

Working for the Canadian Armed Forces and Veterans Affairs Canada

A Guidance Document for Occupational Therapists



Ottawa, 2017

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Table of Contents

4	CAOT Project Team and Acknowledgements
5	Foreword: A Message from the Canadian Armed Forces
6	Foreword: A Message from Veterans Affairs Canada
7	Executive Summary
9	Section 1: Introduction and Context
10	An introduction to this Guidance Document
10	Putting this document into context: an introduction to the Canadian Armed Forces
10	Members of the Canadian Armed Forces
11	Military life
12	Health care in the Canadian Armed Forces
13	Section 2: Working with Members of the Canadian Armed Forces
14	Introduction
14	Working for the Canadian Armed Forces
14	Description of the role of DND OTs
15	Canadian Armed Forces occupational therapy client base
15	Commonly addressed issues by DND OTs
15	Commonly used assessment tools by DND OTs
15	CAF priority levels for assessment and treatment
16	Description of the role of Blue Cross Occupational Therapists
18	Reporting standards
19	Canadian Armed Forces Mental Health Services
19	Conclusion
20	Section 3: Working with Veterans and Veterans Affairs Canada
21	Introduction
22	Working for Veterans Affairs Canada
22	Description of the role of Field Occupational Therapy Services Officers
23	Description of the role of Case Managers
24	Description of the role of Blue Cross Service Providers (Field Occupational Therapists)
25	Description of the role of Clinical Care Managers
27	Veterans Affairs Canada client base
27	Commonly addressed issues
27	Commonly used assessment tools
28	Implementing trauma-informed care in your practice
30	Tips for occupational therapists: preparing to assess for trauma
30	Veterans Affairs Canada programs
30	Veterans Affairs Canada Rehabilitation Program
31	Benefits and programs
31	Veterans Independence Program

31	Conclusion
33	Section 4: Working with Military Families
34	Introduction
34	Unique elements of military life
35	Mobility
35	Separation
36	Risk
36	Specific challenges for military families
36	Health
37	Education
38	Moving forward
38	What about Veteran families?
40	Epilogue: a message from the Executive Director of CAOT
41	References

Practice tips

11	Practice Tip 1.1
16	Practice Tip 2.1
16	Practice Tip 2.2
17	Practice Tip 2.3
18	Practice Tip 2.4
21	Practice Tip 3.1
21	Practice Tip 3.2
21	Practice Tip 3.3
24	Practice Tip 3.4
34	Practice Tip 4.1
37	Practice Tip 4.2
38	Practice Tip 4.3
38	Practice Tip 4.4

Tables

11	1.1 Members of the Canadian Armed Forces
16	2.1 CAF priority levels for assessment
29	3.1 Commonly used assessment tools
31	3.2 Programs of Choice
32	3.3 Services available through the Veterans Independence Program

Additional information

- 10 1.1 Life in the Canadian Army
- 12 1.2 Ranks within the CAF
- 12 1.3 Want to learn more about the Canadian Armed Forces?
- 18 2.1 What is an Occupational Therapy Redacted Recommendations Report (OT-RRR)?
- 18 2.2 What is an “occurrence”?
- 19 2.3 Making the transition to Veterans Affairs Canada (VAC)
- 22 3.1 What do we know about the transition from active military personnel to Veteran?
- 22 3.2 Occupational therapists working for Veterans Affairs Canada
- 24 3.3 Resolving challenges as a community therapist working for VAC
- 25 3.4 Interested in registering as a Blue Cross Service Provider?
- 25 3.5 What does the CCM role look like in daily practice?
- 26 3.6 Mary’s experience working with Veterans
- 28 3.7 What are the symptoms of post-traumatic stress disorder (PTSD)?
- 28 3.8 Occupational therapy and PTSD (video clip)
- 29 3.9 Signs of a trauma response
- 30 3.10 Want to learn more about trauma-informed care?
- 34 4.1 Positive experiences of children growing up in Canadian military households
- 35 4.2 Did you know?
- 36 4.3 Childrens’ perceptions of deployment

Commonly used abbreviations

Abbreviation	Term
CAF	Canadian Armed Forces
CCM	Clinical Care Manager
CFHS	Canadian Forces Health Services Group
DND OT	Department of National Defence Rehabilitation Occupational Therapist
FOTSO	Field Occupational Therapy Services Officer
OTSSC	Operational and Trauma Stress Support Centre
PTSD	post-traumatic stress disorder
VAC	Veterans Affairs Canada

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Foreword

A Message from the Canadian Armed Forces



The Canadian Forces Health Services, which includes occupational therapy, is happy to partner with the Canadian Association of Occupational Therapists (CAOT) and Veterans Affairs Canada (VAC) on this valuable document.

It is fitting that this relationship between the Canadian Armed Forces (CAF), CAOT and VAC continue, since many of the early advances of occupational therapy as a profession originated as a result of the World Wars when returning wounded soldiers required occupation and activity to assist with their recoveries back to daily living roles. Even today, it is evident that the rehabilitation professions, including occupational therapy continue to evolve in response to the health care needs of today's injured soldiers.

The everyday activities of CAF members can be demanding. Whether deployed on domestic or overseas operations, training exercises or even routine office work, injuries requiring occupational therapy can, and often do, occur. Whether it is an assessment and treatment provided by a DND Occupational Therapist or a Medavie Blue Cross

Occupational Therapist, their primary objective is clear: to collaborate with the Canadian Forces Health Services Medical and Rehabilitations team to assist the CAF member to return to full duty.

Occupational therapists are uniquely suited to meet this objective as they support, assess and treat the CAF member in their home, community, military garrison or place of work. They do this by identifying the CAF member's strengths and current deficits in everyday activities and assist them to re-organize and re-integrate into wanted and expected roles and routines. The diversity in assessment and treatment arenas provide a breeding ground for innovative evidence informed practice.

It is encouraging to see CAOT develop this Guidance Document on working with members of the CAF and VAC. Articulating occupational therapy roles, goals, standards and procedures for delivery of services across the expanse of Canada in a document such as this is essential. This Guidance Document is yet another way to ensure optimal standardization and CAF member access to occupational therapy services.

Jim G. Kile, OMM, CD, MSc, MD.

Colonel

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Foreword

A Message from Veterans Affairs Canada



Congratulations to the Canadian Association of Occupational Therapists for producing this Guidance Document on working with the Canadian Armed Forces and Veterans Affairs Canada. If the key to positive outcomes is client-centred care then

understanding your client population is crucial to success. Having read this document, I believe its audience will find it most useful in understanding the unique needs of the military and Veteran populations.

Occupational therapy has a long and rich history of working with military personnel and Veterans and it is heartwarming to note that there is a will for this engagement to continue. Military personnel face many transition stages throughout their career and lifetime. From a state of health to one of dealing with illness or injury (transitional or permanent), from wearing the uniform to transitioning to civilian life, from one employment to another or to retirement, all these stages present challenges. The mandate of Veterans Affairs Canada is to support and assist Veterans in transitioning seamlessly through these

transitional stages. I consider occupational therapists to play a key role in assisting military and Veterans in these important transition steps whether it is assisting with physical or mental health needs. Occupational therapists are de facto transition specialists.

In the same manner that occupational therapists take a holistic approach to care, this Guidance Document provides a complete picture of Veterans' health issues. It is important to understand that Veterans are a product of the military therefore the section on the Canadian Armed Forces is crucial. And whatever impacts a military member or a Veteran also affects their family members, so the section on working with military families is also of utmost importance.

Veterans Affairs Canada has employed occupational therapists for several decades and their value to the care management team and to the clients they serve is without question. This document will be of great value to those who choose to help those who served valiantly for their country.

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Executive Summary

Occupational therapists have a long history of working with active Canadian Armed Forces (CAF) military members and Veterans. The goal of this Guidance Document is to educate occupational therapists on the unique aspects of working with both the CAF and Veterans Affairs Canada (VAC). This in turn will help occupational therapists provide the highest quality services to CAF members and Veterans.

Canadian Armed Forces

Occupational therapists provide services to serving CAF military members in two capacities:

1. **Department of National Defence Rehabilitation Occupational Therapists (DND OTs)** working within DND are part of the Canadian Forces Health Services (CFHS) Physical Rehabilitation Program and work with ill and/or injured military members. DND OTs' services are primarily provided on military bases within rehabilitation clinics. The primary objective of DND OTs is to work with other CFHS professionals to assist ill and/or injured military members to return to duty. As DND OTs are part of the CFHS Physical Rehabilitation Program, they primarily address physical health concerns. Currently, DND OTs are not formally involved in the CAF Mental Health Program. Three programs exist to support CAF members who are struggling with mental health issues: Mental Health Programs, the Psychosocial Program, and Operational and Trauma Stress Support Centres.
2. **Blue Cross Occupational Therapists (Blue Cross OTs)** services are accessed through Medavie Blue Cross when specialized treatments are required or when a CAF member is stationed/posted on a military base not currently offering occupational therapy services. Blue Cross OTs provide services to CAF members in their homes and communities, addressing a broad range of physical and mental health issues shown to directly impact everyday function. Blue Cross OTs are required to follow a standard procedure set out by CAF for the approval of recommendations and the allotment of treatment time.

Veterans Affairs Canada (VAC)

Veterans are military members who have been released from the CAF with an honourable discharge. Occupational therapists working for VAC can work in four different roles:

1. **Field Occupational Therapy Services Officers** work within VAC offices as consultants where they are primarily responsible for coordinating referrals of VAC clients to therapists in the community.
2. Community therapists registered with Medavie Blue Cross, referred to as **Field Occupational Therapists**, provide direct treatment to VAC clients in their homes and communities.
3. **Case Managers** work with Veterans and their families who are having difficulty with the transition from active military personnel to civilian life, coordinating appropriate services.
4. **Clinical Care Managers (CCM)** provide short-term, intensive case management services to VAC clients who are experiencing complex health needs, working directly with clients in the community.

VAC clients receiving referrals to occupational therapy require support to engage in the meaningful occupations of civilian life. Common occupational therapy interventions centre around home adaptations, prescription of assistive devices, addressing mental health concerns and dysregulated routines, and addressing occupational issues resulting from traumatic brain injury. VAC has several programs available to support their clients, including the Veterans Affairs Rehabilitation Program, Programs of Choice, and the Veterans Independence Program.

Military Families

Mobility, separation, and risk strongly influence the lifestyles of military families. Military families are required to frequently relocate at the discretion of the CAF, and often experience prolonged periods of separation when the military members

are completing training missions or deployment overseas. Military service involves inherent risk of death or injury, increasing anxiety for family members. Military lifestyle significantly impacts access to required health care and educational services for children, especially those with special

needs. As research in this area continues to develop, occupational therapists must support these families by understanding the distinctive factors that shape their lifestyle, and providing them with client-centred care in all practice settings where they may encounter them.

Section 1: Introduction and Context



An introduction to this Guidance Document

Occupational therapists have a long history of working with Canadian Armed Forces (CAF) members and Veterans. The aim of this Guidance Document is to educate occupational therapists on the unique aspects of working with both the CAF and Veterans Affairs Canada (VAC). An important component of working with these departments is an understanding of common areas of assessment, interventions and processes utilized to provide occupational therapy services to military and Veteran populations. With this information, it is our hope that occupational therapists will be well-equipped to provide services to the CAF and VAC, continuing the legacy of providing client-centred services to those who have served or continue to serve our country.

Putting this document into context: an introduction to the Canadian Armed Forces

The Canadian Armed Forces (CAF) is the armed military forces of Her Majesty, Queen Elizabeth, organized and funded by Canada. The CAF, along with the Department of National Defence (DND), work together to fulfill the Canadian government's mission to defend Canadian interests and values, and to contribute to international peace and security (Department of National Defence, 2015). The CAF consists of three elements: Canadian Army (land), Royal Canadian Navy (sea), and Royal Canadian Air Force (air). Those who are employed by the CAF belong to either the Regular Force (full-time employment) or the Reserve Force (part-time employment). CAF members are subject to the contract of unlimited liability, meaning that when necessary, CAF may request its members to engage in work which may be harmful to their health, or ultimately result in death (National Defence and the Canadian Armed Forces, 2006). The organizational goals of the CAF differ from those of Veterans Affairs Canada (VAC), which involves transition and

integration to civilian life. Veterans and VAC will be discussed in further detail in Section 3.

When preparing to provide occupational therapy services to CAF personnel, an understanding of military life, culture, and processes is necessary to ensure military members receive the highest quality occupational therapy services. This introduction provides a brief overview of the categories of CAF members and the pertinent aspects of military life and the Canadian Forces Health Services. This will provide context to the content discussed in the remainder of this document.

Members of the Canadian Armed Forces. Within the Canadian Armed Forces (CAF), there are two categories of members: Regular Forces and Reserve Forces. See Table 1.1 for more information.

All CAF personnel engage and participate in military duty. Military duty is the combination of a CAF member's ability to be both operationally ready and highly skilled in a military trade (also called occupational trade or military work). Operational readiness refers to the member's physical and mental ability to react in a moment's notice to threats/crises domestic or abroad. In addition to being operationally ready, CAF members must be trained and skilled in their specific military trade, which can include training as infantry soldiers, military police officers, physicians, navy seamen, pilots, etc. These essential elements of military duty (operationally and trade ready at all times) are directly linked to occupational therapy goals with ill and/or injured military members: to work with Canadian Forces Health Service personnel to assist the member to return to duty.

Additional Information 1.1

Life in the Canadian Army

Watch this YouTube video Life in the Canadian Army for a firsthand view of the CAF Army recruitment and training process: <https://www.youtube.com/watch?v=KiDfiZsh7XY>

Table 1.1
Members of the Canadian Armed Forces

Regular Forces	Reserve Forces
68,000 members	27,000 members
Members have made the military their career	Members volunteer to devote a portion of their time to military service
Deployment is not voluntary	Deployment is voluntary
Full-time career	Can be full-time or part-time work. Many members have a career outside of the military
Members enrolled in the Navy, Army or Air Force	Members can enroll in the Navy, Army or Air Force
Consists of Officers and Non-Commissioned Officers of all ranks	Consists of Officers and Non-Commissioned Officers of all ranks
Members can release from the military after a Term of Service contract has been completed	Reservists have no minimum time commitment; members can choose to leave the Reserve Force at any time. If a reservist has taken a deployment, the member must complete the mission
Members will be posted and move around during their career. Their location is based on where they are posted or deployed to	Members will not be posted or do a military move. They remain with the Reservist Unit that they joined. They can volunteer to move to another base
Members can be deployed on a mission overseas	Members can volunteer to go on a mission overseas

Military life. Military life is filled with activities, traditions and customs that are very different from civilian life (Department of National Defence, 2015). Many of the activities required of military members are mandatory. Military life provides members of the CAF with the opportunity to work, live and train in dynamic, ever-changing environments, building strong interpersonal relationships within their units, resulting in a high level of pride in one's service.

Command structure is a key cornerstone of military life (NHS North East and North of England Mental Health Development Unit, 2013), meaning CAF members must abide by the military's chain of command. Each member is assigned a rank, and the CAF command structure is based on authority, where the lower ranks obey the higher ranks. Military managers expect to be obeyed, and ranks below them cannot question their authority. As a CAF member is promoted in rank, they also take on more responsibility and authority within the organization

(National Defence and the Canadian Armed Forces, 2015). Members of the Air Force, Army and Navy all wear unique uniforms with insignia that indicates their rank.

According to the Department of National Defence and Canadian Forces Ombudsman (2013), the distinctive military lifestyle of CAF members is strongly tied to three factors: mobility, separation, and risk. CAF members and their families must often relocate (at the discretion of the CAF), and

Practice Tip 1.1

When working with military personnel, it is proper etiquette to address them by their rank and last name. If you are unsure of their name, using Sir or Ma'am is appropriate. You should not address military members by their proper name unless you have been given permission.

Additional Information 1.2

Ranks within the CAF

For information on specific ranks within the Air Force, Army and Navy, please visit:

<http://www.forces.gc.ca/en/honours-history-badges-insignia/rank.page>

For information on specific insignia associated with ranks, please visit: http://www.forces.gc.ca/assets/FORCES_Internet/docs/en/honours-history-badges-colours-flags/insignia-poster.pdf

often experience prolonged separations due to deployment or training missions. Being a member of the CAF also comes with inherent risk and danger. The impact of these three factors on the lifestyle of military families is further explored in Section 4.

Health care in the Canadian Armed Forces.

The health of CAF personnel is a top priority, as CAF members are required to be physically fit, employable, and deployable at all times (Canadian Forces Health Services Group, 2014). CAF military personnel utilize CAF medical services, called the Canadian Forces Health Services (CFHS) Group. The CFHS are under the command of the Surgeon General (National Defence and the Canadian Armed Forces, 2017). The CFHS mission is to provide high quality health services to Canada's fighting forces, wherever they serve. When a CAF member requires medical care, this will be provided or coordinated by the CFHS. In some cases, ill and/or injured personnel are unable to complete their military duties and a CAF physician will place the individual on sick leave. As the member's medical status improves, they will be able to return to military duty and are assessed to ensure that they meet operational readiness standards. If the illness and/or injury is prolonged for any reason, other more graduated processes are required, such as comprehensive rehabilitation.

The CFHS has a rehabilitation program, the Physical Rehabilitation Program, consisting of uniformed and non-uniformed physical therapists and non-uniformed occupational therapists. The Physical Rehabilitation Program's mission is to provide the clinical expertise, coaching, and resources to assist CAF personnel in the reintegration of meaningful activity and return to active duty (National Defence and the Canadian Armed Forces, 2011). Rehabilitation staff provide services with the belief that an injured CAF member is at the center of the rehabilitation team, and that injured CAF members are recovering athletes who must be provided with an appropriate level of challenge to reach their rehabilitation goals (National Defence and the Canadian Armed Forces, 2011). These beliefs have an important influence on the assessment and intervention approaches that occupational therapists use when providing services to CAF members.

Additional Information 1.3

Want to learn more about the Canadian Armed Forces?

An online learning module can be completed here: [Canadian Forces 101 for Civilians](https://www.cafconnection.ca) (<https://www.cafconnection.ca>)

Section 2: Working with Members of the Canadian Armed Forces



Introduction

Working with members of the Canadian Armed Forces (CAF) provides occupational therapists with a unique practice context that requires special consideration. The overarching goal of occupational therapy interventions with CAF members is return to duty, leading to the ability of CAF members to sustain active military duty. For those who cannot return to duty, the goal of occupational therapy services is to facilitate a smooth transition to civilian life (Brown & Marceau-Turgeon, 2015).

Occupational therapists work with members of the CAF to address a broad scope of issues that impact RTD including physical health issues, pain, and vocational challenges (Brown & Marceau-Turgeon, 2015). There are underlying assumptions that influence therapeutic efforts with a member of the CAF. According to Brown and Hollis (2013), rehabilitation outcomes with CAF personnel are strongly tied to motivation, effort, and support. This is also a variable noted by the Physical Rehabilitation program (National Defence and the Canadian Armed Forces, 2011).

This section will explore in what capacity occupational therapists are employed by the Canadian Armed Forces, and what services are available to CAF members. The current role of occupational therapists within the CAF continues to evolve and emerge. The Canadian Forces Health Services (CFHS) strive to improve everyday participation of CAF military members in valued roles and routines by reviewing and integrating new approaches within the CFHS organization.

Working for the Canadian Armed Forces

The following information was gathered through consultation with the CAF and existing literature related to rehabilitation services within the CAF. While processes may vary between bases and individual providers, the goal of this information is to provide a general understanding of what an occupational therapist may encounter in providing occupational therapy services to CAF personnel.

The CAF involves occupational therapists in two different capacities:

1. Occupational therapists may work directly on base for the Department of National Defence (DND) as a **DND Rehabilitation Occupational Therapist** (DND OT).
2. Occupational therapists can also register to be Blue Cross service providers and work in the community as **Blue Cross Occupational Therapists** (Blue Cross OTs).

Description of the role of DND OTs. There are currently four DND OTs in Canada who work with CAF members directly on military bases across Canada and one national occupational therapy coordinator hired as part of the CAF Physical Rehabilitation Program. These DND OTs are located in Edmonton, AB; Valcartier, QC; Ottawa, ON; and Halifax, NS. The CAF Physical Rehabilitation program was officially launched on September 1, 2008 to meet the high-level rehabilitation goals and needs of CAF members (Besemann, 2011). The primary goal of the program is to return injured personnel to their previous duty as soon as medically possible. When return to duty cannot be accomplished through a physical rehabilitation program, the secondary goal is to prepare CAF personnel for alternative military employment. If this too is not a realistic goal, the tertiary goal is to prepare CAF members for an optimal transition to civilian life (Besemann, 2011).

In line with the goals of the Physical Rehabilitation Program, the CAF members that are clients of DND OTs can be categorized into three different groups: members with transient and intermittent injuries, members who are severely injured, and members with permanent injuries (Brown & Hollis, 2013). For each of these groups, the goals of occupational therapy intervention may differ depending on the desired occupational outcome (i.e. return to duty, alternative military employment or transition to civilian life). If a CAF member is referred to a DND OT, the assessment and treatment can take place in either the Physical Rehabilitation Clinic within the base, the member's home/community, or the member's place of work.

DND OTs use a biopsychosocial approach with their clients, which provides some opportunity, when appropriate, to utilize mental health screening tools/frameworks and the provision of mental health interventions if it directly relates to restoration of functional activities.

Canadian Armed Forces occupational therapy client base. CAF members can access occupational therapy services in numerous ways. A CFHS health professional (i.e. physician, nurse, physiotherapist, DND OT or Nurse Case Manager) who identifies a need for occupational therapy assessment and/or treatment can refer a CAF member to occupational therapy. If the CAF member is located on a base where there is a DND OT, a referral is sent to this occupational therapist. If there is no occupational therapist working on base, the CAF member may be referred to occupational therapy services provided by a Medavie Blue Cross OT. If a CAF member is in the hospital for an injury in which occupational therapy is deemed appropriate, they will be assessed and treated by the publicly funded occupational therapist within the hospital setting. If occupational therapy is warranted upon discharge, a CFHS health professional will arrange for either a DND OT or a Blue Cross OT to continue with the case.

Commonly addressed issues by DND OTs. This list of issues commonly addressed by occupational therapists working with CAF members is by no means exhaustive; it aims to identify the most common issues addressed:

- orthopedic problems
- musculoskeletal problems
- sleep disorders
- amputations
- chronic pain
- traumatic brain injury
- need for mobility aids
- need for assistive devices/equipment
- needs for home adaptations
- need for vehicle adaptations
- dysregulated routines and habits

Commonly used assessment tools by DND OTs.

Each CAF base tends to have unique and specific CAF member needs/populations referred to occupational therapy, thus each DND OT will have various assessment tools in their toolbox. The following list is an example of occupational therapy assessments used on one of the CAF bases:

- Beck Anxiety Inventory (BAI)
- Beck Depression Inventory (BDI)
- Behavioral Assessment of Dysexecutive Syndrome (BADS)
- Box and Block Test (BBT)
- Brain Injury Visual Assessment Battery for Adults (biVABA)
- Canadian Occupational Performance Measure (COPM)
- Contextual Memory Test (CMT)
- Headache Impact Test (HIT-6)
- Insomnia Severity Index (ISI)
- Jebsen Hand Function Test (JHFT)
- Montreal Cognitive Assessment (MoCA)
- Motor-Free Visual Perception Test (MVPT)
- Neurobehavioral Symptom Inventory (NSI)
- Patient Health Questionnaire-9 (PHQ-9)
- Pittsburgh Sleep Quality Index (PSQI)
- Purdue Peg Board
- Rivermead Behavioural Memory Test (RBMT)
- Standardized Concussion Assessment Tool 3 (SCAT3)
- Tampa Scale of Kinesiophobia (TSK)
- Test of Everyday Attention (TEA)

Occupational therapists select assessments based on a number of factors, including available assessment tools, client needs, and the context of the assessment and intervention.

CAF priority levels for assessment and treatment.

When CAF members are referred to an occupational therapist, whether a DND OT or Blue Cross OT, they are assigned a priority level, which identifies the period in which the member must be seen by an

Table 2.1

CAF priority levels for assessment

Priority 1 members: Assess the member within 72 hours	Priority 2 members: Assess member within 7-10 business days
<ul style="list-style-type: none"> • Require immediate immobilization of injury (i.e. splinting) • Are at a high risk of falls (i.e. fall history, has mobility aid, abnormal gait, and/or disoriented) • Palliative status • Issues with essential activities of daily living (ADLs; bed/toilet transfers, mobility, self-care, feeding) • At risk of pressure sores • Scheduled surgical intervention affecting essential home/work functioning 	<ul style="list-style-type: none"> • Impaired functioning in military duty or military trade requirements • Decreased home/community mobility or decreased independence with essential activities of daily living (ADLs) due to: <ul style="list-style-type: none"> - Incident of cognitive dysfunction - Physical dysfunction - Sleep difficulties and/or high levels of perceived pain, pain behaviours or kinesiophobia - Visual-perceptual impairments • Other

occupational therapist. Priority 1 members should be assessed within 72 hours of receiving a referral, while priority 2 members should be assessed within 7-10 business days. See Table 2.1 for more information.

Description of the role of Blue Cross Occupational Therapists. Occupational therapists working in the community or private practice can register with Medavie Blue Cross to become Blue Cross service providers (herein referred to as Blue Cross OTs), making them eligible to provide direct service to CAF members requiring occupational therapy. To work with members of the CAF, Blue Cross OTs must have a unique billing code which can be acquired by signing up on the Blue Cross Service Providers

Practice Tip 2.1

Blue Cross OTs working with CAF members use a different system for documentation and reporting than those working for VAC. It is important that a Blue Cross OT knows if he/she is working with a Veteran (via VAC) or a military member to ensure proper reporting requirements are met.

Practice Tip 2.2

If you are contacted to provide services to a priority 1 CAF member, you are being asked to see that member within 72 hours. If you are unable to meet this time line, please do not agree to take the member as a client.

website (<http://web.medavie.bluecross.ca/en/health-professionals/register>). Within the application, there is the option to become a provider for the Canadian Armed Forces and/or Veterans Affairs Canada (VAC).

“Outsourcing” is the term used when a CAF member is referred to a Blue Cross OT. Members may be referred to Blue Cross OTs for a variety of reasons including: when no on-site occupational therapy services are available; the DND OT (located in Ottawa, Halifax, Valcartier or Edmonton) is unable to book a client within the required priority timeline; the member requires specialized assessment or treatment that is not available on-site (e.g. hand therapy, functional capacity evaluation); or the member lives/works at a distance from the primary DND OT location.

The role of Blue Cross OTs within VAC is discussed further in Section 2.

DND OTs will often outsource members that are in the process of releasing from the CAF and transitioning to services from VAC. It can, therefore be helpful that Blue Cross OTs are registered with both the CAF and VAC, to be able to provide better continuity of care. It is the same process to register for both services. If you choose to register with Blue Cross, it is important to keep your contact information up to date as Canadian Forces Health Services (CFHS) medical clinics can contact Blue Cross to get a current list of local occupational therapists to whom they can refer their members.

Services provided by Blue Cross OTs are typically provided within the military member's home, as home assessments are the principal reason for referrals to a Blue Cross OT. When a client faces multiple occupational performance issues, the referral source requests a full, initial home assessment. This initial assessment should be comprehensive and include:

- home safety
- medication and health management
- accessibility of home space
- mobility (essential transfers and movement)
- cognitive screenings and/or assessment
- social support
- caregiver physical/mental health requirements
- comparisons of present versus past ability to function in everyday roles and routines
- fit between home environment and member's current functional abilities

Less often, Blue Cross OTs may provide services within environments that can include driving training facilities, mental health or hospital settings, and other community venues such as the military/local gym. On occasion, Blue Cross OTs may assist with on-base job site assessments. Blue Cross OTs may also participate in case conferences with CFHS team members and the CAF member/family (virtual, via phone, or in person).

Practice Tip 2.3

If you are a Blue Cross OT who lives near Edmonton, Ottawa, Halifax, or Valcartier, there are local DND OTs that you can contact for additional information.

Contacts:

Physical Rehabilitation Department

Edmonton: (780) 973-4011 ext. 4242

Physical Rehabilitation Department

Ottawa: (613) 945-1585

Physical Rehabilitation Department

Valcartier: (418) 844-5000 ext. 5783

Physical Rehabilitation Department

Halifax: (902) 721-8739

How does the process between the CAF and a Blue Cross OT work? The typical process for coordinating referrals and services between CAF and a Blue Cross OT is as follows:

1. DND OT/referral source speaks with Blue Cross OT to ensure that the OT can meet the required priority timeline.
2. Appropriate information is provided to the Blue Cross OT including: client referral, reporting standards, and any other important information.
3. Blue Cross OT contacts CAF member to arrange initial assessment.
4. Blue Cross OT and CAF member meet.
5. Blue Cross OT writes an initial report which includes all information outlined in the reporting standards (discussed below).
6. Blue Cross OT submits the reports to the referral source.
7. The recommendations on the occupational therapy report are reviewed by the referring health care provider. This involves the following:
 - A. Occupational therapy report is reviewed for medical need and justification of recommendations, and how the recommendations meet what CAF funds under various programs;
 - B. Recommendations that meet funding and

Practice Tip 2.4

It is important to communicate to the CAF member during the OT's assessment that the recommendations provided by the Blue Cross OT are not always approved by the CAF.

medical need criteria are broken down into the various funding pools; and

- C. Each group of recommendations (by pooled funding) is then addressed. It is possible that recommendations will be provided at different times as each pool of funding is accessed differently.

Reporting standards. The following is a generalized list of the standards required for Blue Cross OT reports that are being submitted to the CAF:

- Initial assessment reports must be submitted to the CAF within 10 business days of the initial assessment.
- Progress reports must be submitted within 10 days of the halfway point of the occupational therapy treatment.
- Discharge reports must be submitted within 10 business days after the date of the last visit with the CAF member.
- Every report requires a recommendations summary page with an accompanying medical justification for all recommendations. This

Additional Information 2.2

What is an “occurrence”?

The term occurrence is used to denote time spent related to a client. An occurrence is considered direct time with the client, communications time with the team, travel from clinic to client and back, document review and report writing. The rate of billing will depend on the service being provided as well as the region of practice.

includes recommendation of follow up sessions, equipment, home modifications, etc.

- Every report requires an **Occupational Therapy Redacted Recommendation Report (OT-RRR)**.

Any recommendations for follow up with an occupational therapist must have medical justification. It is recommended that the OT follow up with the referral source to note the need for follow-up sessions, explain medical justification/reasoning, and ask for the funding of additional **occurrences**.

When required, it may be possible for Blue Cross OTs to recommend their attendance at any upcoming interdisciplinary collaborative care meetings regarding a certain CAF client. They would need to communicate with the CFHS health professional (referral source) and detail how they would add meaningful information to an upcoming meeting

Additional Information 2.1

What is an Occupational Therapy Redacted Recommendations Report (OT-RRR)?

All reports submitted by Blue Cross OTs must include an Occupational Therapy Redacted Recommendations Report (OT-RRR). This report is mandatory and is a stand alone page that is scanned into the Canadian Forces Health Information System (electronic health records) with the occupational therapy report. The OT-RRR is identical to the recommendations summary page of the OT's full report, but is void of any medical information and only includes information about functional issues. The intent of the OT-RRR is to reduce CFHS employees' time redacting full occupational therapy reports, and to provide non-medical personnel access to occupational therapy reports void of medical information but access to functional justifications. These reports provide non-medical personnel, who control certain pockets of funding, with access to occupational therapy reports void of medical information, while still providing functional justifications of recommendations.

and organize with the referral source additional occurrences for billing.

CAF members requiring more than 10 sessions must have a request for extension of care, accompanied by justification for additional occurrences through a progress note with evidence-based substantiation for treatment from their Blue Cross OT, authorized by the Base Surgeon.

Canadian Armed Forces Mental Health Services

Although DND OTs are not currently involved in CAF's mental health programs, it is important that occupational therapists who are working with CAF members be aware of the programs within the CAF for those with mental health concerns. For a brief overview of programs provided by the Canadian Armed Forces, please visit <http://www.forces.gc.ca/en/caf-community-health-services-mental/index.page>. If an occupational therapist identifies potential mental health concerns with a CAF member, the referral source should be made aware.

Conclusion

The Canadian Armed Forces provides opportunities for occupational therapists to work with active military members experiencing functional difficulties that are impeding their ability to meet the

occupational demands of military service through the roles of Department of Defence Rehabilitation Occupational Therapist (DND OT) and Medavie Blue Cross Occupational Therapists. This can involve working with military members with transient, severe, or permanent injuries on base, in their homes, or in the local community. Occupational therapists are well-suited to work with CAF members by virtue of their solution-oriented, practical approach to return-to-duty. Given the unique context, an understanding of CAF system structures, as well as what services and benefits are available to clients is critical in providing the best possible care to CAF clients.

Additional Information 2.3

Making the transition to Veterans Affairs Canada (VAC)

At times, CAF members may have a DND OT or a Blue Cross OT working with them prior to medical discharge/transition to VAC services. The DND OT or the current Blue Cross OT billing to the CAF will assist the member with the transition a variety of ways, including helping to identify a VAC Blue Cross OT appropriate and qualified to meet the member's needs. Ideally, a Blue Cross OT billing under CAF would also bill through VAC, and would be able to continue to work with the member through their transition out of active service.

Section 3: Working with Veterans and Veterans Affairs Canada



Introduction

Veterans are defined as “Canadian Armed Forces members and Reserve Force members who meet the Department of National Defence’s military occupational classification requirements and have been released from the Canadian Armed Forces with an honourable discharge” (Department of National Defence, 2015, p. 130). According to the Department of National Defence (2015), Veteran status recognizes the potential risk that Canadian Armed Forces members have assumed by donning the uniform and pledging allegiance. It is important to note that Veteran status does not mean that all former Canadian Armed Forces members are eligible to receive Veterans Affairs Canada (VAC) benefits and services; a Veteran should contact VAC to determine their eligibility (Department of National Defence, 2015).

While Veterans may share many of the same physical and mental health issues as active military personnel, working with Veterans differs in that the focus is on re-establishing a civilian life rather than returning to active duty. Some Veterans may have had to leave active military service due to complex physical or mental health conditions, illness, or injury. This shift requires consideration of not only health and medical circumstances, but also of the occupational impact of leaving a predominant life role.

There are components of military life that may make the transition to Veteran status more difficult. Military life is very structured, from the daily routine followed on base, to the chain of command that dictates role and rank. When a person leaves the military, it may feel foreign to be in an environment that lacks such rules, structures, and standards (NHS North East and North of England Mental Health Development Unit, 2013). Veterans may feel that they have lost

Practice Tip 3.2

From an occupational perspective, consider the impact of transitioning from active duty to Veteran and what this means for your client, including occupational repertoire and occupational roles.

the comradery that exists among military personnel, and may now be separated from their primary social network. Veterans also may struggle to form bonds with those around them who have not shared similar experiences. This can be further exacerbated by mental health issues such as depression and post-traumatic stress disorder (PTSD), when a Veteran feels that they cannot talk to their friends and family about what they have experienced in the military (Edgelow & Cramm, 2015).

Another unique consideration when working with Veterans is that they may have never experienced everyday tasks that are often taken for granted, including applying for a job, finding housing, managing a household budget, or registering with a family doctor (NHS North East and North of England Mental Health Development Unit, 2013). This is especially true for those who joined the military at a young age, and those who have spent much of their life in the military.

The mission of Veterans Affairs Canada is to “provide exemplary, client-centred services and benefits that respond to the needs of Veterans, our other clients and their families” (Veterans Affairs Canada, 2015c, § “Our Mission”). This involves addressing the medical, psychosocial, and vocational needs of Canada’s Veterans. Occupational therapists are well-positioned to work with Veterans to enable them to engage in

Practice Tip 3.1

Consider asking your clients if they have served in the Canadian Armed Forces. If they have, they may be eligible for benefits from Veterans Affairs Canada.

Practice Tip 3.3

During the assessment phase with a new Veteran client, it may be important to determine the circumstances of their release from active duty.

Additional Information 3.1

What do we know about the transition from active military personnel to Veteran?

The *Journal of Military, Veteran and Family Health* published these “Fast Facts”:

1. Most recently-released Veterans adjust well to civilian life
 - However, those who experienced a difficult adjustment were more likely to be those with a medical or involuntary release, and those who released mid-career
2. Chronic conditions are more common in Veterans
 - Conditions include arthritis, hearing problems, obesity, pain, depression, anxiety, and activity limitations
3. The majority of Veterans work after release
 - In 2013, 72% of Regular Force Veterans were employed in the civilian workforce

(VanTil et al., 2015)

a meaningful civilian life. This section will explore in what capacity occupational therapists are employed by Veterans Affairs Canada and what services are available to Veterans.

Working for Veterans Affairs Canada

The following information was gathered through consultation with occupational therapists working in various capacities for Veterans Affairs Canada (VAC), and through information posted on the official Veterans Affairs Canada website (<http://www.veterans.gc.ca/eng/>). While each individual's experience may be unique, the goal was to gain a general understanding of what an occupational therapist may encounter in working for VAC.

VAC employs occupational therapists in four different capacities. Occupational therapists work for VAC in the role of Field Occupational Therapist Services Officer (FOTSO) or Case Manager. Occupational therapists can also register to be Blue Cross service providers and work in the community as Field Occupational Therapists or Clinical Care Managers with VAC clients on a contract basis.

Description of the role of Field Occupational Therapy Services Officers. Field Occupational Therapy Services Officers (FOTSOs) work within a VAC office, where their primary roles are as a consultant

who coordinates occupational therapy referrals, and as a member of an interdisciplinary team. Occupational therapists working as a FOTSO do not provide direct treatment to clients. The FOTSO role involves acting as an intermediary between other VAC staff, Case Managers, and community therapists (referred to as Field Occupational Therapists) to help ensure VAC clients receive occupational therapy services to meet their needs. Most FOTSOs are not employees of VAC but are independent contractors engaged by VAC. However, there are a small number who are employed directly by VAC.

When a VAC client is identified by another VAC staff member as needing an occupational therapy assessment, their file is sent to the FOTSO. The FOTSO then reviews the client's concerns and functional issues, and sends a referral to a Field Occupational Therapist in the community. Maintaining a strong relationship with Field Occupational Therapists in

Additional Information 3.2

Occupational Therapists Working for Veterans Affairs Canada

1. Field Occupational Therapy Services Officers (FOTSO)
2. Case Managers
3. Field Occupational Therapists
4. Clinical Care Managers

their local area is an important part of the FOTSO role, as this allows the FOTSO to refer clients to the most appropriate occupational therapist based on the client's needs.

Along with the client referral, the FOTSO sends a blank mental health screening tool to complete and may also suggest assessment tools for the Field Occupational Therapist to use during their assessment relevant to the client's occupational performance issues. For example, if a client is identified as having mobility challenges, the FOTSO may provide a form for the Berg Balance Scale (Berg, Wood-Dauphinee, Williams & Maki, 1989). Commonly used assessment tools will be discussed later in this section.

Once the Field Occupational Therapist has completed an assessment of the client, the report is sent back to the FOTSO. The FOTSO reviews the report, and makes recommendations based on the client's needs, the Field Occupational Therapist's recommendations, VAC policies, and VAC benefits that the client may be eligible for. The recommendations generated by the FOTSO may align with those provided by the Field Occupational Therapist, or they may propose alternative options. Another key component of this process involves reviewing financial quotes for proposed recommendations generated by the Field Occupational Therapist. A comprehensive package including recommendations and financial quotes is then provided to the decision makers (i.e. Case Managers, Veteran Service Agents, etc.) for review. Presently, FOTSOs do not have decision-making power (authority) regarding funding and service provision; their role is to communicate their recommendations for clients with the goal of obtaining approval. Once approval is granted by the Case Manager or Veteran Service Agents, the recommendations would then be implemented by the Field Occupational Therapist working directly with the client in the community. Some of these processes may vary slightly by regional office.

Description of the role of Case Managers.

Occupational therapists can work for Veterans Affairs Canada as Case Managers. VAC Case Managers assist Veterans and their families with the transition from active military personnel to civilian life. Not all Veterans require case management; it is a service

designed to assist those who may be finding it particularly difficult to navigate the transition. When preparing to leave the military, military personnel are screened to determine if case management services would be beneficial to them and their family (Veterans Affairs Canada, 2015b). Case Managers can also become involved with Veterans when they are experiencing difficulties due to other transitions or changes, including illness or loss of a loved one (Veterans Affairs Canada, 2015b).

Case Managers come from diverse professions including social work, nursing, counselling, psychotherapy, physiotherapy, occupational therapy, and social service work. They work with a caseload of clients on a one-on-one basis. Case Managers work with clients to identify potential barriers to engagement in civilian life and to coordinate and approve services. Case Managers do not provide direct treatment to their clients, and instead refer them to services in the community, including physiotherapy, psychotherapy, and occupational therapy. The frequency of contact between a Case Manager and client is dependent on client needs and can range from weekly to monthly visits. VAC aims to employ enough Case Managers so that each Case Manager has no more than 25 clients at one time (Veterans Affairs Canada, 2016c). Clients continue to work with a Case Manager until they have met their identified goals, which can take several years (especially in the case of vocational goals).

Occupational therapists are well-positioned to excel in the role of Case Manager given their unique holistic approach combined with medical knowledge. Occupational therapists will consider physical health, mental health, and other critical factors, such as environment and social support, to understand how a Veteran's issues may impact their return to civilian life.

Consultation with a VAC Case Manager enabled the compilation of a list of knowledge and skills that would be important for an occupational therapist to have to excel in this role. This list includes:

- general knowledge of physical health issues and treatment strategies;
- general knowledge of mental health issues and treatment strategies;

- knowledge of assessment and intervention for chronic pain;
- knowledge of available community resources (including Blue Cross service providers);
- experience in vocational rehabilitation (specifically interpreting Functional Capacity Evaluation results);
- motivational interviewing skills; and
- knowledge of suicide prevention intervention strategies.

Description of the role of Blue Cross service providers (Field Occupational Therapists).

Occupational therapists working in the community or private practice can register with Medavie Blue Cross to become Blue Cross service providers, making them eligible to provide direct service to VAC clients. These occupational therapists are referred to within the VAC context as “Field Occupational Therapists”. Field Occupational Therapists provide services to VAC clients in their homes and within the community. To become a Blue Cross service provider, you must

Practice Tip 3.4

Calling your local VAC office to introduce yourself and your services may be necessary to increase the opportunity for receiving referrals.

complete an online application and provide Blue Cross with your curriculum vitae (CV) to demonstrate that you are qualified to work with military and Veteran populations. Once approved, you will be added to the Blue Cross online system and provided with a provider number (used for referrals and billing). Blue Cross has an online portal that is used for sending and receiving referrals and streamlining billing information. Being on the list of Blue Cross service providers does not guarantee you will be sent referrals from VAC.

The amount that a Field Occupational Therapist is paid per visit with a VAC client depends on the nature of the visit (i.e. initial assessment, follow-up visit) and which province they practice in. For information on the

Additional Information 3.3

Resolving challenges as a community therapist working for VAC

We asked: “How do [you as a] community therapist resolve challenges around not having decision-making power, and potentially not having recommendations approved?”

“I think these challenges are similar to any occupational therapist (OT) working in private practice, be it auto insurance, worker’s compensation or Veterans Affairs Canada. You make your recommendations and give your best rationale, and might advocate for the client if the request is denied. My experience in the last 6 years is that my requests are typically approved for treatment time. OTs making equipment recommendations, especially expensive home modifications, may not see full approval for those costs, or may need to work with the office to meet the client’s needs within budgetary restrictions.” – VAC Field Occupational Therapist

“I have learned that being able to demonstrate that my treatments are effective through the use of outcome measures helps to justify what we do. I have found the use of the COPM [Canadian Occupational Performance Measure] to be particularly effective in this regard. The district office that I report to has been tremendously supportive of the role of occupational therapy. There are two OTs in case management roles who are good advocates for our profession.” – VAC Field Occupational Therapist

“How I respond to the challenges? I use my occupational therapy skills to treat clients. I encourage them to know their benefits and access what they need through VAC. I have clients talk to their [other health professionals] and let me know what I can follow up on for them. That’s nice, because the client is part of the conversation and decision making.” – VAC Field Occupational Therapist and Clinical Care Manager

specific rates in each province, please visit: http://www.veterans.gc.ca/eng/services/health/treatment-benefits/poc/poc_search (Select “Program of Choice 12 – Related Health Professionals”). It should also be noted that VAC may reimburse for travel time but not mileage, however this can vary among regional VAC offices.

In the Veterans Affairs context, occupational therapists are viewed as external providers. While an occupational therapist may complete a full comprehensive assessment of a client, it is important to understand that the decisions are made at the administrative and funding level, meaning that not all the occupational therapist’s recommendations may be funded and implemented.

How does the process between VAC and a Field Occupational Therapist work? VAC will send a referral to the Field Occupational Therapist, who will then complete a comprehensive assessment and generate recommendations for the Veteran client. This is then sent back to VAC for approval. VAC will then approve a designated amount of time for the therapist to work with the client towards their identified goals. Approving an amount of time rather than specific intervention strategies/approaches allows the client-therapist relationship to remain dynamic and client-centred, however VAC does require the occupational therapist to provide a general treatment plan outline.

VAC requires progress reports at the halfway and end of the allotted time. If the approved time with the client runs out and a therapist feels that the client has not met their goals, a case can be made for requesting more time. One occupational therapist stated, “VAC isn’t like other insurance companies or funders; they are very open to occupational therapy services. They definitely err on the side of providing more services rather than not enough.” This highlights that despite many steps to obtain approval for services, VAC is demonstrating its commitment to ensuring that Veterans are receiving quality interventions.

Description of the role of Clinical Care Managers. Since 2009, another role available for occupational therapists working with Veterans Affairs Canada (VAC) clients is the position of Clinical Care Manager

Additional Information 3.4

Interested in registering as a Blue Cross service provider?

Visit: <http://www.veterans.gc.ca/eng/services/health/treatment-benefits/info-providers>

(CCM). CCMs provide short-term, intensive case management services to VAC clients who are experiencing complex health needs (Veterans Affairs Canada, 2015d). Clients who work with CCMs often have serious mental health symptoms, comorbid conditions, are disconnected from social and community supports, and struggle with various areas of their daily lives (including maintaining stable housing or employment; Hutton, 2010).

To work as a CCM, occupational therapists are required to have a minimum of five years of experience working in mental health (Veterans Affairs Canada, 2015a). The CCM role is also staffed by nurses, social workers, and psychologists. Many informants described the CCM role as similar to that of an occupational therapist on an Assertive Community Treatment Team (ACTT), in that the role involves helping clients to navigate life in the community while living with mental health issues

Additional Information 3.5

What does the CCM role look like in daily practice?

One CCM informant identified concrete examples of tasks she has completed with clients as a CCM:

- Scheduling and attending medical appointments
- Finding affordable childcare
- Finding housing and getting resituated
- Engaging in physical activity (such as daily walks)
- Money management
- Advocating for accommodations (e.g. more time to complete academic tasks)

Additional Information 3.6

Mary's experience working with Veterans

Mary* is a community occupational therapist working in a small town. Mary is a Blue Cross service provider and receives referrals from VAC to work with clients primarily in the area of mental health. Mary's clients commonly have diagnoses of post-traumatic stress disorder (PTSD), depression and/or anxiety. Many of Mary's clients have dysregulated daily routines and poor sleep hygiene (including poor sleep quality and day-night reversals).

Mary helps her clients reach their goals which often involve re-establishing regular routines and re-engaging in their daily occupations. Some of Mary's clients are also interested in volunteerism or returning to school. In some circumstances, Mary may act as a health system navigator for Veteran clients who do not yet have health cards or family doctors (as these services were previously taken care of by the military during active enrolment).

When working with VAC clients with mental health concerns, Mary knows that it is important to ensure rapport is built before engaging the client in any form of treatment or intervention. Focus on client readiness is essential, and the initial few sessions between Mary and her clients focus simply on meeting and talking. Trust between Mary and her clients is a critical component of the client-therapist relationship, and helps Mary to gauge when a client is ready to begin working towards their occupational goals.

Some key intervention strategies that Mary uses in her practice include **coping strategies** (such as mindfulness, relaxation, and grounding), **reactivation strategies** such as the ones proposed in the Action Over Inertia program (Krupa et al., 2010), and **community integration strategies**, including peer support and volunteer groups.

** Name has been changed*

and associated challenges.

Duties of a CCM can include (Hutton, 2010):

- building a strong supportive relationship with the client and/or family;
- assisting the client with follow through on the case plan objectives;
- being a personal link to community resources;
- promoting access to necessary treatment services
- providing regular support to the client;
- collaborating with the VAC case manager;
- consulting with other health care providers; and
- advocating for clients

How does the process between VAC and a Clinical Care Manager work? To work as a Clinical Care Manager, you must be registered with Blue Cross. Field Occupational Therapists with mental

health experience often work as both VAC Field Occupational Therapists and CCMs. When receiving a client referral from VAC, the referral will indicate if it is a referral for occupational therapy or a CCM.

CCMs work closely with VAC Case Managers. CCMs assist Case Managers by providing more intensive and frequent support to clients within the community. The VAC Case Manager is the referral source for the client to access the CCM. The Case Manager will send the CCM the client's referral using the Blue Cross online system. Throughout their time working with a client, the CCM communicates with the Case Manager by sending reports and updates using the Blue Cross system. When establishing a relationship with a client, the CCM completes forms for "Identified Needs" and "Desired Outcomes" and sends these to the Case Manager. These would be comparable to the treatment plan outlines that a Field Occupational Therapist would send to VAC.

Consultation with a current VAC Clinical Care Manager enabled the compilation of a list of knowledge, skills, and experience that would be important for an occupational therapist to be familiar with to excel in this role. This list includes:

- experience working as a community occupational therapist;
- experience in mental health;
- knowledge of resources available in local community, including funding options and public transportation;
- flexibility; must be able to think “on the spot” as role can be unpredictable;
- ability to advocate for clients;
- ability to research to find needed information (e.g. academic accommodations at college for students with mental health conditions); and
- comfort in a variety of situations where client may need support (e.g. meeting with banks, professors, realtors).

Veterans Affairs Canada client base

Veterans can be referred to occupational therapy and case management services in multiple ways. Veterans often call the Veterans Affairs general inquiry line, where they are screened for functional issues and may be directly referred to occupational therapy (in which case their file would be sent to a FOTSO at their local VAC office). VAC also receives referrals from hospitals or community services (such as the Community Care Access Centre) when these organizations identify one of their clients as being a Veteran.

The age range of VAC clients may range from very young Veterans in their early twenties to much older Veterans, into their nineties. VAC has serviced Veterans from World War I, World War II, the Korean War and now also serves today’s Canadian Armed Forces Veterans who have been involved in missions in Africa, the Baltics, and the Middle East. The Veteran population is changing, with younger Veterans presenting more diverse and complex needs, including those related to mental health (Craig, 2016). Occupational therapy interventions with Veterans are

commonly associated with home assessments and recommendations for adaptive equipment to assist with safety, mobility, and independence (Card, 2015). Intervention strategies can vary, and may include cognitive rehabilitation and mental health services for Veterans who may present with traumatic brain injury or mental health issues, including PTSD (Card, 2015). Occupational therapists also provide support in creating new routines and daily structure related to sleep hygiene, pain management, and coping skills (Craig, 2016).

Commonly addressed issues. A list of physical and mental health issues commonly addressed by occupational therapists working with Veterans was compiled. This list is by no means exhaustive; it aims to identify the *most common* physical and mental health issues addressed:

- chronic pain
- physical limitations (including range of motion, mobility)
- need for mobility aids (prescription of scooters, wheelchairs, mobility devices)
- need for home adaptations (handrails, ramps, stair glide)
- need for assistive devices and equipment (prescription of assistive devices, bathroom equipment)
- depression
- anxiety
- post-traumatic stress disorder (PTSD)
- substance abuse
- dysregulated routines and habits
- social isolation
- issues resulting from a traumatic brain injury (TBI)

Commonly used assessment tools. Corresponding to the commonly addressed issues, a list of commonly used assessment tools can be seen in Table 3.1. Please note that this list only identifies specific standardized assessment tools, and therefore does not present the full scope of assessments used. Field Occupational Therapy Services Officers (FOTSOs) may attach assessment tools to referrals to Field Occupational Therapists, however Field Occupational

Additional Information 3.7

What are the symptoms of post-traumatic stress disorder (PTSD)?

Post-traumatic stress disorder is the most prevalent operational stress injury reported among CAF members (National Defence and the Canadian Armed Forces, 2013). Given its high prevalence, recognizing, and addressing PTSD is important for occupational therapists working with both active military personnel and Veterans.

PTSD has four common symptoms (National Center for PTSD, 2015):

- 1. Reliving/re-experiencing the event:** Memories of the traumatic event can come back at any time. This can involve:
 - nightmares
 - flashbacks (the feeling that you are going through the event again)
 - triggers (something that causes you to relive the event, such as noises or smells)
- 2. Avoiding situations that remind them of the event:** Someone with PTSD may avoid situations or people that trigger memories of the traumatic event. They may avoid talking or thinking about the event. This can include keeping busy or avoiding seeking help so that they do not have to think or talk about the event.
- 3. Negative changes in beliefs and feelings:** The way a person thinks about themselves and others changes. A person with PTSD may:
 - stay away from relationships, and have difficulty being close with others
 - not be able to talk about traumatic event and may forget details of the event
 - believe the world is completely dangerous, and no one can be trusted
- 4. Hyperarousal** – A person with PTSD may be jittery, or always alert and on the lookout for danger. They might suddenly become angry or irritable. They may:
 - have difficulty sleeping
 - have difficulty concentrating
 - be easily startled by a loud noise or surprise
 - want to have their back to a wall in public settings (so they can see their environment)

Therapists are not limited to using only the attached assessments. For a list of assessment tools and forms used within VAC, please visit <http://www.veterans.gc.ca/eng/forms>.

issues related to trauma experienced either during service or in their personal lives. Those involved with military duties have a significant risk of experiencing trauma related to their occupational duties. Trauma

Implementing trauma-informed care in your practice

Trauma-informed care is an important perspective to utilize when working with military members, Veterans, and their family members who may be experiencing

Additional Information 3.8

Occupational therapy and PTSD

YouTube Clip: How do occupational therapists help individuals ease back into the world after TBI and/or PTSD? https://www.youtube.com/watch?v=M0q_M2S0fvk

Table 3.1

Commonly used assessment tools

Category	Assessment tool
Pain	<ul style="list-style-type: none"> • McGill Pain Questionnaire (Melzack, 1975) • Brief Pain Inventory (Cleeland & Ryan, 1994)
Physical health	<ul style="list-style-type: none"> • Braden Scale for Predicting Pressure Sore Risk (Bergstrom, Braden, Laguzza & Holman, 1987) • Berg Balance Scale (Berg, Wood-Dauphinee, Williams & Maki, 1989)
Cognition	<ul style="list-style-type: none"> • Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005) • Mini-Mental State Exam (MMSE; Folstein, Folstein & McHugh, 1975)
Mental health	<ul style="list-style-type: none"> • Kessler Psychological Distress Scale (K6; Kessler et al., 2003) • Hamilton Depression Rating Scale (Hamilton, 1967) • Cohen-Mansfield Agitation Inventory (Cohen-Mansfield, Marx & Rosenthal, 1989)

is defined as “a single experience, or enduring repeated or multiple experiences, that completely overwhelm the individual’s ability to cope or integrate the ideas and emotions involved in the experience” (Klinic Community Health Centre, 2013, p. 9). Trauma-informed care encourages occupational therapists to consider an understanding of trauma in all aspects of service provision and place priority on the core principles of safety, choice, trust, and compassion (Klinic Community Health Centre, 2013). This perspective assists in ensuring a client-centred recovery.

Trauma-informed care extends beyond just considering CAF members and Veterans with

operational stress injuries and mental health disorders; occupational therapists may encounter military personnel and Veterans in a variety of settings where trauma should be considered. For example, occupational therapists working with current or former CAF members in physical rehabilitation settings should consider that the person may have experienced trauma in relation to their physical injury.

A common misconception is that trauma-informed care is something that must be done in addition a therapist’s regular practice which is not the case; trauma-informed care aims to incorporate

Additional Information 3.9**Signs of a trauma response**

Being able to identify signs of trauma is important to distinguish when a client may be experiencing a state of distress. Signs of trauma include:

- Shaking
- Change in breathing
- Muscle stiffness
- Difficulty relaxing
- Flood of strong emotions
- Rapid heart rate
- Inability to speak
- Startle response, flinching
- Sweating
- Staring into the distance
- Becoming disconnected
- Losing focus
- Inability to concentrate or respond to instructions

the consideration of trauma into all therapeutic encounters.

Tips for occupational therapists: preparing to assess for trauma. Kitchen and Hosegood (2015) highlight the following tips for occupational therapists:

- Reflect on your own trauma history and barriers.
- Learn more about trauma and its effects on daily life.
- Practice asking about trauma.
- Increase your own comfort in responding to disclosures of trauma.
- Provide education about the effects of and responses to trauma.
- Be aware of physical space.
- Reinforce your client's resilience and strengths.

Veterans Affairs Canada programs

Veterans Affairs Canada Rehabilitation

Program. The VAC Rehabilitation Program assist Veterans in re-establishing civilian life. Each client in the Rehabilitation Program works with a VAC Case Manager to develop and implement an individualized rehabilitation plan based on needs identified during the assessment process (Veterans Affairs Canada, 2016a). The assessment process is undertaken by a multidisciplinary team involving

relevant professionals, such as the Client Service Team Manager, Regional Rehabilitation Officer, Interdisciplinary Team members and community health and rehabilitation professionals. It is the role of the Case Manager to consult and gather expert advice from both VAC and community professionals to assess each client's specific needs and to determine suitable rehabilitation services (Veterans Affairs Canada, 2016d). Rehabilitation plans are developed to outline the treatments, interventions, and activities required to eliminate barriers related to the Veteran's ability to re-establish within civilian life, including within their family, community, and workplace (Veterans Affairs Canada, 2016a).

Rehabilitation plans include an anticipated completion date, which will be established by the Case Manager in collaboration with the client. Pre-authorized services are included in the plan to assist the client in meeting their goals. Client participation in their rehabilitation plan is mandatory (Veterans Affairs Canada, 2016e).

Three types of rehabilitation services are available through the Rehabilitation Program:

1. **Medical services** "include any physical or psychological treatment aimed at stabilizing and restoring basic physical and psychological functions of a person" (Veterans Affairs Canada, 2016a, § "Medical Rehabilitation Services").
2. **Psychosocial services** are psychological or social interventions "aimed at restoring a person to a state of independent functioning as well as facilitating their social adjustment" (Veterans Affairs Canada, 2016a, § "Psycho-social Rehabilitation Services").
3. **Vocational services** include identifying and achieving an appropriate vocational goal for the client given their state of health due to their physical or a mental health problem, and the extent of their education, skills and experience (Veterans Affairs Canada, 2016a).

Eligibility for the Rehabilitation Program extends beyond Veterans themselves, including spouses and common-law partners of Veterans who have been determined to be permanently incapacitated, and

Additional Information 3.10

Want to learn more about trauma-informed care?

Check out these resources:

[Trauma-Informed Practice Guide \(2013\) - BC Provincial Mental Health & Substance Use Planning Council](http://bcewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf) (http://bcewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf)

[Trauma-Informed Toolkit \(2013\) - Clinic Community Health Centre](http://www.trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf) (http://www.trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf)

survivors of Veterans who died as a result of a service-related injury or disease (Veterans Affairs Canada, 2016e). For further information on the Rehabilitation Program, please visit: <http://www.veterans.gc.ca/eng/services/transition>.

Benefits and services. Aside from providing rehabilitation services, Veterans Affairs Canada also provides Veterans with funding towards equipment and aids for daily living. The funding benefits available to Veterans are called “Programs of Choice” (POC). There are 14 existing POCs, however two are particularly relevant to occupational therapists working with Veterans (see Table 3.2). POC 1 funds Aids of Daily Living, and POC 13 funds Special Equipment (for those Veterans who are eligible; Veterans Affairs Canada, 2016b).

For more information on these and other Programs of Choice, please visit: <http://www.veterans.gc.ca/eng/services/health/treatment-benefits/poc#>.

Veterans Independence Program. The Veterans Independence Program (VIP) aims to help

Veterans remain independent in their homes and communities. Services provided by the VIP fall into three categories: Grounds Maintenance Services, Housekeeping Services, and Other Services (which can include personal care, transportation assistance, and home modifications; see Table 3.3). For information on eligibility, please visit: <http://www.veterans.gc.ca/eng/services/health/veterans-independence-program>.

Conclusion

From coordinating services for VAC clients (as a Field Occupational Therapy Services Officer or Case Manager), to providing direct treatment (as a Field Occupational Therapist) and support within the community (as a Clinical Care Manager), Veterans Affairs Canada offers a variety of positions and opportunities for occupational therapists. There are multiple pathways that Veterans can take to gain access to occupational therapy services, including using the general inquiry telephone line, referral from a community source, or directly through their

Table 3.2
Programs of Choice

POC 1 – Aids for Daily Living	POC 13 – Special Equipment
<p>Provides coverage for devices and accessories designed to assist in the activities with everyday tasks. Necessary repairs and maintenance are also covered.</p>	<p>Provides coverage for special equipment required for the care and treatment for eligible Veterans. These benefits must be prescribed by a VAC approved health professional and in many cases supported by the recommendation of another health professional. In addition, VAC may provide coverage for home adaptations or modifications (e.g. wheelchair ramps, door widening) to accommodate the use of the special equipment in the home.</p>
<p>Examples of benefits that are covered include:</p> <ul style="list-style-type: none"> • Walking aids, such as canes, walkers, ice grippers/rubber tips • Self-help aids for dressing and/or feeding • Bathroom aids, such as grab bars, raised toilet seats, bath boards, bathtub rails 	<p>Examples of Special Equipment benefits covered:</p> <ul style="list-style-type: none"> • Wheelchairs • Walkers • Power mobility devices • Transfer/lift devices • Hospital equipment • Ergonomic equipment

Note. From Veterans Affairs Canada, 2016b, § POC 1, POC 13.

Table 3.3
Services available through the Veterans Independence Program

Grounds Maintenance Services	Housekeeping Services	Other Services
Can include services such as: <ul style="list-style-type: none"> • Snow Removal • Lawn Mowing 	Can include services such as: <ul style="list-style-type: none"> • Housecleaning • Laundry • Meal Preparation • Errand Services 	Depending on health need, Veterans may also qualify for financial assistance with one or more of the following services: <ul style="list-style-type: none"> • Personal Care • Access to Nutrition • Health and support services • Ambulatory Health Care • Transportation Services • Home Adaptations • Intermediate Care Services

Note. From Veterans Affairs Canada, 2016f.

Case Manager. Given the wide range of client ages, diagnoses and occupational performance issues of VAC clients, an understanding of VAC system structures, as well as what services and benefits are available to clients is critical in providing the best

possible care to VAC clients. If you're interested in contacting the Health Professionals Division of Veterans Affairs Canada for more information, please email VAC.HPAdmin-PSAdmin.ACC@vac-acc.gc.ca.

Section 4: Working with Military Families



Introduction

According to the Vanier Institute, there are approximately 54,000 military families, and more than 64,000 children growing up in military families in Canada (Battams, 2016). A common misconception is that military families receive services through the same systems as active Canadian Armed Forces (CAF) members, however this is not the case. Accessing health care, as well as special education services, pose a significant challenge for military families. Barriers that military families face in accessing these services, which include wait lists, lack of universality, and difficulties due to relocation, will be explored further in this section.

While active members of the Canadian Armed Forces are provided with all their health care services through Canadian Forces Health Services, their family members are dependent on the civilian (provincial) health care system. Military families are most likely to access occupational therapy services within the local communities where they live through publicly funded or private systems. Occupational therapists engage with military families in the same settings as they would with civilians, including contexts such as acute care, outpatient clinics, and school-based services (Edgelow & Cramm, 2015).

Most research related to military families is international in origin, with the majority stemming from the United States. Researchers are just beginning to explore the needs and experiences of military families in the Canadian context. The Department of National Defence (DND) and Canadian Forces Ombudsman (DND/CF Ombudsman) has called for a greater emphasis to be placed on research of military family issues in Canada (DND/CF Ombudsman, 2013). The DND and CAF has identified that there are many

Practice Tip 4.1

When working with a new client, consider asking if they are part of a military family. This information can help you to anticipate possible occupational performance issues they may be experiencing related to military lifestyle or the deployment of a parent or spouse.

facets of a military lifestyle that can significantly impact spouses/partners and children of Canadian Armed Forces personnel. This section will explore some of the unique elements of military family life (specifically, mobility, separation, and risk) and how these greatly impact access to health care and education for military families.

Unique elements of military life

According to the DND/CF Ombudsman (2013), the distinctive military lifestyle of Canadian Armed Forces members is strongly tied to three factors: mobility, separation, and risk. An understanding of these elements is important when providing occupational therapy services to ensure you are practicing in a client-centred manner. As explained in that report: “In isolation, none of these three characteristics is unique to CAF members and their families. [However,] when combined, the distinctiveness of the military career becomes more obvious,” (DND/CF Ombudsman, 2013, p. 3). There are few professions that involve recurring geographic relocation, prolonged family separation and elevated levels of risk throughout much of one’s career (DND/CF Ombudsman, 2013).

Additional Information 4.1

Positive experiences of children growing up in Canadian military households

A study explored the positive implications of growing up in CAF households from the perspectives of military children and found the following:

- they felt happy and proud of their military parents;
- their families received special benefits (i.e. military discounts on goods and services);
- they spent more time with the at-home (non-deployed) parent; and
- their families experienced new people and places through relocation.

(Bullock & Skomorovsky, 2016)

Mobility. Military families are required to geographically relocate on a recurring basis, relocating three to four times more often than civilian families (Cramm, Norris, Tam-Seto, Eichler, & Smith-Evans, 2015). These relocations may be across provinces or outside of Canada, and occur at the discretion of the CAF. Families having little input as to when, where or for how long they are relocated, with most military personnel relocating repeatedly throughout their military career (DND/CF Ombudsman, 2013). Frequent relocations greatly impact access to health care services, and affect children's participation in school, academic progress, and access to educational accommodations for those with disabilities or unique learning needs (Cramm et al., 2015). With each relocation, families must navigate the jurisdictional differences that exist between cities, provinces, and countries in order to access health care and special education services, often leaving them unable to obtain equivalent services as those that they had in their previous location. The ability to engage in employment may also be disrupted for non-military family members due to frequent relocation (Cramm et al., 2015). Despite these challenges, some research suggests that mobility associated with a military lifestyle is viewed as a positive aspect, as it allows families to experience new people and places (Bullock & Skomorovsky, 2016).

Separation. Canadian Armed Forces members are frequently required to be away from their families during training missions and deployments. Deployments can last up to 15 months at a time, with

some CAF members being away more than others. Separation is an integral part of military life, and it is rare that a CAF member would never experience a separation from their family (DND/CF Ombudsman, 2013). Research indicates that there are many health consequences related to prolonged separation resulting from deployment or training missions. For example, research has found that deployment is associated with increased use of medical specialist office visits for both spouses and children of military personnel, as well as increased use of antidepressants and anti-anxiety medications (Larson et al., 2012). Depressive symptoms are reported in approximately one in every four children experiencing the deployment of a parent (Siegel & Davis, 2013), with research suggesting a positive correlation between mental health diagnoses in children and longer parental deployment periods (Mansfield, Kaufman, Engel & Gaynes, 2011).

Family response to the cycle of deployment.

Research suggests that children and youth experience predictable emotions and responses during each cycle of deployment (Pincus, House, Christenson & Adler, 2001). Prior to the deployment of a parent, a child or adolescent may experience emotional withdrawal, apathy, or exhibit regressive behaviours as they anticipate the parent's impending deployment. Early in deployment (i.e. during the first month), children may feel overwhelmed, sad, or anxious, have more somatic complaints, or develop aggressive behaviours. As the deployment continues, these emotions often diminish as children enter a readjustment phase, which involves development of new routines and supports. When a family member returns from deployment, there is excitement, anticipation, and relief. Emotional conflict may arise as the serving family member integrates back into everyday family life (Pincus et al., 2001). Many families identified the first three months after the military member's return home as the most stressful part of the deployment cycle, with families indicating that it can take between one month to over a year for them to shift back into their pre-deployment family routine (DND/CF Ombudsman, 2013). The shift back into the pre-deployment routine can be made even more difficult if the military member is experiencing an operational stress injury (OSI), such as post-traumatic

Additional Information 4.2

Did you know?

Children's behavioural responses and emotional state during parental deployment are closely linked with the mental health and well-being of the at-home (non-deployed) parent (Flake, Davis, Johnson & Middleton, 2009).

Therefore, supports for military spouses are important factors in maintaining positive mental health in military children (Stelnicki & Schwartz, 2016).

stress disorder (PTSD), as there may be increased conflict, decreased communication and cohesion, and further issues with adjustment (Norris, Cramm, Eichler, Tam-Seto & Smith-Evans, 2015).

Research by Harrison and Albanese (2012) explored the phenomenon of “parentification” in Canadian adolescents experiencing parental deployment. They describe parentification as “an interactional pattern within families in which children or adolescents are assigned roles and responsibilities that are typically considered the responsibility of adults, but which parents have relinquished” (Harrison & Albanese, 2012, p. 2). Their research identified that adolescents carried out extra chores during deployments, and provided instrumental and emotional support to their siblings and non-deployed parent. Parental emotional unavailability was also identified as a significant aspect of the daily life of children or adolescents with a deployed parent. The deployed parent is considered unavailable due to deployment, while the parent at home may be “unavailable” due to employment, navigating their new status as a single parent, and/or due to the anxious state of mind caused by their partner’s deployment. This unavailability is often a precursor for parentification, as a child or adolescent may then assume adult roles in the household to compensate for their parents’ “unavailability” (Harrison & Albanese, 2012). This concept is important for occupational therapists to consider when working with children of military families, as these children may have responsibilities and roles beyond what may be expected for a child or adolescent of a certain age.

Additional Information 4.3

Childrens’ perceptions of deployment

According to the DND/CF Ombudsman (2013), the most difficult part of deployment for children was:

- Not seeing/talking to parent – 75%
- Feeling lonely – 8%
- Increased family responsibilities – 8%
- Problems at school – 4%
- No difficulty with deployment – 4%

Risk. The concept of risk, including the possibility of permanent injury, illness or even death, is accepted as a central tenet of membership in the Canadian Armed Forces. This risk is not exclusive to deployment overseas. Training for combat operations requires intensive, realistic simulation, employed in all types of environments, conditions, and scenarios, pushing individuals to their physical and mental limits. Training injuries and deaths do occur despite the many precautions and safety measures put in place (DND/CF Ombudsman, 2013).

The effects of the risk associated with being a member of the CAF extends beyond the military member themselves, and has a significant impact on their family members. The CAF’s recent change in focus from peacekeeping missions to deployments involving active combat has significantly altered the lives of affected CAF members and their families (Harrison & Albanese, 2012), and brings with it more concern for the deployed person’s safety. Additionally, with an increase in communication thanks to technological advances, military families are much more aware of the deployed military personnel’s environment and duties, which can be anxiety-provoking when they are involved in high-risk activities (Rowan-Legg, 2016). Spouses/partners and children of those deployed may experience constant worry that something will happen to their deployed family member.

Specific challenges for military families

When looking at the challenges faced by military families, the categories of health and education are often identified as two significant areas that pose distinct challenges.

Health. As previously mentioned, accessing health care is a significant issue for military families. While active members of the Canadian Armed Forces are provided with all their health care through Canadian Forces Health Services, their family members are dependent on the civilian health care system. Frequent relocations lead to the need to repeatedly navigate access to a family physician and any required specialists, often facing challenges across provincial

jurisdictions where eligibility for services and systems may vary (Cramm et al., 2015). When moving among provinces, military families must apply for new health cards, which often involves a waiting period, as a starting point to access other health care services.

Research suggests that Canadian military families are four times less likely to have a family physician than civilian families (DND/CF Ombudsman, 2013). Given the long wait times for family physicians, a family may never get off the wait list in a certain geographical location before being posted by the CAF to another area. Thus, many military families receive their health care through emergency rooms and walk-in clinics, or travel long distances to their former posting to see their former physician (DND/CF Ombudsman, 2013). Because of this, families may miss periodic health assessments, routine screenings, immunizations, and preventive care (College of Family Physicians of Canada, 2016). Aside from limited access, civilian physicians working with military families may be unaware of the unique aspects of military life and their impact on the prevalence of certain health conditions. For example, children of deployed military members have been found to experience physical issues, increased stress, and sleeping problems at more than double the rate compared to similar children from the civilian population (DND/CF Ombudsman, 2013). Teens of a military parent were more likely to have hospital admissions for injury, suicide attempts, and mental health diagnoses than non-military teens (Pressley, Dawson & Carpenter, 2012). Additionally, lack of consistency in the transfer of medical records from location to location further impacts quality of care (DND/CF Ombudsman, 2013). Military family members may have received occupational therapy services in the past, however without any records, their new occupational therapist has no information on what services they were previously receiving.

Not having a family physician can have significant consequences for families who have children with special needs (College of Family Physicians of Canada, 2016), as well as for families with a child with a chronic illness, developmental disorder, learning problem, or complex medical needs (Rowan-Legg, 2016). Families may face delays related to diagnoses and required treatments (Rowan-Legg, 2016), as family

Practice Tip 4.2

Encourage military families to keep their own copies of all medical documents, including immunization forms and occupational therapy records.

physicians are crucial for timely diagnosis, referrals to specialized care, and educational supports (College of Family Physicians of Canada, 2016). Additionally, smaller communities where military families have been posted may lack access to necessary specialists, posing further challenges for families (Rowan-Legg, 2016).

Education. Education is another area that poses challenges for frequently relocating military families. Many of the challenges associated with education are similar to those in the areas of health care, revolving around difficulty with access, delays, and varying services in different geographical areas. With each relocation, children must adapt to new curriculums, new classroom expectations, and the challenges of socializing with new peers and classmates (Rowan-Legg, 2016). Educators and peers may not have a good understanding of the experiences of military children, and the role that this lifestyle can play in relation to academics. For example, research suggests that children who are part of a military family can experience academic difficulties, and that academic performance can be impacted by having a military parent deployed. Coulthard (2011) found that the prevalence of extended deployments impacts school performance, with children of deployed parents achieving lower test scores. Additionally, children who have relocated may experience academic gaps as curriculums vary from school to school.

Children with disabilities or learning needs from military families often face difficulties accessing educational accommodations at their new school. As a child starts at a new school, the assessment and resource allotment process begins from the beginning, which can create significant stressors for children and their families (Cramm et al., 2015). This process is often associated with a significant wait list, which further delays access to required services.

Practice Tip 4.3

Offer to provide parents with copies of information regarding their child's occupational therapy services. This may be valuable to assist with the transition to their new school.

Furthermore, children are often starting at a new school without any occupational therapy or special education records, meaning that their new school has no information on what services the child was previously receiving. These challenges are further complicated by the fact that available resources and criteria for services may vary by school, school district, or province. This means that a child who was eligible for services or supports in one school, may not be able eligible to access the same supports elsewhere.

Moving forward

With Canadian military families slowly becoming a more prevalent topic of research, there will likely be more information available on how to best meet their needs in the coming future. At present, the most important consideration when working with military families is to simply be aware that military families exist, and to consider them as their own special population, with unique needs and considerations. The Department of National Defence and the Canadian Armed Forces have increasingly emphasized the role of families in supporting CAF members, as well as the impact of military life on military families. As a result, there is increasing attention in civilian

Practice Tip 4.4

When working with a child from a military family, take into consideration the possible impact of mobility, separation, and risk when assessing the child's occupational performance issues.

For example, a child who is anxious and struggling in the classroom may have recently moved, has a parent deployed, and/or is experiencing academic gaps because of changing schools.

Canada on learning more about and helping these military families to navigate potential challenges. As occupational therapists, it is our 'duty' to support these families by understanding the distinctive factors (i.e. mobility, separation, and risk) that shape their lifestyle, and providing them with client-centred care in all practice settings to support their occupational engagement, mental health, and overall well-being.

What about Veteran families?

While Veteran families do not experience the same challenges related to mobility, separation, and risk, the military member's transition out of the Canadian Armed Forces (CAF) has implications for their family. Issues may include difficulty accessing health care services, strained family and marital relationships, and lack of social networks. Further research is necessary to understand the experiences of Veteran families in the Canadian context.

As mentioned in Section 3, Veterans who have been in the CAF for many years, or those who joined when they were young, may not have experience accessing the civilian health care system. They may require assistance in finding and registering for a family doctor, and are often not used to experiencing the significant wait times associated with the provincial health care systems, and may be unable to access required services in a timely manner. For Veteran families who relocate to a new community after the military member has left the Armed Forces, the entire family may need to reapply for a family doctor in their new location. As identified with military families, civilian health care professionals may lack an understanding of the unique military context and how this has impacted both the physical and mental health of Veteran clients and their families.

Mental health issues experienced by Veterans who have transitioned out of the CAF can have a significant impact on their family members, and can make the adjustment to civilian life more difficult. Literature suggests that operational stress injuries (OSIs) such as post-traumatic stress disorder (PTSD) resulting from experience during military service can have an impact on family members of former military personnel

(Galovski & Lyons, 2004; Norris et al., 2015; Sayers, Farrows, Ross & Oslin, 2009). As stated by Norris and colleagues (2015), “When families include a Veteran living with an OSI, family members experience more emotional, psychological, behavioural, social, academic problems, and are also more vulnerable to experiences of neglect or abuse than other families” (p. 48). The transmission of distress from the Veteran who experienced trauma to those around them, such as their family members, is referred to as secondary traumatization (Galovski & Lyons, 2004).

Symptoms associated with PTSD and other mental health issues can contribute to poor conflict management, poor problem solving, and aggressive behavior if family members are perceived as a threat (Rivers & Saunders, 2016). Emotional detachment, avoidance, and disinterest in activities and places that were once part of a meaningful family relationship can cause further difficulties (Rivers & Saunders, 2016). Sayers and colleagues (2009) identified challenges that Veterans with mental health issues faced in renegotiating their place in their family; challenges included “feeling like a guest” in their own home, their children being fearful of them, and their partner or children not acting warmly towards them. While mental health issues can negatively impact family dynamics, familial issues can make the adjustment to

civilian life more difficult, further exacerbating mental health issues (Sayers et al., 2009). Veteran families may experience serious relationship difficulties that result in marital breakdown upon transitioning out of active duty. This can lead to difficulties in finding housing, decreased access to their children, and a sense of isolation (NHS North East and North of England Mental Health Development Unit, 2013). Isolation may also be experienced by Veterans families who feel that they have lost a significant social network that they built up while part of the military community (NHS North East and North of England Mental Health Development Unit, 2013).

At present, there is limited research available about the experiences of Veteran families in the Canadian context. Along with incorporating a Canadian perspective, future research consideration should be given to other OSIs, including traumatic brain injury, depression, anxiety, and substance use (Norris et al., 2015). Most existing research focuses on the impact of PTSD, which is by no means representative of the experiences of all Veteran families. Additionally, OSIs must continue to be considered within a family context, and addressed using family-centred approaches (Norris et al. 2015), as the impacts of military service extend far beyond just Veteran themselves.

Epilogue

A Message from the Executive Director of CAOT



Serving the profession since 1926, the Canadian Association of Occupational Therapists (CAOT) is the professional organization that gives voice to the more than 16,000 occupational therapists who work or study in Canada. Our members improve the

health and well-being of Canadians by creating solutions that help them participate more fully in activities that are important to their everyday lives. To enable our members to better serve Canadians, CAOT provides advocacy, practice resources, and professional development.

Recent advocacy initiatives brought us to work closely with the Canadian Armed Forces (CAF) and Veteran Affairs Canada (VAC) to promote occupational therapy as an essential service for the health and well being of military personnel, Veterans, and their families. CAOT is hopeful that we will see increased opportunities for occupational therapy service provision within CAF and VAC in the coming years. Anticipating, new roles and new hires to fill these roles, it became quite clear that there was an opportunity to educate occupational therapists on the unique contextual elements related to working within VAC and CAF systems.

The production of this document was a major project undertaken by the CAOT Intern Katelyn Bridge, under the direction of Havelin Anand and Julie Lapointe. The content creation involved an extensive literature search, engagement with our members with

experience working with CAF and VAC, consultation and engagement key staff at CAF, VAC, as well as military and Veteran health researchers.

This Guidance Document is a practice resource; created to help occupational therapists prepare themselves to optimally provide effective, client-centred services within the context of CAF and VAC. CAOT's vision is that this document will be used by students and occupational therapists interested in understanding more about a day in the life of occupational therapists working in military and Veteran settings. CAOT believes that this document may spark interest and encourage therapists to seek out and apply to work with CAF and VAC. And, most importantly, help those who do secure these posts be successful by truly understanding the unique needs of the military and Veteran populations.

Next steps: CAOT will continue to work closely with VAC and CAF to lobby for more occupational therapy positions, lobby to have occupational therapists positioned within the mental health programs of CAF and ensure that CAF and VAC optimally use occupational therapists to their full scope of evidenced-based, client-centred enablement of occupation. Occupational therapists are ideally positioned to help injured soldiers return to duty, prepare for alternative military employment or transition to civilian life and to assist Veterans to engage in the occupations that bring meaning and satisfaction to their civilian life. I hope that readers of this document will be inspired to serve those who serve our country.

Janet M. Craik, OT Reg. (Ont.)
Executive Director
Canadian Association of Occupational Therapists

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