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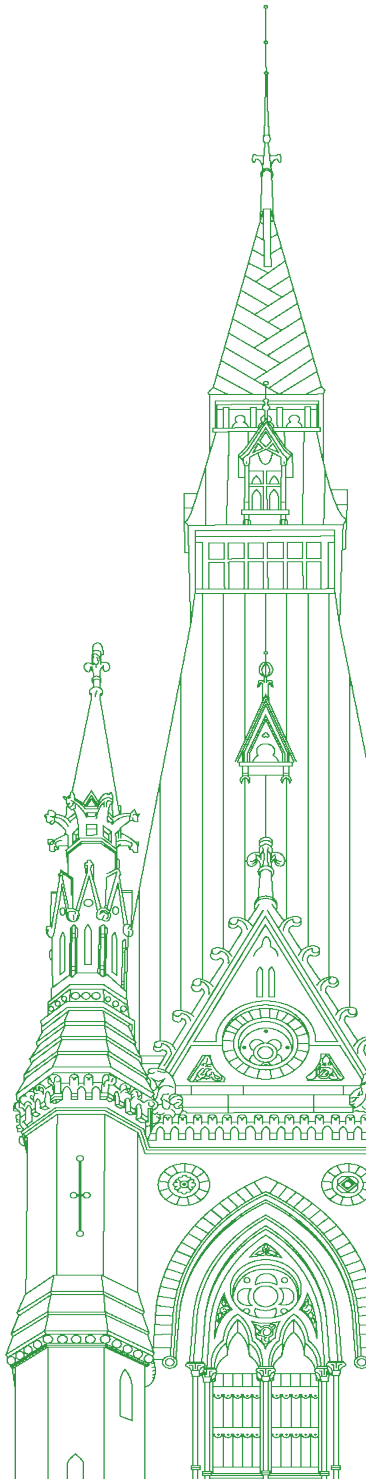

Chair: The Honourable John McKay

Standing Committee on National Defence

Friday, April 28, 2023

● (0845)

[*English*]

The Chair (Hon. John McKay (Scarborough—Guildwood, Lib.)): I call the meeting to order.

We have quorum and we have our witnesses in place.

We are about to commence a study on the military health system and provision of health and transition services under the Canadian Forces Health Services Group, based upon a motion taken earlier to study this matter. This is our first meeting.

I want to welcome the panel. I see three unfamiliar faces and one familiar face.

Maybe I can turn to Lieutenant-General Lise Bourgon and ask her to introduce her colleagues and—whether it's her or someone else—to please give an opening five-minute statement.

[*Translation*]

Lieutenant-General Lise Bourgon (Acting Chief of Military Personnel and Acting Commander Military Personnel Command, Canadian Armed Forces, Department of National Defence): Thank you very much, Mr. Chair.

Good morning everyone.

[*English*]

I guess I come here too often, since you know me.

The Chair: You're a veteran.

LGen Lise Bourgon: As you know, I'm Lieutenant-General Lise Bourgon. I'm the acting chief of military personnel and commander of military personnel command.

First this morning, I would like to acknowledge that we are gathered on the traditional unceded territory of the Anishinabe people.

[*Translation*]

As Acting Chief of Military Personnel, I am responsible for recruitment, training, retention, education, career management, policy, pay and benefits, health services, military career transition, morale and welfare programs, and a host of other corporate and personnel support services. It is a very broad mandate.

[*English*]

I am joined here today by three of my senior commanders.

First, to my right, is Major-General Marc Bilodeau, the surgeon general, who is the medical adviser to the chief of the defence staff and to the Minister of National Defence. He's also the functional authority for the professional and technical aspects of the medical and the dental care to our members.

I'm also joined by Brigadier-General Scott Malcolm, commander of the health services division, whose responsibility it is to deliver health care to CAF personnel to ensure their readiness and enable CAF operational success through the provision of agile health service capabilities around the world.

[*Translation*]

To my left is Commodore Daniel Bouchard, Commander of the Canadian Armed Forces Transition Group that provides military career transition services to serving or retired members, including active, retired, healthy, ill and injured members, and families of deceased members.

[*English*]

I would like to thank the committee for its interest in better understanding our military health system, the provision of health services and the transition support to our members. These are indeed important topics, because, first and foremost, we have a duty to take care of our people who put service before self.

[*Translation*]

Unlike any other institution, the provision of health care to our members is the responsibility of the CAF, and not the province or territory where they reside.

[*English*]

Together, all of us here today are focused on providing the required supports and services to our members through all aspects of their military careers, whether they are healthy, ill or injured, transitioning to civilian status or deployed on operations.

Our priority is the long-term health and wellness of our military members and the provision of high-standard and quality health care to the full diversity of the CAF. This is achieved primarily through the Canadian Forces Health Services Group, which is responsible for the care and well-being of about 64,000 regular forces members as well as our reserve forces members on operations or in full-time service.

[*Translation*]

Canadian Forces Health Services, or CFHS, is a key enabler to our military missions around the world through pre-hospital, primary, surgical and specialized care.

● (0850)

[*English*]

Here at home, CFHS provides health services through 37 primary care clinics across the country, and 31 of those offer specialized in-house mental health care. The multidisciplinary teams of mental health care providers include social workers, mental health nurses, psychologists, psychiatrists, addiction counsellors and mental health chaplains.

[*Translation*]

The CAF's mental health program has been recognized by our NATO allies and civilian organizations for its robust approach to mental health care, stigma reduction initiatives, and mental health research, training and awareness programs.

[*English*]

For example, the road to mental readiness program, launched in 2007, helps promote mental resilience and improves mental health awareness.

[*Translation*]

We also have a special program called "Resilience Plus" created specifically for military college students.

[*English*]

Given the unique nature of our jobs, sometimes our members become significantly ill and injured. Whether their injury is physical or mental, they may require enhanced support through a return-to-work program or to transition within the CAF or, sadly, to post-military life.

[*Translation*]

That is one of the reasons why Canada's 2017 defence policy Strong, Secure, Engaged directed us to create the CAF Transition Group. In close collaboration with Veterans Affairs Canada and other valued partners, we now have 32 transition centres at bases and wings across Canada.

CAF Transition Group staff work to offer the best possible service and support to all CAF personnel and their families to prepare for and, at the appropriate time, complete a seamless and successful transition to civilian life.

[*English*]

It is important to note that transition does not automatically mean leaving the forces. CAF TG—transition group—offers services and programs to support, first and foremost, the return to duty of our members, whether that is by reintegrating them into their home units or helping them transfer their skills and experience to new career paths within the CAF, such as through occupational transfer.

The Chair: General Bourgon, are we close to the end?

LGen Lise Bourgon: I am almost done.

We know we have more work to do to continue to provide quality service to our members. That is also why we are working to improve the spectrum of care that we provide and how it is provided, especially on service and support for women and diverse members.

I think that budget 2022 announced $144 million over five years to expand the CAF health services and physical fitness program to be more responsive to women and gender-diverse members.

[*Translation*]

We are also taking concrete steps to make our health resources and services more inclusive. For example, we have reviewed our transgender care program to make it more inclusive and comprehensive for our members.

[*English*]

We also continue to work with our women members to offer person-partnered care and to identify gaps and needs in order to act on them.

Whether our personnel are on the road to recovery, rehabilitation, returning to duty in the CAF or transitioning to civilian life, we are committed to assisting them in their journey.

[*Translation*]

Thank you once again for this opportunity to appear before you today. We welcome questioning from committee members.

Thank you.

[*English*]

The Chair: Thank you, General Bourgon. It's not even nine o'clock and already I've cut a general off.

With that, we'll start with Mr. Bezan.

Mr. James Bezan (Selkirk—Interlake—Eastman, CPC): Thank you, Mr. Chair.

I want to welcome our witnesses to committee.

General Bourgon, it's good to see you back.

You mentioned the JPSU, which we had stood up as part of the road to mental readiness program to help them with that transition.

JPSU no longer exists. There is a new format. Can you explain, for those who are medically releasing for either visible or invisible injury, how we handle them specifically?

● (0855)

LGen Lise Bourgon: Yes. Mr. Chair, thank you very much for the question.

I will give the floor to Commodore Bouchard, whose job it is to be the leader of the CAF transition group.

Commodore Daniel Bouchard (Commander, Canadian Armed Forces Transition Group, Canadian Armed Forces, Department of National Defence): Thank you very much, Mr. Chair.

The JPSU, as you said, was stood up in 2009 to assist our ill and injured in their transition and their support. In 2017, we stood up "Strong, Secure, Engaged", recognizing the requirement to increase the support to our members who are transitioning. In 2018 my organization, the Canadian Armed Forces transition group, was stood up in order to provide that support.

We have developed a process for military to civilian transition. All regular force—and soon reserve force members—will be transitioning through our organization to civilian life.

Our primary focus also is on retention. As General Bourgon was saying, we have stood up 32 transition centres in nine regions to support the process of transition.

Mr. James Bezan: They don't have to report in like they used to under JPSU to be part of a unit. They aren't required to parade or be on exercises or training or anything—

Cmdre Daniel Bouchard: That is correct. They are employed in accordance with their military employment limitations. Some can continue on with some parts of work, and the idea is to reintegrate them as best we can into the—

Mr. James Bezan: Release happens when everything has been assessed. Do you hand them off to Veterans Affairs with pensions in place as well, or do they still have to wait sometimes months and years, especially our reservists, before they receive a pension or any of their disability benefits?

Cmdre Daniel Bouchard: With our new process at the TC, it's a holistic approach, and we have Veterans Affairs Canada embedded with us to better support our members as they transition. Our ill and injured are supported by a service coordinator, who provides them with a personalized approach across the services that they require, and we ensure that the services will transition with them if they are releasing from the Canadian Armed Forces.

Mr. James Bezan: I'm going to switch gears a little bit here.

When we are deploying our troops to places like Latvia, Kuwait, Poland or the U.K. right now, do we provide our own medical teams to accompany them or do we rely on allies to provide their medical care?

LGen Lise Bourgon: The answer depends, but mostly we have our own integral medical resources.

General Malcolm, you may want to add to this.

Brigadier-General Scott Malcolm (Commander, Canadian Forces Health Services Group, Canadian Armed Forces, Department of National Defence): Mr. Chair, thank you very much for the question.

As it stands right now, in terms of support to operations Impact, Reassurance, Unifier and Projection, all of the medical personnel deployed there are providing supporting medical care to our troops on the ground. It's only in our other operations that they are there as trainers.

Mr. James Bezan: In Poland, where do our guys go for medical attention if they get a sprained ankle in theatre? They're out there training—

BGen Scott Malcolm: We do have internal—

Mr. James Bezan: What level is it? Is it a medic? Is it a doctor or a nurse?

BGen Scott Malcolm: Our trainers right now are typically med techs and medical aides, who are all capable of dealing with basic medical issues that our folks are going to run into.

Mr. James Bezan: If somebody had operational stress injury while serving abroad, what process comes into play then?

BGen Scott Malcolm: If they've faced a traumatic event or a stressful event, in that case the first assessment is always with our med tech or the next available provider. If it's outside their scope to deal with it, then it would be referred higher. If there's no one in the immediate area to support them, they can be referred either to local civilian care or, if necessary, repatriated back to Canada, or if they are in theatre, to one of our locations like Geilenkirchen where we have a clinic.

Mr. James Bezan: Okay.

We know that recruitment has been an issue and that we don't have all of the troops we need, whether it's soldiers, sailors or aircrew. How has the recruitment crisis affected health services?

LGen Lise Bourgon: Thank you, Mr. Chair. That's a really good question.

As you're all tracking, from a chief of military personnel standpoint, recruitment, retention and training modernizations are my number one priorities. All are important, and indeed the medical side has suffered in the same way on the recruitment side and the retention.

I will pass the floor to General Bilodeau, who might be able to talk about specific recruitment and retention efforts targeting—

● (0900)

Mr. James Bezan: Historically, having psychiatrists, psychologists, therapists on the mental health side has always been a challenge. I think a lot of that has to do with location, and money talks. The other side of it, of course, is the overall crisis in mental health itself, not just in the forces but right across the country.

The Chair: It's a good question. Unfortunately, you're going to have to answer it at another opportunity.

With that, we have Ms. O'Connell for six minutes, please.

Ms. Jennifer O'Connell (Pickering—Uxbridge, Lib.): Sorry, Mr. Chair, but we're getting the French translation on the English channel.

[*Translation*]

The Chair: Very well. You have the floor for six minutes.

Some hon. members: Oh, oh!

[*English*]

Ms. Jennifer O'Connell: I can't hear anyone else, so it's not just for me: It's that I can't hear the witnesses. Can you make sure that this is fixed?

The Chair: Do you want to move on until we correct that? What's the issue?

Ms. Jennifer O'Connell: No, I can answer, but I'm just saying that it's translating into French, so I can't.... I turned off the sound to hear the answers, so can that be corrected before I start?

The Chair: Okay.

Can you talk about the weather for a second?

Ms. Jennifer O'Connell: Hi, Mr. Chair.

I'm home in my riding. It's beautiful and sunny.

The Chair: Okay. It sounds as though it's fixed.

Ms. Jennifer O'Connell: Okay. Thanks so much.

Thanks to all of our witnesses for being here.

General, you spoke in your opening statement about some of the gaps, in particular with respect to health services for women and persons of diverse backgrounds.

The presence of women in the Canadian Armed Forces is not new, so I wonder how long these gaps have existed, and I'm very concerned to see that these gaps exist currently. Can you elaborate on what some of these gaps are?

LGen Lise Bourgon: When we look at the CAF—and some of you have probably heard me say it before—we see that the CAF was built for men by men. Those are the policies. Those were the services that we provided to the majority, and that's what we need to change, and we are changing to become more inclusive.

A big part of that is looking at the health services, doing the gap analysis and coming up with programs whereby women and gender-diverse members will feel valued and we will look at each member as an individual.

I think I'm going to pass the floor to General Bilodeau, who is responsible for the women's health and diversity file.

Major-General Marc Bilodeau (Surgeon General, Canadian Armed Forces, Department of National Defence): Thank you, General Bourgon.

Mr. Chair, that gap in the women's health data and research is not unique to the military. It exists in society. Most of the research in health care, unfortunately, historically, has focused on males, and there's very little data on many conditions related to women. Obviously we're impacted by that in the military, which means that more research is required in order to inform better care for women.

That goes from preventing injury and diseases to managing health conditions in a military environment, which is the area that is unique to us and one that we need to study more.

We're doing an honest job regarding women's health. In our screening for breast cancer and our data on cervical cancer, for example, we're on par with Canadian society. That being said, we can do a lot better. That's why we're very fortunate to have been funded through the last budget with a significant amount of money to build a women's health program. That program will be based on four pillars, one of which is improving the health care that we provide to our women. That speaks to the quality of the care but also to the spectrum of care itself, because there are some items currently not covered that women would benefit from having covered.

We're looking at injury prevention, and for that we're in partnership with our partners, the directors general of morale and welfare services, who are, basically, our fitness providers.

With respect to research and engagement, I spoke about research. There are lots of gaps there. We are going to engage with our research partners in order to fill those gaps from a research perspective and have better data to be able to monitor the health of women as well as the efficacy of our preventive measures and treatment measures.

Finally, we need to measure what we do. We need to have better quality and performance measurements regarding the health of our women. We lack data, and we need to build that data in order to make sure that what we do ultimately leads to improvement and better results.

● (0905)

Ms. Jennifer O'Connell: Thank you.

In a previous answer it was stated that there are clinics around the world for serving members and that if the services on the ground or for the mission can't accommodate the injury, a member can be moved to a clinic.

How many clinics are there around the world, or is that in relation to the number of missions there are? Could somebody perhaps elaborate on what those clinics look like and how they are employed? Are they CAF members, or do you rely on the local expertise to staff those clinics?

LGen Lise Bourgon: Thank you for your excellent question.

It depends on the location of our troops.

I'll give the floor to you afterwards, General Malcolm.

In some areas we have our own clinic, but in some areas we only have our own integral medical support. We can also tap into the environment, so if it's a NATO alliance, we will use other alliance medical capabilities. If we're deployed around the world, in some countries we will also tap into the national medical services, depending on where we are.

Scott, do you want to add to this one?

BGen Scott Malcolm: Thank you, Ma'am.

To carry on, in Canada proper, including our clinic in Geilenkirchen, Germany, and in Belgium, we have 37 clients. We would characterize those as enhanced primary care, meaning that you don't just have access to doctors, nurses, physician's assistants and nurse practitioners; in most of those clinics you also have access to a pharmacist and, in some of our larger centres, to X-rays, and in some of our largest centres, a CT scan.

You also have access to labs, and in 31 of 37, you also have access to mental health services, which could include psychiatrists, psychologists, social workers and mental health nurses. That's why I would say it's more of an enhanced primary care.

In our overseas deployments, currently in Kuwait, Latvia, Poland and the Indo-Pacific on our ships, we have integral medical support, meaning it is provided by our folks. Both overseas and in Canada, as was alluded to by Lieutenant-General Bourgon, if there's a service that's required that's not immediately available or is not of the right type, we're able to refer members out, whether it's in Canada to our civilian partners or overseas to validate—

The Chair: Unfortunately, we have to leave the answer there.

Thank you.

[*Translation*]

Madame Normandin, the floor is yours for six minutes.

Ms. Christine Normandin (Saint-Jean, BQ): Thank you very much.

It is always a pleasure to have you here. Thank you for being with us today.

I want to follow up on the discussion started by Ms. O'Connell about the status of women. I also want to touch on the sharing of information by the CAF with other entities. Yesterday at the Standing Committee on Veterans Affairs, it was said that data gathered by the CAF were not necessarily adequately shared with other organizations, such as Veterans Affairs Canada.

We know that many female members are released from the armed forces for medical reasons. For instance, military equipment is not always adapted for women, even if things are improving in that regard. Veterans Affairs Canada, in that sense, is sort of like an insurance company that only considers symptoms while ignoring root causes. There is no feedback loop.

Are you aware of this problem? How can that situation be handled?

LGen Lise Bourgon: Thank you very much for that excellent question.

We need to keep working on this issue. We know that there are gaps in information sharing. The Veterans Affairs working group, among others, is examining ways to streamline the flow of information. That work will have to be extended to provinces and territories in the future, because the data is vital for handling the situations veterans find themselves in after they leave the forces.

I would like to turn to Major-General Bilodeau, who will give you specific examples of what is being done currently and what is projected to remedy this in the future.

● (0910)

MGen Marc Bilodeau: Thank you.

I think this is a major issue for me as surgeon general, because my job is to ensure the safety and quality of health care. Mismanaging the transfer of information has a negative impact on the transition from military to civilian life. Transferring information, in that context, is critical. We recently launched a great initiative to give Veterans Affairs officials access to CAF members' electronic medical files in order to simplify data sharing. That is done internally between two federal departments.

As far as information sharing between the federal and the provinces is concerned, that is another question entirely. That is no easy task, because we have to find 13 different solutions, one for each province and territory. There is a lot to do on that front. Currently, we give CAF members a copy of their medical file when they are released, so they can have the information if they need to give it to another organization. There is no way to do that electronically, because there is no single medical file per province. Some have only one, but the majority have many different electronic medical files. We will need to pay close attention to this to make sure that information transfers are done safely and securely.

Ms. Christine Normandin: Thank you very much.

I'd like to pursue the same line of questioning.

There seem to be two problems with the transfer of medical records to the provinces. The first is that the first two years are the most critical part of any transition, but the provinces are short on doctors and it isn't unusual for new veterans to not be able to find one. The second issue is that, even when they have access to the medical records, some doctors believe that their code of ethics requires them to start the process over from the beginning.

Are there any initiatives that would allow new veterans to keep having access to Canadian Forces health services for a year or two to ease the transition? Are such avenues being considered?

Is it a human resources issue or more of a financial issue?

Some people have explained to us that they have expertise as physician assistants in the armed forces but can't work as civilians because their credentials aren't recognized. And yet, they could work for the federal government and help our troops in their transition.

I'd like to hear your opinion on this. Are these realistic solutions?

MGen Marc Bilodeau: Thank you, Mr. Chair.

Thank you for the question, Ms. Normandin.

It's true that the transfer of care during the transition to civilian life can be problematic due to the issues with the civilian health care system. As you're no doubt aware, the system is unable to meet current needs.

We've implemented a process by which our members can stay in uniform longer to ensure a safe transition. This is something that we manage in partnership with the transition group. We're ensuring that our members have access to all of the health care and support they need. That allows us to bridge the gap, so to speak, in light of the resource availability issues on the outside.

We're looking at a number of initiatives with Veterans Affairs Canada with the goal of improving access to family physicians when our members leave the Canadian Forces. For instance, in partnership with the College of Family Physicians of Canada, we've put together a document to help family physicians understand what life is like for veterans and to encourage them to take patients that were released from the armed forces into their care.

We're obviously looking into the options you mentioned, like utilizing professionals with varying backgrounds. Physician assistants are increasingly popular in Canada. The majority of provinces agree on the issue of allowing physician assistants to practise. Those that haven't quite come around yet are getting in touch with us to get the benefit of our experience in the matter. The Canadian Forces have been employing physician assistants for 50 years now. It's a profession we understand well, and we know that physician assistants can help improve access to primary health care and reduce the backlog in the health care system.

LGen Lise Bourgon: I'd like to add something about the transition group.

Before members are released from the Canadian Forces for medical reasons, there's an assessment to ensure that it will be possible to transfer their medical records to the civilian system. Those who are released from the forces aren't left to fend for themselves in the jungle; they have support. We ensure that they're ready to be released from the forces. The beauty of the transition group is that files are managed on a case-by-case basis, and members' personalities are taken into consideration.

There's also the Maple service, which offers transition services to members released from the forces who don't yet have access to health care in their province. It's a telemedicine network that they can access—

● (0915)

[*English*]

The Chair: Unfortunately, again we'll have to leave it there.

So that I don't continue to cut off a bunch of generals, just look up here every once in a while. I'll try to indicate where the time is at. That way I won't feel like I'm interrupting important answers to important questions.

Ms. Mathyssen, it's your important question, please. You have six minutes.

Ms. Lindsay Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair.

To continue on with that, I think the conversation was a bit more in terms of general medical practices. Maybe we could talk about the transition for mental health services.

When someone is going through specific trauma or circumstances dealing with mental health, the relationship with their care provider is often unique, and it takes a lot of trust. How is the transition group working in terms of that continuity of care? To just stop care, specifically for people with a higher traumatic issue that they're dealing with and so on.... How do they do that continuity of care?

Telehealth may be okay in some situations, but certainly not in others. You said you were dealing with that one on one, but specifically, how do you do it with mental health?

LGen Lise Bourgon: Thank you, Mr. Chair, and you can interrupt me any time you want. It's okay.

Voices: Oh, oh!

LGen Lise Bourgon: Those services are in place. OSISS is the operational stress injury group that provides that service.

I'll turn the floor over to Commodore Bouchard to provide a little more information on what this service does.

Cmdre Daniel Bouchard: Thank you very much, Ma'am, and Mr. Chair.

Yes, OSISS, the operational stress injury social support, is a partnership program that we do with Veterans Affairs Canada. It's a group of 70 managers/coordinators and 70 volunteers. They have lived experience. They are also on their own journeys in assisting our members through this difficult process. It's a one-on-one peer support group that provides these volunteers. It can be done virtually and in person. It can be done on the base. It can also be done at a civilian establishment off the base, which is sometimes required in order to have that further discussion.

On average, we'll support about 2,000 peers. That's divided by peers. It's also with their families. The families are invited to these support systems. Twenty per cent will be serving members: 11% are the members themselves, with 9% being their families. The other 80% are veterans: 55% are the veterans themselves, and 25% are the families who accompany them on these services. On average, we have 2,000 peer interactions to support these individuals throughout, and again, it's in partnership with Veterans Affairs Canada.

MGen Marc Bilodeau: I'd like to add, Mr. Chair, that we also have our network of operational stress injury clinics, which are clinics that are led and funded by Veterans Affairs all over the country and are specifically designed to take care of members who are releasing and who have mental health issues. We have a close partnership with those clinics through a memorandum of understanding that we have between our military clinics and those OSI Veterans Affairs clinics. That allows us to do a safe transition of care specifically for mental health issues for our members, on top of the peer support program that Commodore Bouchard spoke about.

Ms. Lindsay Mathyssen: In terms of health care providers in the military, how do they balance the obligations and the principles they have to face with their medical licensing bodies versus their military directives? What barriers do health care providers face in terms of finding that balance?

LGen Lise Bourgon: Thank you, Mr. Chair.

On that one, I'll give the floor back to General Bilodeau.

MGen Marc Bilodeau: Thanks for the question.

It is a challenge that all of our health care providers are faced with, because obviously we're health care providers first and foremost. We need to be there for the patients who are in front of us and make sure that we're providing them with the right level of support from a diagnostic and treatment perspective and with follow-up, recovery and so on. We also have an obligation to the employer, basically, to make sure that how these members are employed is in accordance with their medical condition and the medical employment limitations that we're obliged to provide to the employer.

I would say that in most cases this is something that can be managed without too many challenges, because we always put our patients first. As providers, we have an obligation. Also, I have an obligation to the college that gave me my licence to treat my patient first, so the obligation to the employer usually comes second. It's not less important, but it's a second consideration after the first one. This way, we're ensuring that it's the care and the health of our patients that is considered before everything else. Secondly is the security of the armed forces and its mission.

● (0920)

Ms. Lindsay Mathyssen: This has come about a lot, especially....

Justice Arbour spent a great deal of time in her review on the details of the impact of “duty to report” specifically for health care providers. At that time, there was a working group that was considering exemptions for provincially regulated health care providers to ensure there was that balance and that medical needs did outweigh the requirements of military service. She made it really clear in her report that the duty to report needed to be abolished outright.

Can one of you update the committee on that working group and the impacts around the duty to report in a medical environment and what's going on there?

The Chair: Again, it's an important question, but when you have one second left to answer it, it's probably not going to work.

Colleagues, we need some collegiality here. Otherwise, I'm going to end up cutting you off all morning.

With that, Ms. Kramp-Neuman, please don't let me cut you off.

Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC): Good morning.

Thank you, Mr. Chair, and thank you to all of our witnesses for being here today.

My first question is to General Bourgon.

Can you speak to the effects that the current PSAC strike is having on service delivery to our CAF members, particularly regarding the sexual misconduct response centre and grievance officers?

LGen Lise Bourgon: Mr. Chair, that's a very good question.

I am not tracking the impact for the SMSRC, the sexual misconduct support and resource centre, but I can certainly give the floor—if that's okay with you—to General Malcolm. He can talk about the impact that it has on our health services right now.

Scott.

BGen Scott Malcolm: Thank you for the opportunity to respond.

As it stands right now, we're tracking that our clinics across the country are still able to deliver the services to our patients. The absence of our public service employees is mitigated by uniformed members. We're able to carry on with the delivery of care.

Mrs. Shelby Kramp-Neuman: Switching gears, can we speak to systems that are currently available to provide health care supports for spouses and children of CAF members? In concert with that, how do these supports adjust for the frequent mobility of military families due to being stationed in new locations regularly?

LGen Lise Bourgon: That's a really good question.

The mandate of the health care services for our members is that we provide support to families, spouses and children through using services provided by the Canadian Forces Morale and Welfare Services. They are provided with funds to liaise at the base level and provide mental health support and educational support for our children. Again, it is difficult to move every three or four years.

I think that Seamless Canada is a great working group. Hopefully everyone is tracking the work of all of the provinces and territories working with CAF and DND in looking at those three files. There's spousal employment, child care and health care so that we can smooth the way for our families when they're asked to move across provinces. Great work is being done. I think it was established in 2018. The next one will be in Gagetown in May.

It's really working hard on those three lines of effort. They are small steps, but it's a huge step at the end of the day for our CAF members.

Mrs. Shelby Kramp-Neuman: Does that suggest, then, that the CAF has been working with provinces to ensure family doctors are more readily available to military spouses and families living on bases in rural and remote areas?

● (0925)

LGen Lise Bourgon: Yes, but it's not CAF, it's more the SM-SRCs. They are liaising and coordinating at the local level and trying to work with the local communities with availability at the tactical level to try to facilitate our families in getting access.

It's more of a service that's being provided. We're not doing it from a uniform and a CAF perspective, but the service for coordination at the local level is being done, yes.

Mrs. Shelby Kramp-Neuman: Do you think the concern about support in this area is undermining recruitment and retention overall?

LGen Lise Bourgon: Again, we are looking at everything to improve our recruitment. This is part of the things we need to continue working on with the provinces, the federal government and the territories. It's about how we can keep working and making the situation better. It's a problem across Canada. We're just a player in there.

Mrs. Shelby Kramp-Neuman: You have been cited as saying that we're presently 16,000 members short of authorized regular and reserve force strength of 101,500 personnel. That may be causing higher attrition rates.

To what extent could the lack of military support be impacting these attrition rates? In addition to that, could you speak to what types of health care professionals you're looking for in recruitment?

LGen Lise Bourgon: At this point, out of our 71,500, we are about 8,000 regular forces member short. Those are the stats.

Again, looking at recruiting Canadians, we have to change. Let's be honest: The last three years has hurt the reputation of the CAF a little bit. We need to regain that reputation. We need to connect with Canadians again. We need to change.

I think that the recent cultural evolution and all of the initiatives we're coming up with are really making a difference. It's bringing new Canadians and Canadians into the recruiting centre.

Mrs. Shelby Kramp-Neuman: Just to complement that—

The Chair: Sorry—

Mrs. Shelby Kramp-Neuman: I'll save it for next time.

The Chair: Yes, save it for next time. There are going to be plenty of rounds. We have these folks for two hours, so we can go back to it.

Madam Lambropoulos, you have five minutes, please.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Thank you, Mr. Chair.

Thank you to our witnesses for being here with us today.

This was a study that I put forward, and the main reason I put it forward is that when I sat on the veterans affairs committee several years back, there were clear concerns that I had that have been raised here already. However, I do want to push a little bit and see if there's more information that we can gather here today.

At the time, officials from Veterans Affairs were saying that they're very limited in terms of the information they receive about these veterans' medical histories within the forces. It was very much up to the veteran to go and seek help. There wasn't anybody reaching out to them. There wasn't a database of people who should be checked on every couple of years. It was very much up to the veteran to reach out for help.

Clearly, there's a lot of work that needs to be done there. One of the recommendations that we made in that study, which only went to Veterans Affairs—it did not go to National Defence—was to have a consent form signed to allow their medical information to be transferred to Veterans Affairs when they're signing other forms as they are being released.

First off, I would like to know if you think that would make a difference and if you think that could be a recommendation that we have in this committee for this particular study that would go to National Defence.

Second, I know that you've been speaking, Monsieur Bouchard, about a recent program, a transition program. I'm wondering if you can explain a little bit further. Specifically, what in the last couple of years has been done in order to merge these two departments together in order to better offer services to our people?

LGen Lise Bourgon: I think that the CAF transition group—and I'll give the floor back to Commodore Bouchard—was really a jewel of the SSE in 2017 by providing that transition in one place. All the services are being provided, and then we are integrated with Veterans Affairs Canada for our members.

Dan, I'll give you the floor again.

Cmdre Daniel Bouchard: The intent of the transition group and the various transition centres across Canada—there are 32 of them—is also to centrally provide these services to not only our ill and injured but all the regular force members transitioning out. We're focusing on the families.

Retention is always key. We're trying to retain our folks as much as possible and we're trying to transition them to another career within the Canadian Armed Forces. However, when a decision is made to release from the military, then for that continuous care, a transition adviser is provided to the member and their family, and the adviser oversees a transition plan. They oversee a five-step process for what we call the military to civilian transition. There is the decision to transition and then their understanding of it. They have a plan, and it's monitored, and there's some training provided to them. Then there's a support continuum. By having Veterans Affairs Canada embedded with us at the transition centres, we can ensure that continuity of care.

As of this summer, 75% of our transition centres will be established. We will be at our full operational capability by April 2024, and we expect to have the full spectrum available at all of the transition centres.

● (0930)

LGen Lise Bourgon: I may add that when we look at the full spectrum, we see it is the full spectrum. It's financial. It's insurance. It's VAC. It's medical. It's physical fitness. It's the entire spectrum. It's for our members and also for their families to ensure that they're fully ready to transition.

I've been wearing this uniform for 36 years, so the day I decide to release from the military, I lose my identity—let's be honest. How do we empower our people and their families to do that gracefully if they're ready to transition to a civilian life or to veteran life now?

Ms. Emmanuella Lambropoulos: Thank you.

Just to be clear, would you recommend that a consent form be signed upon release in order for the information to be transferred to Veterans Affairs so that it can have the information necessary when someone shows up?

MGen Marc Bilodeau: This is already happening. That's the process by which the medical file is being released to either the member or somebody whom they choose that they want it to be released to, whether it's a family physician or a psychiatrist or whatever.

This is the process. The challenge in that process is that we need to go from an electronic system and print it out or put it on a memory stick and transfer it back to the civilian system, which is going to require a full printout and re-scanning. The process is not smooth. It's not only us at our level, but we're definitely trying to ease that.

The beauty is that within the transition groups, we have nurse case managers that are ours, who work for the CAF, who are responsible for ensuring a smooth medical transition for members who have been identified as having medical issues at the time of release. The challenge we have is that if a member does not disclose that issue at release and later develops a health issue, then there's potentially an access issue there, which I know VAC is working on, but we're potentially losing those. I think that with the new transition program that Commodore Bouchard is working on, we're going to catch more of those people, but that's still a challenge, in my view.

The Chair: + Thank you for that, Madam Lambropoulos.

Madame Normandin, you have two and a half minutes.

[*Translation*]

Ms. Christine Normandin: Thank you very much, Mr. Chair.

I'd like to return to the subject of telemedicine, which came up earlier.

My understanding is that the Maple telemedicine service is mainly for families of serving members. The services are mainly provided by civilian physicians, because medical officers aren't part of the program.

Has anyone considered the possibility of setting up a similar telemedicine service? In other words, could medical officers provide services to members transitioning out of the forces, for example? These members are likely to have greater trust in medical officers than civilian physicians.

Is this option being considered?

LGen Lise Bourgon: Mr. Chair, I thank the member for the question.

The Maple service has two components. On the one hand, it provides services to military families who just moved to a new province and don't yet have access to health care. These services are provided through Canadian Forces Morale and Welfare Services.

On the other, Maple also provides services to veterans, those members who were released from the Canadian Armed Forces. Veterans who move to a new province and don't yet have access to health care can use the Maple service.

I'd now like to yield the floor to Major-General Bilodeau, who will be able to tell you all about the practice of telemedicine on the military side.

MGen Marc Bilodeau: Thank you, Mr. Chair.

The fact is that we've always used telemedicine. In the past, services were mainly provided over the phone. Military members could call a doctor to get a prescription renewed, for example. Of course, when the pandemic hit, we had to quickly find new ways to apply technology to telemedicine, among other things through the use of video conference.

The things that were implemented were implemented because we didn't have any other choice. We acted out of necessity, especially in the first few months of the pandemic, when everything was closed. We understood that was the only way for us to keep seeing our patients and giving them the care they need.

The challenge involves the fact that our current telemedicine system isn't fully integrated with our electronic health records system. It's a real problem, mainly in terms of coordination and logistics. These problems should be resolved within a few years, with the modernization of our various systems.

That said, telemedicine certainly has added value, because some of our members are deployed in places where there are no military clinics nearby. Telemedicine also allows us to provide greater support to our members deployed abroad, for instance when they need to consult a specialist. A lot of issues can be resolved through video conference. In-person consultations aren't always needed. The same can be said for most mental health issues.

Telemedicine allows us to provide our members with more specialized care. There's no doubt that telemedicine adds a lot of value—

● (0935)

[*English*]

The Chair: Thank you, Madame Normandin.

You have two and a half minutes, Ms. Mathyssen.

Ms. Lindsay Mathyssen: On the working group and the duty to report, in terms of what the medical practitioners deal with, what is the progress of that working group to date?

LGen Lise Bourgon: The working group on the duty to report is continuing to work with the recommendation from Justice Arbour. This is a lead, and it is being led by the chief of professional conduct and culture with JAG, the judge advocate general, but on the health service side, I think it's important to remember that there's a difference on the duty to report.

I'll give the floor to General Bilodeau.

MGen Marc Bilodeau: We, as licensed health care providers, have an obligation to protect the confidentiality of the information that is disclosed to us within a clinical encounter, so we don't apply that duty to report for health care providers, because if I were to do that in reporting something—an incident—against the member's consent, I could lose my licence, and I probably would.

None of our licensed health care providers do it, despite the policy. We can't adhere to the policy, because we'd all end up without a job. For us it's an non-issue, and we've already provided direction against that policy to protect our health care professionals from that perspective.

LGen Lise Bourgon: If I might add to that, the chaplains are the same way also.

MGen Marc Bilodeau: Yes.

LGen Lise Bourgon: Because of their duty, they have that exception on that duty to report. We're still working on the actual policy, but in actual day-to-day business, they're exempted.

Ms. Lindsay Mathyssen: The CDS actually mentioned switching over to a "duty to respond". I don't know if you wanted to add to that as well, but what is the deadline for that working group to actually report back on the duty to report?

LGen Lise Bourgon: They're working very hard on this and trying to deliver as soon as possible with all of Justice Arbour's recommendations. I'm not privy to the actual deadline and when it's going to happen. I'm sorry.

Ms. Lindsay Mathyssen: And on "duty to respond"?

LGen Lise Bourgon: That's all part of that same file. They're working on the way forward to try to come up with a solution and put it into our policy and regulations.

Ms. Lindsay Mathyssen: Thank you.

The Chair: Madam Gallant, you have five minutes, please.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

It was reported to me that last week there were three suicides on Base Petawawa. Would you please tell the committee what number of mental health workers are currently available to members at Garrison Petawawa?

LGen Lise Bourgon: Thank you, Mr. Chair. I'll return the floor to General Malcolm.

If you have the info....

BGen Scott Malcolm: Mr. Chair, thanks for the question. I don't have the specific numbers on how many folks we have in Petawawa. Across the country, we have approximately 500 military, public service and contracted psychiatrists and psychologists, mental health nurses and social workers.

Mrs. Cheryl Gallant: How are the medical personnel, including doctors, regular physicians and pharmacists, recruited into military? How do you get the people who are actually serving the members? Are they all military, or do you have civilians as well to augment them?

MGen Marc Bilodeau: Mr. Chair, we have a hybrid of health care professionals, some in uniform, and there are different ways by which they come to duty in uniform.

Some of them come directly from the civilian sector through civilian health care professional development programs. That's the case for many of our physicians, nurses, physiotherapists, social workers, pharmacists and so on. We also have public service positions in our clinics that are for our physicians, nurses and some of our mental health professionals as well.

Obviously we have some vacancies in those positions, which we're backfilling through contractors.

● (0940)

Mrs. Cheryl Gallant: How are these contractors recruited?

MGen Marc Bilodeau: We have a contract with a big firm. It's Calian that has that contract currently. Basically, they're responsible to meet our needs. We're signifying the needs that we have for whatever professional in whichever location, and they're responsible to do the recruiting and to find those professionals.

Mrs. Cheryl Gallant: Calian is given a contract. In essence, they get a cut of the salaries for the physicians, pharmacists, etc., whom they recruit. How competitive are the salaries of these physicians and other medical health care professionals to salaries in the private sector—to anyone not dealing through Calian?

MGen Marc Bilodeau: Mr. Chair, I can't comment on the specifics of the numbers of the contract. What I know is that our contractor is adjusting its rate based on the cost of living and the ability to hire in different areas of the country. For example, a physician hired in Edmonton won't be paid the same as someone hired in Nova Scotia.

Mrs. Cheryl Gallant: Do we currently have any mental health providers on base in Petawawa?

The reason I ask is that a number of years ago, this committee travelled to Base Petawawa in the dying days of the Afghanistan conflict. We visited the mental health centre. I drove there, but the rest of the committee took a bus. They were held up for over an hour and half by a general who was giving them a briefing before the bus even left. Subsequent to that meeting, we learned that while they were being detained in Ottawa, the people at the centre for mental health on the base were scrambling to find people to make it look like the offices were actually occupied.

That's why I'm concerned right now that we have psychologists or psychiatrists on hand, or do our people get loaded into buses and sent to Ottawa for their treatment?

BGen Scott Malcolm: We do absolutely have mental health practitioners in Petawawa. I did a unit visit there less than two weeks ago in the new facility, so we absolutely do. There are times when, if members in Petawawa require more specialized services, they can be referred to practitioners here in Ottawa, but we certainly do have mental health providers in Petawawa.

The Chair: Thank you, Ms. Gallant.

We will move on to Mr. May for five minutes.

Mr. Bryan May (Cambridge, Lib.): Thank you very much, Mr. Chair.

Thank you to all of you for being here and helping us kick off this study.

General, you talked a little bit about Seamless Canada, which I obviously have an affinity for, as co-chair. I have the opportunity to co-chair that steering committee with the Honourable Mary Wilson from New Brunswick. Last year, of course—and you talked a little bit about this—we were able to get the provinces to waive the 90-day waiting period for health cards, not just for CAF members but for their families. We are meeting again in Gagetown next month.

My question is, what should that steering committee be addressing next, in your opinion?

LGen Lise Bourgon: Thank you, Mr. May, for the effort and for co-chairing Seamless Canada, because it is very important.

Again, when we look at the military, the strength behind our uniforms is our families. We are all tracking the recruitment and the retention.

One of the main reasons people leave the military is the impact of service on their families. From a point of view of health care access, by the time you get on the list to have access to a doctor, you're moving again. It's the same thing for child care. It's very difficult to find child care every time you move.

There's also spousal employment. Again, when one of our members is posted, their spouse needs to find a new job in the new location. Usually they end up at the bottom of the list again, with the lowest salary.

Those three lines of effort are the core of Seamless Canada. If the provinces can work on those three lines of efforts and on finding.... It's not going to be magic. There are small victories that we have to achieve through the years to facilitate those three areas of friction when our members are moving across the country.

For me, that's the core. I'm a mother. My husband was in the military. Raising two kids and having to wait for child care access when you're deployed and when you're working crazy hours is so stressful. If I had a magic wand, I would use it for access to child care.

It's great if we can look at subsidized child care. That's great for our members, but having access is absolutely essential for our service members to be able to do their jobs and to be operationally effective because they don't have to worry about what's going to happen to their kids.

I landed a Sea King in Halifax in a parking lot. It was quarter to six, and my husband was deployed. I was like, “Oh my God, who's going to go get the children, because the MFRC closes at six? What are they going to do?” We didn't have family members because we were not posted where we had family members.

That access to child care, for me, would be critical. We're working very hard, but if I had one wish, it would be that one.

● (0945)

Mr. Bryan May: Thank you, General.

I was at CFB Esquimalt a couple of weeks ago, and I had the opportunity to connect with the family resource centre on the base.

I'm wondering whether you can take a moment to explain that to the committee. Is that a model that we are hoping to expand to other bases?

LGen Lise Bourgon: The military family resource centres were established in the late eighties or early nineties. My history fails me, but it was in that area.

They're a jewel too. They're bricks and mortar areas where our families and our service members can go to seek support ranging from family support—like homework support for our children doing homework—to mental health and socialization. Some of our military family centres have day care. They're provincially run day cares, not run by the military, but there's a location. There's a day care there. Many of the services are being provided for our spouses. There's a network of employment opportunities at the tactical level in different communities.

It's interesting, because Australia came for a visit a few months ago, and they went to visit our military family resource centre because it's something that they don't have. It is something that they're going to create for their veterans, because veterans also have access. Family members have access. We don't turn away anyone from accessing the programs that are being delivered at those military family resource centres.

I would encourage.... If you want to go visit, we can provide a session on what they provide, because it's incredible.

Mr. Bryan May: Thank you.

The Chair: Thank you, Mr. May.

I must admit that showing up at day care with a Sea King is pretty impressive.

Voices: Oh, oh!

LGen Lise Bourgon: Mr. Chair, I didn't make it.

The Chair: It's almost as good as landing on top of a Tim Hortons.

Madame Normandin, you have two and a half minutes.

Hang on, it's Mr. Kelly.

Colleagues, before Mr. Kelly.... It's 10 minutes to 10. I propose two more five-minute rounds. Is that okay?

Some hon. members: Agreed.

The Chair: I'm sorry about that. Go ahead.

Mr. Pat Kelly (Calgary Rocky Ridge, CPC): I'm going to carry on with the military family resource centres because those were identified within the total health and wellness strategy. I want to talk about the status of the goals set out under that strategy.

How much have wait times for mental health services been reduced through the expansion of the military family resource centres?

LGen Lise Bourgon: As we are tracking the total health and wellness strategy released in March of 2022, which looks at that holistic, evidence-based approach to health and looks at the physical, the mental and the spiritual, on your specific question, I know there were funds provided to the MFRC to increase the support they provide to the families, but I don't have that data.

● (0950)

Mr. Pat Kelly: What about telemedicine service improvement? Do we have a measurable improvement on that one under this strategy, or is it—

LGen Lise Bourgon: Maple, the telemedicine initiative, was created based on total health and wellness. The Maple services that are available to our families as they move across the country are part of a clear initiative that was produced.

Mr. Pat Kelly: I'm looking for measurable changes and whether we've seen improvement.

LGen Lise Bourgon: We can certainly give you the numbers—

Mr. Pat Kelly: Please do.

LGen Lise Bourgon: —in terms of how many people from our families access Maple.

Mr. Pat Kelly: Okay. It would be great if you could provide that to the committee.

The total health and wellness strategy included the hiring of 30 additional occupational therapists and 48 additional nurse case managers to support recovery. Have those hires taken place? Are those personnel now in place?

LGen Lise Bourgon: I'll give you the floor, Marc.

MGen Marc Bilodeau: Thank you.

We've done a first wave of hiring of case managers and occupational therapists through the first wave of funding that we had. This year we're receiving a second wave of funding that will allow us to complete the hiring process for—

Mr. Pat Kelly: The 48 is contingent on receipt of the funding that's just—

MGen Marc Bilodeau: That's it exactly.

Mr. Pat Kelly: Thank you.

The strategy included the establishment of an additional office of disability management and additional regional offices. Has that taken place?

LGen Lise Bourgon: We will need to provide that answer later.

Mr. Pat Kelly: That's fantastic. If you don't have an answer, that's great. If you will undertake to provide it later, then we can get more questions in.

We've heard even today that getting access to family physicians for families is difficult. How many members' families currently lack a family physician?

LGen Lise Bourgon: We don't have that data, sir.

Mr. Pat Kelly: Is it that you don't have it at your fingertips or that the forces doesn't track it?

LGen Lise Bourgon: We can certainly ask if we're tracking that.

Mr. Pat Kelly: Okay. Please do.

LGen Lise Bourgon: The movement and the agility of the forces and the data change daily, but we'll look into this to see if we have access to that.

Mr. Pat Kelly: Okay. I think that would be an important one to track. If we're talking about the factors that affect the ability to recruit and retain, I think we'd like to know about the status of families and their ability to access basic medical services for their families. That's if there's data. If there isn't, I think there probably should be.

How many members' families lack access to mental health services in the communities near where they're stationed? Many members are stationed in Canada quite far from large urban centres, so this is a real challenge. Do you know how many members have access or lack access?

MGen Marc Bilodeau: Do you mean members or family members?

Mr. Pat Kelly: I mean family members. How many members' families have access to those services?

LGen Lise Bourgon: Again, this is not something I have on hand. Hopefully we are tracking this, because again it is part of the evidence that we need to better understand—

Mr. Pat Kelly: Absolutely.

LGen Lise Bourgon: —as we look at gaps in recruitment and retention. You have to remember that this is not our mandate, but we do need to facilitate that mandate for the recruitment and retention of our people.

Mr. Pat Kelly: Okay. If you could, ask your staff if that data exists, and please have it sent to the clerk of the committee.

Do I have any time left at all, Mr. Chair?

The Chair: You have 15 seconds.

Mr. Pat Kelly: All right. Well, I won't get an answer even if I squeeze in a question.

The Chair: Thank you, Mr. Kelly, for that generous allocation of time.

Mr. Sousa, you have five minutes.

Mr. Charles Sousa (Mississauga—Lakeshore, Lib.): Thank you for being here and enlightening us on some of the challenges you face.

Some time ago, my uncle was a young doctor in the navy, and it was seen as a practicum for him. He ended up going back as a civilian into pathology and forensics. It seemed to be sort of a launching pad in order to get the big opportunities that existed.

I understand the challenges, and you explained to us the concerns, which we all share. Given the great demand with respect to mental health that is now coming upon us, how are you attracting people to become doctors, nurses and practitioners in the military?

LGen Lise Bourgon: In military service for the entirety of the CAF members, that purpose to serve in meaningful employment needs to be in every new applicant. Why people join after that depends on their respective situations.

I'll turn the floor over to General Bilodeau, who might have a better perspective of the medical side.

● (0955)

MGen Marc Bilodeau: Thank you, Mr. Chair.

We are hiring in 19 different health care occupations—

Mr. Charles Sousa: I can't hear.

I'm sorry. Go ahead.

MGen Marc Bilodeau: We're hiring in 19 different health care occupations. Obviously, we need to have a targeted approach for each of those. They are not trained in the same types of schools. They're not trained in the same environment or in the same locations in the country. We're trying to have a very targeted approach for each.

For example, for physicians, we're putting advertisements in medical journals. We're going to med schools to do presentations on what it is to be a military doctor. Usually, we bring somebody in uniform to talk to the med students as well, so that they understand the environment, the conditions, the benefits and everything we offer them as an exciting career.

We're also doing this through a network of specialist recruiters who are specialized in recruiting health care professionals. There are people working full time for us in different areas of the country where the main focus is really to recruit health care professionals on our behalf.

Obviously, we're recruiting a lot of people, but a lot of people are leaving after their obligatory service because they've decided to do something else with their lives, so retention becomes a challenge for us. We need to do better from a retention perspective and try to make sure that we keep them excited while they're serving so that they are willing to serve. We need to create that sense of identity, as well, that General Bourgon was talking about, and that sense of purpose.

Mr. Charles Sousa: Because it's a unique group that you have, is it also used as a test? You know how they try.... In terms of sharing and doing research, is the membership called upon at times to be used in that regard, so that they can have a more controlled group to monitor? It's done willingly, obviously.

MGen Marc Bilodeau: Yes. There's a bit of research happening in our organization, if that's the question. Some of our professionals are interested and are doing research.

I fund a health research program. That is allocated in my budget. We have a captive population that is easier to study, I would say, than the rest of the population. I would say it's not the majority of our people who are interested in research, certainly not early on in their career, but we definitely have a platform for our people when they're interested.

LGen Lise Bourgon: We get a lot of our medical practitioners through internal transfers within CAF. They join in an occupation; then they fall in love with the CAF way of life and they apply to become doctors or nurses, and they join. We're seeing a lot of internal transfers.

None of us is doing this for the money. The financial security has to be there, but it's that purpose and that desire to serve. That's who we want to go and connect with. That's our challenge.

Mr. Charles Sousa: Thank you very much.

The Chair: You have a little less than a minute.

Mr. Charles Sousa: That's even better.

On the challenges that you've associated with accessing health care, I suspect that in some remote areas, it's very difficult for you to share civilian resources in whatever country you may be in.

How do you deploy some of that? You need to station people there for a long period of time in order to have a substantial or a strong base of medicine and support for those members.

BGen Scott Malcolm: Thanks for the question.

Basically, an analysis is done of what the local resources are. We have two permanent standing clinics, one in Geilenkirchen and one at SHAPE, that are able to provide some support to folks in Europe.

When it comes to specific deployments, the assessment is made of what's available locally and what other allied resources there are, and we develop a medical plan in order to ensure that we have continuous support for our folks. Ultimately, if there's a big issue, they are transferred back to Canada.

The Chair: Thank you, Mr. Sousa.

You have two and a half minutes, Madame Normandin.

[*Translation*]

Ms. Christine Normandin: Thank you very much,

I'd like your opinion on the possibility of a partnership between the Canadian Forces Leadership and Recruit School in Saint-Jean-sur-Richelieu and the city's community sector.

The Centre de crise et de prévention du suicide du Haut-Richelieu-Rouville provides recruits with a room reserved and paid for by the armed forces. It's a real win-win. The centre offers specialized services and it can remove recruits from a crisis situation.

Are such partnerships being considered in other areas? I know some people from the suicide prevention centre will be appearing before the committee later, but I'd like to know if, broadly speaking, this is something you're considering.

● (1000)

MGen Marc Bilodeau: Thank you for the question.

There are a number of community partnerships right across the country. At the local level, we encourage a lot of our clinics to show leadership in that regard. They can enter into partnerships to improve the services they provide to our members. These kinds of relationships are critical to ensuring proper follow-up of medical records.

There are certain services that our military clinics don't provide, and so we need to purchase these services from the provinces and the various community organizations. It's a beneficial arrangement in that we enter into a contract with an insurer, namely Medavie Blue Cross, which facilitates payment of all the health care services our members need. These partnerships only get better with time, and they allow us to have our needs met and to lead our members back to health so that they can keep doing their job.

Ms. Christine Normandin: Who's responsible for liaising with these service providers or for making sure the service exists? Is it the community organizations who reach out to the Canadian Forces and offer their services?

MGen Marc Bilodeau: It happens in different ways. Sometimes, our own teams who work in local clinics show initiative and establish partnerships. As surgeon general, I also get offers sent to me, which I refer to my subordinates. I'd also mention the civilian partnerships that already exist at my level. We're striving to encourage our local teams to build these kinds of relationships, as they ultimately allow us to improve the services we provide our members.

Brigadier-General Malcolm, do you have anything to add?

[*English*]

The Chair: We're out of time.

You see? General Malcolm is catching on.

You have two and a half minutes, Ms. Mathyssen.

Ms. Lindsay Mathyssen: I want to follow up.

On one of my questions, you referred to provisions provided by OSISS in terms of mental health, but that isn't actually applicable to sexual trauma and the service's sexualized trauma experience within the military. I noted that it's referred to the SMSRC. However, in terms of that transition, when members ideally are served by SMSRC, that doesn't happen for veterans, so how do you manage that transition for people who are experiencing sexualized trauma?

LGen Lise Bourgon: I'm not sure that I can answer all of your questions here, because that's outside my field, outside my wide responsibilities. That one is not in there, but in relation to military sexual trauma and the work that is being done by OSISS, the organization that Commodore Bouchard...that great network is being replicated for MST survivors. This is being led by the SMRC, of course, but based on the development of OSISS. They're kind of replicating the same system. Because it's working so well for operational stress injuries, the MST network and survivors will be developing that same system.

I can't answer more than this because that is a responsibility of the SMRC to provide, but I know that OSISS is being used as the tool to provide that MST support to our survivors.

Ms. Lindsay Mathyssen: Is that information something you can get to this committee in terms of timelines that will show that progress, or the plans for it?

LGen Lise Bourgon: We can take this back as a question for the SMS...SM....

A voice: It's SMSRC.

LGen Lise Bourgon:*Merci*.

They've changed the name. There's one more “s” now. We can ask them to provide an update on their MST supports.

Ms. Lindsay Mathyssen: Okay. That's perfect.

You had been talking about the Medavie Blue Cross services provided to members. Can you let me know what the timelines are for renewal for those benefits and policy agreements for the CAF?

One of the concerns I heard was about chiropractic services. There are a lot of requirements. Obviously, service members deal with a lot more. There have been requests for access to chiropractors, but that's not provided through Medavie, and they're worried about the agreements being renewed and what will be included in them.

The Chair: We'll have to take that question under advisement.

Ms. Mathyssen is very clever. She asks her questions with no time left. It's very clever.

Ms. Lindsay Mathyssen: I want answers, Mr. Chair.

The Chair: You're going to get answers, but you're not going to get them within the two and a half minutes.

We'll go to Ms. Kramp-Neuman.

● (1005)

Mrs. Shelby Kramp-Neuman: Thank you.

What I'll do is follow up on the question that didn't quite get answered in the last session for my colleague. Could you possibly provide or could the CAF survey families to determine the rates of access to physical and mental services that we could include in draft recommendations? From our perspective, if we can't measure it, we can't manage it.

LGen Lise Bourgon: In the CAF and DND, there's a very robust survey program, and I will ask the question of the director general of military personnel research and analysis.

My gut feeling tells me it's already a question that they're asking about the caveat on access to child care and access to family mental health and medical care. I will ask that question, but I'm 90% certain that it is being done.

Mrs. Shelby Kramp-Neuman: If, as you mentioned earlier, these are the number one reasons people are leaving or are not joining, then I think it's super important that we look into it and get the numbers to support the decisions moving forward.

To follow up on my last question earlier in the session, we were talking about civilian doctors, and doctors in general, for the CAF. Is there an opportunity for the Department of National Defence to help with foreign accreditation of new Canadians with regard to family doctors?

LGen Lise Bourgon: Can you repeat that question and potentially explain it a little more, please?

Mrs. Shelby Kramp-Neuman: Certainly. My question is this: Do you see an opportunity for the Department of National Defence to help with foreign accreditation of new Canadians?

LGen Lise Bourgon: I'm just going to confirm that you're looking at the Department of National Defence to take a lead in the accreditation of the qualifications of new residents who come in with a medical or a health service background.

Mrs. Shelby Kramp-Neuman: That's correct.

LGen Lise Bourgon: I'm sorry, Marc; I'll throw it your way.

MGen Marc Bilodeau: This is definitely outside of our mandate. There are national organizations that are responsible for that. The Canadian Medical Council is one of them, and obviously all the regulators in each of the provinces.

Mrs. Shelby Kramp-Neuman: Okay. I'll move forward with regard to mental health.

The 2023-24 departmental plan acknowledged that the aim was to improve mental health support by reducing wait times for support and services. Could you speak to the current wait times and the central cause of them?

MGen Marc Bilodeau: There's a challenge currently in health care, not only in the military but also in the country overall, as you know. There's an increase in demand overall for health care, especially mental health services, that is challenging the system overall. There are just not enough mental health care providers in the country currently to meet the demand. Obviously that is impacting us as well, because our members are a sample of Canadian society, so that demand for health care has increased also.

That trend started, by the way, before the pandemic, and it was just exacerbated during the pandemic. I think there's a new set of stigmas that are not as present as before from a health care perspective, which is good. I think it's going to bring more people into care earlier, which probably will improve the overall outcome of all those people who are suffering with mental health issues, but this need is currently creating a lot of pressure on our systems.

We're obviously still trying to recruit as much as we can to have our piece of it, if you will, from the perspective of mental health care providers. We currently have 50 active hiring processes going on through our contractor, Calian, to bring in additional mental health professionals. It's not easy, because we're in competition, obviously, with our colleagues from the provinces, and we can't afford to steal everything from them either. We need to share in some ways.

What we're doing, although internally, is trying to re-look at our program and at the way we deliver mental health care to see if we can become more efficient, if we can "responsibilize" more patients and if we can stick to our patients less than we are currently. All of that is part of what we're doing.

There are lots of applications online now, for example, to do some mental health treatment, if you will. We need to capitalize on that. I think that would save resources for us and allow us to treat more people if we do that. However, it's an ongoing challenge that we're working on actively.

Mrs. Shelby Kramp-Neuman: In speaking with former CAF members, how do you see them transitioning to other supports following their time with CAF to ensure long-term support for veterans?

● (1010)

MGen Marc Bilodeau: There is other support, but I can speak to the medical aspect of it.

As I said, I have a responsibility to make sure that all our members who have a medical issue at release are transferred safely to a health care team post-release. We're doing that through our nurse case managers, who are the main pivot to facilitate that transition. Then we need to liaise with the provinces and the territories as well as Veterans Affairs.

That's a three-partner dance, basically, that needs to happen at the time of release. It 's a challenge now because of a lack of access to health care in the civilian sector. This is why we have that good mechanism that allows us to potentially keep members a bit longer to make sure the bridging is done properly and safely.

The Chair: Okay, we're going to have to leave the questioning there.

I have Ms. O'Connell as the next....

Will it be you?

Ms. Emmanuella Lambropoulos: Yes.

The Chair: Madam Lambropoulos, you have five minutes.

Ms. Emmanuella Lambropoulos: Thank you. I'm going to continue the conversation about mental health.

You mentioned earlier that if somebody is a veteran and their mental health condition comes out later, as is often the case with PTSD, which is something a lot of veterans deal with, there is an issue in terms of receiving the services or in terms of that transition.

I am wondering if it is mandatory for members of the CAF to receive mental health support. Is it mandatory to see a psychologist, social worker, psychiatrist, addiction counsellor? Is there somebody who is automatically checking in on members, periodically or regularly, to make sure that people are not being missed, and what is the process for that in general?

MGen Marc Bilodeau: There are lots of different touchpoints with our members throughout their careers that allow us basically to identify when they are suffering from mental health issues. That starts at recruiting. The first day that they enter a recruiting centre, we're asking them if they have active mental health issues.

Then it goes on through our periodic health assessments that we are doing on a regular cyclical basis, based on their age and gender. That goes on through the pre-deployment screening that we do before they go on any mission and the post-deployment screening that we do when they come back from a mission. That goes on through any touchpoint that we have with our members for reasons other than a mental health issue. That's an opportunity we have to basically ask if they are suffering in any way and to make sure they are offered the support they need, based on their disclosed condition.

LGen Lise Bourgon: I think Commodore Bouchard wants to add something.

Cmdre Daniel Bouchard: I would like to add something with regard to the family support system that we have.

In the transition process, we have a family liaison officer for the more complex cases, and there is also a family transition adviser for the less complex cases. With the families and the immediate supporting members, we go through a process to ask these types of questions and to develop understanding of the member who is proceeding on release. It's to make sure that we have these opportunities and also to see whether there are any red flags or issues that need looking into.

LGen Lise Bourgon: I want to add, too, that we do mental health readiness. The road to mental readiness is training that everyone needs to do at different steps in their life—before deploying, coming back from deployment, on basic training—so people are familiar with the spectrum of mental readiness outside of the health services and so that leadership and members are tracking it.

Ms. Emmanuella Lambropoulos: Would you say that members feel comfortable disclosing if they are going through a mental hardship? Is it often that members will say they are going through something, or do you think masking is something that's regular in the armed forces? These people are so tough and have to be the defenders of our country, so it's very hard for someone to admit when they're going through something.

In COVID-19, seeing how many civilian Canadians were suffering from mental health issues during the pandemic, I can only imagine that with going through the traumatic experiences that someone in the armed forces would go through, it's automatic that they must need help in some ways.

Could you comment on that?

MGen Marc Bilodeau: Yes, there is still a stigma, but it is less than it was 20 years ago. It keeps reducing, I guess, in some ways. The reason is that I think we have normalized what it is to be suffering from a mental health issue. We have made it normal.

There is still a concern from some members that it's going to negatively impact their career, though, and that is the biggest stigma we need to fight against. We're trying to work on policies that will alleviate that. For example, there was a policy in the last few years that you could still be promoted even if you were being actively treated for a mental health condition—for any condition, in fact. This is an example of policy factors that are basically impacting the stigma.

We still need to work on that, though, and I think leadership is critical. That's where the military leadership, the chain of command, is critical in reducing the stigma and normalizing access to care. That's why we're working in partnership with the military chain of command and the members in trying to make sure that we all understand it is a shared responsibility.

● (1015)

Ms. Emmanuella Lambropoulos: Before I let you go and I let him cut me off, I want to mention perinatal mental health.

It was brought to my attention that once women exit the forces, they begin having children in many cases, and may recognize that the trauma comes out while they're pregnant or afterwards.

I want to put that on your radar, because it's not something that's discussed very often. It's something we need to start talking more about, in terms of offering medical care or mental health care in that area for the younger women who may plan on starting a family soon. That's just so they're aware and your mental health practitioners are aware as well, because it's not something that is regularly discussed yet.

The Chair: If that can be worked into another line of questions, that would be very helpful.

Colleagues, that completes the third round. I propose one more five-minute round.

I have Mr. Bezan, Ms. O'Connell, Madame Normandin, Ms. Mathyssen, Mr. Kelly and Ms. Lambropoulos. Mind you, Mr. McKay might like to get into something. I'm just hinting.

With that, Mr. Kelly, you have five minutes.

Mr. Pat Kelly: Thank you.

Getting back to the total health and wellness strategy and its goals, one of them was introducing the workplace harassment and violence prevention centre of expertise. Is that up and running?

LGen Lise Bourgon: That part of the total wellness strategy belongs to the chief of professional conduct and culture, so I cannot comment. It's part of our strategy, but it does not fall into my chief of military personnel mandate.

Mr. Pat Kelly: Are you not sure if it's running or not?

LGen Lise Bourgon: It's running. I just don't know how much progress has been made. More people were to be hired to make it more robust. I cannot give you an update.

Mr. Pat Kelly: Do you know how many complaints or appointments it can handle in a month?

LGen Lise Bourgon: No, sir.

Mr. Pat Kelly: Okay.

On the CAF transition group for transition to civilian life, how many members are currently in the transition group?

LGen Lise Bourgon: I'll give you the floor to Dan.

Cmdre Daniel Bouchard: For our ill and injured posted in our transition group, there are 1,502 individuals at this time across Canada.

Mr. Pat Kelly: Normally, how long is a member in transition?

Cmdre Daniel Bouchard: It varies with each individual. Generally speaking, it's a three-year period, but we have some who have been with us for up to six years.

Mr. Pat Kelly: Is the number who are in transition static, or do you see that becoming a larger or smaller number at a particular moment?

Cmdre Daniel Bouchard: At this time, I don't have the trend with me. My apologies. It's been around 1,500 over the past two or three years.

Mr. Pat Kelly: How are forces members made aware of the supports that exist?

Cmdre Daniel Bouchard: For our ill and injured and those who are posted to us, there's a service coordinator who will do the transition process with them and will coordinate their services with them and their families.

● (1020)

Mr. Pat Kelly: Regarding the implementation of the women's health framework strategy to support women's health care in the military, how far along is the implementation of the women's health framework?

LGen Lise Bourgon: I'll give the floor to General Bilodeau. He will talk about the health side, and I will just add with regard to the CFMWS and what it's doing.

MGen Marc Bilodeau: We're just starting. We're now building a team. We're hiring people in our clinics, and then the work will start, looking at our research framework, surveillance framework, prevention framework and health care framework. We need people, obviously, to do that, and people are being hired as we speak.

LGen Lise Bourgon: Regarding the CFMWS and occupational fitness, we're a bit more advanced, because we leaned forward last year to ask CFMWS to start delivering on its line of operation. The first initiative is looking at women recruits as they go through Saint-Jean, trying to provide support before they arrive in Saint-Jean from a physical fitness perspective, because we know women have a deficit on that fitness side.

We provide support ahead of time. We now have a physical fitness program, which is available online, to ensure that women, as they're waiting to go to Saint-Jean—they have about three months—can start to work out and improve their physical fitness.

Mr. Pat Kelly: You have a very specific target for base, wing and unit fitness. You talked about hiring 44 additional staff.

Have those additional staff—all 44—been hired?

LGen Lise Bourgon: I cannot guarantee that the 44 have been hired, but I know CFMWS has leaned forward and hired everyone they were asked to hire. They're a bit more flexible in their hiring procedures, given that they're not public employees. They're part of the NPF employees, the non-public funds employees.

I would say yes.

Mr. Pat Kelly: Okay.

How were they recruited, then? Can you say that again?

LGen Lise Bourgon: They're non-public fund employees. CFMWS has a construct different from that of public employers. I will not go into details, because it's very complicated and we won't have time.

Mr. Pat Kelly: All right.

I think I'm out of time.

The Chair: Thank you, Mr. Kelly.

Madam O'Connell, you have five minutes.

Jennifer, are you hearing me?

No, you're not.

I was thinking that Emmanuella asked a very key question and I thought it deserved an answer.

Mr. Bryan May: For some reason, Jennifer can't hear. She just texted me.

Go ahead.

Ms. Emmanuella Lambropoulos: I'll continue on the question of perinatal mental health.

I wonder whether you can tell me if there's anything being done. I don't know whether some members in the armed forces are having children and dealing with this as well. Is it something on your radar? Is it something you've been dealing with?

MGen Marc Bilodeau: We're currently in the process of hiring specialists—OB/GYNs—who will help us provide advice to build a better program there. They will advise us how to better manage, from a health care perspective, women in the perinatal period, and make sure we're preventing any potential injuries. We know that's a period prone to injuries, so we're working in partnership there. We hope to be able to build a better prevention program, and also a care program. We won't reinvent the wheel, though, because a lot of it has already been done, mainly by our colleagues in the U.S. and the U.K. That's why international collaboration is so important.

In February, we were lucky to host a symposium at the Canadian embassy in the U.S. We invited our partners from the Five Eyes community and tried to share what we're doing, respectively, from a women's health perspective. We agreed at that conference to keep working together to develop the clinical practice guidelines that will allow us to move together in improving women's health in the military.

LGen Lise Bourgon: On that aspect, and again from a physical fitness standpoint, emphasis is put on pre- and postpartum fitness at our gym, with experts. Pelvic floor therapy you are going to see across.... I believe it was in Petawawa that it was done for the first time. Mothers or parents with their newborn can go to the gym and have physical fitness developed for them. It's both prevention and recovery. There are very good initiatives going forward.

● (1025)

Ms. Emmanuella Lambropoulos: I'm happy to hear that.

I guess that's why we haven't heard it on the Department of National Defence side; we've heard it more from veterans who don't necessarily have that support and who.... It comes in later. That will be one of our recommendations going forward. Perhaps we'll look for a little more information on that.

I'll pass the floor to my colleague Mr. May.

Mr. Bryan May: How much time do I have, sir?

The Chair: You have three minutes.

Mr. Bryan May: I know we've talked about some of the gaps in the system right now. I'm wondering whether you can take us through the process or the point at which—if there is a point—a person in care is handed off to a provincial health care system. I'm thinking about cancer treatments and things like that.

I'm wondering whether you can explain the level of health care that exists within the military and where there's that transition to public care.

MGen Marc Bilodeau: As General Malcolm described earlier, we're providing enhanced primary care in our clinics. In most of our clinics—the 37 we mentioned—we have a primary care team, which is usually led by a family physician. Many of them are augmented by physiotherapy and mental health. Those are our two main areas of focus from a health care perspective. In some of them, we have some diagnostic technology, such as X-rays and labs, but not in all of them. We need to outsource everything that goes beyond that, including specialty care and hospital care, because we don't have it in the military.

Mr. Bryan May: Do you have MRIs within the clinics?

MGen Marc Bilodeau: We do not have MRIs. We have two deployable CT scanners, but we don't have MRIs in our clinics, so every time a member requires services beyond what we have, we do a referral. It's the same as in the civilian sector. It's a referral to a specific clinic or providers to receive the care they need.

Mr. Bryan May: Is there any preferential treatment for CAF members in terms of those referrals, or are they going into a queue scenario?

MGen Marc Bilodeau: Officially, there's no preferential treatment, but if we have a special operational requirement that requires a member to have a knee arthroscopy, for example, in advance of others because we need them to deploy in six months, if we develop a good relationship locally, then we're usually able to negotiate that access.

We're trying to be careful with that. We know we're competing with all Canadians. We need to be careful in terms of how we're managing it. In some exceptional cases, I believe it's justifiable, since the security of our country depends on it.

The Chair: Thank you, Mr. May.

Madame Normandin, go ahead, please, for two and a half minutes.

[*Translation*]

Ms. Christine Normandin: Thank you very much.

I'd like to come back to the issue of mental health services. You spoke of the importance of making them more efficient. I'd like to hear your thoughts on the way to make that happen on the operational level.

For instance, when a person receiving mental health services is transferred, do they have to start the whole process over with a new professional or is there some kind of follow-up? I suppose that the bonds of trust people have with their mental health practitioner aren't the same as those people develop with a doctor who might treat a sprain, for example.

MGen Marc Bilodeau: Thank you, Mr. Chair.

Actually, the beauty of our system is that it involves the maintenance of pan-Canadian electronic health records. All of the information related to the care that's provided to patients is recorded in these files, which are accessible from anywhere. That way, when a member is transferred or temporarily assigned to another base for operational reasons, access to care is much easier.

As for the therapeutic bonds that exist with our members, I agree with you that it plays a major role not only in terms of the quality of care, but also in terms of the support we can offer our members.

Furthermore, the advantage of telemedicine is that it allows us to ensure follow-up with a professional even when a member moves around. That said, this only happens on occasion, since the majority of our members don't get transferred when they're very sick. It remains an option we can use when we need to, however.

We also occasionally authorize our members to travel to meet a health care professional. That only happens in exceptional circumstances since the majority of mental health care services can be provided through telemedicine.

● (1030)

Ms. Christine Normandin: Can members' mental health issues be considered a good reason to avoid transferring them? Isn't it preferable to wait for their condition to stabilize and spare them from having to deal with the stress of being transferred?

MGen Marc Bilodeau: I completely agree with you on that. The advantage of our relationship with the chain of command is that we establish limits to employment and that we dialogue with the chain of command and the member to ensure that responsibilities are shared. The goal is to foster the necessary conditions to allow the member to recuperate. In some cases, it's a matter of recommending delaying the transfer so that care can be provided.

[*English*]

The Chair: Thank you, Madame Normandin.

Ms. Mathyssen, go ahead, please, for two and a half minutes.

Ms. Lindsay Mathyssen: I'm going to try to put two questions in together so that I can trick the chair into giving me more time.

I didn't get a response, so can you let us know the timeline for the renewal of the benefits for CAF members under Medavie Blue Cross extended care?

Also, is the team considering increasing coverage for chiropractic services, as I understand has been requested by many service members?

In addition, I have a colleague who has introduced Bill C-206, a private member's bill that ultimately would change the National Defence Act, which makes self-harm a disciplinary offence. He wants to recognize that self-harm is obviously a mental health issue. Removing it would represent taking a step forward against a lot of that stigma that you're talking about and recognizing that mental health is an issue that we address differently, from a physician's point of view.

MGen Marc Bilodeau: On the question of renewal of benefits, there are two pieces there that I might answer on. I don't know if I'm going to touch on what you're looking for.

First, we're in the process of renewing the contract with Blue Cross. Is that what...?

Ms. Lindsay Mathyssen: It's the timeline, yes.

MGen Marc Bilodeau: That's done by Veterans Affairs. That's a three-department contract among us, the RCMP and Veterans Affairs. They're the lead. I can't comment on the specifics of it.

With regard to chiropractic care specifically, it's already included in our list of benefits. We are allowed to refer our members to receive chiropractic care. It's basically funded through our payment mechanism with Blue Cross. That already exists.

Ms. Lindsay Mathyssen: Okay.

LGen Lise Bourgon: On the aspect of subsection 98(c) and self-harm, this is more of a legal question. They are looking into that legislation.

At the end of the day, self-harm due to mental health is never going to be actioned in a punitive way.

Ms. Lindsay Mathyssen: The point of the bill.... We've been told that it's never going to be actioned, so why wouldn't the act just be changed?

LGen Lise Bourgon: You have to go and look at unlimited liability and going to war. Look at World War I and World War II. People were cutting their fingers so as not to be.... I know it's based on history. Mental health in that aspect will not be used. I think it's well protected in the health services.

It is something we have on our list to amend, but it's a question of priorities and sequencing, because there's a lot of legislation that needs to be modified right now. We have limited resources and bandwidth.

The Chair: Thank you.

Mr. Bezan, you have five minutes.

Mr. James Bezan: Thank you, Mr. Chair.

We've referred to the total health and wellness strategy. It touches on parts of what you're doing in health care. It also touches on other parts.

I know there are deadlines tied to that strategy. Would you be able to table in the House how the strategy has been executed and whether or not we're meeting those deadlines?

A few times in the testimony today, we talked about the Seamless Canada initiative and how that's especially impacting the consistency and the continuity of care for CAF members as well as their families, especially when they are moving back and forth across the country.

Could we have a copy of that agreement with the provinces tabled with committee so that we can see exactly how it's going to be implemented?

LGen Lise Bourgon: We'll look into this.

I think we provide a report every year on the total health and wellness strategy implementation plan.

Mr. James Bezan: We looked online and we couldn't find it.

LGen Lise Bourgon: I think it's releasable.

Mr. James Bezan: Even if you could get the link....

LGen Lise Bourgon: We'll go back and look into it. It might be in the process of making its way up to the minister for a signature.

It's something that we have to do every year anyway, so we'll ensure that it's made available when it's ready to be made available.

Mr. James Bezan: Okay. Thank you.

We supported the government's announcement to expedite the pathway to citizenship and recruit permanent residents into the Canadian Forces. Have you looked at using that as a tool to recruit specific new Canadians who are trained in health care but don't have their credentials recognized here in Canada? It would provide the opportunity to have their credentials recognized while serving in the Canadian Armed Forces in their field of expertise and training.

● (1035)

MGen Marc Bilodeau: The challenge with that is we're not a regulator. I'm not giving licences to practise. The colleges of physicians, for example, are in the provinces. They are the ones that will give them the authority to practise or tell them what they need to do it order to gain their permits.

That would be a very challenging space for us to get engaged in, as we don't have all the levers.

Mr. James Bezan: I think it would be an opportunity for the Canadian Armed Forces to fill in vacancies and work with those colleges to ensure that those professionals are getting accredited while providing the care that our members need.

Moving on and going to the CAF transition group, we have some of the numbers there. Originally, when they go into the transition group, not everyone hears, "Okay, we're going to release you." There are some we may want to retain and retrain. Do we know what those numbers are? What are the percentages and success rates?

Finding people, especially those with national security clearances, is getting more and more difficult, it seems.

Cmdre Daniel Bouchard: I do not have the numbers, because in the transition group for all regular force members, we are not at full operational capability at this time. However, we are tracking these numbers. It is something that I have asked the team to look at to make sure that we have an idea.

We've also—

Mr. James Bezan: Could you provide those numbers to the committee as well?

I would be interested to see what careers they're transitioning from and into, even if they are going to transition as civilians and go back and work for DND. I think there's an opportunity there to take those people with operational know-how and put them in on the civilian side.

Talking about recruitment, I'm hearing that the percentage of women who walk into our recruitment centres across this country is on the decline. Of course, we've had bad news with CAF for a number of years. I wanted to know if you could confirm that number.

I have heard that only 8% of women have actually darkened the doors of recruitment centres across Canada.

LGen Lise Bourgon: Thank you for the question.

That is not a fact, actually. When we look at the numbers of women, about 28% of the applicants in our recruiting numbers right now are women.

The issue we are seeing right now is that a lot of women are going for the same occupations. Canadians and Canada as a society are still quite traditional and gender-traditional in roles, so they're going towards those traditional occupations, which are mostly medical, logistics and support. Those numbers are actually limited. That is where the issue is. If we could get more women to go into the non-gender-traditional roles across the CAF, we could have 28% women.

The Chair: Thank you, Mr. Bezan.

I'll take the last question. There's a saying that there are no atheists in foxholes, yet we managed to have an almost two-hour discussion without discussing the spiritual well-being of CAF members.

In my riding, the rhythms of a lot of my constituents are governed by their spiritual and religious affiliation, whether it's Muslim or Christian, primarily, yet we've had no discussion about the spiritual well-being of our people.

Do you think that this is an impediment to recruitment?

LGen Lise Bourgon: I said the word "spiritual" when I talked about the total health and wellness strategy. Again, it's the physical, spiritual and mental.

We have a robust spiritual section under the chaplain general. The chaplain general is responsible for providing chaplains across the CAF and DND. When we look at the chaplains, we've seen in the last 18 months a growth in chaplains and a growth in the non-traditional faiths of chaplains. Now we have a Muslim chaplain, an indigenous chaplain and a humanist chaplain available across the CAF. It is so important. It's part of the command team aspect that's part of the support at the tactical level.

The chaplains, regardless of their faith base, are all trained. A lot of them have social work backgrounds, so on top of that social work help, they also provide that spiritual base—not based on a religion—across the spectrum.

It is an important piece of the total health and wellness strategy. We've been working very hard with the chaplain general to broaden the spectrum of what is available for our troops.

● (1040)

The Chair: Putting aside the distinction between spiritual and religious, which many would say there is no difference between, do you think that chaplains who represent or are affiliated with organized religions whose beliefs are not synonymous with the diverse and inclusive workplace are being excluded from chaplaincy? A misinterpretation would pretty well eliminate all of the Abrahamic religions from any application to be chaplains in the forces.

I'd be interested in knowing how you square that circle. It does, on the face of it, appear to be hostile to a large percentage of Canadians whose faith determines how they live.

LGen Lise Bourgon: We're looking at what the role of a chaplain is. That spiritual aspect is more important in service to our CAF members. Right now, every chaplain coming into the CAF, regardless of their faith group, has to first respect the values of the CAF by serving every member and being inclusive. If a chaplain coming in cannot meet the CAF values because their faith restricts them from doing that, then honestly, the CAF is not the place for them.

The first thing is being able to serve and provide support to every CAF member regardless of their faith, gender, identity and everything else. That has been very clear across all of our chaplains.

I think, personally, that we have to also provide our members with religious support. It is important, but every religion must also be respected, so those services are available for all of our CAF members. We are looking at a much more inclusive chaplain group, and one that respects the CAF values and our ethos first.

The Chair: Thank you for that. You're right on time, too. I had one second left over.

With that, I do want to thank you for your attendance here.

Why are you waving at me?

Mr. Bryan May: I just want to remind the chair that we may have a quick question for the committee about travel.

The Chair: Do we have a quick question about the touring committee?

Let me release the witnesses first.

Again, thank you. You've given us a great deal of information with which to launch this study. Ultimately, I hope that the report the committee produces will be useful as you go on. Committees have an ability to actually pull in a lot of information from both inside and outside and hopefully move the ball forward as far as useful directions for the CAF are concerned, which I think is ultimately our goal for everyone.

With that, thank you.

I'm being told to not bring the gavel down until we deal with...what?

● (1045)

The Clerk of the Committee (Mr. Andrew Wilson): Mr. May asked about this before the meeting started.

The deadline for a travel submission for the committee is May 19. We talked about it at the subcommittee, but just to fill in all members, we are unable to extend the budget approval that we have already received from SBLI, so if the committee wishes to submit a travel submission for the July to September period, we would need to do so by May 19.

It's a shorter process than it was before. Basically, what I would need from the committee to start the process is to know where you would want to go, and then I can start the detailed budget process, which would then need to be approved by the committee at a later date.

The Chair: Go ahead, James.

Mr. James Bezan: Mr. Chair, I would just say that we want to submit that travel request. We want to add the U.K. as a stop in order to visit our troops who are training Ukrainian troops in Operation Unifier, and if we have to drop a location, I'd suggest that it be Lithuania.

The Chair: Okay. We're good.

I have some reminders.

On May 2, next Tuesday, we have Minister Anand. Also, May 2 is the deadline for witness submissions for procurement. May 5 is cancelled. May 19 is cancelled. On May 9, May 12 and May 16, we continue our study. The Polish deputy prime minister and minister of national defence is coming May 8. If you could let the clerk know who's interested....

With that, is everyone good?

The meeting is adjourned.