

The Caregiving, Health and Work of Canadian Forces (CHAW-CF) research project: Using community based research methods to influence family policy in the Canadian military

Cyndi Brannen

IWK Health Centre

Kathy Petite

Deborah Norris

Mount Saint Vincent University

Major Cheryl Baldwin

CPO1 Barbara Corbett

LCdr Donna Harding

Department of National Defence

The Caregiving, Health and Work of Canadian Forces Members (CHAW-CF) Research Program is an innovative collaboration between researchers, military members, and Department of National Defence stakeholders with an aim of developing policies and programs that lead to better health for military members and their families. In this paper, we present the framework for this alliance, discuss the origins and challenges of our collaboration, and reflect upon this “work-in-progress.” We offer our framework as a tool to help other researchers wishing to embark on community participatory research alliances with the military or other large organizations.

Community participation in research is widely accepted as a method that empowers vulnerable and marginalized populations by giving a voice to community participants throughout the research process thereby improving the relevancy of the research and increasing the likelihood of positive outcomes (e.g., Eversole, 2003; Thurston, Farrar, Casebeer, & Grossman, 2004). Whyte (1989) advocated the use of a participatory action framework that furthers the generation of knowledge and provides a beneficial practical outcome for the community. Furthermore, Whyte (1989) proposed this approach could also be applied to corporate cultures. Regardless of the type of community, participants serve as key informants who contribute “expert” knowledge through all aspects of the research process including focus, design, instruments, and dissemination (Eversole, 2003; Thurston, Farrar, Casebeer, & Grossman, 2004; Whyte, 1989). Despite this desirable and worthy goal, several authors have acknowledged the challenges including trust, community heterogeneity, consensus, and resource strain (Eversole, 2003; Suarez-Balcazar, Harper, & Lewis, 2005; Thurston et al., 2004; Wells et al., 2006). However, the challenges of community based research projects are minor drawbacks

compared to the benefits of conducting research that meets the needs of a particular community, especially those which have not received much research attention.

The Canadian military, particularly female members constitute an undeveloped research community. The Caregiving, Health and Work of Canadian Forces (CHAW-CF) is based on a community participatory model, adapted to be appropriate for the Canadian military. This novel approach has helped to develop a research program that is appropriate in both design and content for members of the Canadian Forces (CF). Key to the success of this alliance is the collaboration between researchers and Department of National Defence (DND) stakeholders and the participation of military members as advisors on the project. This innovative approach will facilitate findings that family policy makers at DND can utilize, thereby maximizing knowledge translation.

Previous to our collaboration, a researcher-stakeholder-community alliance model had not been utilized within DND. Initially, as researchers we were interested in having the community involved from the earliest stages of the project, but the challenge was how to translate an action research model for use with the military. The other major challenge in the

development of this project has been the lack of basic information about the experiences of women in the Canadian military. This gap in the literature underscores the need for research with this particular community. Recognizing these two challenges at the very beginning of the project helped the preliminary team decide that a community based participatory research design would be the most appropriate method for this project. We felt that this approach would contribute to knowledge translation at the community and stakeholder levels. Given the dearth of information about women in the Canadian Forces, the first step that we (the university based researchers) took was to form an advisory committee that would help us gather basic knowledge before we developed a research focus. We wanted to ensure that military women felt that there was need for research on their health and work/life balance and that they would be open to participating in such a project. We originally focused only on female Canadian Forces members because there was virtually no research on their caregiving and very little on their health.

The Canadian Military Context

Military service requires a very high level of personal and family commitment. Central to being in the military is the requirement of “operational readiness,” meaning that a member could be required to leave for a dangerous task and/or for a long time with very short notice. The traditional military member profile of a young man with no dependents is no longer the norm in the Canadian Forces. Thus, necessity to be ready to leave with very short notice has been confronted with the reality of having to address members’ caregiving responsibilities. While the Department of National Defence (DND) has worked to adopt policies and programs that facilitate readiness by supporting caregiving responsibilities, there are still large gaps between the realities of members and official practice. For example, members are required to complete a Family Care Plan before they leave for deployment, but there is little support available to help them complete this task. Moreover, DND has admitted to their struggle in defining who is eligible for support programs such as emergency child care and in finding ways to support members who are in nontraditional families,

particularly for single parents. In addition, caregiving support programs focus only on care for dependent children, while the aging workforce in the Canadian military may be dealing with caring for dependent adults.

Within the current climate of the Canadian Forces (CF) of increased size and operational requirements, a need has developed for programs and policies that enhance recruitment and retention of members and for family health policies that permit the member be in a constant state of combat readiness. Over and above the continually increasing deployment requirements is the changing demographic composition of the military. Notably, women comprise about 14% of the CF (Department of National Defence [DND], 2006a). Females have been fully integrated into the Canadian military for over fifteen years. Along with this statistic comes the reality that there is a high percentage of dual-career military couples (8.4%) (DND, 2006a). Further, the age restrictions for joining the Canadian Forces have been relaxed in the past few years leading to an increase in average age for women from 23 – 27 while men remained around 23 years (DND, 2006b). There has also been increased emphasis on family-friendly policies and practices. For example, CF members are eligible for up to one-year of fully paid parental leave, the same as for Canadian federal civil servants.

These initiatives are important steps towards making the Canadian military an “employer of choice,” however there are major gaps in knowledge about the realities and needs of CF members, particularly women. In addition, the DND has policies that are moving towards gender “equity” where opportunities for male and female members are situated within gender-appropriate contexts. This includes the previously mentioned parental leave policy, but also ad-hoc practices by many commanding officers that facilitate caring for children and other family members. However, these practices need to be studied in order to translate the practice to formalized policies and programs. It is also imperative to be cognizant of the overarching mandate of the CF to prepare members for operational deployments. Within this context, we felt there was a strong need to investigate the connections between caregiving, health and work of CF members.

Gender Considerations

While women have been integrated into the Canadian Forces for many years, little research has been conducted on their lives. More importantly, there has been a complete lack of gender analysis examining the linkages between work, health and caregiving of military members. The changing nature of the military, paralleling societal changes in women entering nontraditional careers, has huge implications for the CF. In addition, men may be assuming more caregiving responsibilities as their female partners work more, whether in the military or in civilian jobs. Many of the career and caregiving responsibilities of female CF members are similar to those of all working women. However, there are important differences: First, women in the CF are in a nontraditional career for women; second, both women and men in the CF can anticipate being separated from their families for extended periods of time. These are the two major differences between women in the CF and other working women.

Given that research consistently shows that working women still maintain the role of primary caregiver in the home, extra strain may be placed on women in exceptional careers, particularly for female forces members who have caregiving responsibilities. These women may be trying to maintain the traditional caregiving responsibilities of providing care to children and other family members while experiencing the additional stresses placed on them from being in an exceptional career. Not only could their work environment be unprepared for workers with caregiving responsibilities, but the nature of work requiring periods of separation would require specialized managing of caregiving responsibilities. The Department of National Defence has attempted to address some of the caregiving needs of CF members, but there are large gaps in knowledge about the caregiving responsibilities of CF members that must be addressed in order to develop appropriate policies and programs.

At present, there is very little research on the relationship between caregiving, work, and health for women in the Canadian Forces. There is a very small body of research on the deployment of women and the impacts on family, but almost all of this work has been focused on

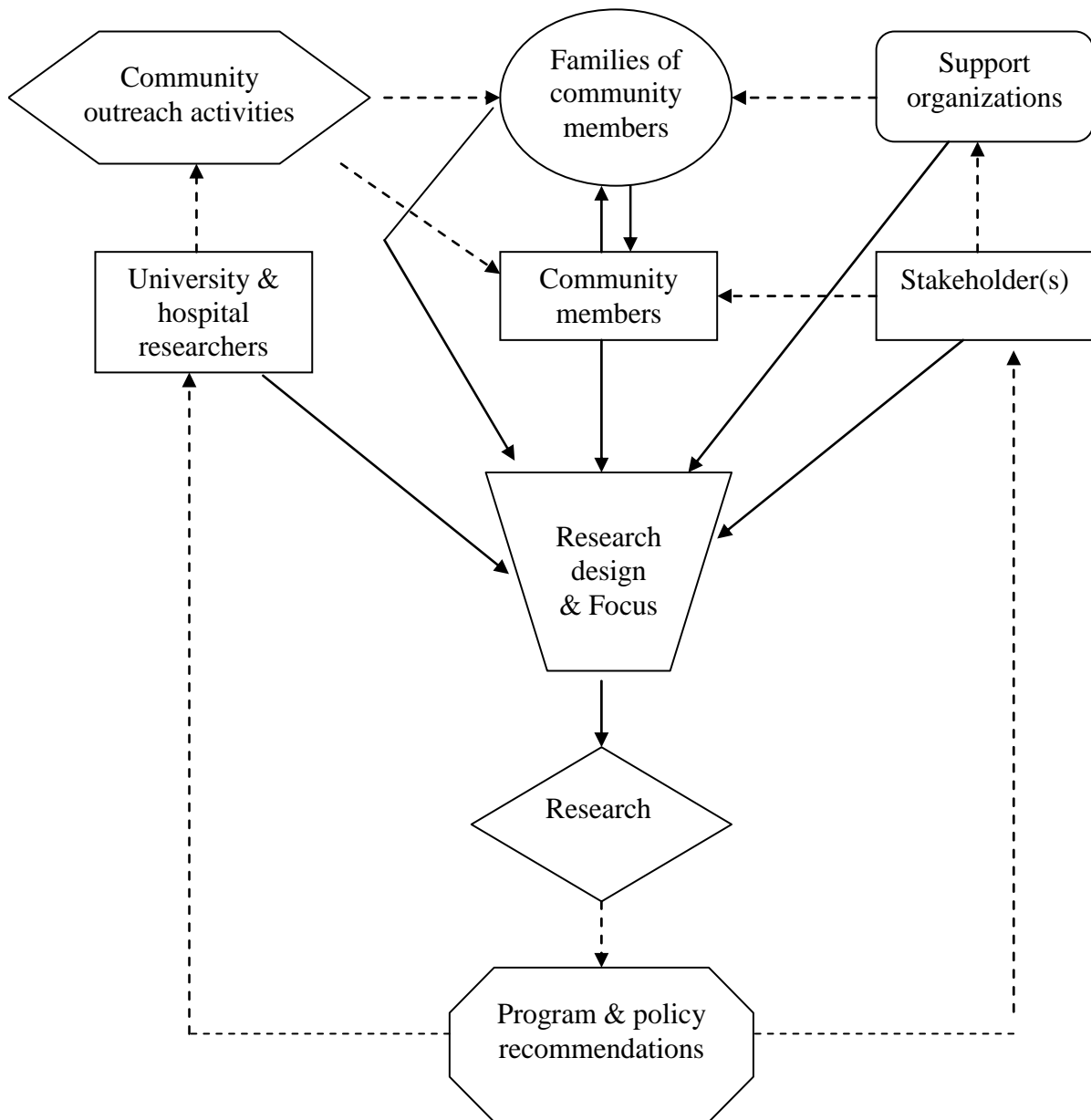
the American forces (e.g., Kelley, Herzog-Simmer & Harris, 1994). This literature has also tended to focus on the impact on the family rather than on the female service member. Clearly, there is a need for research that examines the caregiving responsibilities of all CF members, but particularly for female members. Our research project examines the work-caregiving balance of CF members, with a particular focus on caregiving. A gender-based analysis has been applied to the data gathered as a means to better understand how women and men in the Canadian Forces experience caregiving, work, and health.

Developing a Community Based Partnership with Military Members

Once we had decided to explore caregiving experiences within the military context, the hospital and university based researchers focused on the feasibility of a community based approach with the Canadian military. We decided to form a community advisory reference group using informal networks of the first three authors of this paper in order to evaluate the viability of this approach. Fortunately, the development of the Military Caregiving Reference Group (MCRG) was facilitated by the credibility the hospital and university researchers had with the military community. The first author of this paper became interested in this topic because her partner is in the military, the second author was a long-time employee with the local Military Family Resource Centre and the third author has held research contracts with the Department of National Defence. However, we feel these aspects helped to create a safe forum for the women to speak freely. Essentially, we considered ourselves to be “outsiders-within” (Collins, 1990), a unique standpoint effective in building coalitions and stimulating dialogue. The reference group also clearly indicated the need to include military spouses and families as advisors and beneficiaries of our project even though they are not the focus of the research.

A New Approach to Military Family Research

The model that emerged as our partnership progressed can be found in Figure 1. At the heart of our model is the Military Caregiving Reference Group (MCRG). This group consists of members from each branch of the Canadian



Note: Solid lines represent existing connections and activities while dashed lines represent future endeavors.

Figure 1: Model of University Researcher-Community-Stakeholder framework for Caregiving, Health and Work of Canadian Forces Members Project

Forces (i.e., the Air Force, Army and Navy). The members are a diverse group with varied backgrounds, different demographic characteristics, a variety of ranks and trades, and differing caregiving responsibilities. In addition, we have members from the Military Family Resource Centre (MFRC), a non-profit arm's length support organization of DND that provides input from the perspective of military families. In addition, many of our members have professional roles that complement the research focus, whether working in health promotion or in human resources.

Since the first meeting, members of the MCRG have taken their role very seriously and have provided guidance to the project. The meetings of the reference group follow a semi-structured format. This practice was adopted after the first meeting, which originally had a very structured format. However, given the eagerness of our group members to discuss the proposed research, we adopted the more reflexive semi-structured format for the subsequent meetings. For example, meeting agendas and topics for discussion were changed to respond to issues brought forward by group members. Reference group members arrived for meetings well prepared to discuss the various topics on the agenda, and also contributed invaluable suggestions and experiential input to the project. Each meeting built upon previous ones, so that a topic brought forward at a meeting could be further discussed. In addition to the actual meetings, group members also communicated with the research team via email between sessions. We distributed typed notes of the meetings to all members for their review and approval.

During our first two meetings, we discussed both research content and design. At the first meeting, in particular, women were highly motivated to discuss their views and share their experiences. In general, the members felt that a survey would be the best route to gather basic knowledge about the connections between paid work, caregiving responsibilities, and mental health impacts. There was some discussion about military members "being surveyed to death" by DND, but the consensus was that people would willingly participate because of the relevance of caregiving issues. At

the next two meetings, we discussed the content of the survey and how the survey would best be administered. In regards to the content, members generated items on positive and negative impacts that caregiving could have on different types of work relationships, (e.g., with superiors, coworkers, general climate). Members remained very grounded with their suggestions for content, often incorporating their own experience or others' into their discussions.

DND stakeholders became part of the team while we were developing the survey and subsequently also contributed greatly to the scope and content. Once the content of the survey was finalized by the research team, the MCRG, and, the DND partners, we submitted applications to the university and the hospital and DND ethics committees. The content of the survey was an iterative process that involved the reference group, the research team, and stakeholders.

One notable challenge occurred when the DND ethics committee required us to include a measure of mental health. We had not previously discussed including this type of instrument with the reference group. We then returned to the reference group to discuss how appropriate they felt it was to measure mental health and to have them review the measure we had agreed upon with the DND ethics committee. Some of the members were concerned that there would be a perception by participants that DND was trying to "profile" their mental health. We were able to negotiate with the DND ethics committee to have a general screening questionnaire used rather than a diagnostic tool. Reference group members were more comfortable with this approach, although some still felt that certain military members might not participate given the nature of the questions. However, they did give approval for the final version.

In terms of survey administration, reference group members recommended that individuals within each target area be placed in charge of the survey rather than having the coordination conducted from outside. We found that using these local survey administrators was extremely beneficial when conducting the survey. The administrators organized the distribution and collection of surveys within their own working environment. This allowed ownership of the survey for each location. These few examples

illustrate the central role that the reference group has had in this project. One of their most important recommendations was that we approach DND stakeholders and ask them to be involved.

Bringing in the Department of National Defence

There were two major recommendations made by the reference group members at the first meeting. The first was that men needed to be included from the outset of the project. The reference group members agreed to recruit at least one male for the next meeting. The second recommendation was that the Department of National Defence needed to be involved at the outset of the project. The networks of the reference group members helped the researchers to make the appropriate contacts within DND. We changed our initial entry point from the agency that administers the family resource centres (Director of Military Family Services) to the Directorate of Quality of Life (DQOL) that strategically assesses and develops caregiving policies (e.g., family leave, compassionate leave) on behalf of the Chief Military Personnel. The Family Policy Team Leader at DQOL was keen to have her team sponsor the project. As a stakeholder, they have a need for evidence-based information to inform policy.

With the sponsorship of DQOL, our researcher-community-stakeholder collaboration was formed, and is most timely given the current context of the Canadian military. This alliance is novel within military research in Canada. Typically, DND researchers and university-based investigators have worked at arm's length from one another on their projects. In particular, DND is in the practice of contracting university researchers to conduct specific projects. Unlike our project, where we have a Letter of Agreement outlining the sharing of data, DND is the proprietary owner of the projects conducted as contracts. Our collaboration is driven by the university researchers with the sponsorship of DQOL and the guidance of our reference group.

Reflections on a Work-in-progress

We refer to this article as “reflections on a work-in-progress” because the format and focus of the project have continued to evolve as we

have moved forward. We started as a modest project hoping for collaboration with military family resource centres, we ended up collaborating with the family policy branch of the CF. Two of our original reference group members have become the community champions and were instrumental during the data collection phase. Another part of our process is that the composition of our group will continually change as members get “posted” to other parts of Canada or are deployed. As members leave, we ask them to try to find their own replacement. As we expand beyond our reference group to conducting a survey, we are certain that the “process” will continue to change.

The current model (Figure 1) not only reflects our existing connections but also projects the future outcomes of this project. We hope by including the community, the stakeholders, and military families in our research collaboration that we will be able to influence outcomes that will lead to better work-life balance and improved health for CF members. One of the greatest challenges so far has been how to balance the recommendations of the reference group with the reality of our alliance with the DND, as we recounted for the mental health measure. We wanted to ensure that the voices of actual CF members would continue to guide the research after we entered into a formal association with DQOL as our sponsor. To help accomplish this goal, our agreement with DND specifically outlines the role of the reference group as an equal partner in the research process.

Another challenge that we have, like most community based participatory projects, focuses on resources - both human and financial. Community based research takes time, although our reference group members are accustomed to bureaucratic “red tape” and have a great deal of patience. Formalizing our relationship with DND has enabled us to overcome resource issues. For example, the community members on the reference group need to have official work release to attend meetings. DQOL was instrumental in helping the project receive endorsement from the three branches of the military. This support ensured that military members were able to participate in the survey during work. In terms of financial resources, DQOL has committed to in-kind support for staff

to administer the survey and to cover expenses required in data collection. In regards to ethics, we have approval from the hospital of the first author and also DND. The ethics process has been challenging, as previously noted.

An additional challenge during data collection has been the notion of informed consent. Perhaps this is the best illustration of the balance we have strived to maintain between scholarly researchers and military decision makers. A lengthy discussion of the nature of informed consent for research is beyond the scope of this paper. The notion that each participant is fully aware that their participation is completely voluntary and that they can withdraw (or refuse to participate) at any time is at the heart of the scholarly research process. However, this is contrary to the military model of unquestioning compliance with orders from superiors. During the development of the survey and the ethics approval process, it was necessary for the university-based researchers to clearly indicate the importance of choosing to participate. Indeed, our university and hospital ethics boards required us to use a traditional informed consent form that was very unfamiliar to our DND partners and our reference group members. We were successful at clarifying the importance of consent and all survey administrators were fully briefed on the meaning of participation. However, a couple of the almost 200 participants in the survey indicated that they felt that they had been forced to participate. We took steps to remedy this situation, and believe that it was a case of a lack of understanding by the individual participants rather than a failure on the part of the survey administrator for that location.

One consideration of the project that could have been a challenge, but hasn't been is that the research team consists almost entirely of women, although we have one stakeholder and one reference group member who are male. We have never experienced any behavior that could be interpreted as gender-related and others have not framed the project as "a woman's issue." This is to the credit of the Canadian Forces and the Department of National Defence. The integration of women has meant a profound shift in the mindset of the

Canadian military towards issues that may have once been deemed irrelevant. For example, we recently traveled to a small base for a community consultation. We were most pleased when over half of this garrison attended our meeting, the overwhelming majority of whom were men who took the project very seriously. However, we are also aware of the legitimacy afforded to the researchers because of our various connections to the military. It may well be that we have been so accepted because of these connections.

We should further address our unique perspective for this project. Our curiosity on the connections between caregiving, health and work of military members, especially women, was born from personal experience and not purely from scholarly inquisitiveness. Given this starting point, it seemed most appropriate to utilize a community based participatory model for the project. Our "insider" perspective and the close network we have developed within the research team and with the reference group helps to solidify our commitment to the project. We would highly recommend that researchers interested in developing community based projects draw from their own experiences and frame their projects within this context when possible.

We feel that the community based participatory research design of the project has enabled us to overcome these challenges and turn them into triumphs. The time that we have invested in developing our community contributions and our formal network with DND will help ensure that there are many triumphs ahead, particularly that the research we conduct will directly influence policy and programs that contribute to well-being of Canadian Forces members. The key lesson we would like to share with other researchers is that knowledge transfer can be facilitated with a participatory design that includes the organization, especially when everyone shares the common goal of improving health.

References

- Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Boston: Unwin Hyman.
- Department of National Defence (August 2006a). *Human Resource Management System, Output Report D0045R01*. Ottawa, ON:

Author.

Department of National Defence (August 2006a). *Human Resource Management System, Ad Hoc Report q_109074*, 30. Ottawa, ON:

Author.

Eversole, R. (2003). Managing the pitfalls of participatory development: Some insight from Australia. *World Development*, 31 (5), 781-795.

Kelley, M. L., Herzog-Simmer, P. A., & Harris, M. A. (1994). Effects of military induced separation on the parenting stress and family functioning of deploying mothers. *Military Psychology*, 6 (2), 125-138.

Suarez-Balcazar, Y., Harper, G. W., & Lewis, R. (2005). An interactive and contextual model of community-university collaborations for research and action. *Health Education & Behavior*, 32 (1), 84-101.

Thurston, W. E., Farrar, P. J., Casebeer, A. L., & Grossman, J. C. (2004). Hearing silenced voices: Developing community with an advisory committee. *Development in Practice*, 14 (4), 481-494.

Wells, K. B., Staunton, A., Norris, K. C., Bluthenthal, R., Chung, B., Gelberg, L., et al. (2006). Building an academic-community partnered network for clinical services research: The community health improvement collaborative (CHIC). *Ethnicity & Disease*, 16 (1), S1-3 – S1-17.

Whyte, W. F. (1989). Advancing scientific knowledge through participatory research. *Sociological Forum*, 4 (3), 367-385.

Acknowledgements

The Caregiving, Health and Work of Canadian Forces Members (CHAW-CF) Project is currently funded by the Nova Scotia Health Research Foundation through the Community Research Alliance program. The authors wish to acknowledge the support of the Healthy Balance Research Program (funded by the Canadian Institute of Health Research) during the earliest stages of project development.

Disclaimer

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of

National Defence, the Canadian government, the IWK Health Centre or any of the institutions with which the authors are affiliated.

Author biographies

The first author is the principal investigator on the Caregiving, Health and Work of Canadian Forces (CHAW-CF) project. Dr. Cyndi Brannen is the Research Associate for the Centre for Research in Family Health at the IWK Health Centre in Halifax, Nova Scotia, Canada. She has previously held a Canadian Institutes of Health research fellowship. Dr. Brannen's primary research focus is caregiving and stress in military families and for rural Canadians. She has been mentored by her co-principal investigator who is the third author on this project, Dr. Deborah Norris, who is the Chair of the Department of Family Studies at Mount Saint Vincent University. Dr. Norris has studied military families for over 20 years.

The second author on this paper is Kathy Petite who is the research coordinator for CHAW-CF and is working on her Master's degree with Dr. Norris.

Major Cheryl Baldwin is the acting director of the Directorate of Quality of Life at DND headquarters in Ottawa. She is responsible for the coordination of the preliminary survey and also has a strong role in developing the research program. We have two local community champions who are key contributors to the CHAW-CF project.

Lieutenant-Commander Donna Harding is the Senior Staff Officer Naval Reserves at Maritime Forces Atlantic Headquarters in Halifax and acts as the local military point of contact for the project. Additionally, she served as the Military Co-Chair for the Defence Women's Advisory Organization (DWAO) Atlantic Region for which this research is highly relevant.

Address correspondence to

Cyndi Brannen, PhD, Post Doctoral Fellow

Women's Health in Rural Communities

IWK Health Centre

8th Floor, 5850/5890 University Avenue

P.O. Box 9700, Halifax, NS

Canada, B3K 6R8

Ph: 902-470-7521

Fax: 902-470-6534

Email: Cyndi.brannen@iwk.nshealth.ca