shared disability or type of suffering, but because one shares an occupation or workplace with those one supports or counsels. Critical Incident Stress Debriefing and Critical Incident Stress Management programs use this model, with the peer counsellor sometimes pairing up with a mental health professional, to provide debriefings or defusings and follow-up support [31]. Advantages of this model include the proximity of the PSW to those he or she supports. Challenges include the “add-on” nature of the role, where the PSW carries this job in addition to a regular workload. As well, since this person may not have experienced the injury or condition from which the peer suffers, the PSW’s ability to be an effective role model may be compromised.

The OSISS program

The OSISS program, a national peer support program funded jointly by the Department of National Defence and Veterans Affairs Canada, has incorporated elements of all four models. However, its structure and functioning most closely resembles the model of “consumer or peer-run services”.

OSISS was launched in 2001, by an officer who had himself developed PTSD following a tour of Rwanda. After spending many years struggling with his symptoms, LCol Grenier decided to develop a program for assisting his fellow military members who suffered from similar conditions. Following extensive research and consultations with military peers, veterans, and professionals, LCol Grenier made a recommendation to launch a nationwide peer support program for the Canadian military. His proposal was accepted, and in May, 2001, he was appointed as the program manager of OSISS.

Two concepts were central to the vision of the OSISS program: enhanced, structured social support for recovery from operationally-related mental health problems, and reduction of stigma.

Enhanced, structured social support

The literature on risks for developing PTSD after trauma exposure, identifies lack of social support as a significant risk factor [32]. Therefore, OSISS developed a system of Peer Support Coordinators (PSC’s) and volunteers to be available to outreach to members, veterans and their families, and to provide one-on-one, as well as group social support.

Within the OSISS model, it is essential that the individuals hired to work as PSC’s have suffered from an operational stress injury such as PTSD. In the case of PSC’s hired to work in family support, they have all lived with or supported a CF member or veteran suffering from an OSI.

Prior to beginning their jobs, the PSC’s must attend mandatory training, which is provided by a multidisciplinary team of mental health workers at Ste. Anne de Bellevue Hospital, the only remaining Veterans Affairs hospital in Canada. The peer support training includes knowledge and skills development in peer support, helping relationships, conflict resolution, active listening, problem solving, crisis management, and suicide intervention. Training in management of volunteers, facilitating support groups, as well as understanding and respecting boundaries, and the principals of self care, is also provided. The program provides on-going professional development to the PSC’s through quarterly workshops.

The PSC’s are required to remain in a therapeutic relationship with a mental health clinician. They are also linked to mental health professionals in their own community so that they have a daily contact if they need support, guidance, advice, or direction concerning their work, as well as their own health and well-being.

Reduction of stigma

The literature and clinical experience are clear on the negative effects that the stigma of mental illness has on soldiers, and the barriers stigma creates to accessing treatment. The OSISS program has attempted to combat stigma in a number of ways. The creation of the term “operational stress injury” is an example of this. During combat, soldiers can be physically injured. This kind of injury is considered honourable. However, others develop a psychological injury. When military members and veterans were consulted, they supported the use of a term that would characterise psychological injuries much like the physical wounds other soldiers sustain. The term “operational stress injury” was developed, and then officially endorsed by the Canadian Forces Surgeon General [5].

Another avenue to reduce stigma is to bring about a change in attitudes among the Canadian Forces troops and chain of command. OSISS is attempting to do this through its Speakers Bureau. Inspired in part by a provocative multimedia advertising campaign aimed at destigmatizing mental illness in Canada [33], OSISS developed didactic material in the same manner used in advertising. At its core, the goal was to “sell” a new idea of how to perceive operational stress injuries.

A literature review [34] and analysis was conducted by Defence Research and Development Canada on the effectiveness of a strategy using veterans to educate military members. It was believed that in order to reach and convince the military chain of command, as well as the troops, that operational stress injuries were not imaginary and that most who suffer from them do not fake their condition, seasoned veterans could be employed to credibly communicate this message.

Although still in its infancy, the Speakers Bureau now delivers a half-day of awareness training, using pre-designed educational modules, to all new recruits in the Canadian Forces, and 90 minute professional development periods to formed military units and personnel around the country. The modules include an historical overview of OSIs, a clinical module, two moderated group discussion workshops where scenarios are presented and at the end, practical tips and lessons learned are shared. The participative approach and the careful selection of credible veterans as speakers are the cornerstones of the program. Although the Speakers Bureau was designed to change attitudes within the military community towards those suffering from operational stress injuries, a by-product of openly addressing the issue of OSIs, has been a positive impact on treatment-seeking among the injured population.

Excerpt from an email written by Dr. Heber to LCol Grenier, in the fall of 2005

Dear Stephane,

At the OTSSC, we are holding our psychoeducational group for members with OSI's. In one of the modules, which I was facilitating, we had a discussion about denial, and the ways in which members will 'kid themselves' for many years that there is nothing wrong with them. One of the group members, an officer, talked about how for years he attended the mandatory briefings on PTSD and deployment-related trauma, and although he could recognize that he had most, if not all the symptoms they talked about, he would say to himself, "But I don't have PTSD, because I'm still working and I'm not curled up in a corner acting crazy". He then went on to say, "But one day I attended this presentation where a Colonel stood up and talked about how he had PTSD, and he was so open about it, and when he described his problems and how he had been thinking and behaving, I could really identify with him, and this completely broke down my denial. That was when I finally admitted it to myself and came for help. No offence to you guys, but all the psychiatrists and social workers and other professionals in the world couldn't do for me what that man was able to do during that one briefing." Then another group member piped up and said, "Yeah, the same thing happened to me when I heard a talk like that. It was LCol Grenier. Is that who you heard speak? and the officer replied, "Yes. That's exactly who I heard speak". So at the end of our group session, I

asked these two men if it would be OK with them if I told you what they had said. They were both very pleased that I was going to pass on to you how meaningful your talk had been for them.

OSISS is currently developing more advanced training which will be delivered in increments as military members gain experience and seniority within the military system. It will include discussions on leadership responsibilities, and awareness of departmental policies pertaining to OSIs, to ensure that as they move up in rank, the members' actions are consistent with the departmental ethos, objectives, and philosophy.

COMBINING PEER SUPPORT AND CLINICAL TREATMENT

In the early implementation stages of the OSISS program, many clinicians were critical of the plan to involve veterans and families in caring for others who had experienced OSIs. However, a handful of clinicians foresaw the benefits of such a program and decided to collaborate in its development. The support OSISS management has received from these clinicians has been instrumental in the decision-making process, as well as the training and continuing education of all OSISS employees. Mental health staff collaborate in many ways in the operation of the program. They are involved in hiring PSCs, they sit on management boards, and disciplinary committees. They serve as educators. As OSISS management identifies systemic gaps or shortfalls, collaborating clinicians are brought together to discuss potential solutions. In 2005, it was determined that several of the PSCs were at times over-identifying with their clients and as a result, it was decided that a lecture on transference and counter-transference would be the focal point of continuing education at the quarterly meeting. This commitment to cooperation with clinicians has been a cornerstone of the program and often is cited as one of its strengths.

In addition to the issues of stigma that prevent soldiers from coming forward, there are structural factors in the Canadian military that present barriers to care. It is now generally accepted that for people with PTSD to attempt a meaningful recovery, their family must be provided with necessary treatment as well [35,36]. However, although Canadian military members are provided with complete health care services within the military, their spouses and children must access most of their medical and mental health care through the civilian health care system. This approach fragments the care these families receive. Although PTSD and other OSI's are conditions that affect all members of a family, assessment and treatment of couples and families can only be offered to a limited degree when it is deemed to be in the best interests of the serving member [37]. Spouses are offered emotional support, and education about operational stress injuries under this provision. However, many of these families have much greater need for services than the OTSSC or the local base mental health centres can provide.

Another structural problem is that mental health and medical care offered to serving members is discontinued once the member releases from the Forces. He or she then becomes a client of Veterans Affairs Canada, for any ongoing services. This state of affairs further bifurcates and fragments the care of members suffering from OSI's. Having recognized this as a problem, the Canadian Forces and Veterans Affairs Canada has struck joint committees and organized projects to explore avenues for providing seamless care to members before and after release from the military [38].

One of the benefits of the support provided by OSISS is that it crosses the above-mentioned divides. As a joint partnership initiative between the Department of National Defence and Veterans Affairs Canada, OSISS is mandated to support and care for both serving military members and veterans, as well as the families of those who suffer from OSIs. Peer Support Coordinators can provide a constant link in the continuum of care for the Canadian Forces members and their families before, during and after release from the military.

As the OSISS program was created, and the new Peer Support Co-ordinators were trained and started working with military members and veterans across Canada, the clinicians assessing and treating operational stress injuries started having contact with them, often through their patients. It became increasingly common for patients to mention, during their appointment with their doctor or social worker, that they had started attending the peer support group organized in their local community by the OSISS Peer Support Coordinator, or that they'd had coffee with the PSC last week, and found it helpful to talk to someone who'd been through similar experiences. Or perhaps the patient had attended a briefing on PTSD, and a PSC had been one of the speakers, and had talked about personal experiences struggling to put his or her life back together. In other, more serious cases, an OSISS worker could be directly involved in providing critical crisis support to a suffering member.

Sergeant Jones's case is an example of this. This 35 year old member, married father of three children, had been deployed overseas to war zones four times in the past eight years. He was first seen in the OTSSC four months after his last tour of duty. He presented severely depressed and met criteria for PTSD. He had been having suicidal thoughts on and off for several months. Because he was posted to a base that was a three-hour drive from the OTSSC, the patient was only seen once every month by his psychiatrist, and he was followed by a community psychologist and the medical officer at his home base. The patient told his doctor that he had met with the OSISS worker on his base, who had invited him to a group meeting, but the patient found the group triggered too many memories and created a great deal of anxiety for him. The OSISS PSC had therefore suggested they continue to meet, one-on-one, as often as the patient wanted, just to chat. Sergeant Jones found this helped, even though he didn't talk much, and because of his poor concentration, couldn't often remember what he and the PSC had spoken about. With the patient's permission, the psychiatrist contacted the OSISS PSC, who was enthusiastic about collaborating with the treatment team in the care of this man.

At one point early in his treatment, Sergeant Jones's symptoms increased. He began ruminating about the mistakes he had made in his life, and became convinced that he was a bad person, not worthy of living. His suicidal thoughts became stronger and he developed a plan to kill himself. His psychiatrist decided to admit him to hospital. The PSC accompanied Sergeant Jones and his wife to the emergency department. During his hospital stay, the PSC and members of the OSISS support group visited Sgt. Jones daily, and took him off the ward for brief outings as soon as he was no longer a risk to himself. After discharge, when he returned to see his psychiatrist at the OTSSC, Sergeant Jones reported that the time the PSC had spent with him had had a profound effect on him. He said that he had been surprised and grateful that the PSC and members of his support group had not abandoned him when he became very ill. The non-judgemental support of these peers had remained an important constant in his life as he struggled with his symptoms and impulses.

The collaboration between OSISS and clinical staff around the country has continued to expand and become more formalized. In some clinics, the OSISS PSC calls the OTSSC program leader with questions or concerns about accessing the system. In others, the OSISS worker has been integrated into the group treatment programs. In the Ottawa OTSSC, providing information about OSISS, and the Peer Support Coordinators' contact numbers to each new patient has become standard procedure. This is also the case in the VAC OSI clinic in London, Ontario, where every patient seen by the psychiatrist is referred to the local OSISS PSC. Because of the large geographic catchment area in Ontario, the Ottawa OTSSC and regional OSISS PSC's have established biannual meetings, where they meet as a group to discuss issues of mutual interest and concern.

The following are some of the early observations made, and guidelines established by the authors for setting up peer support programs and clinician-peer support partnerships.

Observations and guidelines for establishing a peer support program:

- Recovered OSI sufferers can be employed in a peer support role.
- The peer support worker should follow a “low key” communications approach with the target population.
- It takes six months to one year for a peer support worker to get comfortable with the role.
- Remind them that trust builds slowly, one success at a time.
- Multi-Disciplinary advisors are key.
- Issues of confidentiality and information-sharing must be addressed.
- A focus on self care and boundaries is essential.
- Organized training is critical.
- Policies must be clear, and reviewed regularly.

Observations and guidelines for establishing a collaborative model:

- Examine your own attitudes and beliefs.
- Poll your clinical staff to determine their attitudes.
- Secure funding for the peer support component.
- Do not make this a secondary function.
- Incorporate support and self-care of the peer support worker into the program.
- Take a "ground-up" approach. This fosters front-line collaboration and familiarity.
- Think about boundaries and boundary maintenance. Plan to include this subject in peer support worker and clinician training and orientation.
- Establish guidelines related to confidentiality.
- Include an education/outreach component.
- Consider doing research, and network with others.
- Incorporate a patient/peer evaluation or feedback component.

CONCLUSION

The literature describes the negative effects that the erosion of social support has on outcomes in those suffering from psychological trauma. Social support is a critical element in the recovery of these individuals. The power of peer support described in this paper resides in a number of factors which include: The peer’s ability to identify with the suffering member, to convey interpersonal acceptance, to display resourcefulness, and to establish a special credibility in the eyes of those (s)he serves. In the Canadian Forces and Veterans Affairs Canada, a collaboration between clinicians working with operational stress disorders and the national peer support program has been established to decrease stigma, and to provide the treatment and support that soldiers suffering from operational stress injuries require.

The authors wish to thank the following people for their support and encouragement in the creation of this paper: Ms. Maureen Fedorus, Division Manager of Psychosocial and Spiritual Services, CF HSC (Ottawa); LCol Leslie Newell, Commanding Officer of CF HSC (Ottawa); LCol James Kile, NCR Surgeon of CF HSC (Ottawa); Mr. Jim Jamieson, CF Medical Liaison to OSISS, and Ms. Johanne Isabelle, Ms. Francine Gagnon, and Mr. Juan Cargnello, of the VAC Ste. Anne’s Centre.

This paper is dedicated to our patients and our peers.

REFERENCES

- [1] Kessler RC, Sonnega A, Bromet E, Nelson CB. Posttraumatic stress disorder in the national comorbidity study. *Archives of General Psychiatry* 1995;52:1048-1060.
- [2] Forbes D, Creamer M, Hawthorne G, Allen N, McHugh AF. Comorbidity as a predictor of symptom change after treatment in combat-related posttraumatic stress disorder. *Journal of Nervous and Mental Disease* 2003;191:93-99.
- [3] Jetly Maj R. Personal Communication. September, 2004.
- [4] Kile J. From Afghanistan to Zaire: Canadian forces medical services missions abroad. Ottawa, Canada: October 2005. presentation.
- [5] Cameron Col S. Personal Communication. January, 2006.
- [6] Dallaire RA. *Shake hands with the devil: the failure of humanity in Rwanda*. Toronto, Canada: Random House, 2003.
- [7] Faulder L. Dallaire fights post-traumatic stress disorder. *Winnipeg Free Press*. September 25, 2005.
- [8] Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan: mental health problems and barriers to care. *New England Journal of Medicine* 2004;351:13-22.
- [9] Stuart H. Stigma and work. *HealthcarePapers* 2004; 5:100-111.
- [10] Goffman E. *Stigma: notes on the management of spoiled identity*. Englewood Cliffs, N.J.: Prentice Hall, 1963.
- [11] Dovidio JF, Major B, Crocker J. Stigma: introduction and overview. In: *The social psychology of stigma*. New York: Guilford Press, 2000.
- [12] Sartorius, N. The world psychiatric association global programme against stigma and discrimination because of stigma. In: *Every family in the land*. London: Royal Society of Medicine Press, 2004.
- [13] Schulze B, Angermeyer MC. Subjective experiences of stigma. a focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science and Medicine* 2003;56:299-312.
- [14] [Canadian Mental Health Association. Stigma and mental illness. \(Accessed October 29, 2005 at www.mentalhealthworks.ca.\)](http://www.mentalhealthworks.ca)
- [15] Underwood N. *Suffering in silence: stigma, mental illness and the workplace. (Accessed November 17, 2005 at www.Canadian Health Network.ca.)*
- [16] Marin A. *Special report: systemic treatment of CF members with PTSD. Report to the Minister of National Defence. Ottawa, Canada, September 2001.*
- [17] *Ombudsman: Annual report 2002-2003. National Defence and Canadian Forces; 1-44.*

- [18] Froland C, Brodsky G, Olson M, Stewart L. Social support and social adjustment: implications for mental health professionals. *Community Mental Health Journal* 2000;36:61-75.
- [19] Labonte R. Community and professional empowerment. *The Canadian Nurse*. March 1989;23-28.
- [20] Mead S, Copeland ME. What recovery means to us: consumers' perspectives. *Community Mental Health Journal* 2000;36:315-328.
- [21] Dixon L, Krauss N, Lehman A. Consumers as service providers: the promise and the challenge. *Community Mental Health Journal* 1994;30:615-625.
- [22] Davidson L, Chinman M, Kloos B, Weingarten R, Stayner D, Tebes JK. Peer support among individuals with severe mental illness: a review of the evidence. *Clinical Psychology: Science and Practice* 1999;6:166-187.
- [23] Felton CJ, Stastny P, Stern DL, Blanch A, Donahue SA, Knight E, Brown C. Consumers as peer specialists on intensive case management teams: impact on client outcomes. *Psychiatric Services* 1995;46:1037-1044.
- [24] Hodges JQ, Markward M, Keele C, Evans CJ. Use of self-help services and consumer satisfaction with professional mental health services. *Psychiatric Services* 2003;54:1161-1163.
- [25] Emerick RE. Self-help groups for former patients: relations with mental health professionals 1990. *Hospital and Community Psychiatry*;41:401-407.
- [26] Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal* 2004;27:392-401.
- [27] Carling PJ. *Return to community : bulding support systems for people with psychiatric disabilities*. New York: The Guilford Press, 1995.
- [28] De Sousa L, Leung D. A vision and mission for peer support – stakeholder perspectives. *The International Journal of Psychosocial Rehabilitation* 2002;7:5-14.
- [29] Wintersteen RT, Young L. Effective professional collaboration with family support groups 1988. *Psychosocial Rehabilitation Journal*;12:19-31.
- [30] Shubert MA, Borkman TJ. An organizational typology for self-help groups. *American Journal of Community Psychology* 1991;19:769-787.
- [31] Mitchell JT. Development and functions of a critical incident stress debriefing team. *Journal of Emergency Medical Services*, Dec 1988;43-46.
- [32] Brewin CR, Andrews B, Valentine JD. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology* 2000;68:748-766.
- [33] Canadian Psychiatric Research Foundation. (Accessed November 15, 2005 at www.cprf.ca/media.)
- [34] Thompson MM, McCreary DR. Attitudes and attitude change: implications for the OSSIS speakers bureau programme. *Stress and Coping Group Defence, Research and Development*. Canada, Toronto, 2003.

- [35] Galovski T, Lyons JA. Psychological sequelae of combat violence: a review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior* 2004;9: 477-501.

- [36] Shehan CL. Spouse support and Vietnam veterans' adjustment to post-traumatic stress disorder. *Family Relations* 1987;36:55-60.

- [37] RX 2000: The Canadian Forces Medical Clinic. (Accessed December 14, 2005 at http://hr3.ottawa-hull.mil.ca/health/information/PCRI/engraph/POLs_e.asp?Lev=7&Lev2=11.)

- [38] Matheson, LCol H. Personal Communication. January, 2006.