The Mapping and Gaps Analysis of Services for Military Families Report

Comprehensive Military Family Plan

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Résumé

Le Plan global pour les familles des militaires (PGFM), qui correspond à l'initiative 24 de la politique *Protection, Sécurité, Engagement* de la Défense nationale, vise à améliorer l'appui offert aux familles des militaires. Bien qu'elles représentent la véritable force derrière l'uniforme, elles en ressentent néanmoins les nombreux stress et risques et doivent faire de nombreux sacrifices.

Afin de mieux soutenir les familles dans les nombreux défis qu'elles rencontrent, notamment en raison des déménagements fréquents, l'une des composantes du PGFM a consisté à cartographier et à analyser les écarts en matière de services et de programmes en vue de fournir un portrait de leur distribution qui permettrait d'améliorer leur connaissance, leur disponibilité et leur alignement d'une communauté à l'autre et d'une famille à l'autre.

Le processus a conduit à l'identification de deux types d'écarts ainsi qu'à la formulation de recommandations et d'éléments d'action.

Les écarts systémiques, comme les disparités géographiques, la communication, les environnements physiques, politiques et sociaux, peuvent exercer des effets de levier importants lorsqu'ils sont abordés. La plupart des écarts systémiques qui ont été définis pourraient être réduits moyennant du temps de concertation, une meilleure planification stratégique ainsi que l'implantation d'un système de mesure de rendement et de satisfaction des usagers pour tous les programmes. Ces mesures permettraient notamment de réaligner et de mieux promouvoir les services existants ainsi que de les rendre accessibles à tous.

- 26 écarts systémiques et 119 écarts liés aux programmes ont été identifiés.

Quant aux écarts de programmes, leur représentation en continuum de services a permis de déceler les ruptures de programmes et services pour certains segments de population qui ne reçoivent pas l'attention ou les services dont ils auraient besoin dans les sphères critiques au bien-être des familles. Le réalignement des efforts et des ressources aurait le potentiel d'assurer une meilleure continuité et une meilleure accessibilité des services, tandis que l'exploration de nouvelles approches et de nouveaux modes de prestation pourrait permettre de soutenir davantage les familles dans leur capacité à prendre soin d'elles-mêmes.

- 18 recommandations ont été formulées et 120 activités stratégiques, destinées aux intervenants (fournisseurs de services), ont été générées.

Finalement, l'analyse des écarts en matière de services indique comment le fait de veiller à la santé et au bien-être d'une population relève d'une entreprise complexe et de longue haleine exigeant des efforts constants, itératifs et coordonnés. Mais surtout, l'analyse démontre l'envers des écarts, c'est-à-dire tout le travail qui a été réalisé jusqu'à maintenant et qui témoigne d'un nombre impressionnant de programmes et services et d'un niveau d'engagement organisationnel inconditionnel envers les militaires et leur famille.

Abstract

The Comprehensive Military Family Plan (CMFP), established in response to Initiative 24 of Canada's defence policy *Strong, Secure, Engaged*, aims at improving support to military families. While being the true strength behind the uniform, families also experience the many stressors and risks that are inherent in the military lifestyle and require great sacrifices.

To better support families through the numerous challenges they face, including frequent relocations, one of the CMFP's components was to map out and analyze the service and program gaps to obtain an overview of their distribution that would allow for increased awareness, continuity and access, from one location to another and from one family to another.

The process led to the identification of two types of gaps as well as the formulation of recommendations and action items.

The systemic gaps identified, such as geographic inequalities, communication, and physical, political and social environments, can be leveraged to great effect. When addressed, they have the potential to generate substantial changes. Most of them could be reduced through consultations, improved strategic planning, and the implementation of a performance and user satisfaction measurement system for programs across the board. Among other benefits, such efforts would make it possible to realign and better promote existing services, and make them accessible to all.

- 26 systemic gaps and 119 programming gaps were identified.

Using a continuum of services to illustrate program gaps led to the identification of service disruptions and inconsistencies for specific population segments who do not benefit from the attention or services they need in the critical areas of family wellness. Realigning efforts and resources could potentially improve service continuity and accessibility, while exploring new approaches and delivery methods could help support and empower families to take care of themselves.

- 18 recommendations and 120 action items for the stakeholders (service providers) were generated.

Finally, the service gap analysis demonstrates how ensuring the health and wellness of a population is a complex and long-term undertaking requiring ongoing, iterative and coordinated efforts. Most importantly, it shows the hidden side of the gaps, i.e. all the work done to date,

including an impressive array of services and an unconditional corporate engagement towards CAF members and their families.

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List of Abbreviations, Initials and Acronyms

CA	Canadian Army
ADM(RS)	Assistant Deputy Minister (Review Services)
BGRS	Brookfield Global Relocation Services
B/W	Base/Wing
CAP3	Canadian Army Performance Triad
CFMAP	Canadian Forces Member Assistance Program
CFHA	Canadian Forces Housing Agency
CMFP	Comprehensive Military Family Plan
DND	Department of National Defence
FIL	Family Information Line
GBA+	Gender-Based Analysis Plus
JPSU	Joint Personnel Support Unit
MFRC	Military Family Resource Centre
MFS	Military Family Services
MM	Military member
PSP	Personnel Support Programs
O&M	Operations & Maintenance
OSI	Operational Stress Injury
PEI	Prince Edward Island
RCAF	Royal Canadian Air Force
RCN	Royal Canadian Navy
SISIP	SISIP Financial
VAC	Veterans Affairs Canada

Introduction

The Comprehensive Military Family Plan (CMFP) is an initiative of Canada's National Defence policy—*Strong, Secure, Engaged*. Published in 2017, the policy introduces initiatives and measures dedicated to the physical, psychological, and social resilience and support of CAF members and their families throughout their entire military career.

The CMFP, established in response to Initiative 24, aims to improve the support offered to military families. While being the true strength behind the uniform, families also experience the many stressors and risks that are inherent in the military lifestyle and require great sacrifices.

To better support families through the numerous challenges they face, one of the CMFP's components was to map out and analyze the service and program gaps to obtain an overview of their distribution that would allow for increased awareness, continuity and access, from one location to another and from one family to another.

The objective of this report is thus to summarize the methodologies, processes, and outcomes of the mapping and analysis of CAF member and family program gaps, leading to the formulation of recommendations and action items.

With the hope that this report will be useful to the plethora of stakeholders working within the Department of National Defence, it is above all else a testimony of their unwavering commitment and efforts to ensure the health, welfare and resilience of CAF members and their families.

1. Program and Service Mapping

1.1. Methodology

An inventory of all the programs and services offered to the different types of military families[1] of Canada's Regular Force was conducted between March 5 and July 31, 2018.

Data was collected from numerous sources: websites[2], grey literature, reports and scientific research on existing CAF services or on one of the six challenges members and their families face, as well as face-to-face, telephone or email conversations with key informants. These key people filled out two tables: [3] the first identifying their programs and which of the eight determinants of wellness [4] these programs support, the second listing the methods used to evaluate these programs.[5]

The inventory results were recorded in an Excel file with the following information: program name, description, organization/division/department, contact person, web link, family members targeted according to family type, targeted level of influence (individual, family, community/interpersonal), and delivery mode.

It should be noted that this same process will eventually be used in a subsequent phase of the CMFP to learn more about the services offered to reservists and military families living abroad.

1.1.1. Development of analysis axes

Following the creation of a program inventory database, nine analysis axes were developed and combined to reflect the complexity of the CAF environment and to produce the most accurate portrait of program and service distribution. Manipulating data according to these analysis axes allowed us to produce a set of figures, presented in sections 1.2. and 2.

These axes were developed from different models, approaches, work, research and reports[6] to highlight certain characteristics such as access, resource availability and the relevance of the services currently offered.

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[1] Types of families: single CAF member and their family; new family with young children; mature family with adolescents; post-secondary family; childless couple or empty nest family; retired family.
[2] Appendix 5.
[3] Appendix 1.
[4] Determinants of wellness: physical, psychological, intellectual, social, occupational, spiritual, financial and environmental.
[5] Appendix 3
[6] Among others: *The Sociecological Model of Health*, public health continuums of care, Ombudsman's reports (2018, 2013), *La planification de la santé* (Pineault and Daveluy, 1995), CMFP conceptual model.

Axes of analysis:

- Family member(s) the program is aimed at: CAF member, parent(s), spouse, young adult (19–25 years of age), adolescents (13–18 years of age), children (0–12 years of age), and families as a whole.
- Level of influence of the program: individual, family, community/interpersonal.
- Challenges related to the military lifestyle: absences due to operational tempo, relocations, illness, injury or death. These challenges were also combined by level of influence.
- Challenges for military families: mental health and wellness, financial stress, intimate partner relationships. These challenges were also combined by level of influence.
- Type of service and target population: communication, promotion/prevention, support and treatment; universal service/service for all, service for all injured CAF members (targeted). These challenges were also combined by level of influence.
- Geographic distribution throughout the 32 locations served by MFRCs according to levels of influence.
- Eight determinants of wellness: spiritual, physical, financial, occupational, psychological, social, and intellectual (Fig. 2).
- Combination of geographic distribution and determinants approach to see how existing programs in each base and wing support each family member according to the determinants of wellness.
- Equality between military and civilian spouses in terms of access to programs and services.

1.1.2. Inclusion and exclusion criteria

By programs and services, we mean activities, or in some cases activity categories, implemented with the goal of meeting precise objectives related to the needs of a defined population.

At the national level, all programs and services have been identified as independent units: programs, services, national Facebook groups and mobile applications. Regarding websites, Facebook pages and publications (guides and national journals), they have been classified in a separate list from the program inventory.[7] They have been considered in certain parts of the analysis (e.g. service type, continuum of services). For the analysis of health determinants, they were placed under “intellectual” and “environmental”.

At the local level and because of the great diversity of programs and services reflecting the unique needs of each base and wing, programs and services were grouped in categories. For example:

[7] Appendix 5

- PSP Community Recreation: as there are hundreds of different clubs, clubs represent their own category, thus a program.
- MFRC: as volunteer opportunities differ from one MFRC to another, they all appear in the "volunteer" category and thus count as a program.

Local Facebook pages, local websites, educational or promotional tools (e.g. pamphlets) and policies have not been considered.

1.1.3. Variation factors

While the inventory was conducted by consulting the majority of stakeholders, the mapping process does contain a certain level of variation due to:

- The attribution of a program to a determinant or category.
- The codification and establishment of categories in which programs are placed.
- The information available or provided by stakeholders.

Nonetheless, the portrait painted by this process represents a sufficiently accurate overview, from which we can raise questions and inform the analysis process of military family service gaps.

1.2. Mapping results

The mapping process served as a preliminary step in the analysis of gaps by providing an overview of program and service distribution according to the nine axes of analysis presented above. This step allowed us to pinpoint areas that needed further investigation, to raise questions, and to make certain observations that would prove to be decisive in the gaps analysis process.

The following diagrams represent about half of the work performed, while the other half can be found in Section 2.

1.2.1. Levels of influence

The classification of programs and services according to "individual", "family" and "community" levels of influence shows a net advantage in favour of programs geared towards individuals, in comparison to the other two levels of influence (Fig. 1).

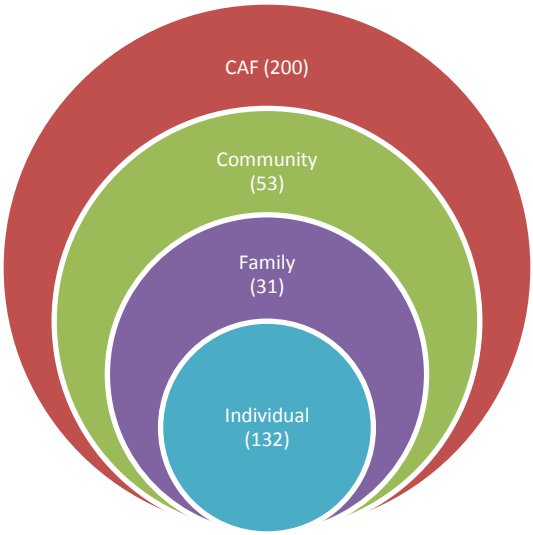

Figure 1. Number of programs by level of influence[8]

1.2.2. Determinants of wellness

The health and wellness of individuals, families and communities depends in large part on personal, social, economic, and environmental factors. These factors, also known as determinants, are supported by the programs and services offered to CAF members and their families (Fig. 2).

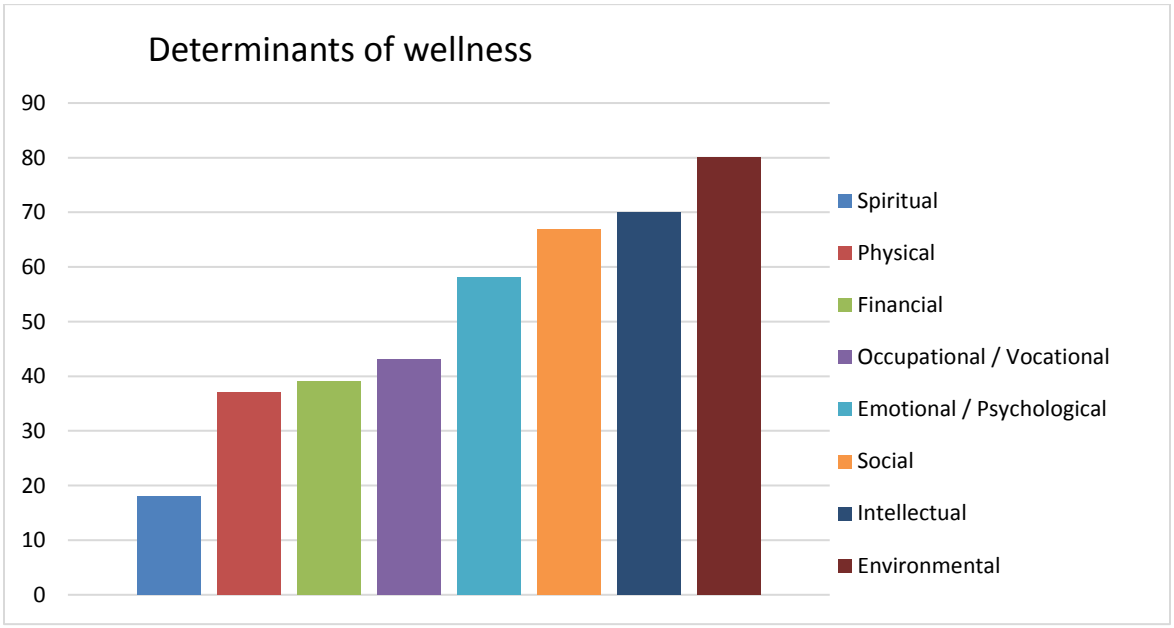

Figure 2. Determinants of wellness supported by national and local programs and services[9]

[8] There are 200 programs and services. Some programs have been entered into more than one category.
[9] The "environmental" determinant is in reality much greater as it includes all equipment and infrastructure.

1.2.3. Military journey and family journey challenges

Programs and services can be grouped according to the three challenges of the military lifestyle (illness, injury or death, operational absences, and relocations) and to the three family challenges (financial stress, intimate partner relationships, and mental health and wellness) (Fig. 3).

There are significantly more program categories (on the left in Fig. 3) that support family challenges and illness, injury or death compared to the other challenges (relocations, absences due to operational tempo).

By comparing subcategories (on the right in Fig. 3), we notice that mental health, wellness and emotional support receive more attention while special needs, relocations, health services and childcare receive less.

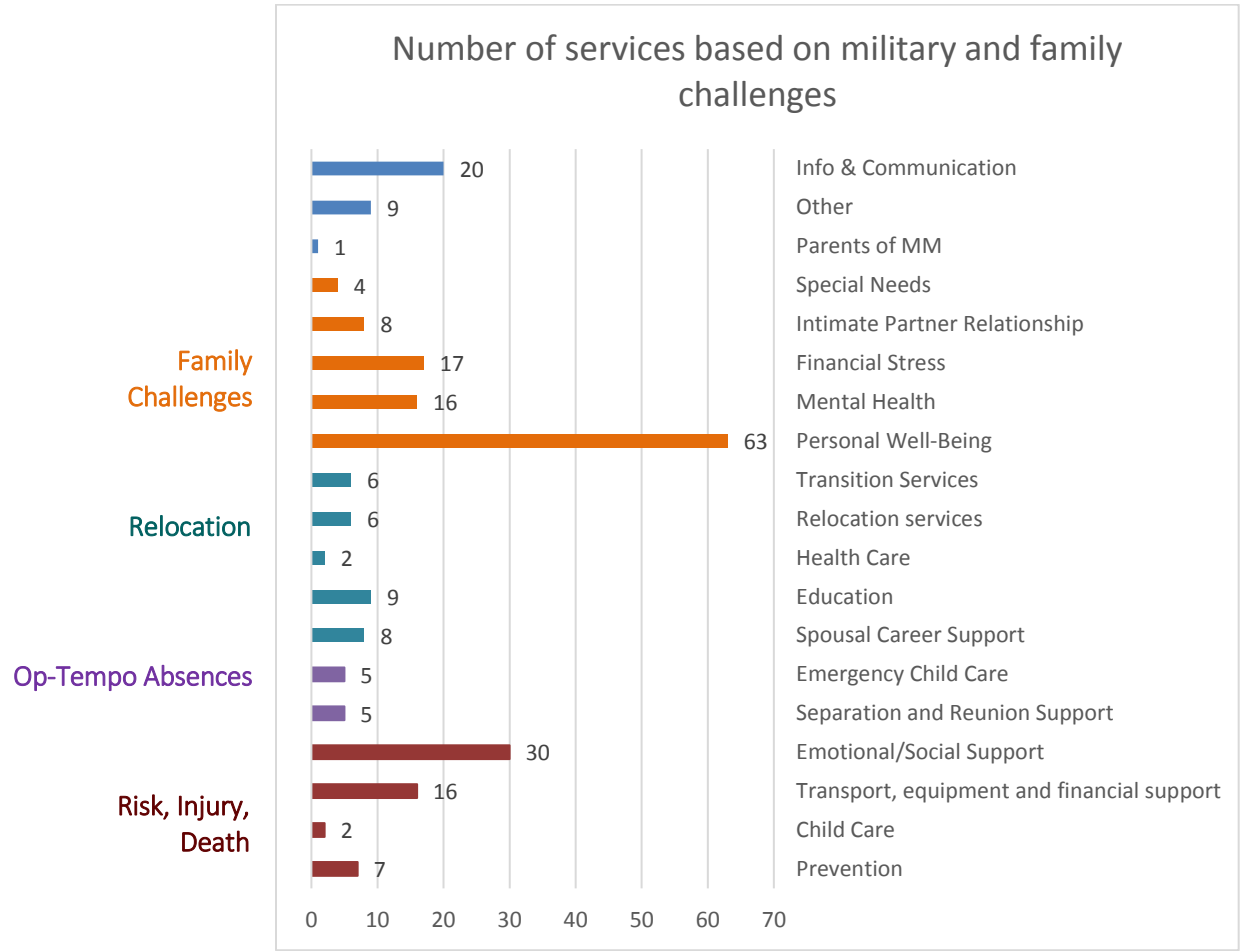

Figure 3. Number of programs and services based on military journey and family journey challenges[10]

[10] The total number of programs does not match what is shown in Figure 1. because Figure 1 does not include websites, Facebook pages and national publications (journals, guides).

1.2.4. Continuum of services

When programs are presented by program type (info/communication, promotion/prevention, intervention), target clientele (universal, targeted) and level of influence (individual, family, community), we observe that: the majority of universal programs (for all) focus on promotion and prevention, while programs for injured CAF members and their families focus more on intervention. There are fewer communication efforts for injured CAF members and their families and for families as a whole compared to efforts geared at individuals (Fig. 4).

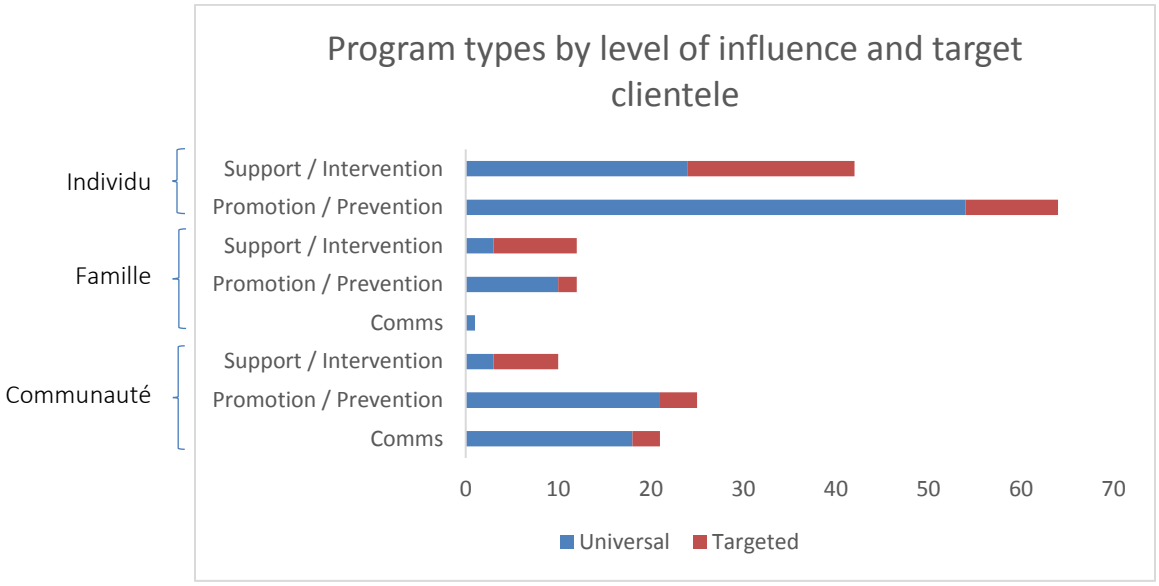

Figure 4. Program types by level of influence and target clientele

1.2.5. Service providers

Last, the 200 programs inventoried are offered by multiple service providers and stakeholders (Figs. 5, 6).

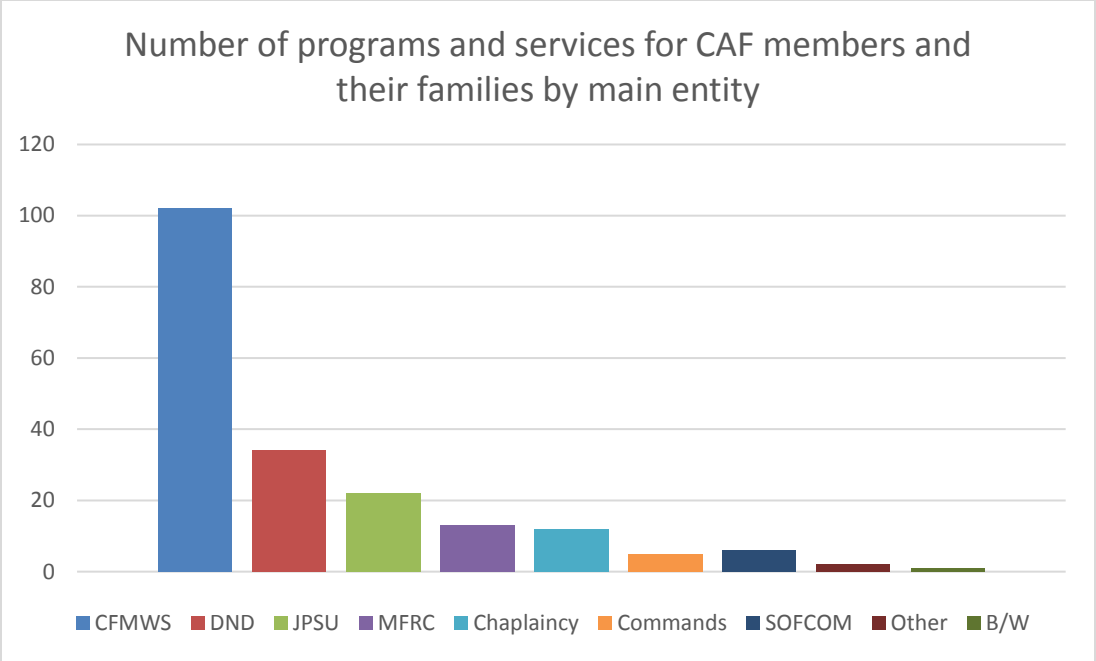

Figure 5. Number of programs and services for CAF members and their families by main entity

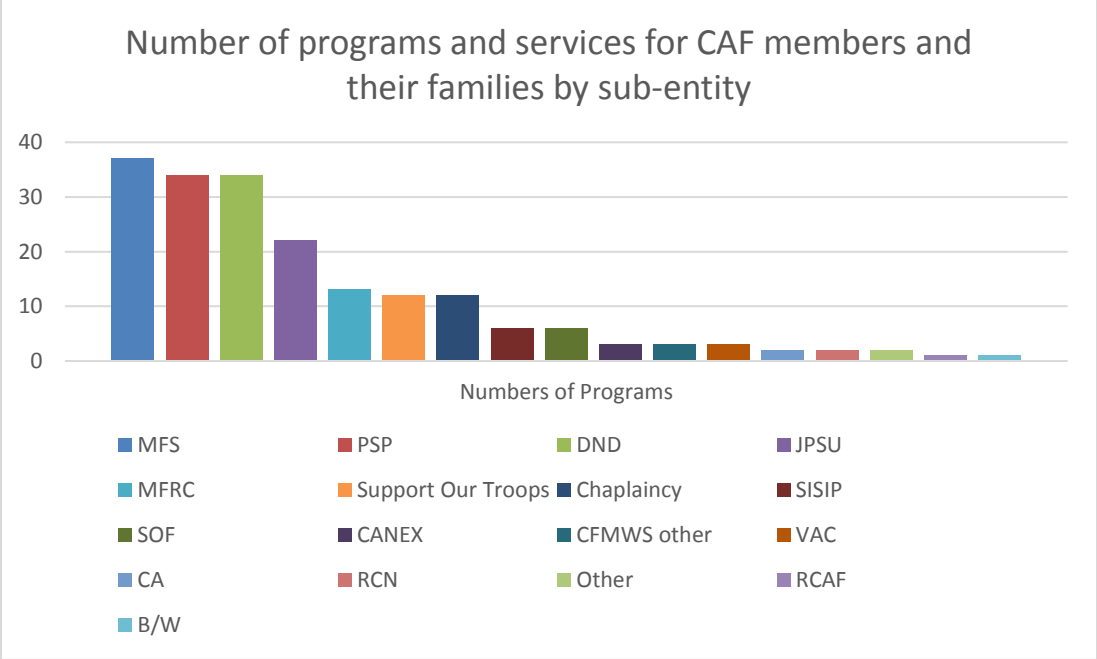

Figure 6. Number of programs and services for CAF members and their families by sub-entity

2. Analysis of Program and Service Gaps

2.1. Methodology

Considering the complexity of the analysis to be done, a process and analysis grids were developed from conceptual frameworks and the following documents:

- The mapping process, which identified locations that required more detailed investigation (e.g. geographic gaps, equality between spouses).
    - Geographic gaps:[11]
        - Locations affected by the absence of a program.
        - Affected population (number of people).
        - Connection to research or investigative reports.
        - Presence of equivalent services in the community.
    - Equality between spouses (GBA+).
    - Communication (when and where information can be found).

- The Ombudsman (2018, 2013) and ADM(RS) (2013) reports have identified gaps, some of which still persist today.

- The Treasury Board of Canada Secretariat and *La planification de la santé* (Pineault and Daveluy, 1995).
    - Program gaps (resources, evaluation, reach, etc.).[12]

- Public continuums of care,[13] which allows the mitigation of service disruptions or inconsistencies experienced by users.
    - Review of the continuum of services for military lifestyle and family challenges.
    - Comparison of categories between continuums of services.
    - Types of services and delivery modes.

- Intervention strategies according to Pineault and Daveluy (1995) and public health intervention types according to Litvak (2011).

- The Comprehensive Military Family Plan:
    - Strategic goals (Awareness, Advocacy, Availability, Alignment).

[11] Appendix 2
[12] Appendix 3
[13] Appendices 4, 6, 7

    - Family types, challenges and needs.
    - Determinants of wellness and resilience factors.
    - Under-served populations (special needs, parents of CAF members, caregivers, families taking care of elderly parents).

- The Socioecological Health Model, tailored to the military environment, which identifies the levels of influence on which to intervene (individual, family, community, Unit/B/W, command, CAF).

- The Ottawa Charter for Health Promotion, which identifies the five fronts on which to intervene to influence the health of a population:
    - Build healthy public policy.
    - Create supportive environments.
    - Strengthen community action.
    - Develop personal skills.
    - Reorient health services.

- The collective impact approach, which identifies five aspects on which to act to influence systems and produce a collective impact:
    - Backbone support.
    - Continuous communication.
    - Mutually reinforcing activities.
    - Common agenda.
    - Shared measurement.

2.1.1. Gap types

The analysis grids developed allowed us to highlight two types of gaps: systemic gaps[14] and programming gaps.[15] Systemic gaps refer to structures, processes and organizational strategies as well as obstacles relating to program delivery or access. They have the potential to impact the largest number of people and concern all stakeholders.

Program gaps deal with how programs align with the needs identified through research and within continuum of services for each family member and family type. They address specific people and have the potential to impact smaller groups of people.

[14] Appendix 8
[15] Appendix 9

2.1.2. Gap ranking

Last, a point system allowed us to rank gaps caused by the absence of certain programs by order of importance.[16] This way of proceeding helped us evaluate the relevance of implementing programs and services not currently offered to all Canadian military communities on a national scale.

Table 1. Gap ranking criteria

Which communities are affected?	1–3 community(ies) = 0 pt 4–8 communities = 2 pt 9+ = 3 pt
Connection with the Ombudsman (2018; 2013) and ADM(RS) (2013) reports or with research (see references)	2 pt
Military lifestyle and family challenges	2 pt
The final CAF Community Needs Assessment 2016 Overall Results (PRA, 2016)	1 community = 0 pt 2 communities = 1 pt 3 communities+ = 2 pt
Presence of an equivalent service in the community?	yes = 0 pt no = 1 pt

2.2. Results of systemic gaps analysis

The majority of systemic gaps could be reduced by an improved coordination of collective efforts, improved strategic planning processes and the creation of a shared systematic evaluation process.

In this section, the systemic gaps are presented according to the CMFP's strategic goals, mostly in point form. To consult the summary table of systemic gaps, please see Appendix 8.

2.2.1. Alignment of programs and services

2.2.1.1. Continuum of services

The organization of programs and services into continuum of services[17] demonstrates how the strongest categories are those that specifically target individuals: information, education, counselling, financial support, monitoring, strategies, and policies. The weakest categories are

[16] Appendix 2
[17] Appendix 4

those that focus mostly on groups and communities: awareness and social marketing, peer support, joint action, community intervention, and professional development.[18]

Individual interventions also appear to take precedence over the planning of healthy physical (e.g. infrastructure, BeneFIT program), social (e.g. mergers, issue tables) and political environments (e.g. strategies, policies). However, the creation of supportive environments encourages the ability to make healthy choices to benefit the greatest number of people.

Last, the organization of services by levels of influence indicates a preference for individual programs, followed by community/interpersonal programs, and, finally, programs for the family as a whole (Fig. 1).

Recommendation 1
Ensure that policies and programs mutually contribute to the creation of social and physical environments that promote the wellness of CAF members and their families.

2.2.1.2. National and local committees

Generally speaking, there are few or no permanent committees dedicated to the wellness of the military community and military families, even though this is encouraged by several policies and strategies such as DAOD 5044-1 Families (Fig. 7). According to the collective impact approach (Tamarack Institute, 2018), these committees have the power to increase the potential impact of local community health interventions and programs by facilitating the coordination and communication between all stakeholders and informing actions according to a common agenda and performance measurements.

[18] The policies belong instead to community-focused measures. Professional development belongs instead to individual-focused measures.

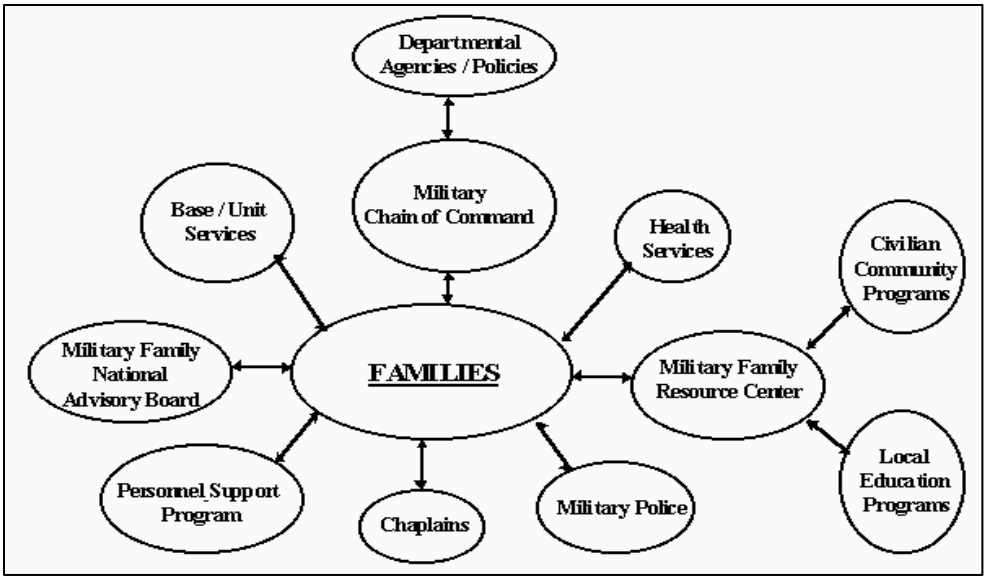

Figure 7. Support groups for military families (DAOD 5044-1)

Recommendation 2
Establish a permanent national committee and consolidate the network of local communities to improve awareness of services, continuous communication, and the development of common strategies, action plans and evaluation systems.

2.2.1.3. Common agenda

Of the 15 gap analysis axes related to military lifestyle challenges, family needs and certain under-served populations, there is only one operation plan for Military Spousal Employment (MFS), one financial health action plan (SISIP Financial) and the Called to Serve 2.0 strategy (Chaplaincy). The other themes[19] do not appear to have similar comprehensive intervention strategies establishing a direction and common guidelines for families. Furthermore, these documents should be available to the greatest number people, which is not the case for the ones mentioned above.

Recommendation 3
Develop joint strategies to inform decision-making, as well as program and service development, delivery and evaluation.

[19] Early childhood, childhood, youth, caregivers, special needs, parents of CAF members, families caring for an elderly parent, operational absences, family health services, intimate partner relationships, personal mental health and wellness and illness, injury or death.

Additionally, there are no mechanisms or guidelines to integrate conflicting interests within the organization, to rally stakeholders around common goals or to operationalize the Canadian Forces Family Covenant.

As a potential mechanism, the Health Assessment Impact (HIA)[20] is a recognized approach with easy-to-use, free tools, which could help create innovative win-win solutions. This would include reconciling conflicting interests, minimizing negative impacts, and maximizing positive impacts on the health and wellness of the military community (e.g. energy drink or beer sponsorships for family events and air shows, online game tournaments, alcohol consumption on deployment).

Establishing guidelines for decision-making regarding sponsorships, contracts and event planning could reduce conflicts of interest between departments and divisions.

Recommendations 4 and 5
Implement an evaluation system for initiatives that could potentially interfere with some entities' positions or that could negatively impact the health, wellness and resilience of one or more segments of the population. Create health and wellness guidelines to inform decision-making, sponsorships and event planning.

Last, there are no measures or tools that allow us to consider the realities or diversities of military families in the development of policies or programs as the Gender-Based Analysis Plus (GBA+) does.

Recommendation 6
Implement a decision support, policy development and evaluation tool to operationalize the Canadian Forces Family Covenant.

2.2.1.4. Performance measurement and program evaluation

The program evaluation processes (user feedback, impact assessment, normative evaluation) are not implemented in a systematic way for all stakeholders. This undoubtedly represents a hurdle

[20] For a practical description of this approach: http://collectivitesviables.org/articles/l-evaluation-d-impact-sur-la-sante-eis.aspx. For an overview of HIA tools: http://www.ncchpp.ca/54/health-impact-assessment.ccnpps

for the delivery of services that truly meet the needs of the military community. Normative evaluations or annual reports, which should include user satisfaction, and impact assessments, should be easily accessible for anyone wanting to consult them.

Table 2. Feedback mechanisms, evaluation and success criteria for 18 stakeholders[21]

	Formal feedback mechanisms	Formal program evaluation	Success criteria
Number of stakeholders	7	3	12

Recommendation 7
Implement performance measurement, program evaluation and user satisfaction systems.

On the one hand, scientific studies allow to document all the axes of analysis examined. This means we are able to provide stakeholders with direction on how to develop and reorient their services and programs.

On the other hand, there are no mechanisms in place to share knowledge or easily accessible platforms for families and stakeholders to promote research and information on the physical and mental health of families and CAF members.

Recommendation 8
Set up a platform where knowledge and research on CAF members and their families would be shared with leadership, stakeholders, families and the public.

[21] Appendix 3.

2.2.2. Knowledge and awareness of services

2.2.2.1. Presentation of information

We have identified 18 websites.[22] There are no evident or systematic links leading to other websites that may also be useful for users. As the myriad sources of information are not coordinated, it is hard to find the desired information.

Program information is not presented in a common and comprehensive fashion. It is thus difficult to know:

- Who the program is intended for and who is eligible for the program: spouses, children (age group), the entire family/couple, reservists, CAF members abroad, and so on.
- The level of commitment required (number of hours and days).
- The delivery mode offered (in person, online, by telephone, flexible or combined delivery modes).
- The type of service and its goal (inform, educate, support, intervene). Reference to the mental health continuum model could be an interesting avenue to explore.
- The language in which the service is offered.
- Whom to contact and how.

On the CAFConnection.ca website, local pages do not necessarily have the same categories as the national pages and do not always reference them either. For example, a person on the Shilo page, must, on top of consulting their local page, also think about consulting the national site if they want information on children with special needs.

Recommendation 9
Use a people-centred approach to standardize how program- and service-related information is sourced and presented.

2.2.2.2. Stakeholders' knowledge of programs and references

Personnel in every entity should be aware of all the programs offered in their location or department. Yet, several MFRCs' personnel contacted by telephone for example did not have information on certain programs in their location. The information did also not appear in a clear manner on their website (CAFConnection.ca).

[22] Appendix 5

There is no training for employees or supervisors on the services offered. And, aside from a few thematic national directories (e.g. You're not Alone) or local pamphlets promoting services (e.g. Wheel of Services), there are no tools facilitating knowledge or referrals to all existing services.

Recommendation 10
Educate Defence staff and volunteers on the full suite of existing programs and services.

2.2.2.3. Awareness, social marketing and service promotion campaigns

There are few recurring awareness or social marketing campaigns that raise awareness with the military community on health and wellness issues, which could be supported by the services offered.

In terms of communications, there is a gap to bridge with regard to families, personnel, and stakeholders. There are a lot of mediums for information, especially for individuals, but this material is not coordinated. Moreover, there are few awareness campaigns for individuals, families and injured CAF members and their families.

Furthermore, in 2016–2017, the CFMAP held 16 information sessions for the organization, which reached 574 members of the entire National Defence population. This number only represents 0.87% of military personnel or 0.64% if we also consider the DND's civilian personnel for that same fiscal year. Of the training offered, none seemed to be organized for military families even though the service is also geared to them.

Recommendations 11 and 12
Plan, coordinate and host recurring targeted awareness campaigns. Host CFMAP information sessions in all B/W and MFRCs.

2.2.3. Advocacy for families

Stakeholders do not have a common holistic client approach or systematic family reference systems that would support family advocacy and facilitate access to the programs they may need.

Additionally, a communication strategy and recurring campaign promoting the power of asking for help as a resilience factor for individuals, families and organizations could encourage access to upstream services.

Recommendations 13 and 14
Implement a holistic client approach founded on program knowledge and references between stakeholders. Create a communication strategy promoting the power of asking for help as a resilience factor for individuals, communities and organizations.

2.2.4. Availability of programs and services

2.2.4.1. Barriers to program delivery

The barriers to program delivery identified by stakeholders can be grouped into three categories:

- Communication and promotion: stakeholders have identified the need to communicate and better promote programs and services with collaborators and potential users.

- Human, material and financial resources: the lack of sufficient resources is an important barrier to program delivery for the largest number of people. This is the case throughout Canada and abroad. This being said, while the delivery of services online represents several benefits (geography, cost), not all members of the military community have access to these services or are at ease with this mode of delivery.

- Policies: policies can impact program delivery and accessibility by members of the military community. Examples: The Caregiver Assistance Benefit (JPSU) is only given to CAF members injured in Afghanistan, the *Privacy Act* limits the ability to contact military families, PSP Community Recreation is not eligible for certain types of Canadian grants.

Recommendation 15
Review and amend the policies that hinder the delivery and accessibility of programs and services or that are likely to have unwanted negative effects on the wellness of CAF members and their families.

2.2.4.2. Program delivery modes

Programs that use remote delivery modes (online, telephone) or combined delivery modes (online, telephone, in person) generally have an individual and specialized approach and usually have a smaller reach. Services adopting a community or group approach (e.g. Chaplaincy, Health Promotion, Soldier On, PSP Community Recreation) are offered in person, contribute to community vitality and have high attendance rates. Figure 8 illustrates delivery mode proportions for adult services and programs.

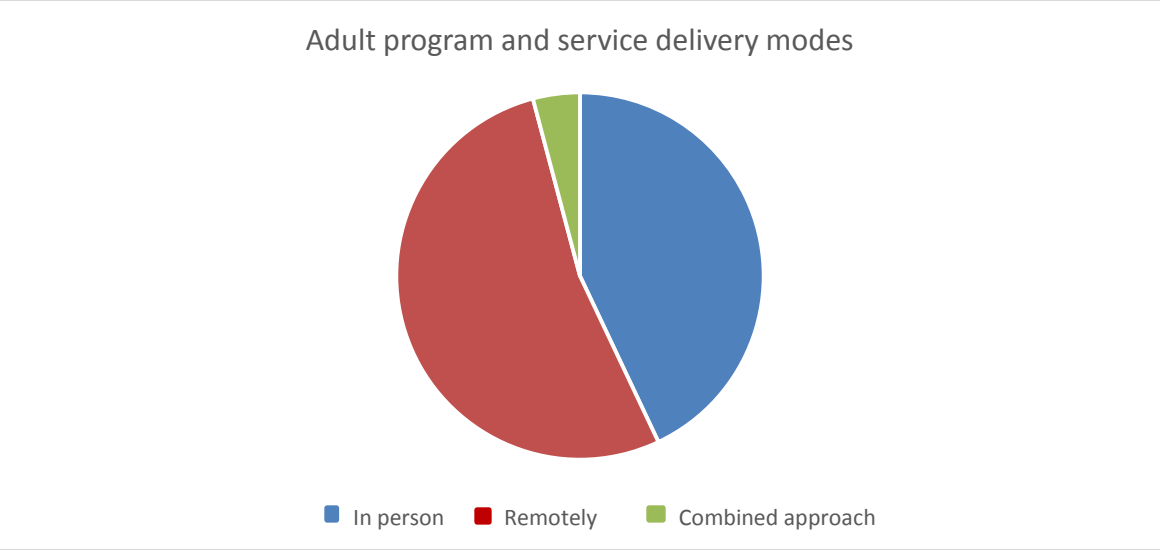

Figure 8. Adult program and service delivery modes

Recommendation 16
Explore new modes of delivery for select programs and services.

2.2.4.3. Equality between spouses

A comparison between services available exclusively to CAF members or the civilian spouse and services available to both demonstrates certain gaps with regard to the number and type of resources available to each.

Aside from services relating specifically to military service, or illness, injury or death in service, the service gaps are considerable for frontline medical care and professional development (Fig. 9). Thus:

- Health care is covered and fully accessible, available and free for military personnel contrarily to civilian members of their family.

- With regard to the mental health care services that are currently available (promotion, counselling, etc.), the number and types of services are the same for one or the other. However, upon closer inspection, a gap in favour of the CAF member exists with regard to frontline long-term therapy (mental health, addiction), which is fully accessible, available and free for members.

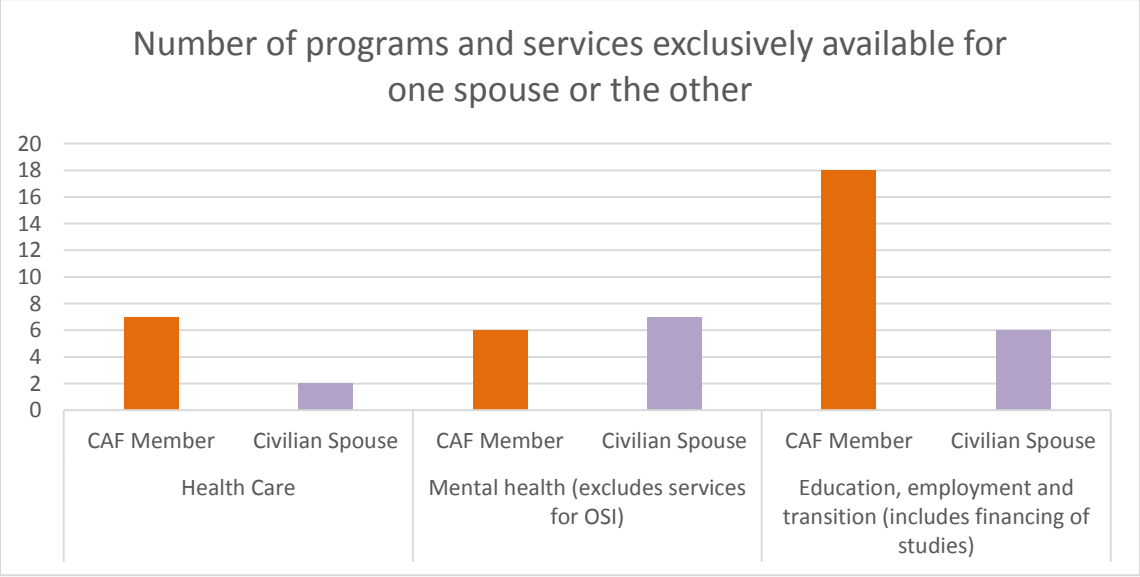

Figure 9. Number of programs and services exclusively available for one spouse or the other

- CAF members are also at an advantage in terms of service diversity and number, allowing them to pursue their studies, change careers, and benefit from professional development opportunities and transition to civilian life.

- While there are resources to help spouses pursue their studies (e.g. Support Our Troops scholarships and loans) or support them in their careers (e.g. Work It Out with MFS, Telfer Entrepreneurship Program for Military Families), access to these resources remains limited in terms of the number of services available and according to geographic location (e.g. variability from one MFRC to another), capacity (e.g. limit of Support Our Troops scholarships), and variety.

- CAF members are at advantage with regard to the opportunity to learn the language of the province of residence, which influences the ability to work or get involved in the host

community. They receive ongoing and intensive language training to learn a second official language, compared to the Rosetta Stone program offered in most MFRCs.

2.2.4.4. Geographic gaps and under-served communities

There is a 36% gap in the distribution of programs and services from one community to another. This gap can be seen in the total number of programs and in the number of programs in each level of influence (Fig. 10).

While it is difficult to evaluate the consequences on communities, it is possible to observe the impact these gaps have on continuum of services (Appendices 6 and 7) and on the determinants of wellness (Fig. 11).

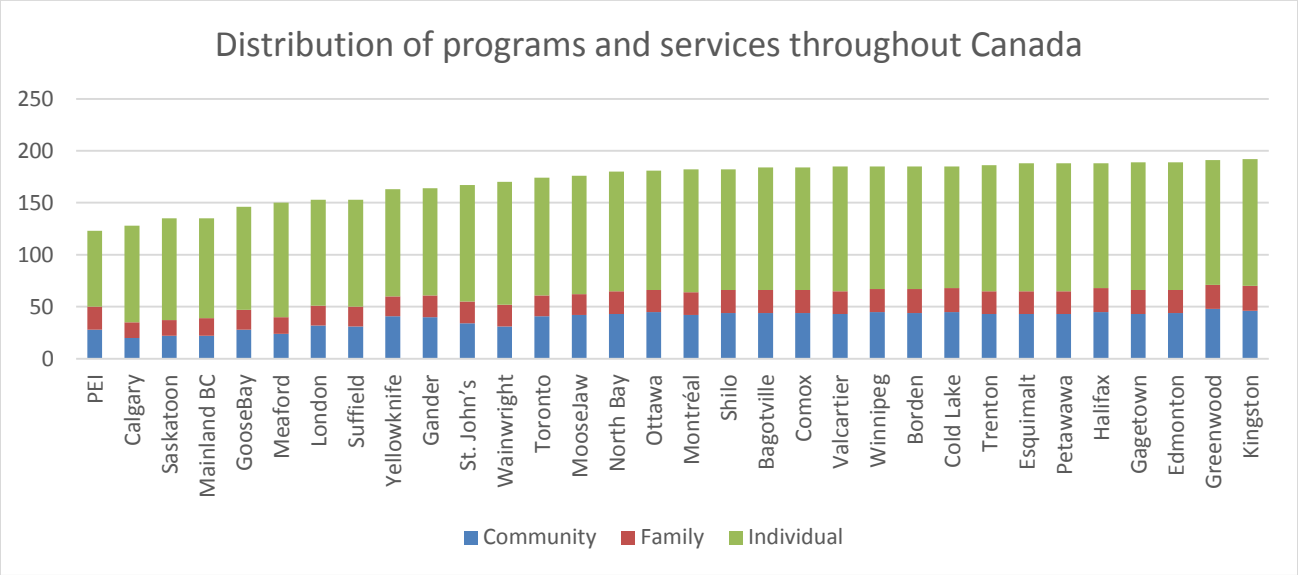

Figure 10. Distribution of programs and services throughout Canada

2.2.4.5. Relationship between geographic gaps and determinants of wellness

By analyzing the relationship between geographic distribution of services and their ability to support determinants of wellness, we can see that different family members do not receive the same support depending on where they live (Fig. 11). It seems that in larger B/W such as Kingston, support is better distributed between family members compared to smaller B/W such as Meaford and London.

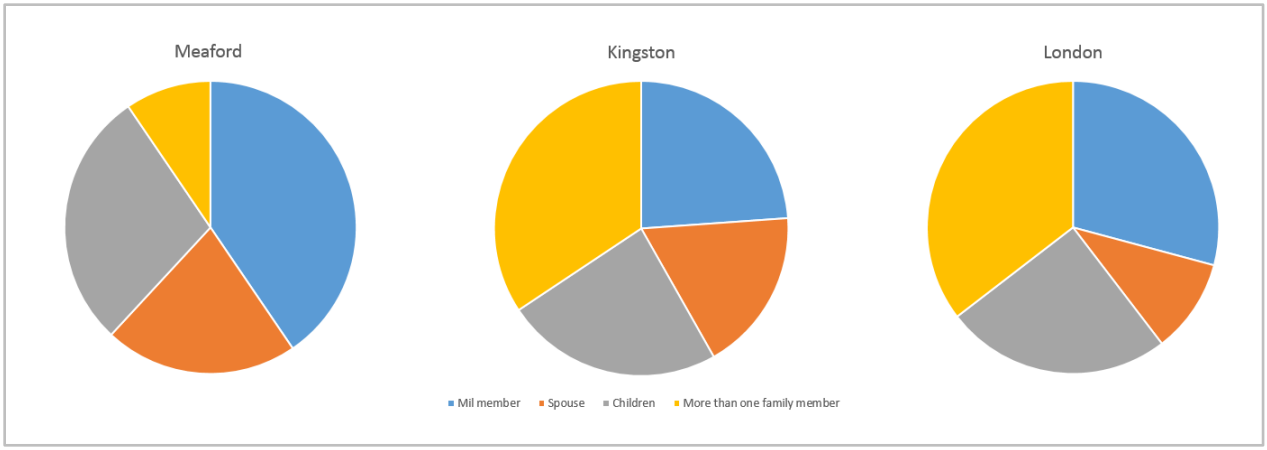

Figure 11. Determinants of wellness that support family members on the community level
Examples of Meaford, Kingston, and London

Recommendation 17
Identify a core of authorized and research-supported programs that should be accessible to all CAF members and their families and in all communities.

2.2.4.6. Impact of geographic gaps on continuum of services

By looking at examples of wellness programs[23] and mental health services for youth between 6 and 12 years of age[24], we can see an important discrepancy between the resources available and those unavailable in under-served communities.

In these communities, family wellness services fall mainly into the information category. Programs that support individuals and provide environments that promote healthy lifestyle choices are predominantly geared at CAF members.[25]

In terms of youth mental health services, while there are diverse sources of information and the presence of specialized and short-term intervention services, there are hardly any promotion/prevention programs.

[23] Appendix 6
[24] Appendix 7
[25] Appendix 6

Recommendation 18
Develop and maintain government and non-government partnerships to increase program and service offerings, stimulate action in the communities and facilitate community integration.

2.2.4.7. Potential reach of geographic gaps by level of influence

The unequal distribution of programs can be seen by examining the "individual", "family" and "community" levels of influence.

The following section allows us to consider the potential reach and benefits linked to the absence or presence of certain programs. It is made up of general and specific observations for programs that are not generally offered everywhere (Fig. 12, 13, 14, 15), as well as a concrete example from an under-served community. The programs appear in order of importance (see Table 1 for the gap ranking method).

Communities that do not meet the national average for programs offered in the "community", "family" and "individual" categories are identified in red throughout this section.

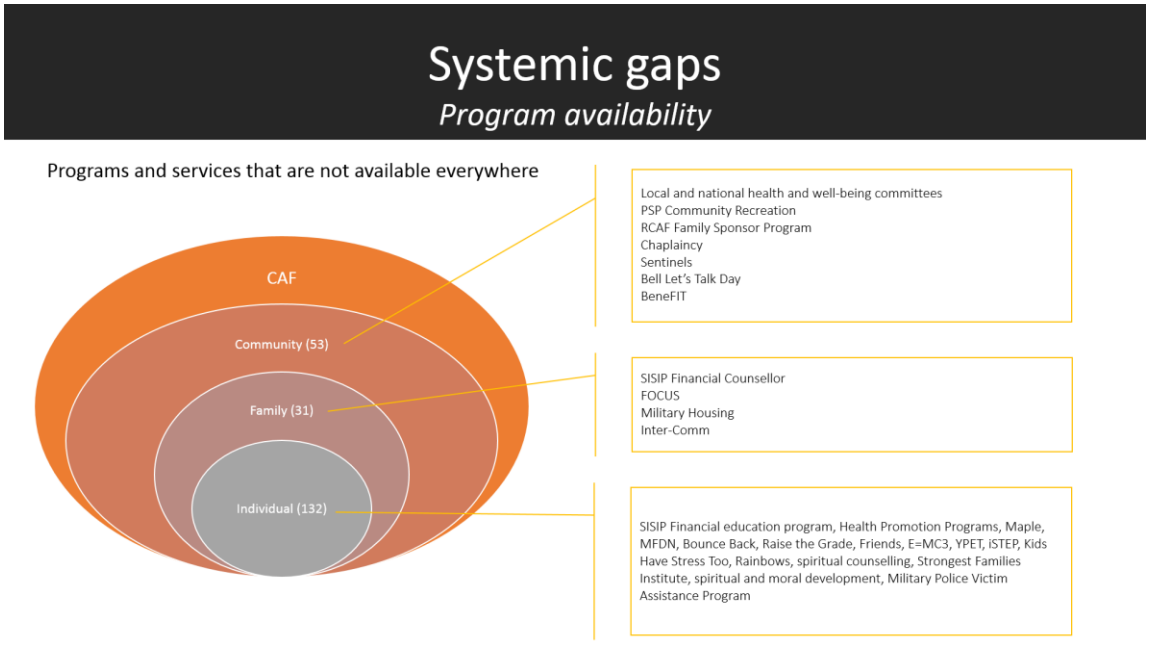

Figure 12. List of programs and services not available everywhere

2.2.4.7.1. Community level of influence

General comments:

- At the community level, the same core communities are generally affected by geographic disparities: *Mainland, Calgary, Dundurn, London, Meaford, Gander, St. John's, Goose Bay, PEI.*
- Between 3,000 and 60,000 people (members, spouses, children) do not receive the services that could be beneficial to them.
- Health and wellness committees, sentinels, the RCAF Family Sponsor Program and Bell Let's Talk Day require very little in terms of budget. They only require time for planning and coordination.
- Families that do not need specialized services are supported by a limited number of programs, which for their part support a limited number of determinants of wellness.
- While they are delivered in person, promotion/prevention programs that promote a large number of determinants (committees, PSP Recreation, RCAF Sponsor Program, BeneFIT, Bell Let's Talk) do not enlist O&M and have a large reach, compared to specialized programs, which are offered remotely.
- PSP Recreation, Chaplaincy Services and BeneFIT are three programs that create environments conducive to wellness, while health and wellness committees represent the only joint initiative in this same field.

Local health and wellness committees

As mentioned previously, these committees have the power to increase the potential impact of interventions and programs dedicated to the wellness of local communities by stirring efforts, resources and performance measurements in the same direction.

Comments:

- 19 B/W do not have committees dedicated to the health and wellness of the local military community, which corresponds to close to 60,000 CAF members and family members who could benefit from such a joint platform: *Comox, Mainland, Calgary, Cold Lake, Suffield, Wainwright, Yellowknife, Dundurn, Toronto, Meaford, Petawawa, Ottawa, St-Jean/Montréal, Bagotville, Greenwood, St. John's, Goose Bay, PEI.*
- These committees have no operating costs.

PSP Community Recreation

Recreation has a protective effect on the health of individuals (self-esteem, talents and skills, and life satisfaction), families (cohesion, resilience, adaptability) and communities (vitality, cohesion, security) by promoting several of the eight determinants of wellness.[26]

Comments:

- 160,000 people register in various activities per year.
- 80,000 children, adolescents and adults benefit from the program annually.
- Close to 6,000 additional military community members could benefit from it: *Mainland, Calgary, Dundurn, London, Meaford, Gander, St. John's, Goose Bay, PEI.*
- Six of the nine communities without fully funded recreational services said they participate in PSP activities to spend time with family. However, they mentioned that the equipment and funds allocated to the program, including infrastructure, were insufficient, and that they needed support to maintain a work-family balance and a certain level of personal wellness (PRA, 2017).
- For eight of the nine communities identified in red, municipal recreational services in neighbouring communities only had minimal services and infrastructure.

RCAF Family Sponsor Program

Comments:

- During the pilot project, 10% of families accepted a sponsor.
- While the program is still in its initial stages and we do not have sufficient data on its efficiency, the national implementation of the program would have the potential of reaching more than 18,000 spouses, facilitating relocation and promoting mutual assistance, friendships and networking.

Sentinel Program

Having a network of sentinels is regarded as a best practice and recognized for being particularly effective in the workplace, especially male-dominant workplaces (MSSS, 2006). Sentinels reinforce the safety net. They act as intermediaries between individuals and official assistance and care services by looking out for signs or symptoms indicating their colleagues need support.

Comments:

- 3,000 sentinels within the CAF have been trained to date.
- The program, managed by the Chaplaincy, operates on a minimal budget.
- Over 3,500 CAF members (Regular Force and Reserve Force) and by extension their families could benefit from the program: *Mainland, Calgary, London, PEI.*

[26] Source: *CAF Suicide Prevention Strategy Initiatives Template*, by Ryan Cane, PSP Senior Management Recreation and Programs.

Chaplaincy

Comments:

- Regular Force chaplain services are not available in four communities: *Mainland, Calgary, London, PEI.* Over 300 Regular Force members and 3,000 Reserve Force members and their families must turn to civilian services in their communities.
- Reserve Force chaplains only serve these communities in case of emergency (e.g. death).
- The CAF Chaplain Services organize about 6,500 activities per year meeting the needs of 167,000 participants.

Bell Let's Talk Day

Mental health and suicide prevention are CAF priorities (DND, 2017). The campaign aims to reduce the stigma, raise awareness and start a conversation around mental health.

Comments:

- The CAF now promotes Bell Let's Talk Day by holding live forums on social media and through activities organized by the 24 local Health Promotion offices in collaboration with several stakeholders.
- While it is still unclear if MFS and MFRCs support the campaign, the following communities (about 500 CAF members and their families) could benefit from a local campaign adapted to the military family context: *Mainland, Calgary, Suffield, Yellowknife, Dundurn, Meaford, Goose Bay, PEI.*

BeneFIT

The BeneFIT Program, a joint initiative between CANEX and the PSP, aims to provide a healthier food environment by identifying healthy options in stores and vending machines.

Comments:

- Over 3,500 Regular Force members and their families as well as over 7,000 Reserve Force members could benefit from online product offerings or the list of products that meet the BeneFIT criteria in the communities where there are no CANEX stores: *Mainland, Calgary, Yellowknife, Dundurn, London, Toronto, Gander, PEI.*
- There do not seem to be any measures in place to mitigate the absence of CANEX stores in these communities (e.g. free shipping).

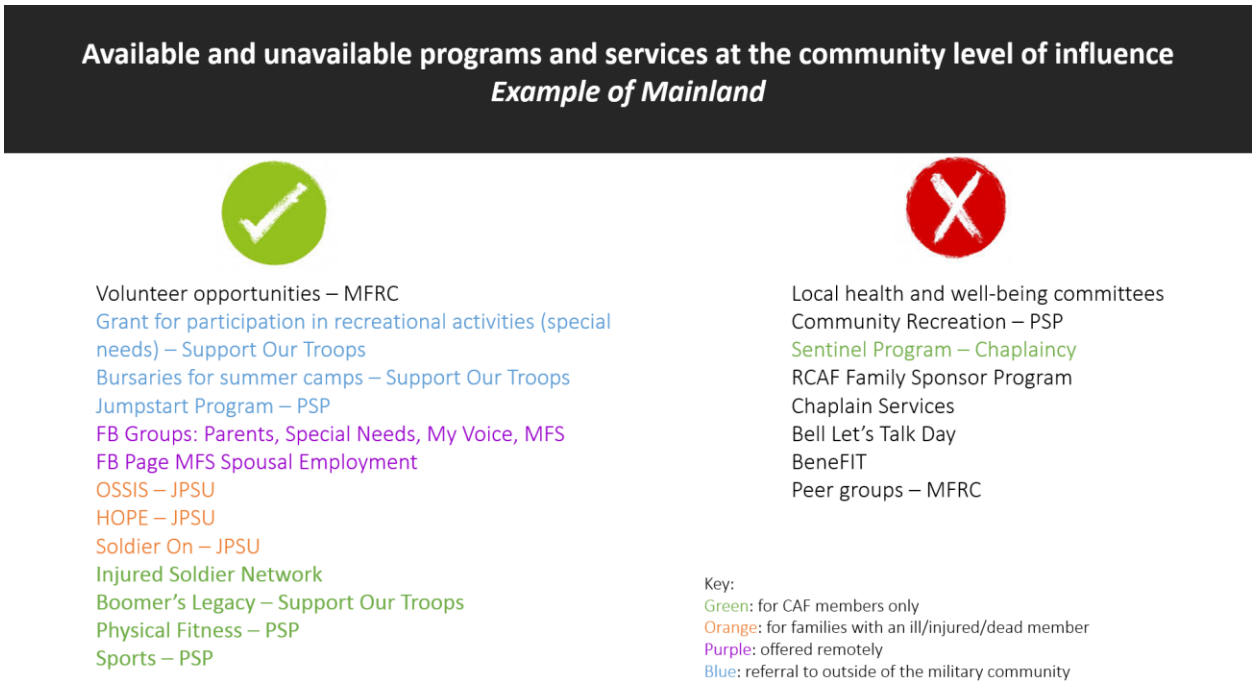

Figure 13. Available and unavailable programs and services at the community level of influence Example of Mainland

2.2.4.7.2. Family level of influence

General comments:

- The same core communities are affected by geographic disparities, representing between 2,000 and 60,000 people (members, spouses, and children): *Mainland*, *Calgary*, *Suffield*, *Dundurn*, *Meaford*, *Goose Bay*, *PEI.*
- According to the information available, the promotion/prevention services have a lower O&M/person ratio than specialized programs (e.g. BGRS, JPSU).
- Services currently offered in person are geared towards injured CAF members and their families.
- Few programs aim to support families and to provide positive environments upstream. Some community and family services should be provided in person as their strength resides in experience and discussions.
- There is information lacking on the attendance and cost of several programs (O&M).

Financial planning and counselling

Comments:

- There are no SISIP Financial offices in nine CAF communities, which represents over 1,275 families, 718 single CAF members and at least 3,200 reservists: *Calgary, Suffield, Wainwright, Moose Jaw, Dundurn, London, North Bay, Goose Bay, PEI.*
- In 2017, 6,500 members of the military community took advantage of financial counselling services and 15,500 members of financial planning services.
- SISIP Financial sends counsellors to a community when there is a request for one. A portion of the work can be done remotely.
- According to the final CAF Community Needs Assessment 2016 Overall Results (PRA, 2016), Wainwright has a high percentage of people who would like to receive more financial guidance, while London and North Bay have a lower than average percentage of financial problems.
- Recommendation 18 of the Ombudsman's Report (2018, 2013) "Empower military families in achieving short—and long-term financial wellness" could justify the presence of a SISIP counsellor or special measures to promote access.
- It is unclear whether families in communities without SISIP Financial services can access SISIP services or have a counsellor come to them.

FOCUS

Comments:

- 18,000 families, representing 60,000 people, could benefit from this training, which is one of the few resources developed for the family as a whole and which aims to better manage the challenges of military life, such as operational absences and relocations: *Esquimalt, Comox, Mainland, Calgary, Suffield, Wainwright, Dundurn, Shilo, Winnipeg, London, Borden, Toronto, Meaford, St-Jean, Valcartier, Bagotville, Gagetown, Greenwood, Gander, St. John's, Goose Bay, PEI.*
- Information on the program is hard to find.
- The training was developed for American military families. While it is an evidence-based training, it has not been adapted or evaluated for a Canadian context.
- There are not a lot of trained instructors and apparently training costs are quite high.
- Participation in the program, program frequency and program delivery are unknown.

Military housing (CFHA)

Comments:

- Six communities do not have access to military housing, which represents about 3,500 Regular Force members and 2,000 dependents: *Mainland, Calgary, London, Toronto, Meaford, Gander, PEI.*
- Five of the six communities identified in red report higher than average commute rates compared to the national average, with commutes ranging between 30 minutes and two

hours from the B/W, while Gander reports a high percentage of people unable to find appropriate housing close to the wing (PRA, 2016).

- As such, while there has been progress on Recommendation 16 of the *Progress Report on Recommendations: On the Homefront: Assessing the Wellness of Canada's Military Families in the New Millennium* (2018), to "provide suitable, accessible and affordable military housing, and facilitate home ownership", the CFHA does not serve all communities and cannot answer all requests for special needs housing accommodations.

Inter-Comm

Comments:

- Approximately 2,300 Regular Force members and their spouses could take the training if it were offered in their community: *Mainland, Calgary, Suffield, Yellowknife, Dundurn, Shilo, Meaford, North Bay, Goose Bay, PEI, Gander.*
- However, while research (Manser, 2018) identified intimate partner relationships as an important issue, the training has seen rather low attendance rates in communities where it is offered (264 participants in 2017–2018).
- There does not seem to be any research that explains why attendance rates are so low for the Inter-Comm training.

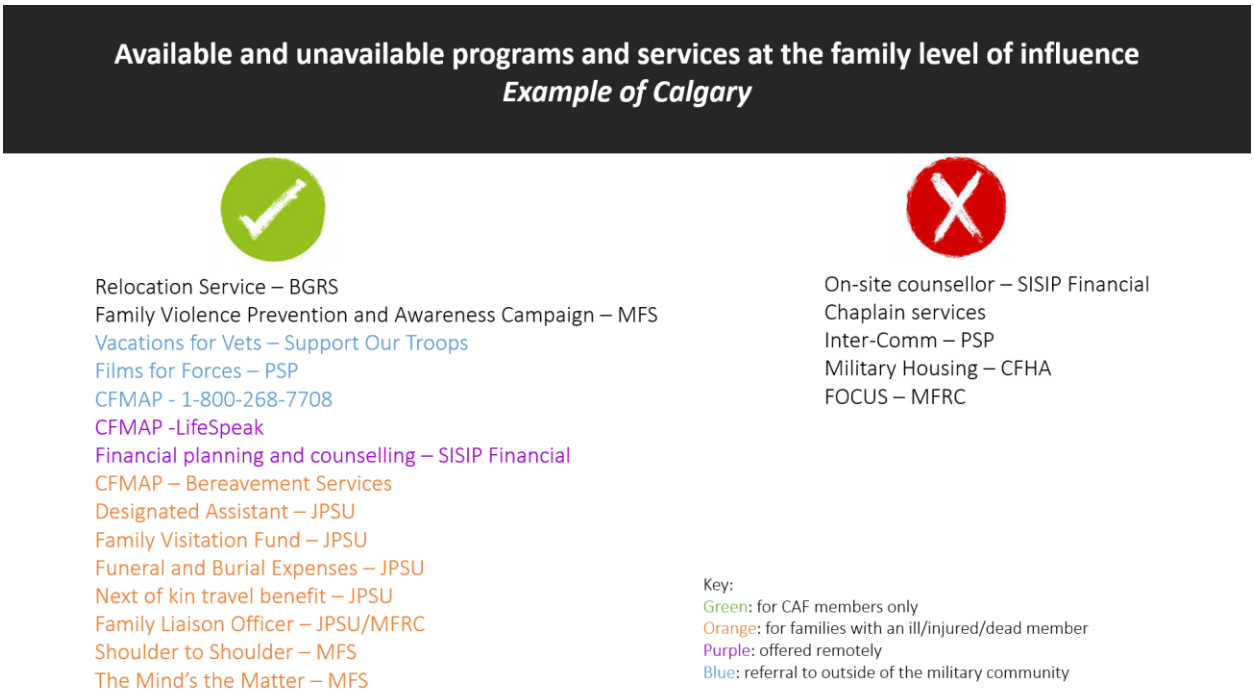

Figure 14. Available and unavailable programs and services at the family level of influence Example of Calgary

2.2.4.7.3. Individual level of influence

General comments:[27]

- The same core communities are affected by geographic disparities: *Mainland*, *Calgary*, *Suffield*, *Dundurn*, *London*, *Toronto*, *Meaford*, *Gander*, *Goose Bay*, *PEI*.
- Between 500 and 95,000 people do not have access to the programs offered in most B/W.
- Of the programs being offered, three of the eight determinants of wellness are supported (financial, psychological, occupational).
- The programs offered focus on intervention and more than half are offered remotely.
- The programs that are not offered fall into the promotion/prevention and education categories: for youth (iSTEP, FRIENDS, Kids Have Stress Too); for adults (SISIP Financial, Health Promotion, Bounce Back).
- Stakeholders supplied little data with regard to the numerous programs studied.

Financial education

Comments:

- Over 95,000 Regular Force members and their spouses could follow the training if it were offered in their community: *Comox, Esquimalt, Mainland, Calgary, Edmonton, Cold Lake, Suffield, Wainwright, Yellowknife, Moose Jaw, Dundurn, Shilo, Winnipeg, London, Borden, Toronto, Meaford, Trenton, Kingston, Petawawa, North Bay, Valcartier, Bagotville, Gagetown, Halifax, Greenwood, Gander, St. John's, Goose Bay, PEI, Ottawa.*
- Three of these communities (Comox, Wainwright and Winnipeg) have expressed needing more financial support and education (PRA, 2016).
- The program currently serves 500 recruits per year.
- Recommendation 18 of the Ombudsman's Report (2018, 2013) "empower military families in achieving short—and long-term financial wellness" could justify the national implementation of a financial education program.

Moral and spiritual development

Comments:

- The Regular Force Chaplain Services are not available in four communities: *Mainland*, *Calgary*, *London*, *PEI*. CAF members and their families must rely on civilian services in their communities.
- There do not appear to be any spiritual resilience programs available in neighbouring civilian communities.

[27] See Appendix 7 for an example on geographic disparities in the mental health continuum of services for children between 6 and 12 years of age.

- Participation in Chaplaincy activities is high, which leads us to believe that they meet a real need.

Spiritual counselling

Comments:

- The Regular Force Chaplain Services are not available in four communities: *Mainland*, *Calgary*, *London*, *PEI*. CAF members and their families must rely on civilian services in their communities.
- Over 30,000 interviews were held in other B/W in 2017, which demonstrates that the service is in demand.

Health promotion

Health Promotion programs foster confidence, the acquisition of knowledge and the development of skills to promote healthy, sustainable behaviours and decisions in the following fields: nutrition (Weight Wellness Lifestyle Program, Top Fuel for Top Performance), addiction prevention (Butt Out!, Alcohol, Other Drugs, Gambling and Gaming Awareness for Supervisors) injury prevention and active living (Injury Reduction Strategies) and social wellness (Inter-Comm, Stress: Take Charge!, Managing Angry Moments, Mental Fitness & Suicide Awareness, Respect in the CAF).

Comments:

- The following communities do not have Health Promotion offices: *Mainland, Calgary, Suffield, Yellowknife, Dundurn, Meaford, Goose Bay, PEI.*
- While a health promoter from another B/W can visit these communities for short presentations, the opportunity to provide programs over the course of several weeks and which support individuals in their behavioural changes is not possible. Furthermore, these health promotion visits mostly focus on CAF members and more rarely on families.
- CNA respondents (PRA, 2016) from *Mainland*, *Suffield*, *Dundurn* and *Yellowknife* have reported problems maintaining a work-family balance or a healthy lifestyle.

Maple

Comments:

- 24% of civilian spouses and 17% of military children do not have a family physician.
- Telemedicine services have the advantage of being offered online and have a high satisfaction rate with the 83 families participating in the pilot project (Halifax).
- The service meets recommendation 15 of the Ombudsman's report (2018, 2013): "assist military families to obtain better access to health care."
- Some segments of the population could benefit from the service: special needs, families taking care of an elderly parent and caregivers.

Strongest Families Institute

Comments:

- Close to 19,000 children could benefit from the program if it were offered in their community: *Comox, Mainland, Suffield, Wainwright, London, Borden, Toronto, Trenton, North Bay, Ottawa, St-Jean, Bagotville*.
- In 2018, 183 people participated in the program throughout the 20 communities where the program is offered.
- Mainland and Suffield have mentioned having difficulties when it comes to the wellness of their children (PRA, 2016).
- The program has been evaluated in depth and has proven to be effective for children with behavioural issues (3 to 13 years of age), anxiety (6 to 17 years of age), and nocturnal enuresis (5 to 12 years of age).
- Anxiety issues are among the most common mental health problems in children from military families (Mahar, Chen, & al., 2018).

Raise the Grade

Comments:

- More than 8,000 children could benefit from the program if it were offered in their community: *Esquimalt, Comox, Mainland, Calgary, Edmonton, Cold Lake, Suffield, Wainwright, Yellowknife, Dundurn, Moose Jaw, Shilo, Winnipeg, Borden, Toronto, Meaford, Trenton, North Bay, Ottawa, St-Jean, Valcartier, Bagotville, Halifax, Gander, St. John's, Goose Bay, PEI*.
- 45 youth participated in the program at the three pilot sites (Kingston, Gagetown, Petawawa).
- Adolescents who relocate regularly experience academic and social difficulties (Manser, 2018b), two issues the Raise the Grade Program addresses.

Our Kids Have Stress Too!

The program helps parents better understand their children's stress and better support them in effective stress management.

Comments:

- Parents of more than 16,500 children between the ages of 6 and 18 could benefit from the training if it were offered in their communities: *Esquimalt, Comox, Mainland, Calgary, Cold Lake, Suffield, Wainwright, Yellowknife, Moose Jaw, Shilo, Winnipeg, Toronto, Meaford, Petawawa, Ottawa, St-Jean, Valcartier, Bagotville, Gander, Goose Bay, PEI*.
- *Mainland, Suffield* and Winnipeg have reported difficulties regarding the wellness of their children (PRA, 2016).

- The program is consistent with Recommendation 17 (Ombudsman, 2018, 2013) to "further support families in providing a healthy environment in which to raise their children."

Friends

The program helps children (4 to 16 years of age) in their development by encouraging resilience and self-confidence, and by teaching them cognitive techniques and emotional skills. It is taught in several British-Columbian schools.

Comments:

- More than 26,000 children between the ages of 4 and 16 throughout the following communities could use it: *Comox, Mainland, Calgary, Edmonton, Suffield, Wainwright, Yellowknife, Dundurn, Shilo, Toronto, Meaford, Trenton, Kingston, St-Jean, Valcartier, Gagetown, Halifax, Gander, Goose Bay, PEI.*
- *Mainland* and *Suffield* have reported difficulties regarding the wellness of their children (PRA, 2016).
- The program has been translated into both official languages.

E=MC3 (4–12 years of age), iSTEP (6–12 years of age), YPET (12–18 years of age)

The three programs focus on youth who have a parent with an OSI.

Comments:

- Between 8,750 and 16,800 children could potentially benefit from the program in the majority of communities.
- An in-depth analysis of E=MC3 and iSTEP could allow us to see if there is duplication or complementarity in the programs, with the first having the advantage of covering 4- and 5-year-olds.
- The programs are translated in both official languages.
- These programs, developed internally, have never been evaluated and are thus not evidence-based.

Bounce Back

Bounce Back is a program founded on convincing data and run by the Ontario and British-Colombia divisions of the Canadian Mental Health Association (CMHA). It is aimed at individuals (15 years+) who suffer from mild to moderate depression, and stress with or without anxiety. The program combines coaching sessions delivered by telephone and individual workbooks.

Comments:

- The program could be offered to CAF community members living outside of Ontario and British-Colombia with proper funding.

Rainbows

Rainbows is a program that helps adults and parents cope with the loss of a loved one and support their children in the mourning process.

Comments:

- The program is not offered in most communities: *Esquimalt, Comox, Mainland, Calgary, ColdLake, Suffield, Wainwright, Yellowknife, Moose Jaw, Dundurn, Shilo, Winnipeg, London, Borden, Toronto, Meaford, Trenton, Kingston, Petawawa, North Bay, Ottawa, St-Jean, Bagotville, Gagetown, Halifax, Gander, Goose Bay, PEI.*
- The program is consistent with Recommendation 17 (Ombudsman, 2018, 2013) to "further support families in providing a healthy environment in which to raise their children."

Military Police Victim Assistance Program

Comments:

- There are no Military Police detachments in the following locations: *Mainland, Yellowknife, St. John's and PEI.*
- It is unclear what happens to victims who live in these communities.

Figure 15. Available and unavailable programs and services at the individual level of influence Example of Goose Bay

2.3. Program gaps

This section deals with gaps for programs organized in continuum of services. These programs focus on the following issues:

- Mental health, social health, childcare and early childhood, childhood and youth education.
- Military lifestyle (illness, injury or death, relocations, operational absences), family challenges (financial stress, intimate partner relationships, individual wellness and mental health).
- Under-served populations (parents of CAF members, caregivers, families caring for an elderly parent, special needs).

To consult the summary table on program gaps, see Appendix 9.

2.3.1. Early childhood, childhood and youth

Early childhood, childhood and youth programs have been grouped into three categories: mental health, social and interpersonal health, and childcare and education. For the most part, these programs support Recommendation 17 of the Ombudsman's report (2018, 2013) to "further support families in providing a healthy environment in which to raise their children."

2.3.1.1. Mental health[28]

- With regard to mental health, a larger proportion of programs focus on short-term intervention, compared to social and interpersonal health where the proportion of promotion programs is greater (Fig. 16, 17).
- There does not seem to be a strategy, awareness campaign or support group for children and adolescent mental health.
- The corpus of psychoeducational training offered by MFRCs deals with different aspects of resilience for children (Friends), parents (Our Kids Have Stress Too!) and families (FOCUS). These programs, offered mainly in person, are not easily accessible by youth who depend on their parents to participate (Fig. 18). Furthermore, these trainings, which require a certification process that can be costly, are not provided equally to the different locations (Manser, Bain, & Swid, 2016).
- Aside from the Strongest Families Institute program offered in 20 communities, there does not seem to be any mental health training or programs for children from military families,

[28] See Appendix 7 for an example of geographic disparities on the mental health continuum of services for youth between the ages of 6 and 12.

special needs support groups except for the Facebook group, or information or awareness campaigns for parents and youth.

- On the treatment side, it is fitting to assume that the limited access to a family physician will influence the diagnosis and treatment of children with mental health issues.
- Additionally, the variability of social workers' training and skills will compromise access to in-person counselling at MFRCs (Manser, 2018a).

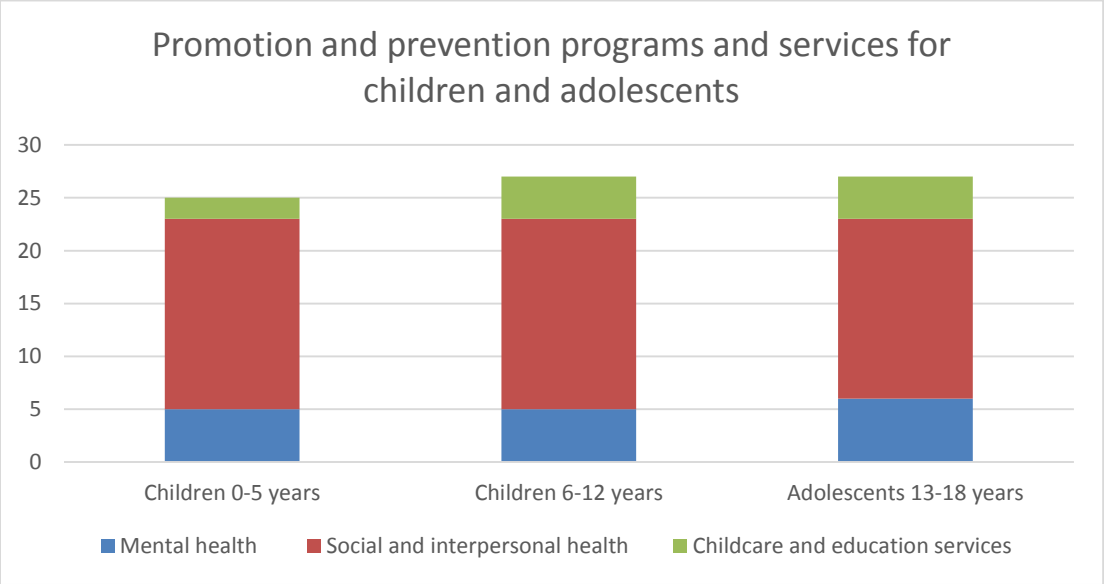

Figure 16. Promotion and prevention programs and services for children and adolescents

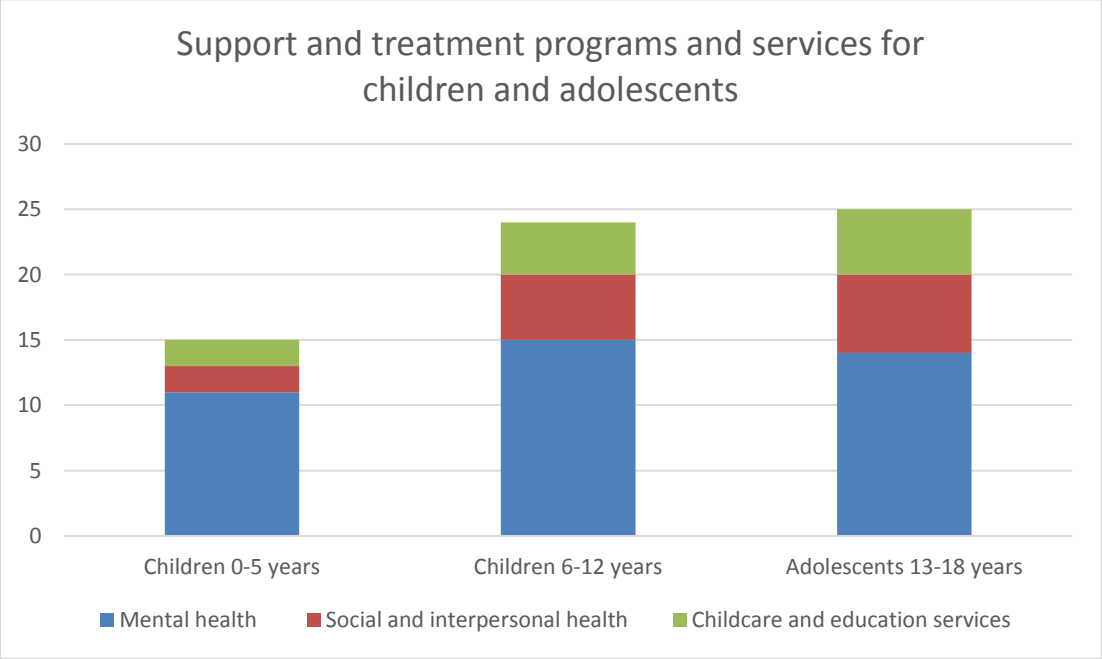

Figure 17. Support and treatment programs and services for children and adolescents

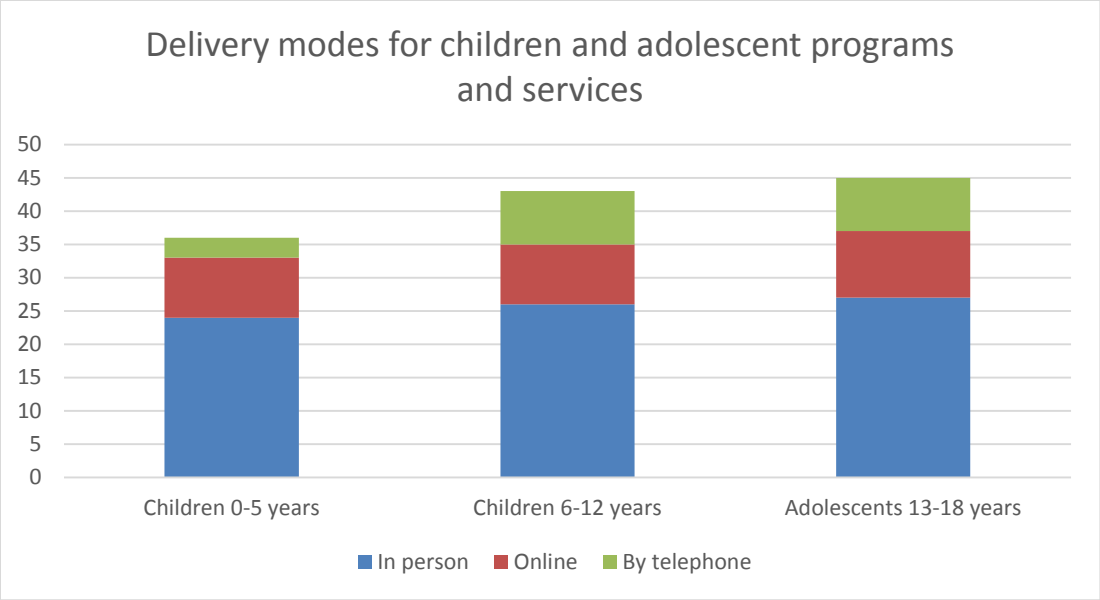

Figure 18. Delivery modes for children and adolescents programs and services

2.3.1.2. Social and interpersonal health

- It is not uncommon to see MFRCs organize activities that fall within the PSP Community Recreation portfolio.
- The financial assistance program, which grants a specific counsellor to children with special needs who want to participate in recreational activities, can only meet 30% of requests.
- Aside from CFMAP, which can refer individuals or families to a service in the community, and FIL, which can refer and support parents, there are no specific programs (coaching, education, counselling) to facilitate the social integration of children and adolescents who relocate regularly.
- PSP Community Recreation services are also not offered everywhere, in the same numbers or for all age groups.
- There is no social and interpersonal health strategy for youth.

2.3.1.3. Childcare and educational services

- There is no reliable and systematic mechanism to update the Family Care Plan.
- The Family Care Assistance program, which supports CAF single parents and service couples, does not cover all childcare costs incurred due to the demands of military service.
- The Caregivers Assistance Program (JPSU) only addresses CAF members injured in Afghanistan (a review request has been submitted).

- Of the 40% of military families use non-parental childcare, 30% of these have a hard time finding childcare services, especially for children with special needs or for atypical working hours (MFS, s.d.).
- It is uncertain whether emergency childcare service can be offered in all Canadian regions and at the right moment.
- It appears that some MFRCs deny the emergency childcare services program to CAF single parents or service couples.
- Stakeholders such as the Children's Education Management do not receive all the information regarding postings requiring relocation or receive the information late.
- Career managers should communicate systematically with stakeholders, such as the Children's Education Management, to choose the most appropriate B/W according to the needs of certain families.

2.3.2. Adults

2.3.2.1. Illness, injury or death

- Programs and services focus more on intervention than promotion.
- There is no family integration program for Soldier On activities.
- There is a large proportion of services for OSI (peer support network, mobile apps, training for family members and CAF members) as opposed to physical injuries.
- There are no recurring campaigns on existing services such as reducing the stigma associated with the use of services.
- Some forms of financial support are limited to injuries sustained in Afghanistan at the expense of CAF members injured during operations in other circumstances (e.g. Caregivers Benefit).
- There is no reliable mechanism to update the next of kin list (NOK).
- It is unclear whether promotion services (Health Promotion, PSP Community Recreation, etc.) are properly adapted to this segment of the population.
- On several local websites (CAFConnection.ca), there is no information stating whether PSP or MFRC equipment is accessible or if activities have been adapted for people with a physical disability.
- There are no tools for professionals that reflect the healing process of families, or the appropriate strategies and services to support each family member (Manser, 2015).
- We are unsure whether Family Liaison Officers receive continuing education or if they are periodically evaluated (Manser, 2015).

2.3.2.2. Operational absences

- There is no reliable or systematic mechanism to update the Family Care Plan.
- Several training courses could help with separations and reunions. These are not offered everywhere and at desired times (e.g. Inter-Comm, FOCUS, Stress: Take Charge!), except for Road to Mental Readiness (R2MR) for families.
- Cafconnection.ca: operational absences should be presented separately from deployments, and not as a deployment.
- There does not appear to be a respite program for spouses.
- MFRCs appear to focus more on deployment support and less on other types of operational absences.

2.3.2.3. Relocations

- Available information is spread over different platforms and is not equally accessible by CAF members and their civilian spouses.
- While it is difficult to reach families, there are no awareness or information campaigns on relocations and the services available to CAF members and their families.
- Relocation services offered by MFRCs are not uniform.
- There is no mechanism available to families to share comments and feedback throughout the relocation process.
- There is no single entity that coordinates all relevant services, program development, research or common performance measurements.
- The RCAF Family Sponsor Program is not available on all B/W.
- There is no point of contact for families to access all services; most services are only accessible by the CAF member.
- There is no training or guide for stakeholders and families.
- There is less support for the relocation preparation phase, including the house-hunting trip (HHT) and travel expenses.
- There are no services that deal with the financial portion of relocations (renting or buying, revenue changes for the spouse, cost of living, etc.).
- Resources accessible to the spouse are not specific to the relocation.
- Families have little control over the relocation process.
- There is no guide to help families in the relocation process that deals with aspects other than those relating to compensation and benefits.

2.3.2.4. Financial stress

- The resources currently available do not support the following determinants: physical, social, occupational, and spiritual.
- There is no official published strategy on the financial health of CAF members and their families.
- There is no recurring campaign on financial health (not to be confused with the promotion of services).
- SISIP Financial educational courses are only given at St-Jean during recruit training and only reach 500 CAF members annually. The courses should be offered throughout the entire military career, on all B/W, and should deal with different topics.
- Every B/W does not have a SISIP Financial office.
- It is unclear whether families know that they can access financial counselling services even if there is no counsellor on site. It is also unclear what SISIP Financial information is available.
- The tools available on the website are hard to find (e.g. Budget Worksheet).

2.3.2.5. Intimate partner relationships

- While intimate partner relationships can be altered by the military lifestyle and financial stress, families are using the CFMAP less than in previous years and consult it less for marital issues. However, they seem to use it more than the consortium (EAS, 2017).
- The Family Violence Prevention and Awareness Campaign is outdated. Furthermore, it did not address the different types of families or different types of violence.
- There are no national campaigns on positive relationship models or the relevance of acquiring the knowledge for a healthy, long-term relationship.
- Aside from the pre-marital counselling offered by the Chaplain services, the FOCUS training and Hold Me Tight, there are no upstream couples' workshops offered in all communities.
- Couples only have access to short-term counselling (there seems to be confusion between military health services and MFRCs on this subject).
- There is no strategy to inform program development, delivery and evaluation on intimate partner relationships.

2.3.2.6. Mental health

- Promotion/prevention programs are not accessible everywhere.
- There is no general training on the mental health of all family members.
- Compared to treatment services for CAF members, treatment services for dependents are not offered in all locations.

- There are no resilience or mental health peer support networks for families.
- There are no recurring or joint campaigns on services for families and CAF members or campaigns that promote asking for help.
- There is no strategy that informs program decision-making, development, delivery and evaluation.
- Family counselling services are short term compared to what is offered to CAF members.
- The level of counselling is not the same from one MFRC to another (Manser, 2018a).

2.3.2.7. Wellness

- Regardless of the geographic distribution of existing resources, these resources support all the determinants of wellness.
- Several MFRC activities are taken from the PSP Community Recreation portfolio.
- There are no guidelines regarding healthy lifestyle information and organizational communication.
- There is no counselling/coaching on healthy lifestyles.
- Some programs are not offered everywhere or regularly (PSP Recreation, Chaplaincy, CANEX, Health Promotion).
- There are few recurring awareness campaigns with a positive approach to CAF member and family health other than the PSP Community Recreation (June is Recreation Month) and the Health Promotion (Nutrition Month) ones.
- While most Health Promotion training courses are also geared towards families, they only touch a small percentage of families. The training courses focus on CAF members and do not really meet the needs of families (PRA, 2016). However, and in addition to the services offered by MFRCs, the Health Promotion programs have the potential to support family advocacy with regard to nutrition, social health, sports injury prevention, and addiction. Furthermore, as there are only 24 Health Promotion offices in Canada and none abroad, a flexible, remote approach could be suitable for the needs of military families.

2.3.2.8. Health care

- There are insufficient funds to implement remote health care services for 17% of military children and 24% of civilian spouses who do not have access to a family physician.

2.3.2.9. Employment

- Many policies govern the employment and education of CAF members as opposed to MFS and families.

- CAF members can access a wealth of resources compared to their spouses (e.g. School of Public Service, Defence Learning Network).
- CAF members have access to a range of financial support that is more varied than what their spouses have access to.
- CAF members have access to a network of choice employers (Public Service Employment Regulations (PSER), Employers Supporting Reservists) compared to their spouses.
- Job support services in MFRCs are not uniform.
- There are no mentoring programs by and for spouses.
- It is unclear if the Rosetta Stone program, offered in the majority of MFRCs, is sufficient to learn a second language.

2.3.2.10. Special needs

- The financial assistance program, which grants a specific counsellor to children with special needs who want to participate in recreational activities, can only meet 30% of requests.
- The CFHA only has a limited budget to adapt its housing, which limits meeting Recommendation 16 to "provide suitable, accessible and affordable military housing, and facilitate home ownership" (Ombudsman 2018, 2013).
- There is no "special needs" section on every local CAFConnection.ca website.
- There are no modules/exercises relating to families taking care of children with special needs in the Health Promotion training courses (e.g. Managing Angry Moments, Inter-Comm, Stress: Take Charge!).
- There are no strategies governing decision-making, development, delivery and evaluation of programs for children with special needs.

2.3.2.11. Parents of CAF members

- MFRCs do not meet the requests or needs of parents of CAF members and their programs are not adapted to their realities (Manser, 2018e).
- Not all programs are available or offered to parents of CAF members, whether they live in an area served by an MFRC or not.
- There are no sections for parents of CAF members on the local CAFConnection.ca websites.
- Organizational communication mechanisms do not appear to be effective for parents of CAF members.
- There is no strategy informing decision-making, development, delivery and evaluation of programs for parents of CAF members.
- Health promotion programs are not accessible to parents of CAF members.

2.3.2.12. Families caring for an elderly parent

- The programs available for families caring for an elderly parent do not support the financial determinant.
- There are no modules on families caring for an elderly parent in the Health Promotion training (e.g. Managing Angry Moments, Inter-Comm, Stress: Take Charge!).
- PSP Community Recreation does not have sufficient financing to implement the High Five program for seniors.
- The Support Our Troops programs are not adapted to this reality (e.g. ensuring emergency care for an elderly parent).
- The list of resources on CAFConnection.ca (national) does not reflect the realities of elderly people living with military families (Manser, 2018d).
- MFRC services are not adapted to or do not meet the requests and needs of these families: "The majority of respondents had not accessed any military family support services, primarily because they had been turned away, they did not have time, or they did not have services that were useful to them" (Manser, 2018d).
- There are no face-to-face or virtual support groups for these families.

2.3.2.13. Caregivers

- Generally speaking, programs for caregivers mainly address those taking care of a person with an OSI. In other words, there are few resources for caregivers of people with a physical disability (60% of medical releases are for physical issues [Manser, 2015]), elderly parents or a child with special needs.
- For caregivers of a CAF member with a physical injury, the resources available do not support the following determinants: intellectual, social (specific), occupational, financial, and environmental.
- There are no peer support groups for caregivers living with a physically injured CAF member.
- There is no training that addresses all types of caregivers.
- The Health Promotion program is not offered to veterans and their spouses despite the fact that certain training courses could be beneficial (e.g. Managing Angry Moments, Stress: Take Charge!, Weight Wellness Lifestyle, Inter-Comm).
- The Attendant Care Benefit (ACB) Program is intended only for CAF members injured in Afghanistan (a request to amend the program to open it up to other injured CAF members has been submitted).
- There are no programs to help all types of caregivers (e.g. Respite).
- Local pages on CAFConnection.ca do not mention national services for caregivers or they are spread out in different sections (e.g. Gander, Moose Jaw).

- There are no modules on caregivers and injuries in the Health Promotion training (e.g. Managing Angry Moments, Inter-Comm, Stress: Take Charge!).

3. General Recommendations

A set of recommendations was formulated from the analysis of gaps. The following recommendations correspond to general measures while specific recommendations for stakeholders have been presented to them directly.

Alignment

1. Ensure that policies and programs mutually contribute to the creation of social and physical environments that promote the wellness of CAF members and their families.
2. Establish a permanent national committee and consolidate the network of local committees to improve awareness of services, continuous communication, and the development of common strategies, action plans and evaluation systems.
3. Develop joint strategies to inform decision-making, as well as program and service development, delivery, and evaluation.
4. Implement an evaluation system for initiatives that could potentially interfere with some entities' positions or that could negatively impact the health, wellness and resilience of one or more segments of the population.
5. Create health and wellness guidelines to inform decision-making, sponsorships and event planning.
6. Implement a decision support and development tool for programs and policies to operationalize the Canadian Forces Family Covenant.
7. Implement performance measurement, program evaluation and user satisfaction systems.
8. Set up a platform where knowledge and research on CAF members and their families would be shared with leadership, stakeholders, families and the public.

Awareness

9. Use a people-centred approach to standardize how program- and service-related information is sourced and presented.
10. Educate Defence staff and volunteers on the full suite of existing programs and services.
11. Plan, coordinate and organize recurring targeted awareness campaigns.
12. Host CFMAP in all B/W and MFRCs.

Advocacy

13. Implement a holistic client approach founded on program knowledge and references between stakeholders.
14. Create a communication strategy promoting the power of asking for help as a resilience factor for individuals, communities, and organizations.

Availability

15. Review and amend the policies that hinder the delivery and accessibility of programs and services, or that are likely to have unwanted negative effects on the wellness of CAF members and their families.
16. Explore new modes of delivery for select programs and services.
17. Identify a core of authorized and research-supported programs that should be accessible to all CAF members and their families and in all communities.
18. Develop and maintain government and non-government partnerships to increase program and service offerings, stimulate actions in the communities and facilitate community integration.

Conclusion

The objective of this report was to summarize the methodologies, processes and results of the mapping and analysis of CAF member and family program and service gaps, as well as the general recommendations that aim to reduce these gaps.

As the health of a population is a dynamic and complex state and requires the development of sophisticated interventions, directing collective efforts to reduce the gaps identified has the potential to positively influence the health, wellness and resilience of CAF members and their families.

Consequently, the alignment of services could be optimized by creating permanent national and local committees to improve awareness of services, continuous communication, and the development of shared strategies, action plans and evaluation systems. These organizations could also act as a means to evaluate programs and initiatives that could potentially interfere with some entities' positions or negatively impact the health, wellness and resilience of one or more segments of the population.

The communication processes such as the amalgamation of the numerous websites into a single one, the coherent presentation of programs, the organization of recurring awareness campaigns, and the creation of a reference system between stakeholders has the potential to facilitate the search for information, and program awareness and access for families.

Program availability could be increased through three types of measures: collective measures (e.g. national and local committees), measures specific to each service provider (e.g. new program delivery modes), and government measures aiming to allocate the resources required to democratize certain key programs (e.g. relocation experts, telemedicine, PSP Community Recreation, and professional counselling for spouses looking for employment).

Last, the gaps presented in this report and the corresponding recommendations aim to promote advocacy and provide different types of families with the power to act. Because, in order for them to keep exercising their important role within the CAF, they must remain strong, confident and committed.

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APPENDIX 1 —Determinants of Wellness

COMPREHENSIVE MILITARY FAMILY PLAN – NEEDS AND SERVICES MAPPING TEMPLATE

Stakeholder: *Consider Populations with Additional Challenges = single parents, dual service couples, dependents with special needs, conflict/breakdown*

Military Lifestyle Challenge→	**POSTINGS RESULTING IN GEOGRAPHIC RELOCATION**											
Family Segment→	Single Member & Parents		New Family Young Children (0-12)		Mature Family Adolescents (13-18)		Post-Secondary Family (19-24)		Empty Nesters / Couples Without Children		Retired Family	
Determinant of Wellness ↓	Existing Program & Services	Canforgen/ related Policies	Existing Program & Services	Canforgen/ related Policies	Existing Program & Services	Canforgen/ related Policies	Existing Program & Services	Canforgen/ related Policies	Existing Program & Services	Canforgen/ related Policies	Existing Program & Services	Canforgen/ related Policies
Physical	•	•	•	•	•	•	•		•	•	•	•
Emotional / Psychological	•	•	•	•	•	•	•	•	•	•	•	•
Intellectual	•	•	•	•	•	•	•	•	•	•	•	•
Social	•	•	•	•	•	•	•	•	•	•	•	•
Occupational / Vocational	•	•	•	•	•	•	•	•	•	•	•	•
Spiritual	•	•	•	•	•	•	•	•	•	•	•	•
Financial	•	•	•	•	•	•	•	•	•	•	•	•
Environmental	•	•	•	•	•	•	•	•	•	•	•	•

APPENDIX 2 — Analysis grid for geographic gaps for community/interpersonal programs

(working document reproduced as is)

Program: Analysis Factors:	RCAF Family Sponsorship Program	Local Health and Wellness Committees	Sentinel Program	PSP Recreation Program	Bell Let's Talk Campaign	MFRC Peer Support Group	Benefit	Spiritual Care and Support
Which locations are affected? [in red are locations that don't have the program and that don't reach the average of program number] 1-3 locations = 0 pt / 4-8 locations = 2 pts / 9+ = 3pts	SCORE=3 Esquimalt (2123)[29], Mainland, Calgary, Edmonton (2103), Suffield (54), Wainwright (316), YK, SK, Shilo (545), London, Toronto (654), Meaford, Petawawa (2607), Ottawa (4804), Montréal (542-798), Valcartier (2991), Gagetown (2541), Halifax (3496), St-John's (66), PEI 3	SCORE=3 Comox (2442-157), Mainland, Calgary, Cold Lake (4339-65), Suffield (261), Wainwright (1517-122), YK, SK, Toronto (2904-3830), Meaford (150), Petawawa (12495-613), Ottawa (20010), Mtl (4461-2408-2975), Bagotville (3386-550), Greenwood (4078-210), St-John's (278-725), Goose Bay (198), PEI 3	SCORE=2 Mainland, Calgary, London (309-3142), PEI 2	SCORE=3 Mainland, Calgary, SK, London (309-3142), Meaford, Gander (306-165), St-John's (278-725), Goose Bay (198), PEI 3	SCORE=2 Mainland, Calgary, Suffield (261), YK, SK, Meaford (150), Goose Bay (198), PEI 2	SCORE=0 SK 0	SCORE=2 London (309-3142), YK, SK, Mainland, Calgary, Toronto (1118-3830/1786), Gander (117-165/189), PEI 2	SCORE=2 Mainland, Calgary, London (3451), PEI 2
Impacted population	Spouses: 18,836	REG Force and dependents: 58,928 RES Force: 9,247	Reg Force and RES: 3,451	Reg Force and dependents: 1,091 RES Force: 4,032	609+	Unknown	REG Force and their families: 3,519 RES Force: 7,161	REG Force: 309 / RES Force: 3142 / Family: unknown
Reach of the program where it is currently being offered	Unknown; however at trial locations approximately 10% of posted-in families accepted sponsors	Unknown	3000 qualified sentinels	160,000.00 enrollments	22/24 HP offices organize activities in addition to HQ	Unknown	Unknown	ALL FAITH COMMUNITIES activities: 2,493 / Participants: 56,240 ROMAN CATHOLIC activities: 2,151 / Participants: 75,560 PROTESTANT activities: 1,719 /

[29] The number in parentheses represents the number of people targeted by the program for each community.

Program: Analysis Factors:	RCAF Family Sponsorship Program	Local Health and Wellness Committees	Sentinel Program	PSP Recreation Program	Bell Let's Talk Campaign	MFRC Peer Support Group	Benefit	Spiritual Care and Support
								Participants: 33,382 Other Faith Ministry activities: 90 / participants: 598 Sessions/interventions: 39,673 TOTAL participants: 165,780 TOTAL activities: 6,453
Linked with ombudsman or ADMRS (2pt)	SCORE=2 SSE 24: Relocation expertise; Ombudsman Report [Communicate more effectively with military families]; ADMRS [Volunteer helps with community engagement. High level of volunteering] 2	SCORE=2 Ombudsman Report [Communicate more effectively with military families]; 2	SCORE=0	SCORE=0	SCORE=0	SCORE=0	SCORE=0	N/A
Linked with Family or Military Journey primary Challenges? (2 pts)	SCORE=2 Relocation 2	SCORE=2 Potentially All 2	SCORE=2 Mental Health 2	SCORE=2 Mental Health/wellness 2	SCORE=2 Death & Injury 2	SCORE=2 Mental Health 2	SCORE=2 Wellness 2	SCORE=2 Mental Health/Wellness 2
Linked with Com Needs Ass (0 pt = 1 community / 1 pt 2 communities / 2 pts 3 communities+)	SCORE=0 **SK**: Higher rate posted less than 2 years (0)	SCORE=2 **St-John's**: Higher % experienced problems with own wellness. **Mainland**: Higher % across most work/life balance problems. **SK:** Higher % want more activities to	SCORE=1 **London**: Can—Higher % experiencing work/life balance problems, Higher % needing counselling for relationship problems, Higher % needing	SCORE=2 **Mainland, PEI**: Higher number live more than 2 hours away from the nearest base, Higher percentage experience problems with child's wellness. **London**: Higher %	SCORE=1 **Dundurn**: Higher % of male and lower % of female. **St-John's**: Higher % experienced problems with own wellness (1)	SCORE=0 N/A 0	SCORE=0 **YK**: Higher % have problems maintaining a healthy diet. (0)	SCORE=2 **Mainland**: Higher % across most work/life balance problems. **Calgary**: Lower rate of problems across all domains. **London**: Higher % experiencing

Program: Analysis Factors:	RCAF Family Sponsorship Program	Local Health and Wellness Committees	Sentinel Program	PSP Recreation Program	Bell Let's Talk Campaign	MFRC Peer Support Group	Benefit	Spiritual Care and Support
		support work/life balance, Higher reliance on the private sector to support work/life balance. **Calgary**: lower rate of problems across all domains. **Petawawa**: Higher % have problems getting access to HC, Higher % needed counselling for relationship problems, Higher % needed professional counselling for personal wellness problems. Suffield: Higher % have child care problems, Higher % have problems with spousal employment, higher % have problems with personal wellness, Higher % have problem dealing with child wellness. **Wainwright**: Higher % have problem finding affordable option for REC, Higher number live on/close to base, Higher % have difficulty finding	counselling for personal wellness problems. **Calgary**: Lower rate of problems across all domains (1)	needing counselling for personal wellness problems, higher % participated in PSP activities to spend time with family, Lower % agreed that there are rec facilities and programs available for people of all ages. **Goose Bay, Gander**: Higher number live on or closer to base. **Gander**: Higher reliance on personal network and MFRC. PSP and private for work life balance. **GooseBay**: Higher % participated in MFRC and PSP, Rated PSP as more relevant to their lifestyle, Rated gym, rec clubs priority for funding, rated fitness and wellness and travel higher to better meet rec and leisure needs. **SK**: Higher % want more activities to support work/life balance, Higher reliance on the private sector to				work/life balance problems, Higher % needing professional counselling for personal wellness problems. 2

Program: Analysis Factors:	RCAF Family Sponsorship Program	Local Health and Wellness Committees	Sentinel Program	PSP Recreation Program	Bell Let's Talk Campaign	MFRC Peer Support Group	Benefit	Spiritual Care and Support
		suitable housing, Higher % have problem accessing after-school REC, Higher % need help accessing HC, Higher % requiring assistance with financial problems. (2)		support work/life balance (2)				
Presence of an equivalent service in the CAF or the civilian community? (YES = 0pt, No = 1pt)	SCORE=0 For service awareness: Ombudsman map, CAF connection. For welcome: welcome package sent by most MFRCs	SCORE=1 Public Health Units but do not necessarily address military family lifestyle challenges 1	SCORE=1 No. But exists in Qc: https://www.aqps.info/se-former/sentinelle.html 1	SCORE=0 PEI: http://recreationpei.ca/index.php?page=programs_overview AND High Five and Jumpstart programs Goose Bay: Municipal Rec yes (minimum), YMCA (day camps, fitness, events), Wing: swimming, clubs and fitness class. Children stuff are taken care of by MFRC St-John's: http://www.stjohns.ca/living-st-johns/recreation-and-parks (JumpStart and High Five): events, classes adults, REC pass with access 7 facilities Gander: https://rec.gandercanada.com/ Meaford:	SCORE=0 Campaign is conducted primarily in the civilian community	SCORE=1 Some community groups/associations and peer support groups exist in the community but nothing related to military family lifestyle. 1	SCORE=1 No, but it is possible to order online CANEX 1	SCORE=0 Yes

Program: Analysis Factors:	RCAF Family Sponsorship Program	Local Health and Wellness Committees	Sentinel Program	PSP Recreation Program	Bell Let's Talk Campaign	MFRC Peer Support Group	Benefit	Spiritual Care and Support
				https://meaford.ca/communityservices/recreation-programs.html London: https://www.london.ca/residents/Recreation/Registration/Pages/Registration.aspx Dundurn: not really / SK: (high five?) https://www.saskatoon.ca/parks-recreation-attractions/recreational-activities-fitness/leisure-guide Calgary: http://recguide.calgary.ca/activities_or_locations Mainland BC: https://ca.apm.activecommunities.com/vancouver/Home				
TOTAL SCORE	**7**	**10**	**6**	**7**	**5**	**3**	**5**	**6**

APPENDIX 3 — Example of a program evaluation grid

		Answer
Relevance	What is the expected outcome of the program?	
	Which identified need was the program created to address?	
Coverage	What is the target population?	
	How many people participate in the program per year?	
	Is it offered to veterans?	
	Is it offered to CAF members and families living abroad?	
	Is it offered to men and women?	
Efficiency	How many times is it offered per year (or how many times was it offered in the last fiscal year?)	
	How many times is it given per year (or in the last fiscal year)?	
	What is the duration of the program in hours?	
	What are the costs associated with the program (O&M)?	
	What is the program's delivery mode(s)?	
	Are stakeholders involved in program delivery?	
Effectiveness	Do you have a system to get feedback from users?	
	Has the program been officially evaluated? If it has, please send the evaluation to: anne.chartier@forces.gc.ca.	
	If the program has never been officially evaluated, how do you know it is effective? What criteria do you use to evaluate the success of the program with regard to the expected outcome?	
Accessibility	Are there hurdles associated with program delivery? What are they?	
Gap	Are you aware of gaps with regard to the program? What are they?	

APPENDIX 4 — Continuum of services summary table

	Develop individual skills				Support individuals			Reorient services		Build public policies	Reinforce community action	
	Social marketing awareness campaign	*Information*	*Education*	*Professional development*	*Support services*	*Counselling*	*Financial support*	*Surveillance*	*Joint action and committee*	*Policies and strategies*	*Peer support*	*Community intervention*
Youth mental health	no	yes	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Youth social health	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Education and childcare	No	Yes	No	No	Yes	Yes	Yes	No	No	Yes	No	No
Intimate partner relationships	Yes	Yes	Yes	No	No	Yes	No	Yes	No	Yes	No	No
Financial stress	No	Yes	Yes and no	No	Yes	Yes	Yes	Yes	No	Yes	No	No
Relocations	No	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Absences	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No
Illness, injury or death	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Adult mental health	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Wellness	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Health services	No	Yes	No	No	No	No	No	No	Yes	No	No	No
Employment	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No
Special needs	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No
Caregivers	No	Yes	Yes	No	No	Yes	Yes	Yes	No	No	Yes	No

APPENDIX 5 — Communication, information and awareness tools

Websites	National Facebook groups	National Facebook pages	Mobile applications	Publications
www.cfmws.com www.forces.gc.ca www.sisip.com www.canada.ca/en/department-national-defence.html www.irp-pri.com/start/cf_members/index.asp www.canex.ca/ www.cfappreciation.ca www.ombudsman.forces.gc.ca www.supportourtroops.ca http://strongproudready.ca/missionready/en/home-en/ www.CAFConnection.ca www.soldieron.ca/ www.veterans.gc.ca/eng/e_services www.canadacompany.ca/en/ www.rcnbf.ca/ http://navybikeride.ca/ https://armyrun.ca/ www.boomerslegacy.ca/Home	Parent support group Special needs My Voice Injured Soldier Network	PSP MFS Spousal Employment	Respect in the CAF Road to Mental Readiness (R2MR) Coach ESPT Canada Connexion TSO	Play Magazine dfit.ca newsletter B/W newspapers Family Guide to Military Experience Veteran Family Journal You Are Not Alone Guide CAP3 Family Guide CAP3 Prepare for Back to School The Guide to Benefits, Programs, and Services for Serving and Former CAF Members and their Families The ABCs of Military Posting

APPENDIX 6 — Summary table of available and unavailable wellness programs and services on an under-served base[30]

Develop individual skills	*Social marketing awareness campaign*	Nutrition month — PSP	June is recreation month — PSP							
	Information	CAP3 Family Guide	CFMAP & LifeSpeak	Play Magazine	Veteran Family Journal	Family Information Line	Dfit.ca newsletter for Families and Veterans	CAFConnection.ca	Mission: resources at your fingertips	
	Education	Health Promotion	Moral and spiritual development							
	Professional development									
Support individuals	*Support services*	PSP Deployment operations support	Sports and physical fitness program, dfit.ca	Soldier On	Religious services	BeneFIT	Films for Forces	PSP Community Recreation	MESS	Dfit.ca for Families and Veterans
	Counselling									
	Financial support	CAF Appreciation Program and MapF1	Vacations for Vets							
Reorient services	*Surveillance*	*Community Needs Assessment* 2016	Health and Lifestyle Information Survey of Canadian Forces Personnel, 2013-14	NANOS 2018						
	Joint action or committee	Local health and wellness committees (13/32)								
Build public healthy policies	*Policies and strategies*	DAOD 5044-1 Families	DAOD 5045-0, Canadian Forces Personnel Support Programs	Total health and wellness	Other charges	Called to Serve 2.0				
Reinforce community action	*Peer support*									
	Community intervention	Chaplaincy special groups and projects								

[30] Key: Green: program for CAF members / Orange: program dealing with the illness/injury/death of a member / Grey: unavailable program / Black: available program

APPENDIX 7 — Summary table of available and unavailable youth (6-12 years) mental health services on an under-served base[31]

Develop individual skills	*Social marketing awareness campaign*							
	Information	MFRC info and references	CAFConnection.ca	Mission: resources at your fingertips	Family Information Line	Family Liaison Officer	MFS Guide on mental health resources	CFMAP
	Education	Kids Have Stress Too	The Mind's the Matter	Friends	FOCUS	Strongest Families Institute	iSTEP	YPET
	Professional development	In-person Resilience Training (every 2 years) SFM	High Five Program					
Support individuals	*Support services*	Family Information Line	E=MC3	Maple	MDFN	Military Police Victim Assistance program	Shoulder to Shoulder	
	Counselling	Kids Help Phone	Family Liaison Officer	CFMAP	CFMAP Bereavement Services	MFRC Counselling		
	Financial support	Financing for special needs Support Our Troops						
Reorient services	*Surveillance*	Mental Health Services for Military Families (April 2016)	Mental Health and Military Families (May 2018)	Community Needs Assessment (2016)	Final Report: Understanding the health of Canadian military families: Special priorities for development of the Comprehensive Military Family Plan			
	Joint action or committee	MFSP Working Group on Family Violence Prevention and Intervention						
Build healthy public policies	*Policies and strategies*							
Reinforce community action	*Peer support*							
	Community intervention							

[31] Key: Green: program for CAF members / Orange: program dealing with the illness/injury/death of a member / Grey: unavailable program / Black: available program

APPENDIX 8 — Summary table of systemic gaps

Systemic Gaps

Many gaps could be solved at the systemic level by better coordinating collective efforts, planning strategically and evaluating program systematically.

Awareness √	Advocacy √	Availability √	Alignment √
Awareness of programs and information search by families √ √ - Too many sources of information that are not centralized, coordinated, and available (DWAN vs non DWAN). - Information about programs is not presented in a common and comprehensive fashion. - National and local don't refer to each other making difficult for families to find all the info they need (ConnectionFAC.ca).	**When, where and how to use available services √ √** - No campaign on when/how/why using services as an individual & family resilience strategy. - No systematic referral system - No holistic customer approach. .	**Barriers to delivery identified by stakeholders √ √** - Lack of continuous communication amongst stakeholders. - Limited resources. - Policies can impact negatively communication with families, delivery and access to program.	**Continuum of services √ √** - Strong in types of services geared to individuals compared to services geared to community (awareness & social marketing campaigns, strategy & policy, joint action, supportive environments). **Family as a whole √ √** - Few programs aim to support the family as a whole. Of those existing, they are not offered everywhere, and in a similar capacity.
Awareness of programs and referrals by stakeholders √ √ - No organizational training or tool (i.e. wheel of services) on existing services. - Stakeholders have a limited knowledge about all CAF programs. - No existing tool to help finding program for referral.		**Geographic inequities √ √ √ √** - Many services are not available in all locations which disrupt most continuums of services. - In remote locations family members are not equally supported in terms of determinants of well-being. - Many services that are not available aim to support community connectivity and vitality. - The following locations are particularly impacted: Mainland, Calgary, YK, Suffield, Dundurn, Moose Jaw, London, Meaford, Gander, St-John's, Goose Bay, PEI.	**Joint Action / Backbone support √ √ √ √** - No permanent national and local (13) committees dedicated to the well-being of the CAF community.
Awareness and social marketing campaigns √ √ - Few recurring awareness campaigns to promote services and positive health to all, families, and ill & injured.		**Fairness amongst family members √** - Disparities in number and types of programs are mainly in the occupational and primary health care areas.	**Common agenda √ √ √** - No strategic documents to guide program development and implementation of new initiatives for families. - No common platform to disseminate research to CoC, stakeholders and families. - No mechanisms to integrate conflicting priorities within a project/initiative
		Program delivery modes √ √ - Program in-person are community and/or promotion/prevention focused but are not offered in every locations and in similar capacity.	**Shared measurement √ √** - Uneven program evaluation processes (process, impact, feedback users).

APPENDIX 9 — Summary table of program gaps

Programming Gaps – Children and Youth

Gaps in programming are mainly caused by systemic ones. Though, many of them could be mitigated by better funding, while others by exploring new modes of delivery.

	Mental Health	Social / Interpersonal	Child Care	Education
Awareness	- No awareness campaign for mental health issues commonly experienced by CAF children √ √ √		- No reliable mechanism to update the Family Care Plan √ - It is unclear if families know about the MFRC emergency child care and the corresponding policy √ √	- Need for all stakeholders to be informed of the upcoming changes to posting (new location, increased in number) √ √ - Need for an increased interface opportunities with CMs to ensure that they are aware of posting location caveats for children of certain age/grades √ √
Advocacy				- Not enough access to military families posted within Canada to CEM Guidance Counselling √ - No database to better help families √
Availability	- Resilience workshops for the different levels of influence but not offered in all locations √ √ - Train the trainer trainings require certification and are costly - No support groups for parents and their children √ - One program only for mental health issues commonly experienced by CAF children offered Canada-wide √ √ - Limited access to physician for 17% of children may impact early diagnosis and treatment √	- No specific program to support social integration for kids who relocate on a regular basis √ √ √ - Special needs REC program cannot address 70% of the requests to provide individual assistance to kids who want to participate in recreational activities √ √ - PSP Community Recreation program is not offered everywhere, at the same capacity and for all group ages √ √	- The CAF Family Care Assistance Program is insufficient to cover child care expanses √ - It is uncertain families can access emergency child care it in remote locations when they need √ - Dual service couple and/or single military member don't have access to MFRC emergency child care in all MFRC √ √ - Caregiver Benefit program is offered just for members injured in Afghanistan √ √ √	- Not enough of Special needs qualified teacher in overseas schools √ - Insufficient French First language programming for JK and SK √
Alignment	- Inconsistency of services offered in MFRCs √ √ - No strategy √ √ √	- Duplication of services in between MFRCs and REC in some locations. √ - No strategy √ √ √	- 40% of families use child care. Of those, 30% struggle to find child care services for special needs kids and atypical working hours √ √ √	- Provincial disparities can cause a child to repeat a year of schooling or have to take extra course. This causes considerable stress for the children and affects the family`s resiliency √ √

Awareness √ Advocacy √ Availability √ Alignment √

APPENDIX 9 — Summary table of program gaps (continued)

Programming Gaps

Gaps in programming are mainly caused by systemic ones. Though, many of them could be mitigated by better funding, while others by exploring new modes of delivery.

	RELOCATIONS DUE TO POSTINGS	FAMILY ABSENCES DUE TO OPTEMPO	OP-RELATED INJURY · DEATH
Awareness	- Information is spread out and not equally available between the MM and the spouse √ √ - No recurring campaign about the relocation process and available services √ √ √ - Inconsistency of services across MFRCs √ √ - No mechanism for families to report problems and communicate with service providers during the relocation journey √ √ √	- Services for op-tempo absences or Imposed restriction cannot be found easily on national and local CAFConnection.ca sites √ √	- No awareness campaigns √ √ √ - It is unclear if local infrastructures are adapted to injured or special needs population (CAFConnection.ca).
Advocacy	- Families have little control over the processes √ - Resources accessible to spouse are mostly non-specific to relocation √ √ - No point of contact for all services and/or to the spouse √ √		- There is no Injury recovery trajectory tool to help families and helping professionals navigating the recovery process √ - No program using evidence-based strategies tailored for the military Canadian context.
Availability	- RCAF Family Sponsorship Program is not offered in all B/W √ - Less services to support the pre-posting and HHT √ - No training for stakeholders and families √ √ - No comprehensive guide to help families navigating relocation	- No respite care for the spouse √ - Some programs can support the family unit during separation and reunion, but most are not necessarily available at the right time and location. √	- Some financial aids (Caregiver Benefit, Spousal Education Upgrade Benefit, Attendant Care Benefit) are limited to injury that occurred in Afghanistan √ √ - No reliable mechanism to update the NOK list. √ √ - No program integrating families in Soldier On activities. √
Alignment	- No one person or agency that knows all the needed information √ √ - No committee to coordinate all stakeholders, research, measurement and actions √ √ √ √ - No expertise in relocation process for many stakeholders (e.g. SISIP)	- MFRC services seem to be focused on deployment and not necessarily on op-tempo absences and IR √	- More intervention than promotion/prevention programs √ √ - No strategy √ √ √ - It is unclear if non-specific promotion/prevention existing programs are well tailored for this population. - It is unclear if Flo and VFP coordinators receive training to help families navigating the trajectory of recovery. - Most programs are for OSI than for physical injuries. √ √

Awareness √ Advocacy √ Availability √ Alignment √

APPENDIX 9 — Summary table of program gaps (continued)

Programming Gaps

Gaps in programming are mainly caused by systemic ones. Though, many of them could be mitigated by better funding, while others by exploring new modes of delivery.

	FINANCIAL STRESS	MENTAL HEALTH & WELL-BEING	RELATIONSHIP WITH INTIMATE PARTNER
Awareness	- No recurring awareness campaign on financial health √ √ √ - It is not clear if families know they can access SISIP services even if there is not counsellor on site. - It is not clear what information is available to families on B/W where there is no counsellor.	- No recurring and joint campaign on how/when/why using services as a factor for individual, family and community resilience √ √ √ - Very few campaigns to promote healthy living lifestyles √ √	- Family Violence Prevention campaign is out-dated √ √ √ - No awareness campaign on positive intimate relationship and available services √ √ √
Advocacy	- No mentoring by and for employment spouses	- No peer support group/sentinel program for families	- Families are using less CF MAP in general and are requesting it less for marital issues, but they use more the service in comparison with the consortium √ √
Availability	- No Financial literacy program for all √ √ - No SISIP counsellor in every locations √ - Few professional development resources for spouses - Limited financial aids to support spousal employment and education - No employer of choice program - Unclear if current MFRC language trainings are enough to facilitate employment for spouses	- Mental health promotion/prevention programs are not accessible in all locations √ √ - Counselling services are not equally dispensed in terms of geographic location and capacity - Limited access to physician for 24% of spouses may impact early diagnosis and treatment - Outside of LifeSpeak, there are no counselling services supporting healthy living of families - No long term counselling services for spouses and children - Many programs supporting well-being are not offered everywhere and/or in the same capacity √ √	- Supporting workshops (i.e. FOCUS, MAM, Inter-Comm, Pre-marriage instructions, Hold Me Tight) are not available in all locations and have small participation rates √ √ √ - Outside of CFMAP, there is no formal couple counseling offered on site.
Alignment	- No formal strategy √ √ √ - Very few strategy and policies to support spousal employment compare to MM. - Inconsistency of services across MFRC	- There are no organizational guidelines to orient communication, information and sponsorship contracts √ √ - No strategy √ √ √ - Duplication of activities between MFRC and Recreation	- No strategy √ √ √

Awareness √ Advocacy √ Availability √ Alignment √

APPENDIX 9 — Summary table of program gaps (continued)

Programming Gaps

Gaps in programming are mainly caused by systemic ones. Though, many of them could be mitigated by better funding, while others by exploring new modes of delivery.

	FINANCIAL STRESS	MENTAL HEALTH & WELL-BEING	RELATIONSHIP WITH INTIMATE PARTNER
Awareness	- No recurring awareness campaign on financial health √ √ √ - It is not clear if families know they can access SISIP services even if there is not counsellor on site. - It is not clear what information is available to families on B/W where there is no counsellor.	- No recurring and joint campaign on how/when/why using services as a factor for individual, family and community resilience √ √ √ - Very few campaigns to promote healthy living lifestyles √ √	- Family Violence Prevention campaign is out-dated √ √ √ - No awareness campaign on positive intimate relationship and available services √ √ √
Advocacy	- No mentoring by and for employment spouses	- No peer support group/sentinel program for families	- Families are using less CF MAP in general and are requesting it less for marital issues, but they use more the service in comparison with the consortium √ √
Availability	- No Financial literacy program for all √ √ - No SISIP counsellor in every locations √ - Few professional development resources for spouses - Limited financial aids to support spousal employment and education - No employer of choice program - Unclear if current MFRC language trainings are enough to facilitate employment for spouses	- Mental health promotion/prevention programs are not accessible in all locations √ √ - Counselling services are not equally dispensed in terms of geographic location and capacity - Limited access to physician for 24% of spouses may impact early diagnosis and treatment - Outside of LifeSpeak, there are no counselling services supporting healthy living of families - No long term counselling services for spouses and children - Many programs supporting well-being are not offered everywhere and/or in the same capacity √ √	- Supporting workshops (i.e. FOCUS, MAM, Inter-Comm, Pre-marriage instructions, Hold Me Tight) are not available in all locations and have small participation rates √ √ √ - Outside of CFMAP, there is no formal couple counseling offered on site.
Alignment	- No formal strategy √ √ √ - Very few strategy and policies to support spousal employment compare to MM. - Inconsistency of services across MFRC	- There are no organizational guidelines to orient communication, information and sponsorship contracts √ √ - No strategy √ √ √ - Duplication of activities between MFRC and Recreation	- No strategy √ √ √

Awareness √ Advocacy √ Availability √ Alignment √