Veterans Affairs Canada | Anciens Combattants Canada

Evaluation of the Residential Treatment Clinic for Operational Stress Injuries (OSI) - Ste. Anne's Hospital

Final: October 2011

Canada

Acknowledgement

The evaluation team would like to gratefully acknowledge the help and contributions of the following individuals: staff of the Residential Treatment Clinic for Operational Stress Injuries and the National Centre for Operational Stress Injuries as well as the senior administration of Ste. Anne's Hospital; the management and staff of Veterans Affairs Canada's Mental Health Directorate; staff of Veterans Affairs Canada's Western and Quebec Regional Offices, the Ottawa District Office and of the Operational Stress Injury Social Support group for their support and contribution to this evaluation. We would also like to acknowledge the contribution of operational stress injury –related staff of the Parkwood Hospital in London Ontario, the Mental Health Directorate at the Department of National Defence, and subject matter experts at the Australian Centre for PTSD and the American Veterans Administration Center for PTSD.

The evaluation team consisted of the following people:
Don Love, Director General, Audit and Evaluation Division
Kevin Edgecombe, Director, Audit and Evaluation
Mike Sheen, Audit & Evaluation Manager
Sandra Currie, Audit & Evaluation Officer

Table of Contents

Page

EXECUTIVE SUMMARY

The purpose of this evaluation is to assess both the relevancy and performance of the Residential Treatment Clinic for Operational Stress Injuries (RTCOSI - hereinafter referred to as the RTC) at Ste. Anne's Hospital. The recent commencement of the RTC's operation in February 2010, has limited the assessment of performance to the immediate outcome of program reach.

Veterans Affairs Canada (VAC) defines an operational stress injury (OSI) as any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian military or executing duties serving as a member of the RCMP. Psychological difficulties may include, for example, a diagnosis of post traumatic stress disorder (PTSD), major depression, alcohol/substance abuse, chronic pain, or various anxiety disorders.

In 2001, Ste. Anne's Hospital operated a pilot OSI outpatient clinic which, in turn, inspired a renewed vision for the facility and the subsequent establishment of an inpatient stabilization treatment program in 2002. The stabilization program offered third- or tertiary-level care for those suffering from a complex OSI condition requiring medical and psychiatric stabilization and necessitating inpatient care of up to 3 - 4 weeks.

Treasury Board approval in 2007 for the establishment of new OSI clinics under VAC's purview led to support for the RTC, designed to provide third-level, inpatient care to Veterans, CF and RCMP members and their families who present with a complex PTSD co-morbid with other OSI conditions such as those above-mentioned and for whom out-patient treatment was insufficient or ineffective. When the RTC commenced operation in February 2010, the existing inpatient stabilization treatment program was co-located with a new residential rehabilitation program in the new clinic.

VAC's Mental Health Directorate statistics reflect the dramatic rise over the March 2004 to March 2011 period in the number of clients with a favourable disability decision for a psychiatric condition. Of the more than 14,000 individuals identified with a psychiatric condition, close to10,000 are identified as having PTSD - representing a rise of 350% over the same timeframe. The size of the target population of the RTC is, however, relatively small. Subject matter experts consulted in Canada, Australia and the United States generally agree that the RTC's potential client-patients represent less than 10% of all those who suffer from PTSD. They also concur that for some of these individuals, inpatient care and treatment will continue to be necessary.

Statistics for the RTC indicate that in 2010, 92 percent of the client-patients directly entered the stabilization treatment program while 8 percent entered the rehabilitation track directly. For clients who entered the stabilization track, 52 percent were subsequently admitted to the rehabilitation track. RTC clinicians have indicated that individuals were presenting with more complex conditions than initially anticipated and taking longer in their recovery. The stabilization track appears to be the backbone

program of the clinic and a prerequisite to further treatment. Annex D to this report features a comparison of respective approaches to combat-related PTSD mental health issues in Australia and the United States. The Australians have migrated their rehabilitation programming (similar to that of the rehabilitation track of the RTC) to an outpatient, day hospital model and, in some instances, to community-based outpatient clinics and are achieving similar, if not stronger, clinical outcomes.

Admission criteria for the RTC are constrained by virtue of its location within Ste. Anne's Hospital, primarily a long-term care facility. The facility is neither set-up structurally nor is the staff equipped to treat individuals presenting with primary level stabilization needs (which normally follow acute care emergency situations). The risk lies in losing track of these individuals. This is not an issue confined to the RTC; rather it presents a service challenge for the department as a whole and represents a "gap" in VAC's Continuum of Care. Efforts to address the needs of family members of client-patients, raised as a concern in a VAC 2008 OSI Network evaluation, remain inadequate. The evaluators noted that the inclusion of peer support staff within the RTC is a key contributing factor for achieving client-patient engagement, comfort, and trust. The peer support coverage within the RTC at the time of this evaluation however, was inadequate.

Despite these and other gaps in services related to accessibility and geographic displacement, the RTC is addressing the needs of a small, but significant segment of the target population commencing with the secondary stabilization of an acute mental condition. One of the noted strengths of the RTC is the level of commitment and dedication of its professional staff and their knowledge of the military culture which helps to establish immediate trust with the client-patient and strengthen the recovery process.

With respect to the core issue of relevance, the evidence attests to the RTC's alignment with federal priorities, roles and responsibilities and confirms that a demonstrable and continuing need exists for the RTC. In terms of the core issue of performance relative to program reach, the clinic is addressing the needs of a small, but significant segment of the target population and client satisfaction is rated as high.

The following recommendations have flowed from the evaluation team's findings and evidence-based conclusions:

RECOMMENDATIONS:

R1 It is recommended that the Director of NCOSI, consider increasing the provision of peer support, in recognition of the invaluable support and contribution to the RTC's multidisciplinary team and the need for such support from the client-patient perspective; and that consideration be given to the provision of female peer support for women Veterans who participate in the RTC programs. (Critical)

R2 **It is recommended that the Director of Mental Health, in collaboration with the Director of NCOSI, develop policy options to better serve and monitor individuals who require crisis and emergency support or acute stabilization services, thereby enhancing VAC's Continuum of Care for Operational Stress Injuries while at the same time addressing barriers to participation in RTC programming . (Critical)**

R3 **It is recommended that the Director of Mental Health, in collaboration with the Director of NCOSI, assess a variety of mental health treatment models for community-level implementation and in doing so, leverage the knowledge, expertise and experience with the military cohort vested in VAC staff; and, furthermore, ensure that future model development is more inclusive of family members. (Critical)**

R4 **It is recommended that the Director of NCOSI review and undertake improvements to the referral process affecting timely admission to the RTC. (Essential)**

1.0 INTRODUCTION

The focus of this evaluation is the Residential Treatment Clinic for Operational Stress Injuries (RTCOSI, hereinafter referred to as the **RTC**) located at Ste. Anne's Hospital outside Montreal, Quebec. Veterans Affairs Canada (VAC), defines an ***operational stress injury*** (OSI) as any persistent psychological difficulty resulting from military or police duty and includes diagnosed medical conditions such as anxiety disorders, depression, addiction, chronic pain, post traumatic stress disorder (PTSD) as well as other conditions that may be less severe, such as anger and relationship problems, that still interfere with one's daily functioning.

OSI is a de-stigmatizing term which focuses on an "injury", as opposed to an "illness"[1]. An OSI can occur as a result of a variety of stresses including exposure to a traumatic incident, cumulative exposure to human atrocities, or simply the sustained exposure to intense military operation[2]. PTSD is an anxiety disorder that can occur after an individual has experienced a traumatic event. Symptoms usually start soon after the traumatic event, but they may not happen until months or even years later. They also may come and go over many years. The defining nature of an OSI is that it is a condition or problem that has been precipitated or exacerbated by military or police service.

The Broader Canadian Context

In May 2006, the Honourable Michael J. L. Kirby tabled a landmark national study of mental health, mental illness and addiction entitled **"Out of the Shadows at Last - *Transforming Mental Health, Mental Illness and Addiction Services in Canada*".** The reports recommendations continue to have a major impact on mental health issues and in the shaping of mental health policy in Canada.

The anti-stigma campaign of the Mental Health Commission of Canada continues to play a vital role in furthering public understanding and acceptance of mental health issues. Both the Department of National Defence (DND) and VAC are active participants in the evolution towards a broader understanding of mental health issues and improvements to care and treatment.

---

1 From a presentation by Major Alexandra Heber, MD FRCPC Clinical Director, Mental Health Services Psychiatrist/Program Leader, Operational Trauma and Stress Support Centre Canadian Forces Health Services Centre Ottawa, Canada

2 Source: Veterans Affairs Canada Website "*Mental Health - What is an Operational Stress Injury"*

VAC's Mental Health Strategy

By virtue of the *Department of Veterans Affairs Act*, the *Pension Act* and, since 2006, the *Canadian Forces Members and Veterans Re-establishment and Compensations Act,* VAC plays a significant role in the healthcare and support of Veterans of military service including care and treatment which addresses the mental health conditions of those who have served. One of the key elements of VAC's early and continuing mental health strategy is to build capacity across the country to provide specialized care to individuals with mental health needs related to military service. This strategy underpinned VAC's decision to develop a network of OSI clinics across the country and later to expand this network. The Department's current mental health strategy focuses on a *service continuum* to prevent Veterans from falling through the cracks, and on *capacity building, leadership and partnerships*. In its efforts to build capacity, VAC has recently undertaken a pilot project in Newfoundland with the objective of building partnerships within the province to augment the capacity and skill sets of VAC staff, other federal and provincial delivery agents as well as private service providers.

The RTC is reflected within VAC's Continuum of Care for Operational Stress Injuries, Figure 1 below. It is an **inpatient facility** dedicated to providing third-or tertiary-level care and treatment to Veterans, CF members and RCMP members and their families who suffer from a complex or severe PTSD co-morbid with another mental health condition(s) such as depression, substance abuse, or anxiety disorders for which outpatient treatment was insufficient or ineffective. As a third-level care inpatient clinic, it offers specialized treatment providing these individuals their best, if not final, chance for recovery. (Figure 1 highlights in orange the RTC's programming within the third-level of care.)

According to the Canadian Mental Health Association, 1 in 10 people in the Canadian civilian population suffer from PTSD. For members of the military and policing sectors, traumatic events are far more likely to occur, and do occur more frequently.

Figure 1: VAC'S Continuum of Care for Operational Stress Injuries

	PRIMARY CARE		SECONDARY LEVEL CARE		THIRD LEVEL CARE				
	Case Management								
	← Clinical Care Management →								
	Operational Stress Injury Social Support (OSSIS)								
SERVICE	Emergency Services Provincial Hospitals	Community Public Health Services (GPs community clinics) VAC Assistance Line	VAC Private Service Providers	OSI Clinics	Pain Clinic	Stabilization Program	Private-public Addiction Centres	PTSD Addiction Co-morbid Program	New Residential Treatment Clinic
Client Profile	Imminent Risk to Self or others	General health and social Issues	OSI condition, mild co-morbidity (mostly non-complex)	Complex OSI conditions (important co-morbid issues)	Complex pain conditions with co-morbid mental health issues	Complex OSI conditions (important co-morbid issues)	OSI condition with co-morbid addictive disorder (primary presenting problem is addiction)	Complex OSI condition with co-morbid addictive disorder (primary presenting problem is addiction)	Complex OSI conditions (important co-morbid issues) significant impairment in daily functioning, ready to engage in intensive therapy. Condition is psychiatrically stabilized
Description of Services offered	Acute care	Prevention, health promotion, screening, diagnosis, treatment, referral.	Discipline-specific interventions (pharmaco-therapy, psycho-therapy, etc.).	Interdisciplinary team approach, specialized assessment and individual/ group.	Interdisciplinary team approach, monitoring continuous assessment and linkage with VAC and community services, individual/ group psycho-educational and treatment services.	Acute medical assessment and treatment services, management of physical symptoms.	Interdisciplinary team approach, continuous assessment and addiction-focussed individual counselling/ group therapy services, aftercare, linkage with VAC and community services.	Interdisciplinary team approach, continuous assessment and co-morbid addiction/PTSD focused individual counseling/group therapy services, aftercare, linkage with VAC and community services.	Interdisciplinary team approach, continuous assessment, individual/ group/peer/ family intervention, opportunities to practice newly acquired knowledge, skills and attitude, aftercare planning.
Facility/ setting	Inpatient facility	Outpatient setting	Outpatient treatment services	Outpatient treatment services	Inpatient setting	Inpatient setting	Inpatient setting	Inpatient setting	Inpatient setting

Source: VAC's Mental Health Directorate

2.0 EVALUATION CONTEXT

This evaluation of the OSI Inpatient Clinic (the RTC) at Ste. Anne's Hospital was conducted in accordance with Treasury Board requirements and guidance material. Based on the Terms of Reference cited in VAC's Multi-Year, Risk-Based Evaluation Plan for 2011 - 2016, the evaluation is intended to inform VAC's Deputy Minister and concerned departmental management of the relevance and performance of the RTC. Previous evaluation work by VAC's Audit and Evaluation Division (AED) with respect to operational stress injuries, took place in 2008 when the AED completed an evaluation of the OSI Clinic network. The findings and recommendations of this earlier evaluation have served to inform the study team for the RTC evaluation.

2.1 EVALUATION OBJECTIVES AND SCOPE

This evaluation is the first assessment of the only federally-owned OSI Inpatient clinic aimed at Veterans, CF and RCMP members. The RTC has been in full operation since mid-February, 2010. Accordingly, the scope of this evaluation has been limited to assessing the relevance of the RTC and only the immediate outcome of the clinic's reach in terms of the RTC's overall performance. While it is premature to assess the intermediate and ultimate outcomes for the clinic, it is noteworthy that there is continuing global research in the area of complex, co-morbid OSIs and on achieving better clinical outcomes. This evaluation will be used to develop policy options and future strategic directions for the RTC. The evaluation meets the Government of Canada requirements under the 2009 Policy on Evaluation, which requires that specific evaluation issues and questions (see Section 2.2 below) be addressed and consideration be given to the risks faced by the RTC.

2.2 EVALUATION ISSUES

The RTC is embedded in the Ste. Anne's Hospital which is cited as a distinct program activity in VAC's 2011 - 2012 Program Activity Architecture. The objectives of the evaluation reflect the core issues cited in Annex A of the Treasury Board's Directive on the Evaluation Function:

- **Issue – Alignment with government priorities:** To assess the linkages between the objectives of the Inpatient OSI (RTC) and (i) federal government priorities and (ii) departmental strategic outcomes.

- **Issue – Consistency with federal roles and responsibilities:** To assess the roles and responsibilities for the federal government in administering the Inpatient OSI.

- **Issue – Continued need for a program, policy or initiative:** To assess the extent to which the OSI Inpatient Clinic (RTC) addresses a demonstrable need and is responsive to the needs of Veterans, CF and RCMP members.

- **Issue – Achievement of expected outcomes:** To assess progress towards expected immediate outcomes with reference to program reach.

The first three objectives relate to the core issue of **relevance**. The last objective relating to **performance** normally encompasses the assessment of *effectiveness, efficiency and economy*. Effectiveness is examined by assessing the extent to which the expected outcomes of the RTC are being achieved - including the immediate, intermediate and ultimate outcomes. As the RTC has only been in full operation since mid-February 2010, the evaluation is limited to assessing the immediate outcome related to program reach. The efficiency and economy of the RTC is also a scope limitation.

2.3 EVALUATION DESIGN

This evaluation employs multiple lines of evidence, both qualitative and quantitative in nature. The lines of evidence were accrued from a literature review, including research studies, and interviews with key informants and subject matter experts, the RTC and NCOSI professional staff as well as VAC regional and district offices, DND senior mental health-related staff and various Operational Stress Injury Social Support (OSISS) related peer support individuals. This evidence was augmented with research and clinical data as well as the commentary of subject matter experts in the United States and Australia to derive the evaluation findings and form the evaluation team's recommendations. The findings address the core issues cited above and will assist senior departmental management in making future decisions regarding the design and delivery of inpatient services for Veterans, CF and RCMP members.

The external analyses in support of this evaluation can be found in Annex C.

3.0 METHODOLOGY

The methodology focused on the use of various lines of evidence, both qualitative and quantitative in nature, to assess the relevance of the RTC and its program reach.

3.1 QUALITATIVE

3.1.1 Interviews

Interview guides were developed and semi-formal, structured interviews conducted in support of gathering qualitative information. Interviews were conducted with a wide range of individuals with knowledge and expertise in the field of mental health. This included individuals with work duties related to the RTC and independent experts providing a balanced perspective in terms of observations and opinions. Moreover, some interviewees were able to provide input from more than one perspective. Additionally, bias was mitigated by conducting multiple interviews within key functions/areas:

- Staff directly engaged with the Residential Treatment Clinic including its professional staff (8),
- Subject Matter Experts in Canada, USA, and Australia and the DND (8),
- Ste. Anne's Hospital senior management staff who provide oversight to the RTC (4),
- VAC staff within the Mental Health Directorate responsible for VAC's overall mental health strategy (6),
- "Front-line" staff in VAC's district and regional offices (4),
- Peer support staff (6), and
- Individuals who are receiving/have received OSI treatment in the RTC (4).

In total, forty interviews were conducted and the resulting comments, information and opinions were reviewed and summarized by evaluation question and then further analyzed in conjunction with other evidence to develop the evaluation findings.

3.1.2 Literature review/research

The literature review has included research studies and related articles, Treasury Board submissions, the Budget 2007 as well as the 2007 and 2010 Speech from the Throne, past evaluations and related websites. In addition, the NCOSI provided presentation decks from Ste. Anne's Hospital dating back to 2001 which outlined the early vision for a residential treatment clinic. For a detailed listing of internal and external sources used to inform this evaluation (refer to Annex C).

3.1.3 Site Visit

The evaluation team visited Ste. Anne's Hospital to observe the RTC facility, conduct face-to-face interviews with staff directly engaged with the Residential Treatment Clinic, as well as senior management of Ste. Anne's Hospital and the NCOSI. In addition, the site visit provided the opportunity to speak with client-patients of the RTC. It is noteworthy that the opportunity to interview RTC program participants originated with the client-patients themselves when they learned that the evaluation team was on site.

3.1.4 Comparison with Australia and the United States

Both Australia and the United States have experienced a longer recent history in armed conflict than has Canada. Both countries sent troops to the Vietnam War and dealt with the physical and mental health issues their soldiers experienced in that conflict. It was important that subject matter experts in both countries be interviewed to determine their respective approach to the care and treatment of their Veterans and their lessons learned. The comparison was enhanced by specific research studies and documents shared by the Australian and U.S. experts with the evaluation team. The comparison is intended to provide further insight and value-added information for VAC decision-makers.

3.2 QUANTITATIVE

VAC's Mental Health Directorate produces a quarterly statistical report which provides data on VAC's clientele, specifically, those with a favourable Disability Benefit decision for a psychiatric condition, as well as a profile of these clients - Veterans, CF still-serving, CF and RCMP members. This report provided useful contextual data on the size of the eligible population and historical trends. Other data references of note include the following:

New Veterans Charter (NVC) Evaluation File Review

A file review completed by an external occupational therapist provided an overall assessment of progress for participants in the NVC Rehabilitation Program. The sample population for this file review consisted of individuals who entered the NVC Rehabilitation Program between April 1, 2006 and October 31, 2009, and had participated in the program for at least six months. A stratified random sample of 350 participants was drawn. This descriptive sample allowed for the analysis of the sample's characteristics and a comparison among various groups, but did not allow for the results to be generalized for the entire participant population. However, the findings from the file review remarkably mirrored the results and percentages gathered when the entire population was studied using departmental statistical information. This evaluation utilized the information from the NVC Evaluation file review as additional evidence on numbers presenting with mental health issues and pain.

Life After Service Study (LASS)

This research study, a joint effort between VAC the DND and Statistics Canada is comprised of four parts. The first part of the LASS is an Income study of CF Members who released over a ten-year period from 1998 - 2007 while the second part is a Survey on Transition to Civilian Life (STCL). The STCL information drew from a nationally representative sample of 4,721 of 32,015 Regular Force Veterans released from 1997 to 2008 and who were subsequently contacted by Statistics Canada during February and March 2010. The majority of the sample responded to the survey (71percent), and the great majority of those (94 percent) agreed to share their responses with VAC and the DND. The information from the STCL report was used to inform this evaluation in terms of the co-morbidity of mental and physical health conditions.

Parts three and four of the LASS will be the subject of a future report on the CF Cancer and Mortality Study and are not intended to inform this analysis.

Client Satisfaction Survey

The RTC professional staff has provided data with respect to the client-patients in both program tracks of the RTC, including client patient demographics and client satisfaction

surveys for the stabilization program component of the RTC. They have also tracked the number of client readmissions and gathered data on discharge/exit surveys.

Additional Data Sources

A DND OSI study, due to be released in 2011, will use a stratified sample of 2,500 to determine how many still-serving CF members have PTSD directly attributable to the military mission. The prediction of the target population for inpatient care and treatment is a vital piece of information as VAC needs to predict the future demand for its services. Data was also gleaned from an Australian research study and from interviews with subject matter experts in Australia and the United States citing the estimated percentage of severe PTSD cases which require inpatient care.

3.3 LIMITATIONS AND CHALLENGES

This evaluation was challenged by the length of operation of the Residential Treatment Clinic. VAC's Multi-Year, Risk-Based, Evaluation Plan for 2011 - 2012, approved in March 2011, limited the evaluation to an assessment of the RTC's relevance and performance. With respect to the latter, performance outcomes as a determinant of the Clinic's effectiveness, were limited to the immediate outcome of program reach. Scope limitations relative to performance also included any assessment of economy and efficiency. The evaluation was spurred by the potential transfer of the Ste. Anne's Hospital to the Province of Quebec and it will serve to inform VAC's Senior Management on the RTC's continuing need and program reach.

The clinical outcomes of the RTC are also a challenge to obtain. The already existing four-bed, inpatient stabilization program which commenced in 2002 was co-located with the new six-bed residential rehabilitation program to form the Residential Treatment Clinic for Operational Stress Injuries in mid-February 2010 to offer two program streams: stabilization treatment and rehabilitation therapy services. The latter is comprised of structured, intensive group therapy sessions for the target population. Thus, while clinical outcomes are available for the longer running stabilization program, clinical outcomes for the residential rehabilitation program and the overall Residential Treatment Clinic program are not readily available. The current action plan for the RTC management team provides for an internal evaluation of clinical outcomes in the near future. The National Centre for OSI has recently issued a public tender for a Client Reported Outcome Monitoring System (CROMIS) which is a web-based data collection system that will generate real time reports both for the client and the clinician to monitor progress, or lack thereof, for the purpose of treatment adjustment. It will be used for the entire NCOSI network. The DND has also adopted the same instrument as VAC to measure client outcomes for similar monitoring purposes.

The breadth of the subject matter has exposed the evaluation team to many areas of need as well as areas where improvements can be made which are outside the

parameters of the evaluation. The challenge will be to organize and effectively communicate these additional findings/observations to the appropriate VAC personnel.

4.0 BACKGROUND

4.1 The Rise of OSI-related Clinics

In the mid-1990s, the Canadian Forces experienced an increased operational tempo with engagements in the First Gulf War, Bosnia-Croatia, Rwanda and Somalia. This increased operational tempo continues today with the deployment of troops to Afghanistan. The nature of these conflicts however, is different than those in which members of the Canadian Forces (CF) were previously engaged. More than ever CF members are placed in harm's way for longer periods of time, and with less time to recuperate. Anyone who has gone through an event such as combat can develop PTSD or another OSI condition. This increased exposure to conflict and traumatic situations has led to a growing number of OSIs. Although most individuals readjust smoothly upon returning to civilian life, many will benefit from additional mental health support and some will be diagnosed with an OSI. Among the most common mental health problems faced by returning troops are post traumatic stress disorder, depression, addiction/substance abuse and social phobia.

The growing demand for specialized mental health services and the strong public support for assistance for returning soldiers prompted the DND's involvement, in the late 1990's, in the establishment of five Operational Trauma and Stress Support Centres (OTSSCs) at key CF bases across Canada - in Halifax, Valcartier, Ottawa, Edmonton and Esquimalt. These OTSSCs were developed to provide specialized mental health services for CF members and their families dealing with an OSI resulting from military operations. While these clinics helped fill the need for mental health services for CF members, insufficient capacity still remained within the centres and within communities in general, for Veterans who were the responsibility of VAC.

In 2001, VAC opened its first OSI clinic at Ste. Anne's Hospital as a pilot project. By 2002, VAC and the DND had jointly announced a mental health strategy to enhance the services and support provided to the growing number of individuals with an OSI. With demand for treatment and services on the rise, VAC responded by developing four additional clinics in Quebec City, London, Winnipeg and Calgary based on the Ste. Anne's pilot.

With the support of the DND and the RCMP, VAC received federal Treasury Board approval in 2007, to establish an additional five clinics, bringing the total of OSI clinics under VAC's purview to ten. The new clinics were established in Vancouver, Fredericton, Ottawa, Edmonton and an additional clinic was established at Ste. Anne's Hospital. The latter differed from the other clinics - it was established as an inpatient facility for those Veterans, CF and RCMP members suffering from more complex PTSD and co-morbid (in combination with) conditions such as chronic pain, depression, anxiety disorders and addictions/substance abuse.

Eight of the ten OSI clinics operate under the terms of a Memorandum of Understanding (MOU) between VAC and the host health organization from whom VAC purchases services. The OSI clinics are a unique type of external health service provider as the operations of each clinic is fully funded by VAC to provide exclusive service for VAC clients. The two remaining clinics, an OSI out-patient clinic and an inpatient clinic are operated from the federally owned Ste. Anne's Hospital for Veterans in Ste. Anne-de-Bellevue, Quebec. All of the OSI clinics serve Veterans, Canadian Forces (CF) members and members of the Royal Canadian Mounted Police (RCMP) and their families. In Figure 2 below, VAC's most recent Mental Health Quarterly Statistical Report illustrates the number of active files and new referrals to its network of OSI clinics as of March 31, 2011.

Figure 2: Mental Health Quarterly Statistical Report – OSI clinics March 31, 2011

OSI Clinics – by Referral Agency		Total	West	Ont.	Que.	Atl.
	Active files					
97	Veterans Affairs Canada	1,191	286	338	458	109
98	Department of National Defence	319	122	71	68	58
99	Royal Canadian Mounted Police	79	43	*	*	26
100	Family members (VAC,DND,RCMP)	159	57	29	65	8

	New Referrals	Total	Files Closed	Total
101	Veterans Affairs Canada	190	Veterans Affairs Canada	115
102	Department of National Defence	51	Department of National Defence	54
103	Royal Canadian Mounted Police	17	Royal Canadian Mounted Police	5
104	Family members (VAC, DND, RCMP)	34	Family members (VAC, DND, RCMP)	16

Source: VAC's Mental Health Directorate

Operational Stress Injury Social Support (OSISS) Program

The Operational Stress Injury Social Support (OSISS) program reference appears throughout this report. The OSISS is a joint VAC-DND program that has as a mission to establish, develop and improve social support programs for current and former members of the Canadian Forces and their families affected by operational stress; bereaved families of military members and Veterans, as well as to create an atmosphere and environment which leads to a better understanding and acceptance of OSI. After more than a decade in operation, this program continues to make a significant contribution to the recovery process. The role of peer support is briefly discussed in Section 5.3 of this report.

4.2 The Founding of a Residential Treatment Clinic (RTC) for Operational Stress Injuries at Ste. Anne's Hospital

Early Vision

The experience gained from VAC's pilot OSI centre established in 2001at Ste. Anne's Hospital led to a renewed vision for what was then referred to as the Ste. Anne's Centre. The vision called for a PTSD Residential Rehabilitation Program (PRRP) "to provide a structured 24 hour-a-day supervised therapeutic setting which promotes strong treatment and recovery values. Admissions to the program are to be housed in a separate building from the hospital centre and must be clinically stable to be self-sufficient for their everyday care and safety needs. All members of the PRRP will be required to participate in at least 25 hours per week of specified therapeutic or rehabilitative activities"[3]. The vision also included the establishment of a pain management clinic and tele-mental health capability at Ste. Anne's.

Stabilization Program Introduced

Continuing to build on its experience and in line with its vision, Ste. Anne's introduced an Inpatient Stabilization Program in 2002, with four beds allocated for 24/7 care. The medical stabilization of an individual's mental health condition is essential and fundamental for any further therapeutic effects and benefits of ongoing care. *"A person living with an operational stress injury (OSI) may experience a period when their ability to face personal, social or work situations is significantly reduced. This can happen if medication needs to be adjusted or if clinical supervision or more intensive psychological support is needed. The Inpatient Stabilization Program for OSI can help individuals develop skills to better manage their symptoms and eventually allow them to continue outpatient treatment in their community.*

Clients stay in a structured, clinical environment at Ste. Anne's Hospital while the most immediate difficulties are addressed. Medication is adjusted while multiple therapeutic approaches help rekindle a sense of well-being"[4].

Residential Rehabilitation Program Added

Over the next few years, clinicians, OSISS and VAC administrators identified the need for residential treatment services for Canadian Veterans. The rationale for the inpatient clinic derived, in large part, from the research and experience gained in working with OSI patients in the Ste. Anne's outpatient clinic. Co-morbid conditions had presented significant challenges to treatment protocols given the complexity of the interaction, and as already indicated, outpatient care had either been insufficient or deemed ineffective

[3] From a presentation deck of June 28, 2002, VAC's Executive Director of Ste. Anne's Hospital and Dr. Pierre Paquette, VAC's Professional Services Director at Ste. Anne's.

[4] http://www.veterans.gc.ca/eng/sub.cfm?source=mental-health/health-promotion/ncosi#stabilization

in dealing with these conditions. The Treasury Board submission for the expansion of the OSI network in 2007 included the request for support to an inpatient clinic at Ste. Anne's Hospital. A full concept paper, prepared in October 2008 by the Clinical Expertise Sector of the National Centre for Operational Stress Injuries (NCOSI), laid the groundwork for the development of the Residential Treatment Clinic for Operational Stress Injuries. The RTC opened its doors in February 2010 with six beds available for inpatient care and dedicated to the provision of rehabilitative services including more intensive group therapy and an increased emphasis on life skills and coping strategies. Within a month of its launch, the stabilization program and its four beds were co-located within the RTC facility thus bringing the two programs under its auspices and raising the total number of beds dedicated to inpatient care to ten.

5.0 FINDINGS

The presentation of findings of the evaluation is structured according to the core issues of relevance and performance (effectiveness, in terms of program reach). There are three core issues which respond to the question of **relevance**:

- Alignment with Government Priorities;
- Consistency with Federal Roles and Responsibilities
- A Demonstrable, Continuing Need for the RTC

5.1 RELEVANCE - Alignment with Government Priorities

In the Budget of March 2007, the federal government showed its support for Canadian troops "by providing $60 million to increase the field operations allowance, establishing five new trauma centres to help Veterans and their families deal with stress injuries related to their military service". In the Speech from the Throne, delivered on October 16, 2007, the federal government reiterated its commitment to "continue to improve support for our Veterans who have contributed so much to defending Canada in the past".

This commitment to supporting Canada's Veterans was further reinforced in the Speech from the Throne in March 2010, when the government stated in its broad agenda outline that one of its priorities was to stand up for those who helped build Canada by continuing to stand up for Canada's military and its Veterans.

The Residential Treatment Clinic for Operational Stress Injuries is one of the trauma centres established as a result of the Budget 2007 commitment. The RTC offers programs consisting of stabilization treatment and rehabilitation aimed at:

- stabilizing a Veteran`s mental health condition;
- optimizing autonomy and functional capacity; and
- facilitating reintegration into the community through rehabilitation efforts to enhance autonomy, self-management and self-reliance and a sense of community and belonging.

These goals align the clinic with the broad objective of supporting our troops and specifically align the clinic with federal priorities by providing specialized care and treatment that assists Veterans and their families to deal with stress injuries related to their military service.

VAC`s 2010 - 2011Strategic Outcome #1 states that “Eligible Veterans and other clients achieve their optimum level of well-being through programs and services that support their care, treatment, independence, and re-establishment”. In terms of its efforts in pursuit of this outcome, VAC has developed a Mental Health Strategy in order to increase the Department’s capacity to meet the needs of Veterans with a mental health condition. The thrust of this strategy is to develop a comprehensive continuum of mental health services that can support Veterans and their families. This includes providing appropriate care at various levels of intensity depending on the needs of the individual and their family.

In addressing OSIs, the RTC thus aligns with VAC’s Strategic Outcome #1 and the Mental Health Strategy by providing intensive, integrated care and treatment for individuals experiencing severe/complex OSI symptoms and for whom other services provided in the continuum are not sufficient.

The RTC is a critical component in the provision of (a continuum of) services for Veterans.

5.2 RELEVANCE - Consistency with Federal Roles and Responsibilities

5.2.1 Legislation

VAC’s role in the care and treatment of Veterans of military service is clearly rooted in its founding Act and in various regulations which preceded the creation of VAC’s OSI Clinics. Under the *Department of Veterans Affairs Act,* the *Veterans Health Care Regulations* define health as a state of physical, mental and social wellbeing. This Act outlines eligibility for multiple benefits including medical care, home adaptations, travel costs for examinations or treatment and other community health care services. The *Pension Act* defines disability as “the loss or lessening of the power to will and to do any normal mental or physical act.” The *Canadian Forces Members and Veterans Re-establishment and Compensation Act* (the New Veterans Charter*)* authorizes the Minister to provide job placement assistance, rehabilitation services, vocational assistance and financial benefits, disability awards, and health benefits for Canadian Forces members and Veterans. The Department provides services to an eligible population which includes Veterans, released CF members and RCMP and their families as well as some still-serving CF and RCMP members who for a variety of reasons seek treatment from VAC. The RTC was established under Treasury Board authority in response to a VAC-identified need for additional facilities given the dramatic increase in demand for such services.

5.2.2 Rationale

Co-morbid conditions, such as depression and PTSD can interact and can compromise relationships, financial stability and/or overall quality of life. Issues that otherwise would be considered manageable can often escalate to a crisis level. The complexity of the interaction of these conditions makes them more challenging to treat and requires more than outpatient care. As such, a need was identified for an OSI inpatient clinic to treat these complex, co-morbid cases. A departmental analysis which preceded a 2007 Treasury Board submission determined that Ste. Anne's Hospital was best positioned to provide OSI inpatient services because it had an OSI clinic, stabilization beds, physical rehabilitation, a pain management clinic, and clinical expertise in dealing with complex PTSD cases.

5.2.3 VAC's Current OSI Services

As previously mentioned, the OSI clinics are a unique type of external health service provider as the operations of each OSI clinic is fully funded by VAC to provide exclusive services for Veterans, CF and RCMP members and their families through Memoranda of Understanding (MOUs) with host organizations in various locations across Canada. **While the OSI clinics offer primarily outpatient services, additional contracted services allow VAC to purchase inpatient services as necessary**

The RTC is a 24/7 inpatient facility which provides an integrated, highly structured, more intensive, multidisciplinary team response to the complex PTSD and co-morbidity mental health conditions of a Veteran, CF or RCMP member. The multidisciplinary team, using an inter-disciplinary approach, is comprised of psychiatrists, psychologists, physicians, mental health nurses, social worker, occupational therapist, psycho-educator, addictions counselor, art therapist and peer support worker. The fact that the RTC incorporates the services of a peer support worker in the clinical team is unique.

The RTC offers a two-track approach -firstly, a stabilization program wherein the Veteran's condition is medically re-assessed and stabilized and individual therapy is provided. Secondly, a residential program which focuses on rehabilitation provides more intensive group therapy aimed at developing more self- coping mechanisms and life skills. The residential rehabilitation program is designed around eight themes and each week is organized around a specific theme. Themes rotate through the cycle on an ongoing basis allowing individuals to enter the program at the beginning of any week. Admissions occur on Sunday afternoons allowing time for participants to familiarize themselves with the facility before engaging in the intensive treatment. Individual services and interdisciplinary case discussions are organized into three distinct phases: orientation/assessment, intensive treatment, and termination of treatment. All clinical programming is offered in both official languages. The Clinic is unique and aimed solely at the military and policing sector.

5.2.4 OSI Service Alternatives

Department of National Defence (DND)

With respect to service alternatives, the DND's OTSSCs provide treatment services for serving members of the Canadian Forces and, in certain circumstances, to their spouses and family members. The OTSSCs provide individualized assessment, education, and initial treatment for members suffering from Post Traumatic Stress Disorder; however, the services **are operated on an out-patient basis.** The OTSSCs are generally operating at full capacity assisting CF still-serving members.

Provincial Service Alternatives

- ***Public hospitals***
  Specialized psychiatric hospitals generally provide acute care only - our Veterans who don't usually meet their admissions criteria as they may be ill but do not present as acute. When they are in need of acute care, these facilities do provide the necessary care typically over very short term stays. Emergency services within provincial public hospitals also address those individuals in crisis mode.

- ***Private clinics***
  Private clinics across Canada, such as Homewood and Bellwood in Ontario and Edgewood in British Columbia, are primarily outpatient facilities as are all of the VAC OSI Network Clinics with the exception of the RTC. While Homewood in Ontario and Le Centre CASA in Quebec offer inpatient services as well, Homewood is usually for acute admissions and Le Centre CASA has a primary focus on addictions treatment.

Provincial Service alternatives are primarily out-patient operations. As indicated in VAC's 2008 evaluation of the OSI Clinic Network, "respondents identified that clients with a more complex OSI require the support of an interdisciplinary team approach, in order to properly address the multiple aspects of treating an OSI. Generally, services in the community do not offer this interdisciplinary team approach which is required to support clients with more complex OSI." Moreover, the current evaluation has determined that community services generally focus primarily on a single presenting mental health condition such as addiction or depression. The current practice of integrated multidisciplinary treatment which takes into account the benefits of the simultaneous treatment of PTSD and co-morbid conditions is not generally possible in these clinics.

Although inpatient services are available both publically and privately in a few provinces, in general, Veterans, CF and RCMP members are treated with civilians, as the numbers seldom justify distinct group treatment. However, respondents indicate that the efficacy of treatment for the Veteran is not as significant when co-mingled with civilians. **The importance of treating the military as a cohort,** which was also

highlighted in the 2008 OSI Network Evaluation, **was confirmed in all stakeholder interviews from subject matter experts to the Veterans themselves.**

Conclusion

In summary, the combination of inpatient, bio-psycho-social treatment for patients with complex PTSD co-morbid with other conditions, which treats the military and policing culture as a cohort, offers peer support services and undertakes an integrated, multi-disciplinary approach, is not readily available in Canada. The RTC uniquely fulfills this combination. In the current absence of adequate provincial and federal alternatives, VAC has assumed the federal role and responsibility for providing the best possible care to its Veterans, CF and RCMP members and their families.

5.3 RELEVANCE – A Demonstrable, Continuing Need for the RTC

To what extent does the OSI Inpatient Clinic (RTC) address a demonstrable need and is responsive to the needs of Veterans, CF and RCMP members and their families? This question is central to the core issue of relevance and was explored by:

1. Determining the target population for the RTC within VAC's eligible population;
2. Identifying the mental health needs of that population;
3. Assessing the RTC's response to the needs of the target population; and
4. Identifying any gaps in responding to those needs.

5.3.1 VAC's Eligible Population

VAC's Mental Health Directorate produces Mental Health Quarterly Statistical Reports amalgamating information provided from the Reporting Database, Federal Health Care Processing System and the National Centre for Operational Stress Injuries. In Figure 3, the historical data for VAC Veterans with a psychiatric condition as well as those specifically diagnosed with PTSD are illustrated.

Figure 3 depicts the dramatic rise in the number of Veterans and members being provided services by VAC. In March 2004 some 4,894 individuals received a favourable disability benefit decision for a psychiatric condition. As of March 3, 2011, the number had risen to 14,111 representing nearly a three-fold increase. **Of the 14,111 individuals identified with a psychiatric condition, 70.4 percent are identified as having PTSD - representing a rise of 350 percent - from 2,824 in March 2004 to 9,928 in March 2011**.

Modern-day released Veterans represent 63.8 percent (9,005) of those individuals with a psychiatric condition while those still-serving CF and RCMP members represent 19.3 percent (2,734). Of particular note is the upward trend which reveals a continual year-over-year rise in the number of those with a psychiatric condition since 2004.

Figure 3: Mental Health Quarterly Statistical Report – OSI Clinics 31 March 2011

Mental Health Quarterly Statistical Report – Data to March 31, 2011						
VAC Client Information		VAC	West	Ont.	Que.	Atl.
1	Clients/dependents/survivors	218,388	80,131	77,910	23,564	36,714
2	Dependents/survivors	78,086	28,047	28,904	8,070	13,035
3	Unique clients *(see Note 2)*	140,302	52,084	49,006	15,494	23,679
4	Unique clients – Regional percentage of national		37.1%	34.9%	11.0%	16.9%

Clients with a Favourable Disability Benefit Decision for Psychiatric Condition							
			Percent of line 3				
Current data – March 31, 2011		VAC	%	West	Ont.	Que.	Atl.
5	Clients with a psychiatric condition	14,111	10.1%	4,955	3,445	2,684	3,027
6	Regional percentage of national			35.1%	24.4%	19.0%	21.5%
Change Since Last Quarterly Report			Percent of line 7				
7	Clients with a psychiatric condition, last report	13,711	%	4,796	3,354	2,644	2,917
8	New clients with a psychiatric condition	508	3.7%	198	125	61	124
9	Clients deceased who had a psychiatric condition	108	0.8%	39	34	21	14
10	Increase in clients with a psychiatric condition	400	2.9%	159	91	40	110

Historical Data		Mar. 11	Mar. 10	Mar. 09	Mar. 08	Mar. 07	Mar. 06	Mar. 05	Mar. 04
11	Clients with a psych. condition	14,111	12,689	11,888	11,045	10,250	8,385	6,491	4,894
12	Clients with PTSD	9,928	8,758	7,996	7,228	6,500	5,541	4,055	2,824
13	Clients with PTSD, percentage line 11	70.4%	69.0%	67.3%	65.4%	63.4%	66.1%	62.5%	57.7%

			Percent of line 5				
Client Profile (continued)		VAC	%	West	Ont.	Que.	Atl.
	Primary Service:						
29	War Service Veterans	2,371	16.8%	794	707	538	332
30	CF released Veterans	7,714	54.7%	2,237	1,957	1,776	1,744
31	CF still serving	1,854	13.1%	485	579	258	532
32	RCMP released	1,291	9.1%	836	108	75	272
33	RCMP still serving	880	6.2%	603	94	37	146
34	Service missing	1	0.0%	0	0	0	1
	Reservists (included in lines 30-31 above)						
35	Reservists released	698	4.9%	243	168	146	141
36	Reservists still serving	49	0.3%	17	12	5	15
	The top **Psychiatric pension conditions** were as follows (clients may have more than one condition):						
61	PTSD	9,928	70.4%	3,755	2,136	1,881	2,156
62	Depressive disorders	2,411	17.1%	753	749	340	569
63	Anxiety and depression	1,190	8.4%	296	336	277	281
64	Anxiety disorders (excluding PTSD)	1,035	7.3%	275	334	216	210
65	Adjustment disorder	478	3.4%	138	115	137	88
66	Schizophrenia	127	0.9%	31	44	30	22
67	Alcohol use disorder	188	1.3%	37	48	55	48
68	Chronic pain	180	1.3%	58	81	10	31
69	Bipolar condition	110	0.8%	30	31	26	23
70	All other psychiatric conditions	344	2.4%	110	123	57	54

			Percent of line 5				
Client Profile (continued)		VAC	%	West	Ont.	Que.	Atl.
	Co-existing Conditions						
71	Head/Brain Injury	107	0.8%	50	25	10	22
72	Hearing Loss	4,644	32.9%	1,706	1,117	920	901
73	Musculoskeletal	7,136	50.6%	2,480	1,728	1,375	1,553

Source: VAC's Mental Health Directorate

5.3.2 The Target Population of the RTC

A population profile

In general terms, and as stated in VAC's Continuum of Care (Figure 1, p.3), the Residential Treatment Clinic at Ste. Anne's Hospital, provides third-level or tertiary-level care aimed at providing treatment and residential rehabilitation services to **Veterans, CF and RCMP members and their families who present with a complex PTSD co-morbid with OSI conditions** such as depression, alcohol/substance abuse, chronic pain, sleep disorders or anxiety disorders, **and for whom outpatient treatment was insufficient or ineffective**. Studies reveal that "more than 50 percent of PTSD sufferers have symptoms of major depressive disorder [5]. Alcohol abuse or other substance abuse affects over 50 percent of those with PTSD [6]. An individual who has depression and anxiety simultaneously has greater functional and psychosocial Impairment. Co-morbid depression significantly increases suicide risk."

A 2005 study of 130 clients from the Ste. Anne's outpatient OSI clinic indicated that 86.9 percent were suffering a significant level of pain. Patients with co-morbid pain and PTSD experience more intense pain, more emotional distress, higher levels of life interference, and greater disability than pain patients without PTSD. Recent research from McGill University highlights the morphological changes which occur within the brain as a result of chronic pain and visually underscores the reduced psychosocial capacity to cope.

An observation cited in VAC's Life After Service Study (LASS) which examined co-morbidity of chronic physical and mental health conditions noted that 55.2 percent of NVC participants had both a mental and physical health condition compared to 9.8 percent of Veterans who were not VAC participants, thus supporting the long held contention that there is a high degree of co-existent physical and mental health issues present in NVC participants.

A file review, conducted in conjunction with the New Veterans Charter Evaluation – Phase III in 2010, noted an exceptionally high proportion of individuals reported pain at baseline functioning (83 percent). At least half of the sample self-reported a significant mental health issue (57 percent), a high stress level (51 percent) and presented with a type of operational stress injury (OSI) (49 percent).

5 Kessler, 1995 as cited in *Combat Stress Injury*, 284.

6 Ibid.

5.3.3 Estimating Future Demand for Inpatient Services

Australian studies cite an historical figure of between 6 percent - 13 percent of troops returning from current conflicts in the Middle East will exhibit combat-induced PTSD. The term "combat-induced" refers to those individuals directly engaged in combat. These individuals also reflect a great propensity for a more complex/severe PTSD. On the other hand, the number of those individuals who present with a complex PTSD, i.e. with a severe PTSD and co-morbid mental health conditions, is a relatively small subset of the percentage and derived numbers above. A DND OSI study to be released in 2011 will use a stratified sample of 2,500 and will attempt to determine how many still-serving CF members have PTSD directly attributable to the military mission. DND firmly believes that one of the better measures for PTSD is the extent of combat. Thus, while they estimate that those suffering from combat-related PTSD will be in the range of 7 - 8 percent, they recognize that the study will be more conclusive. The study results should assist VAC in estimating the potential number of eligible future clients.

Other Considerations

- OSISS peer support respondents unanimously felt that the number of those requiring PTSD care and treatment will increase in the near future. One respondent stated that **"the water has not yet broken over the bow**". This statement was endorsed by OSISS colleagues.

- A CBC News report of June 14, 2011, quoted a former elite soldier in the CF as saying that "the numbers of soldiers who are diagnosed with post traumatic stress disorder will skyrocket in the next few years as Canada winds down its combat operations in Afghanistan." The soldier went on to state that "Now they'll have time to actually sit back and reflect on exactly what it is that they're going through,…They're not deploying so it's more time to actually consider what's going wrong in their lives. We are seeing the tip of the iceberg right now."

- The **manifestation period for PTSD ranges anywhere from one to several years** according to the CF 2002 Canadian Community Health Survey Supplement Study. U.S. subject matter experts indicated that **many older Veterans who are reaching retirement age are now coming in for treatment.** The higher profile accorded PTSD and the outreach efforts by the United States Veterans Administration has brought these Veterans forward after years of trying to suppress such issues.

- The mitigating efforts of DND in terms of **early intervention should reduce the probability of PTSD escalating to a more complex/severe level**. DND has a mandatory post-deployment screening for PTSD implemented at three and six month intervals which according to DND officials, captures about 80 percent of those with PTSD. Despite the identification of PTSD from this screening, it is recognized that the screening is only as effective as the number of individuals who subsequently receive treatment. To this extent, the commanding officers within DND are to ensure those individuals screened undergo treatment. It is

also a reality that not all cases identified with PTSD are directly attributable to the conflict. Some have entered the military harbouring childhood trauma.

- DND is also continuing its **efforts to educate the soldier with respect to the signs and symptoms of PTSD.** This is being accomplished in an increasingly more tolerant atmosphere which has seen **significant progress in the de-stigmatizing of mental health issues within the military**.

- **DND's enhanced post-deployment screening practice** which includes a questionnaire followed by an interview with a mental health nurse **represents a Canadian best practice** and is more rigorous than that found in the U.S. An experienced mental health nurse can validate questionnaire responses from face-to-face questioning, probe for other mental health conditions such as depression, traumatic brain injuries and verify an assessment against tour of duty data.

- The demographic and geographic issues that the Australians confront in terms of addressing the needs of its Veterans suffering from OSIs is more similar to the Canadian experience than is that of the United States. The Australian component to the comparative piece found in Annex D contributes two salient points to this discussion of estimating future demand for inpatient services:

  1. **Less than 10 percent of those suffering from PTSD will likely require inpatient** care and treatment (the American subject matter experts concur).

  2. **Australia formerly treated many more in an inpatient program but found that the outcomes were almost the same in outpatient, day hospital programs**. **As a result, they began to treat most clients on a 4 week, 2-3 days per week outpatient, day hospital program within their own community**. **There was much less distance travelled by the Veteran and it helped him/her avoid the stigma of a hospital when the Veteran was treated in his/her own community. As a result, the outcomes, if anything, were a little stronger from the local program. <u>This challenged the previous thinking on treatment.</u>**

Conclusion

Estimating the number of future client-patients for inpatient treatment with any precision is difficult at best given the preceding considerations, including the perspectives from different stakeholders, the mitigating measures of DND and the de-stigmatization efforts within the military and within Canadian society as a whole. Notwithstanding, given the relatively early Canadian experience and the views of subject matter experts in the United States and Australia based on a longer recent history, it is not unreasonable to assume that less than 10 percent of those individuals with PTSD will require inpatient care and treatment. Finally, the Australian experience suggests that their day hospital model which can operate at the local community level, which carries fewer stigmas,

operates on a more cost effective basis and often achieves stronger clinical outcomes than inpatient facilities, is a model worthy of consideration for the Canadian context.

5.3.4 Meeting the Needs of the Target Population

The RTC Response

The creation of the RTC is a result of the evolution of an inpatient stabilization program implemented at Ste. Anne's in 2002 and growing support over the ensuing years from clinicians, OSISS and VAC administrators, all of whom had identified the need for residential treatment services. The latter was to consist of rehabilitation care with an emphasis on more intensive group therapy. With the new RTC to be housed in Ste. Anne's Hospital, a long-term care facility and not an acute care facility, the development of admission criteria of necessity, took into account the safety and security of the long-term care patients at Ste. Anne's. Accordingly, while the target population for the RTC is expressed on VAC's continuum of care chart (Figure 1, p. 3) in practice, the RTC further defined its target population through the following exclusions:

Admission exclusions for the RTC

- Presenting with pathology – medical/psychiatric condition that precludes the benefits of the treatment. For example, the RTC's professional staff has indicated that those individuals who present with a moderate to high personality disorder will not be accepted for treatment.
- Active substance use or abuse interferes with daily functioning and treatment.
- Lack of up-to-date (last three months) comprehensive medical. psychiatric/psychological (differential diagnosis) assessment report available.
- Suicidal/homicidal ideation, presenting moderate or high risk of acting out (him/herself or others).
- At risk of expressing, or engaging in physically and verbally violent behaviours or sexually inappropriate behaviours.
- Awaiting trial on criminal charges and is under custody or preventive detention order.
- Has been either released from detention on surveillance conditions, or found guilty of criminal charges and is serving a prison sentence or legal procedures significantly interfere with the treatment.
- Under an administrative tribunal order further to a verdict of not criminally responsible on account of a mental disorder, a psychiatrist or hospital has been designated to provide psychiatric treatment.

These exclusions pertain to admittance into the RTC's Stabilization program. Admittance to the Residential Rehabilitation program includes all those above with the following two additions:

- not able to manage own medication, and
- medication requiring significant adjustments**.**

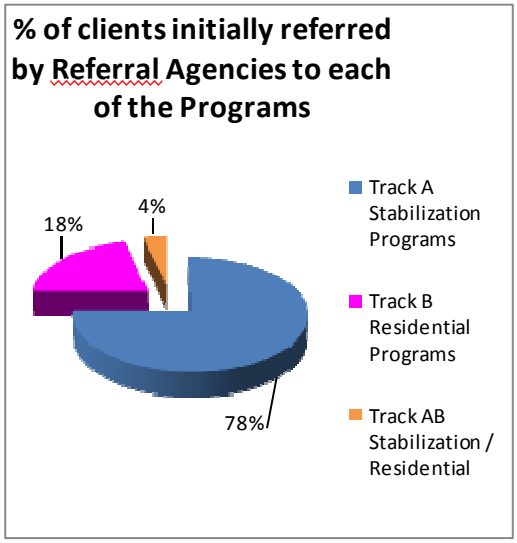
It should be noted that despite the special emphasis on the safety and security of Ste. Anne's Hospital's long-term care residents, the RTC's exclusion criteria are not unlike those adopted by clinics in Australia and the United States which serve to promote a safe, supportive and structured environment for those in inpatient residential rehabilitation programs .

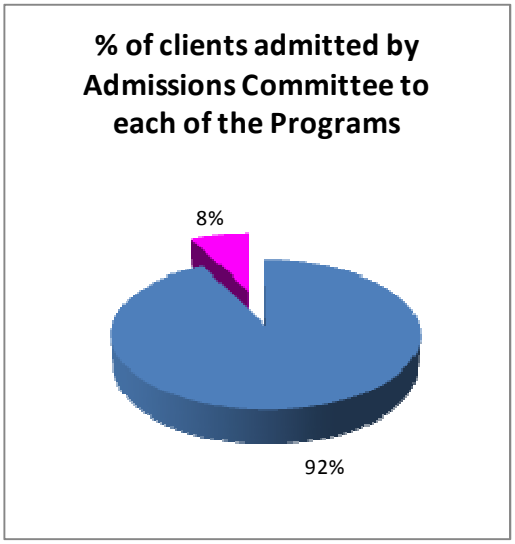
The RTC's professional staff and NCOSI officials concur that the exclusion requirements cited above were developed, in part, around the need to maintain the security of the aging Veterans within Ste. Anne's Hospital and partly due to the fact that neither the facility nor the existing professional staff had the capacity to deal with acute care patients. As a result:

- A significant portion of the target population - partially because of LTC location (not a psychiatric hospital/acute care) is excluded.
- Psychiatrists responsible for the clients under their care have placed considerable restrictions on admittance criteria.
- There are clients in crisis who don't meet provincial criteria for hospitalization but have a need and are also excluded from the RTC.

The number admitted to the residential rehabilitation program is low. It is not merely the fact that the rehabilitative program track of the RTC is new that accounts for the lack of direct entry into the program; rather, the emphasis on more intensive group therapy assumes that the participant is fully stabilized, has had some individual counseling, and is highly motivated and focused. However, RTC clinicians have indicated that individuals are presenting with more complex conditions than initially anticipated and taking longer in their recovery. It is thus **rare that the referral to the RTC does not require time spent in the stabilization track before entering the rehabilitation program.** As a result, in 2010, 92 percent of admissions entered the stabilization track and only 8 percent entered the residential track directly as depicted in Figure 4.

Figure 4: Referrals and Admissions by RTC Program Track





Source: Residential Treatment Clinic

Peer Support is Key

The positive influence of the peer support on the recovery process cannot be overestimated. **Every stakeholder interviewed attested to the value-added of the peer support in assisting the RTC staff and more importantly, its client-patients in addressing their care and treatment needs.** Peer support individuals have experienced and been successfully treated for mental health issues that the RTC patients are currently experiencing. They then become an immediate trusted resource, one who speaks the same language (military experience) and who offers encouragement when it is most needed. The passion and commitment to assisting their "brothers and sisters" in great distress is remarkable. The peer support at the RTC has been engaged on the basis of two 8-hour shifts per week. This coverage is inadequate as patients requiring peer support often must wait, sometimes several days, until the peer support's work shift occurs.

Gender Considerations

Women in the military can experience traumas that include military sexual trauma (MST) as well as combat-related trauma. VAC needs to take into account that in the military setting, women often have different experiences than men. It is vital that those women suffering from MST should be given female peer support to assist in their recovery efforts. The RTC does not currently have this capability.

Client Satisfaction

Participants in the longer running (since 2002) stabilization program indicated an overall satisfaction level of:

- 91.83 percent on average.(22 respondents) in 2008 - 2009;
- 94.55 percent in 2007 - 2008 (17 respondents); and
- 92.11 percent for the period from October 2004 - April 2007 (62 respondents)

The Ste. Anne's Hospital satisfaction norm is 75 percent; therefore, the participant satisfaction level is high for the stabilization track.

The residential rehabilitation program track in the RTC has been in operation for little more than a year. **Participant satisfaction garnered from interviews with client-patients is also high and the feedback generally very positive.**

Client - patients of the RTC have informed the evaluation team that without the RTC programs, their lives would be completely miserable. One respondent went so far as to emphatically state: "I would be dead". Another responded "I have my life back".

Conclusion

In short, the Inclusion/Exclusion criteria for admissibility to the RTC have, in part, been established to align with the capacity of the institution and staff, and not with the range of Veteran mental health needs. These exclusions serve to further narrow the field of eligibility for the RTC and thus the number of individuals who become patients of the facility. For participants in the RTC program tracks - stabilization and rehabilitation - satisfaction remains at a high level. The role of peer support in meeting the needs of the RTC client-patients is crucial and needs to be more than part-time. Provision of female peer support for RTC women client-patients also needs to be addressed. Despite its low numbers, the RTC is responding to a small segment of the target population and client-patient satisfaction is high. Testimonials underscore the value of the RTC to client-patients.

R1 It is recommended that the Director of NCOSI, consider increasing the provision of peer support in recognition of the invaluable support and contribution to the RTC's multidisciplinary team and the need for such support from the client-patient perspective; and that consideration be given to the provision of female peer support for women Veterans who participate in the RTC programs. (Critical)

Management Response:

Management agrees with this recommendation. A budget adjustment for year 2011-12 has already been approved to increase peer support services to a Full Time Equivalent for clients in the RTC program.

Management Action Plan:

Corrective Action to be taken	OPI (Office of Primary Interest)	Target Date
1.1 Ensure the availability and timely accessibility to peer support services.	Director, NCOSI	December 31, 2011
1.2 Ensure the availability and timely accessibility to female peer support for those clients who require this service.	Director, NCOSI	December 31, 2011

5.3.5 Unmet Needs of the Target Population

There was no formal needs assessment undertaken in support of the design and development of the RTC. There was, however, extensive consultation with subject matter experts in Canada and abroad in the design of the programming for the RTC. While there are individuals who benefit from the RTC and its programs, there remain others within the target population who for a variety of reasons are unable to avail of the RTC and its programming. Two noteworthy groups of potential client-patients currently excluded are:

- those individuals “in crisis” and requiring emergency acute care who are referred to local hospital emergency facilities where they are treated quickly and released immediately or are kept for a very few days and then released. While some of these individuals may require further care on an inpatient basis, the risk of losing track of them remains great; and,
- other Veterans and members, not ill enough for emergency care but who still require first level stabilization of their OSI condition. Both these groups present a service challenge to, and a “gap” in, the department’s Continuum of Care. A 2009 **Special Project on the Stabilization and Emergency Services Needs for Operational Stress Injuries (SESN OSI) Working Group Report** corroborates the gap and offers recommendations and a way forward.

There are, additionally, “gaps” in services for those individuals suffering from more complex PTSD and co-morbid conditions and for whom an out-patient program was insufficient or ineffective. Admission criteria, accessibility and family needs are key areas where impediments exist and needs go unmet.

By virtue of admission criteria

Those outside the **admission criteria of the RTC** would include, for example, individuals with:

- moderate to high personality disorders;
- active suicidal tendencies active addictions/substance abuse issues;
- criminal/legal issues, and/or
- high anger issues.

In terms of admittance refusals at the RTC, there were six (6) refusals in 2010 and three (3) from January to March 31, 2011. The reasons for these refusals by the RTC relate, in large part, to individuals presenting with moderate to high personality disorders.

Accessibility needs

In addition to the restrictions of the admission criteria, the fact remains that the combination of inpatient, bio-psycho-social treatment for individuals with complex PTSD co-morbid with other conditions which treats the military and policing culture as a cohort and provides an integrated, multi-disciplinary approach, is not readily available elsewhere in Canada. As a unique facility, the RTC presents an issue of **accessibility** and **geographic displacement** which factors into the willingness of individuals to participate in the RTC programs. This is particularly true for those individuals in Canada’s far western provinces like British Columbia and Alberta. This issue is reflected in the client profile illustrated in Figure 5 which indicates that the preponderance of client-patients in 2010 was from Central Canada and the majority was French speaking. However, as the RTC has only been operating since mid-February 2010, a full trend analysis is premature. Client profile numbers for 2011 thus far

indicate that 20 percent of clients are from Central Canada and 80 percent from the Atlantic and Western regions.

In Annex D, the Australian subject matter experts indicated that the drivers for their Afghanistan Veterans are **accessibility and flexibility.** The younger Afghanistan cohort is looking for care and treatment in their local setting delivered in a flexible way – outpatient, day hospital and at accommodating hours. The Americans agree with their Australian counterparts; however they indicate that the spouses of the young American Veterans are the main impetus for immediate care and treatment in the local setting. They identified another accessibility issue for these young U.S. Veterans, as recognized during field operations, and that is that the use of alcohol and drugs is a more normative practice among young Afghanistan Veterans. Substance abuse in these new Veterans really stems from the use of alcohol or drugs as a form of medication used to deal with the individual's PTSD. As a consequence of their viewing alcohol and drugs in a more normative sense, these young Veterans **refuse to attend substance abuse clinics**; on the other hand, they will more readily acknowledge PTSD and respond to PTSD clinic treatment. "Get them in any way we can, then we can treat them for both conditions" is the prevailing strategy.

It is not unreasonable to assume that returning Canadian Veterans of the Afghanistan conflict will have similar demands for care and treatment to be administered in their local setting.

Figure 5: The RTC Client Demographic Profile

	2010	2011
Client total	**27**	**5**
Gender		
Men	89%	100%
Women	11%	0%
Age Group		
20 - 29	15%	0%
30 – 39	22%	40%
40 – 49	37%	40%
50 – 59	22%	20%
60 – 80	7%	0%
Language		
French	59%	20%
English	44%	40%
Civil Status		
Single or widowed	22%	20%
Married or Common law	70%	60%
Separated or Divorced	11%	20%
Region		
Western Canada	15%	20%
Eastern Canada	15%	60%
Central Canada	70%	20%
	BC = 4% QC = 56% AB = 4% NB = 4 % SK = 4% NS = 0 % MB = 4% PE = 7% ON = 14% NL = 4%	BC = 0% QC = 20% AB = 20% NB = 0% SK = 0% NS = 20% MB = 0% PE = 20% ON = 0% NL = 20%

Source: Residential Treatment Clinic

Family Needs

Stakeholders acknowledged how critical it is to involve the family as part of the client-patient care and treatment. In many cases, the trauma that affects a Veteran with an OSI affects the entire family. Established rehabilitation best practices recognize the importance of involving families in all stages of rehabilitation, because they are the first source of support for Veterans facing an OSI. Where a Veteran suffers from an OSI, the effort to understand and support him/her can place an enormous burden on the family, which can lead to marital conflict, spousal depression, anxiety disorders, and/or child behavioural problems. While the reasons for involving the family are numerous, two specific examples are cited to encourage a better understanding of the issues confronting military families:

- A CBC News report of March 2011 indicated that "Domestic violence on Canadian military bases has climbed steadily in recent years, coinciding with the return of soldiers who carry physical and psychological battle wounds home". This has been corroborated by family peer support workers who are dealing with these issues on a continuing basis.
- Military families experience considerable isolation as a result of frequent moves and military deployments and are often away from their extended family as well. Issues arise when the partner may not want the spouse to talk about the OSI or symptoms for fear of adverse career implications.

Anecdotal evidence indicates that there is insufficient care and treatment available to children of military families who have a family member suffering from PTSD.

VAC's 2008 evaluation of the OSI Clinic Network disclosed that the "most common concern identified by respondents was the need to enhance services offered to family members of clients with an OSI". Currently, family members of a client are not receiving service at an OSI clinic unless the client is receiving treatment at the clinic.

The RTC was designed to include the involvement of family members; however, on a practical basis, the expectations for family involvement exceed the reality. Not only must spouses overcome geographical distance and parental responsibility concerns in order to participate, but these issues are further exacerbated by the same situation as alluded to in the 2008 evaluation: in instances where the Veteran or CF/RCMP member has not sought the services from VAC first, the family is not entitled to the reimbursement of expenses. Respondents indicated that the family involvement aspect related to the RTC is limited. Typically, if family members do come to the RTC, it is generally for a single week-end over the course of their loved one's treatment.

Conclusion

In summary, findings indicate that there are individuals who fall outside the admission criteria of the RTC. The RTC embedded within a long-term care facility (the primary focus of Ste. Anne's Hospital) is not equipped to treat those individuals "in crisis" and requiring acute care or those not ill enough for emergency care but who still require first level stabilization of their OSI condition. According to respondents, the risk of losing track of these individuals is high and their needs are great. This is not, however, merely an issue for the RTC; more significantly, it presents a service challenge for the department as a whole and represents a "gap" in VAC's Continuum of Care. The challenge is further complicated by the fact that while such treatment is often best provided, and preferred locally, for those with co-morbid conditions, first level stabilization services are generally not available locally.

Accessibility and flexibility are deemed to be significant for the younger Afghanistan cohort in Australia who are looking for care and treatment in their local setting and flexible program options. These are worthy of consideration within the Canadian context. Finally, the needs of family members in relation to their loved ones who are receiving care and treatment from the RTC are not being adequately addressed.

Overall Conclusion for 5.3

There are gaps in VAC's capacity to serve all those in need within the target population. Notwithstanding the limitations imposed by the RTC's admission criteria as well as the geographic accessibility constraints for potential client-patients and their families, the RTC is responding to the needs of a small, but significant number of the target population.

The number of individuals who will require inpatient care and treatment will likely remain small - in the area of less than 10 percent of those who suffer from PTSD alone. The Australian experience with their younger Afghanistan Veterans offers some noteworthy considerations for VAC as it plans for future treatment structures. **The accessibility and flexibility drivers for the Australian Veterans align with VAC's mental health strategy to devolve care and treatment capacity to the community level.**

The American subject matter experts concurred that accessibility and flexibility are significant for the U.S. Veteran as well; however, from their perspective, the Veteran's spouse was seen as the primary impetus. Although no evidence has been gathered for Canadian troops, **it is not** unreasonable to assume that the younger Canadian Veterans will have expectations of care and treatment similar to both the Australians and Americans. Toward this end, Australian studies referenced in Annexes C and D indicate the value of the day hospital program model which has demonstrated even stronger clinical outcomes for participants, **among whom are those who would have been previously referred to the residential rehabilitation (more intensive group therapy sessions) track of inpatient programs** because of severe PTSD and co-morbidity.

R2 It is recommended that the Director of Mental Health, in collaboration with the Director of NCOSI, develop policy options to better serve and monitor individuals who require crisis and emergency support or acute stabilization services, thereby enhancing VAC's Continuum of Care for Operational Stress Injuries while at the same time addressing barriers to participation in RTC programming . (Critical)

Management Response:

Management agrees with the recommendation. The 2009 report of the Stabilization and Emergency Services Needs (SESN) for Operational Stress Injuries Working Group examined the needs of Veterans and other clients who require crisis and emergency support or acute stabilization services and provided recommendations for future direction. A working group of internal and external stakeholders will be established to review and update the SESN Working Group report with a view to developing recommendations and an action plan for consideration by VAC senior management on how best to meet these needs.

Management Action Plan:

Corrective Action to be taken	OPI (Office of Primary Interest)	Target Date
2.1 Review and update the 2009 SESN OSI report.	Director, Mental Health Division	April 2012
2.2 Develop an action plan for the recommendations.	Director, Mental Health Division	September 2012

R3 It is recommended that the Director of Mental Health, in collaboration with the Director of NCOSI, assess a variety of mental health treatment models for community-level implementation and in doing so, leverage the knowledge, expertise and experience with the military cohort vested in VAC staff; and, furthermore, ensure that future model development is more inclusive of family members. (Critical)

Management Response:

Management agrees that the option of outpatient programming has the potential to be an effective alternative to residential treatment in some circumstances, that these circumstances should be determined to the fullest extent possible, and that expertise existent in the Residential Treatment Clinic should continue to inform client care. A review of the Australian, and other, experiences will be conducted to ascertain the extent to which programs of the Residential Treatment Clinic may be applied in an outpatient setting, what those settings might be, and how to leverage existing expertise.

Unlike the nine outpatient OSI clinics in the VAC network, the Residential Treatment Clinic does not treat family members. Management agrees that supporting families is essential to supporting Veterans, and agrees with providing supports to Veterans and

their families to the fullest extent authorized by legislation. The planned review will ensure that future model development is more inclusive of family members.

Management Action Plan:

Corrective Action to be taken	OPI (Office of Primary Interest)	Target Date
3.1 A Literature review, consultation with Australian colleagues, and/or those familiar with their programs and an analysis of potential settings.	Director, Mental Health Division	April 2012
3.2 Draft Report.	Director, Mental Health Division	September 2012
3.3 Final Report.	Director, Mental Health Division	December 2012

5.4 RTC PERFORMANCE

5.4.1 Client Satisfaction

Client satisfaction was discussed in the previous needs section 5.3.4. In summary, clients are generally satisfied with their experience at the RTC. Discussions with former participants and OSISS Peer Support Coordinators also revealed strong support for the program although several suggestions for improvements to the program and facility were offered. One overarching suggestion was that the development of a less risk adverse atmosphere would have enhanced the experience. Improved food quality and additional exercise opportunities were also cited.

Stakeholders in general recognized the competency of the RTC professional staff and were highly supportive of the RTC's interdisciplinary approach to care and treatment for these complex client-patients. They also noted that the RTC staff's sound understanding of the military culture has a positive impact on the recovery process. The evaluation team was also impressed with the level of commitment and dedication exhibited by the RTC staff.

5.4.2 Referral Metrics

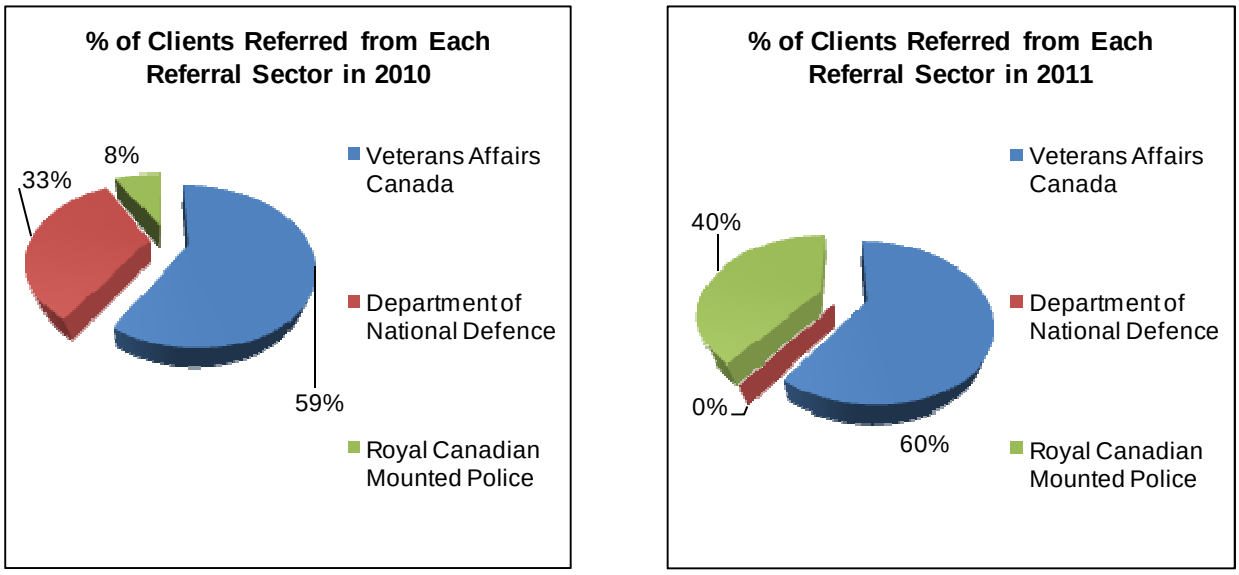
The number admitted to the residential rehabilitation program is low and clinicians have indicated that individuals are presenting with more complex conditions than initially anticipated. In 2010, six clients were refused by the admissions committee and from January to April 2011, three individuals were refused admittance to the program.

Although these numbers are small they attest to a gap(s) in the continuum of mental health services as noted in section 5.3.

The VAC and DND's Joint Mental Health Strategy announced in 2002 created a model for the sharing of services. As a result, the RTC serves CF and RCMP Veterans and

still-serving members. The following charts in Figure 6 indicate the percentage of program participants by referral source. In 2010, the majority of referrals came from VAC sources and presumably the majority of the referred individuals were Veterans. The DND referred 37 percent of the participants who represent still-serving members. The RCMP also referred a small number of individuals to the program representing still-serving RCMP members. For 2011, only the RCMP and VAC have referred individuals to the program (as of March 2011). In discussing their referrals to the inpatient program, DND representatives indicated that generally still-serving members are receiving treatment for OSI conditions early in the symptom development stage, before the condition becomes chronic, allowing the vast majority to be treated on an outpatient basis. This explains in part why there are no DND referrals evident yet in 2011.

Figure 6: Percentage of Program Participants by Referral Source



Source: Residential Treatment Clinic

5.4.3 Program Reach

With the creation of the Residential Rehabilitation Program, the RTC clinic did some initial outreach to VAC staff and stakeholders to raise awareness of the clinic's two program tracks- stabilization and rehabilitation. The outreach approach included presentations and tours of the facility to VAC staff and other stakeholders including the DND personnel. Staff and stakeholders were pleased at the creation of additional rehabilitation resources for those suffering from an OSI. However, the referral process has been reported as a source of frustration, requiring a considerable amount of paperwork and resulting in frustrating delays in obtaining an admission date. When this was coupled with the rigid exclusion criteria of the program, many VAC staff and other stakeholders were reluctant to consider referring Veterans to the RTC programs, opting instead for a more expedient path to care and treatment.

The RTC management which has been under the governance of the Nursing Directorate at Ste. Anne's Hospital since January 2011, has begun to respond to these concerns and has developed a new streamlined admittance form, and undertaken measures to improve the process and functioning of the admittance committee to shorten the time delays noted in the referral process. These measures will be viewed positively by both internal and external referral sources.

Clinic management is currently developing a program marketing and outreach plan which includes efforts to ensure awareness of the clinic across Canada and to clarify the clinic's program and rehabilitation approach. Visits to VAC district offices, other OSI clinics, RCMP and other stakeholders to provide presentations on the RTC and develop enhanced working relationships form part of the marketing and outreach plan. Other tools such as the creation of a publicity brochure and a virtual visit to the clinic via the web also form part of this outreach plan. These outreach measures should improve knowledge of the clinic's programs but uptake will continue to be constrained by the existing exclusion criteria.

Conclusion

The number admitted to the residential rehabilitation program is low. In terms of program reach, the evaluation team found that the vast majority of interviewees were aware of the RTC, felt that the staff was very competent and dedicated and the program treatment structure well designed, but were frustrated as they were not able to refer many of those they felt could benefit from the program due to the admittance exclusions as well as an overly complex referral process. There are current efforts underway to streamline and improve the referral process. Many stakeholders remarked on the high level of professional expertise within the RTC multi-disciplinary team and expressed a desire to leverage their expertise in transferring knowledge and skills to VAC staff and the community of providers at large.

R4 It is recommended that the Director of NCOSI, review and undertake improvements to the referral process affecting timely admission to the RTC. (Essential)

Management Response:

Management agrees with this recommendation. The current business process for referrals to the RTC is being reviewed. Once completed the business process will include a target for turnaround time for the decision of the admission committee and response to the referral organization.

Management Action Plan:

Corrective Action to be taken	OPI (Office of Primary Interest)	Target Date
4.1 Review and adjust the current OSI Clinic Business Process for Referrals including the Referral Form to reflect the uniqueness of the admission process to the RTC.	Director, NCOSI	November 30, 2011
4.2 Establish clear milestones and service delivery standards to monitor the referral process.	Director, NCOSI	January 31, 2012
4.3 Effectively communicate the client flow process from referral to admission into both the stabilization and rehabilitation tracks of the RTC to all stakeholders.	Director, NCOSI	January 31, 2012

5.5 Summation of Findings

With respect to the core issue of relevance, the evidence attests to the RTC's alignment with federal priorities, roles and responsibilities and confirms a continuing need for the facility exists. Given that the RTC's operation commenced in February 2010, the core issue of performance in terms of the immediate outcome of program reach was assessed. While there are gaps in the provision of care and treatment services, the RTC's inability to provide primary level stabilization to those individuals presenting in crisis (or after acute care emergency situations) is indicative of a larger issue - a "gap" in VAC's Continuum of Care. The early growing pains of the RTC, common to most new operations - referral delays, process impediments, modifications and adjustments have also contributed to program reach issues. Other key factors include geographic accessibility and the displacement from family which serve as barriers to family member counseling services.

Although the number of program participants is small, client satisfaction surveys have indicated a high level of satisfaction with both program streams. In 2010, 92 percent of client-patients entered the stabilization track directly, while only 8 percent entered the rehabilitation track directly. The longer running stabilization treatment track has a history of high client satisfaction since 2002 and is the backbone of the RTC.
The comparison with respective approaches in Australia and the United States raises questions around the most appropriate treatment models going forward and provides insights into the characteristics of modern-day Veterans as well as their expectations. The trialed and tested day hospital model widely used at the community level in Australia is particularly noteworthy. The day hospital model has achieved the same, and in many cases, stronger clinical outcomes as the inpatient program. It is used to deliver programming at the community level in Australia similar to the rehabilitation track programming implemented on an inpatient basis within the RTC.

Despite its shortcomings, the RTC is meeting the needs of a small but significant segment of the target population. The experience of other countries and mental health experts suggests that there will be a continuing need to address this small segment with specialized care on an inpatient basis.

6.0 DISTRIBUTION

Deputy Minister
Associate Deputy Minister
Chief of Staff to the Minister
Chair, Veterans Review and Appeal Board
Assistant Deputy Minister, Policy, Communication and Commemoration Branch
Assistant Deputy Minister, Service Delivery Branch
Assistant Deputy Minister, Corporate Services Branch
Executive Director and Chief Pensions Advocate, BPA
Executive Director, Ste. Anne's Hospital
Office of the Veterans Ombudsman
Regional Directors General (3)
Area Directors (12)
Director General, Departmental Secretariat and Policy Coordination
Director, Mental Health Directorate
Director, National Centre for Operational Stress Injuries
National Medical Officer, Veterans Affairs Canada
Deputy Coordinator, Access to Information & Privacy
Program Analyst, Treasury Board of Canada, Secretariat (TBS)
Comptrollership Branch (TBS)

ANNEX A - Significance of Recommendations

To assist management in determining the impact of the observations, the following definitions are used to classify recommendations presented in this report.

Critical: Relates to one or more significant weaknesses/gaps. These weaknesses/gaps could impact on the achievement of goals at the Departmental level.

Essential: Relates to one or more significant weaknesses/gaps. These weaknesses/gaps could impact on the achievement of goals at the Branch/Program level.

Important: Relates to one or more significant weaknesses/gaps. These weaknesses/gaps could impact on the achievement of goals at the Sub-Program level.

ANNEX B - List of Acronyms

CF	Canadian Forces
CFB	Canadian Forces Base
DND	Department of National Defence
NCOSI	National Centre for Operational Stress Injuries
OSI	Operational Stress Injury
OSISS	Operational Stress Injury Social Support
OTSSC	Operational Trauma and Stress Support Centre
PTSD	Post Traumatic Stress Disorder
RCMP	Royal Canadian Mounted Police
RTCOSI	Residential Treatment Clinic for Operational Stress Injuries
VAC	Veterans Affairs Canada

ANNEX C - External Analyses Used to Inform this Evaluation

Evaluation of the OSI Clinic Network (October 2008)

This evaluation was completed in October 2008 and thus preceded the implementation of the RTC. Nevertheless, the evaluation did serve to inform this evaluation. The objectives of the 2008 OSI Network Evaluation were to:

- assess the relevance of the OSI clinic network;
- assess the governance and accountability structure relating to the OSI clinic network;
- obtain information on the relative costs and outputs of the OSI clinics; and
- assess the success of the OSI clinic network in meeting its objectives.

The scope of the 2008 evaluation of the OSI clinic network included operations at VAC Head Office, the NCOSI, VAC regional and district offices, and the OSI clinics. While aspects of how the OSI clinics operate within the network were examined, this evaluation was VAC-focussed. Detailed clinical operations related to the delivery of mental health services provided at the OSI clinics were not evaluated as part of this project.

About the Residential Treatment Clinic for Operational Stress Injuries (October 2008)

This report, prepared in October 2008 by the Clinical Expertise Sector of the National Centre for Operational Stress Injuries at Ste. Anne's Hospital, is the foundation piece for the establishment of the RTC.

Special Project on the Stabilization and Emergency Services Needs for Operational Stress Injuries (SESN OSI) Working Group Report (August 2009)

VAC's National Centre for OSI (NCOSI) and its Mental Health Directorate created a working group to examine the needs of Veterans, CF and RCMP members who require crisis and stabilization services and who could not be readily served by existing VAC and /or community mental health services. The report provides a profile of those in need, potential areas of risk, and the impact of not addressing these needs in addition to recommendations related to medical stabilization, social stabilization and the promotion of VAC services.

Inpatient Versus Day hospital Treatment for Chronic, Combat-related Posttraumatic Stress Disorder: A Naturalistic Comparison (2002)

This Australian study, published in the Journal of Nervous and Mental Disease, compared the treatment outcomes of inpatient - outpatient programs and day hospital programs for chronic combat-related posttraumatic stress disorder drawn from 202 Vietnam Veterans. The study "lends broad support to the recommendation that treatment services for Veterans with PTSD be delivered in the least restrictive

environment"[7]. In other words, the notion that inpatient treatment is routinely more efficacious is clearly not the case from study results.

Outcomes for Depressed and Anxious Inpatients Discharged Before or after Group Cognitive Behavior Therapy (October 2003)

This study, published in the Journal of Nervous and Mental Disease Vol.191, Number 10, was a naturalistic comparison of the treatment outcomes for psychiatric patients with a depressive or anxiety disorder who completed a cognitive behaviour therapy (CBT) while inpatients, with anxious, but not depressed patients who completed CBT as day patients.

Naturalistic comparison of models of programmatic interventions for combat-related post traumatic stress disorder (August 2008)

This Australian study, published in the Australian and New Zealand Journal of Psychiatry, Vol.42 - 2008, compared the clinical presentations and treatment outcomes for Australian Veterans with PTSD who participated in a range of models of group-based treatment. Data was gathered on 4,339 Veterans with combat-related PTSD who participated in one of five types of group-based cognitive behavioural programmes of different intensities and settings. The findings have considerable import for the current evaluation.

PTSD's Diagnostic Trap (February, 2011)

This is a policy review article by Sally Satel, appearing in the American Enterprise Institute for Public Policy Research website at http://www.ael.org/article/103105 . The article, dated February1, 2011, explores the evolution of the term PTSD and the concomitant treatment regimes.

The Life after Service Study [LASS] (2010)

This research study, a joint effort between VAC the DND and Statistics Canada is comprised of four parts. The first part of the LASS is an Income study of CF Members who released over a ten-year period from 1998 - 2007 while the second part is a Survey on Transition to Civilian Life (STCL). The STCL information drew from a nationally representative sample of 4,721 of 32,015 Regular Force Veterans released from 1997 to 2008 and who were subsequently contacted by Statistics Canada during February and March, 2010. The majority of the sample responded to the survey (71 percent), and the great majority of those (94 percent) agreed to share their responses with VAC and the DND. The information from the STCL report was used to inform this evaluation in terms of the co-morbidity of mental and physical health conditions.

Parts three and four of the LASS will be the subject of a future report on the CF Cancer and Mortality Study and are not intended to inform this analysis.

[7] The Journal of Nervous and Mental Disease Vol.190, No.3 P.183, 2002

NVC Evaluation File Review (2010)

A file review completed by an external occupational therapist provided an overall assessment of progress for participants in the New Veterans Charter (NVC) Rehabilitation Program. The sample population for this file review consisted of individuals who entered the Rehabilitation Program between April 1, 2006 and October 31, 2009, and who had participated in the program for at least six months. A stratified random sample of 350 participants was drawn. This descriptive sample allowed for the analysis of the sample's characteristics and a comparison among various groups, but did not allow for the results to be generalized for the entire participant population. However, the findings from the file review remarkably mirrored the results and percentages gathered when the entire population was studied using departmental statistical information. This evaluation utilized the information from the NVC Evaluation file review as additional evidence on numbers presenting with mental health issues and pain.

Report of Consensus Conference: Practice Recommendations for Treatment of Veterans with Comorbid Post Traumatic Stress Disorder, History of Mild Traumatic Brain Injury, [and Pain] (June 2009)

Thirty-one invited participants from the Department of Veterans Affairs (VA), the Department of Defense Centers of Excellence (DCoE), and one national expert in brain injury from outside the VA and DoD met as a consensus panel in Washington, D.C. on June 1 and 2, 2009 to make specific practice recommendations to improve the VA health care services, educational, and systems coordination for Veterans with posttraumatic stress disorder (PTSD), pain and a history of mild traumatic brain injury (mTBI). Participants were purposefully selected to represent experts in mental health, rehabilitation, pain, neurology, primary care, pharmacy and research.

The conference consisted of (1) a day of round-table discussion to review challenges and the current knowledge base in three primary strategic aspects of care delivery to the above patients: clinical assessment, treatment planning and treatment; and (2) a half day of development of clinical practice recommendations and education and systems priorities.

In terms of treatment recommendations, the consensus panel recommended at this time to use the current clinical practice guidelines for PTSD, mTBI and pain for patients who concurrently meet diagnostic criteria for at least two of these disorders. At present, there is no data suggesting that the current clinical practice guidelines should be modified for treatment of comorbid PTSD, mTBI and/or pain. Ongoing systematic treatment monitoring is essential to continuously obtaining evaluation on the effectiveness of recommended treatments for complex patients.

Report of Consensus Conference - Practice Recommendations for Treatment of Veterans with Co morbid Substance Use Disorder and Posttraumatic Stress Disorder (October 2009)

Twenty-two invited participants from the Department of Veterans Affairs (VA) met as a consensus panel in Washington, D.C. on October 22 and 23, 2009. The goal of the Panel was to develop collegial recommendations on how substance use disorder specialists (SUD/PTSD Specialists) who are augmenting VA post traumatic stress disorder (PTSD) teams and services might be most effective in their clinical practice.

Veterans Affairs Medical Center, Battle Creek, MI Post Traumatic Stress Disorder (PTSD) Residential Rehabilitation Treatment Program (RRTP) Program Plan (2010)

The Specialized PTSD Programs at the VAMC, Battle Creek, MI are designed to treat Veterans who suffer from symptoms of Post Traumatic Stress Disorder (PTSD) as a result of military experiences. Military related PTSD affects many areas of the Veteran's life. Treatment modules address neglected areas of daily life through skill-training modules in the treatment program. Problematic areas such as guilt, intrusions, avoidance, anger, and substance abuse are addressed through classes and through group therapy. The PTSD programs at VAMC, Battle Creek, MI include both residential and outpatient treatment.

VA Residential Treatment for Posttraumatic Stress Disorder: Preliminary Report from a National Quality Improvement Effort (May 2011)

Between July of 2008 and March of 2011, NEPEC and the executive branch of the National Center for PTSD collaboratively conducted a mixed-method quality improvement effort in all VA residential treatment programs nationwide. The purpose was multifold and included to: 1). Identify elements of treatment that staff perceive as most effective to foster Veteran recovery from PTSD; 2). Create a descriptive map of treatments and services being delivered across the country; and 3). Establish a communication network among residential PTSD programs in order to share information on programmatic design and functioning.

"Out of the Shadows at Last - Transforming Mental Health, Mental Illness and Addiction Services in Canada" (May 2006)

This was a national study of mental health, mental illness and addiction led by the Honourable Michael J. L. Kirby and involving a 12-member Standing Senate Committee on Social Affairs, Science and Technology. The report has had a major impact on mental health issues and the shaping of mental health policy in Canada.

ANNEX D - Inpatient Care for Veterans: A Comparison of the Australian and U.S. Approach

The Australians and Americans have a longer recent history (both nations were involved with troops in the Vietnam War) in direct conflicts and in combat-related PTSD than do Canadians. In an effort to learn from their approach to the care and treatment of the more complex PTSD co-morbid with other mental health conditions like depression, addiction (alcohol and drug) or anxiety disorders, the evaluation team undertook interviews with subject matter experts in both the United States and Australia. A studies/document review supplemented the information obtained through interviews and both sources of information have contributed to this comparative piece.

Australia

A Brief History of Facility Development

Following WW II, Australia's federal Veterans' Hospitals were gradually devolved to the country's states, akin to our Canadian provinces. There were eight (8) such Veterans' Hospitals which were initially privatized and subsequently repatriated to the state with currently only one or two which remain private. At present, there is **an inpatient facility in each state** so that Veterans can go to a facility reasonably close to where they are living. In addition to these state hospitals, there is also a range of private facilities; accordingly, within each state there are anywhere from 1-3 facilities to which Veterans can be referred. The state hospitals are utilized for severe mental illness (an acute care model of 7-10 days) so Veterans who are "in crisis" are referred there. Their mental health condition must be severe or they will not be admitted. Thus, the majority of Veterans will not be using these facilities. Australian Veterans are usually treated in a private or outpatient hospital.

Noteworthy is the fact that the state facilities were once run as self-help, non-professional programs begun by Vietnam Veterans and their families who owned and ran community self-support clinics. Eventually, a strong push arose to repatriate these clinics back to the state where they now provide multi-disciplinary teams (no psychiatrist) for the treatment of Veterans. The Australians are finding that the process works well as the community facility will refer the more complex Veteran patient to the more intensive program and upon discharge, the patient is referred back to the community clinic for after care on an outpatient basis. The community clinics thus provide a strong role in the state's outpatient treatment continuum, particularly at the level of outpatient care. In the more remote areas, private physicians and local community offices may be used and Australia's Veterans Affairs is billed directly.

Evolution of PTSD-related Treatment Structures

There are similarities in the nature of the symptoms exhibited by Canada's modern-day Veterans and those Vietnam Veterans who returned to Australia back in the '70s. The

Vietnam Veterans were angrier, and presented with more unpredictability than Australian providers had experienced before and it took a number of years for the providers to adjust. The state or repatriated hospitals responded with crisis, stabilization, acute and on-going treatment, but they didn't follow through sufficiently on the providers' quality of care side of the equation.

VA in Australia recognized that the expertise in PTSD was not as strong as hoped which led to the subsequent creation of the Australian Centre for PTSD (ACPTSD) established in 1995 and located within the University of Melbourne. The ACPTSD was engaged to design and develop treatment programs for PTSD for the Department of Veterans'Affairs. From 10-12 facilities across Australia provide PTSD-specific, VA-funded programs for Veterans and utilize the training programs developed by the ACPTSD including training related to their content - the development of staffing profile requirements and program structure as well as specifications around admission and discharge. The expectation was that the programming would have a trauma focus and would be both educative and skill-based. ***In the early days, Australia trialed and modeled all inpatient programs, then modeled out-patient programs and alternative programs such as the day hospital program. They also trialed in-community models and found there was very little difference in Veterans profiles and clinical outcomes.***

When clients have co-morbid problems, the symptoms together can make treatment a challenge. These individuals are currently the only clients now referred to inpatient treatment. ***Australia used to treat many more in inpatient programs but found that the outcomes were almost the same as the outcomes in outpatient and day hospital programs. They began to treat most clients on a 4-week, 2-3 days per week outpatient, day hospital program within their own community. There was much less distance travelled by the Veteran and it helped avoid the stigma of a hospital when the Veteran was treated in his/her own community. This challenged the previous thinking on treatment.***

A 2008 Australian study entitled "***Naturalistic Comparison of Models of Programmatic Interventions for Combat-related Post-traumatic Stress Disorder***" and published in the Australian and New Zealand Journal of Psychiatry 2008: 42: 1051-1059, examined the effectiveness of alternate treatment structures by comparing "clinical presentations and treatment outcomes for Australian Veterans with PTSD who participated in a range of models of group-based treatment." Some 4,339 Veterans with combat-related PTSD, "who participated in one of five types of group-based cognitive behavioural programmes of different intensities and settings" were involved with the study. The results indicated that ***"although significant improvements in symptoms were evident over time for each programme type, no significant differences in outcome were evident between programmes."*** The conclusion of the study is significant in terms of its implication for the forward planning of psychiatric services for Veterans:

"***This study indicates that comparable outcomes were evident across variations in PTSD programme intensity type. There was some suggestion that outcomes may be maximized when Veterans are placed in programme intensity types that match their level of PTSD and comorbidity severity. When such matching is not feasible, moderate-intensity programmes appear to offer the most consistent outcomes. The data also suggest that, for regionally based veterans, delivering treatment in their local environment does not detract from, and may even enhance, outcomes***". These findings, although requiring replication, have substantial implications for the planning and purchasing of mental health services for sufferers of PTSD, particularly for Veterans of more recent combat or peacekeeping deployments.

The most recent shift undertaken by the Australians was the introduction of the travelling clinic which focuses on rural areas. This model brings a team of professionals to where a group of clients (minimum of 5 clients exhibiting combat trauma) requires care. The clinic is typically run from a community facility in the Veterans' local area. Australians have found the outcomes to be similar or even better as the Veteran does not need to leave his/her family. ***In short, VA-funded day-patient and regional delivery models are showing very good outcomes.***

The Australians acknowledge that it is a minority of Veterans who become acute and require inpatient care. **As a result, referrals are made on a case-by-case basis**. The clinical indications for inpatient care include a history and current presentation. Referral to inpatient care is not always simply a measure of those presenting with a severe PTSD but also those individuals presenting with PTSD co-morbid with other mental health conditions such as substance abuse and/or depression or self-harm symptoms. **Trauma facilities have very good outcomes with the day hospital model. Individuals have one shot at these programs as they are very expensive. Australia has embedded these facilities within communities, augmented staff skills and thus the clinic's capacity at the community level.**

The Future Client-Patient

The above-mentioned 2008 Australian study stated the following: "The findings may inform planning of psychiatric services for younger veterans returning from recent military operations, for whom flexible, innovative treatment structures and settings are likely to be required." When asked by the VAC evaluation team to elaborate on what was implied by this statement, one of the study's authors provided a more fulsome explanation. The typical young Veteran emerging from the Afghanistan conflict is of a different generation for whom his/her stage of life is the precipitating need. ***The new Veterans expect services to be flexible and targeted***. They expect the health providers to come to them. Consequently Australia had to build up its outpatient response. The Vietnam Veteran experience had been a proving ground for many lessons learned, one of which included the fact that many of these Veterans were involved in their third marriage. On the other hand, the new Veterans were on their first marriage, had very young kids and were afraid the family would breakdown if they were further displaced for the purpose of mental health treatment. ***Australian health care providers recognized that for the new generation of Veterans, families were all that they had in their lives. Their mental health treatment accordingly was driven by the need for flexibility and accessibility to mental health care and treatment in their local setting. The flexibility Australia built did not cost much in terms of outcomes and provided huge outcomes in terms of continuing client engagement.*** **The new Veterans can be otherwise difficult to engage.**

In terms of a basis for predicting the target population going forward, the Australian experience for those with PTSD is anywhere from 6 - 13 percent of the active troops and of this number, less than 10 percent would likely require

inpatient care and treatment. Australia's prevalence figures are expected to be available in 6 - 12 months.

United States

PTSD-related Treatment Structures

The United States has an extensive range of facilities and services for its Veteran population. From the Veterans Affairs website in the United States, it is clear that Veterans appear to have many options open to them for care and treatment of PTSD:

Specialized Outpatient PTSD Programs (SOPPs)

SOPPs include three basic types of clinics. At these outpatient (not live-in) clinics, you can meet with a provider on a regular basis.

- **PTSD Clinical Teams** provide group and one-to-one treatment.
- **Substance Use PTSD Teams** treat the combined problems of PTSD and substance abuse.
- **Women's Stress Disorder Treatment Teams** provide women Veterans both one-to-one and group treatment.

Specialized Intensive PTSD Programs (SIPPs)

SIPPs provide PTSD treatment services within a "therapeutic community." Many programs are residential (live-in). Activities offered are social, recreational (relax), and vocational (work), as well as counseling.

- **PTSD Day hospitals** are outpatient. They provide one-to-one and group treatment for 4-8 hours each visit. Patients come in daily or several times a week.
- **Evaluation and Brief Treatment of PTSD Units** provide PTSD treatment for a brief time ranging from 14 to 28 days.
- **PTSD Residential Rehabilitation Programs** provide PTSD treatment and case management. The goal is to help the trauma survivor return to healthy living in the community. Stays tend to be 28 to 90 days long.
- **Specialized Inpatient PTSD Units** provide trauma-focused treatment. Hospital stays last from 28 to 90 days.
- **PTSD Substance Use Programs** provide combined evaluation, education, and counseling for substance use problems and PTSD. PSU admissions range from 14 to 90 days.
- **PTSD Domiciliary** provides live-in treatment for a set period of time. The goal is to help the Veteran get better and move to outpatient mental health care.
- **Women's Trauma Recovery Program** was opened by the VA in Palo Alto, CA, in 1992. This live-in program focuses on war zone-related stress as well as Military Sexual Trauma (MST). In the program, Veterans can work on skills needed to deal comfortably with other people. The program is 60 days long.

Other options

Some VA medical centers are now offering walk-in clinics. By walking into the primary care clinic, a Veteran can be seen that day by a mental health provider.
Other VA treatment locations where a Veteran can get PTSD treatment include:

- **Community Based Outpatient Clinics (CBOCs)** which offer primary care programs, provide care in a local setting and whose services include mental health care (at some locations).
- **Vet Centers** are operated by VA's Readjustment Counseling Service. They are located outside medical facilities, many workers are Veterans, they provide a mix of counseling and help with accessing other programs

Inpatient Care

There are 42 residential programs throughout the US. **They are no longer truly inpatient according to American subject matter experts**. (The residential or "lodger" aspect is different than a "true" inpatient structure which provides 24/7 care, programming and attendant professional staff.) The care and treatment in the residential program is however akin to inpatient programs. ***One of the key benefits of the residential/inpatient care is that it allows the affected individual to focus full time on his/her treatment -*** there are no distractions which would otherwise be present in the individual's natural setting such as family and friends or work considerations. In the residential setting, the individual can work on his/her homework at night***. A strong and vital element of peer support is also present in the residential setting.*** It is up to the Veteran how long he/she stays as this is ***individualized/ customized treatment for the more complex cases***. Care is provided 24/7 for 5 days a week but there is very little structure/programming on the week-end. There is more emphasis on families on the weekend especially if the family resides within a decent commute of the facility. Veterans with PTSD and exhibiting suicidal tendencies cannot enter a specialized PTSD program - they need to be stabilized in a psychiatric unit before entering such a program.

The VA Northeast Program Evaluation Center (NEPEC), Yale School of Medicine, VA National Center for PTSD and the Dartmouth Medical School combined on a quality improvement effort to:

1) Identify elements of treatment that staff perceive as most effective to foster Veteran recovery from PTSD;
2) Create a descriptive map of treatments and services being delivered across the country; and
3) Establish a communication network among residential PTSD programs in order to share information on programmatic design and functioning. The methodology included a visit to all 38 VA residential PTSD programs that currently report outcome data to the NEPEC. Over 250 clinicians were individually interviewed and among the many key findings are the following:

Staff as a Key Ingredient/Team Approach
"Staff" is also reported to be one of the essential and effective components of PTSD residential treatment. Programs that consistently conduct formal team meetings, have additional informal mechanisms of communication, and engage in group problem-solving and treatment planning are perceived to be most effective by members of the team. Effective teams are also thought to model positive social interactions for Veterans.

Iraq and Afghanistan Veterans
Programs describe that they are experiencing some unique issues and solutions in working with recent returnees. Issues include: "raw" PTSD and complex mental health symptom presentations; broad readjustment problems; and difficulty with time demands of and readiness for intensive treatment. Program structure (e.g., blended versus era specific therapy), content (e.g., physical activity), and adaptations (e.g., inclusion of family, shortened length of stay) are currently being reviewed by some programs as effective solutions for the care of Iraq and Afghanistan Veterans.

Need for and Inclusion of Family
***Family support is indicated by clinicians to be a necessity for long-term maintenance of treatment gains**. Several programs offer psycho-education for Veterans' families. Some programs have initiated family days, partner groups, and couples therapy.*

The Future Client-Patient

As evidenced in the Australian experience, the U.S. is recognizing a different Veteran in its returning young Afghanistan troops***. Those operating in the field are beginning to realize that the use of alcohol and drugs is a more normative practice among young Afghanistan Veterans. Substance abuse in these new Veterans really stems from the use of alcohol or drugs as a form of medication used to deal with the individual's PTSD. As a consequence of their viewing alcohol and drugs in a more normative sense, these young Veterans refuse to attend substance abuse clinics; on the other hand, they will more readily acknowledge PTSD and respond to PTSD clinic treatment.*** "Get them in any way we can, then we can treat them for both conditions" is the prevailing strategy.

It has also been the American experience that the younger Veterans who are married and maybe with young families do not want to be on the compensation track. ***There is now a higher percentage of these Veterans who realize they can make more***

money than compensation will provide, if they can get healthy. The spouse appears to be the main impetus for getting them engaged in treatment and getting them better.

Other Notes on the American Experience

Approximately one-third of Veterans seeking treatment for substance use disorders also meet criteria for PTSD. In FY 2008, almost 22 percent of VA patients diagnosed with PTSD also received a SUD diagnosis with rates of 70 percent seen in patients hospitalized for PTSD. As the conflicts in Afghanistan and Iraq have continued, increasing numbers of Veterans are presenting to VA clinicians with co-occurring diagnoses of substance use disorder and PTSD. Patients diagnosed with both disorders tend to have poorer long-term prognoses for each condition than do those who have one diagnosis without the other.

The U.S. outpatient clinic model works on providing safety, stabilization and education. ***PTSD co-occurring with alcohol addiction is now managed in an outpatient setting.*** Clinics have staff experts in PTSD and substance abuse who do cognitive behaviour therapy both at the individual and group levels.

There is a small but significant segment which requires more intensive care and treatment in an inpatient facility. (as in Australia, < 10% of those with complex PTSD). The American experience also suggests that things need to be done differently. Returning Veterans want to know how to address their issues. ***The VA is trying to make treatment accessible to them in their areas***. The former notion that services should be offered from 8:00 - 16:30 hours is no longer considered to be adequate for the purpose of care and treatment. ***It is now recognized that treatment can be offered to accommodate the Veterans on their schedules- including evenings.***

Staff development requirements need to change as well, as ***the staff must have a solid understanding of military history and culture in order to better understand their patients.*** Cognitive processing therapy is helping people get better. ***The relationship with the clinician is key to recovery.***

Many U.S. Veterans had mental health problems before entering the military. ***Post-deployment screening measures conducted at the 9-month interval are catching more individuals with other mental health issues besides PTSD. Many older Veterans who are reaching retirement age are coming in now for treatment***. The increased public profile given to PTSD and the outreach efforts of the VA have brought these Veterans forward after years of trying to suppress such issues.

The VA is piloting different forms of tele-health protocols - different programs for those Vets who do not want to come into a clinic, especially those in rural settings. They currently have in the order of 20,000 webcams set up thus saving on transportation expenses.