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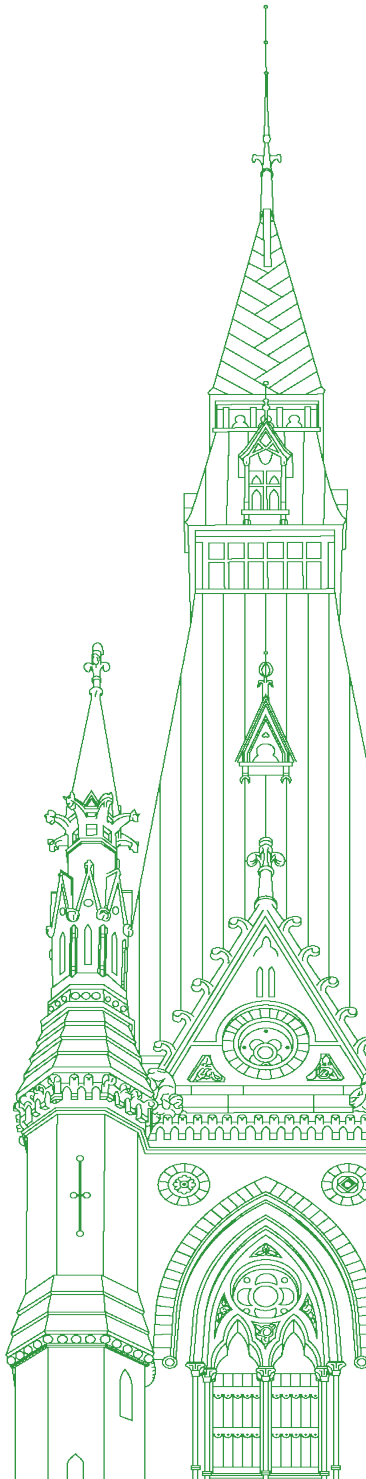

Chair: The Honourable John McKay

Standing Committee on National Defence

Tuesday, May 9, 2023

● (1615)

[*English*]

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

Colleagues, there have been some disruptions, of which you are intimately aware.

I've asked two of the panellists to return at another date and re-empanelled this panel, so that, instead of having two witnesses, we now have three. I particularly appreciate the patience of Madame Tam-Seto, Colonel Pucci and Madame Lafond.

Colleagues, as you know, if the bells start ringing, I have to suspend unless I have unanimous consent to continue. I'm not going to ask for unanimous consent now. I will be asking for unanimous consent when the bells start ringing. I'm hoping to at least get statements done, then go from there.

With that, I will ask Dr. Linna Tam-Seto, then Myriam Lafond, then Colonel Pucci to give their opening five-minute statements.

Again, thank you for your patience, and I look forward to what you have to say.

Dr. Linna Tam-Seto (Assistant Professor, McMaster University, Canadian Institute for Military and Veteran Health Research): Good afternoon, Mr. Chair and members of the committee. Thank you for the opportunity to come before you today to speak about some of the work I've been part of, which is to better understand the experiences of Canada's military veterans and their families, particularly during periods of change and transition.

I come before the committee as a health researcher from McMaster University and the Canadian Institute for Military and Veteran Health Research. I am a civilian with no military experience. I'm not from a military-connected family. I am, however, a registered occupational therapist with over 20 years of clinical and research experience.

I'm here to share with you what we currently know about the experiences of members as they go through the process of releasing and shifting where they receive health care services. Doing the work that I do, I often hear people ask what makes veterans and their families so special: Why should they be treated any differently by the health care system than me and my family?

The answer is simple. Veterans and their families are unique because of the personal sacrifices they have made to serve this country. They should not be put at a disadvantage for that service. That is why my colleagues and I do the work that we do and will continue to do it.

My statement this afternoon will focus on two specific phenomena experienced by Canadian Forces veterans during their military to civilian transition, regardless of the type of release.

First, there is no consistent mechanism by which the health information of members is moved from CF health services into the civilian health care system. Unbeknownst to most Canadians, there is no dedicated health care system that provides services to veterans. Upon release, veterans are placed in the same health care system used by all Canadians and thus face the same challenges, barriers and delays.

Some veterans have preplanned their inevitable transition to the civilian system by reaching out to primary care providers who may already be connected to them through family or friends, which facilitates this process. For many, however, this abrupt stopping of services creates real potential for a gap in their health care. For people with complex or chronic health conditions, the gap is even more severe. We hear stories about veterans who are left to put their names on countless waiting lists or who are forced to use walk-in clinics, urgent care or emergency rooms for routine care. Many veterans have shared that in cases when they are able to see someone, they need to prioritize or choose which of their health conditions will be seen that day. This can be extremely tedious for veterans who are living with multiple health problems.

The second point I would like to highlight is what happens when veterans finally enter the civilian health care system. As I mentioned before, most Canadians are not aware that veterans access health services provided through provinces and territories, and that it is therefore unlikely that these health care professionals and institutions are aware of what it means to be a veteran and how experiences in the military directly impact not only the risks for certain health conditions but also how veterans engage with health care providers.

In other words, for the most part, the Canadian health care system, which includes providers, institutions, policies and processes, does not have military cultural competency. This is necessary to provide veterans, and by extension their families, with quality care that meets their unique health needs, which have been shaped by military service.

Cultural competency is seen as the ability to appreciate the differences among people. Each person is culturally unique and, as such, a product of their experiences, cultural beliefs and cultural norms. Therefore, military cultural competency is the extent to which health care providers like me, who are working with veterans and their families, are aware, knowledgeable and sensitive to the distinct needs and relevant issues related to them. Most importantly, it's what I need to do as an occupational therapist to adjust my practice once I know about their connection to the military.

There are increased efforts by Canadian health professional associations, such as the College of Family Physicians of Canada and the Canadian Association of Occupational Therapists, to create materials aimed at developing a military-specific knowledge base for their members. This is an excellent and commendable start. However, there is much to be done in the training and certification of health care providers.

I've been leading much of the work in Canada, trying to understand what it's like for veterans and their family members when they are receiving care in the community. In addition, I've also been exploring the experiences of health care providers to identify gaps in their awareness, knowledge and skills to be able to be more culturally confident when working with members of the veteran community.

Thank you again. I look forward to our discussion.

● (1620)

The Chair: Thank you, Dr. Tam-Seto.

I've been remiss in not acknowledging that a former colleague of ours is in the room. Karen McCrimmon is a former chair.

Welcome once again, Karen.

[*Translation*]

I will now give the floor to Mrs. Lafond for five minutes.

Mrs. Myriam Lafond (Managing Director, Crisis Center and Suicide Prevention of Haut-Richelieu-Rouville): Thank you very much, Mr. Chair.

I'd also like to thank the committee members for having me.

My name is Myriam Lafond and I am managing director of the Crisis Centre and Suicide Prevention of Haut-Richelieu-Rouville.

The centre is in Saint-Jean-sur-Richelieu, the city where the military base, the Canadian Forces Leadership and Recruit School and the Royal Military College Saint-Jean are located.

The centre opened in 1993 and we provide telephone intervention and in-person follow-up services for individuals with suicidal ideation or who have lost someone to suicide.

From 2010 to 2015, the centre put together its crisis shelter. It provides two beds for people in crisis.

During the time the crisis beds were deployed, the military base contacted the centre for training. Military police and chaplains therefore received suicide prevention training, and they learned about the full range of services we provide, including the crisis beds. They then asked us to set up a service trajectory.

Since 2015, we have therefore being housing military recruits and serving military personnel who need a break, and try to regain their footing and defuse the crisis they are experiencing, whether suicidal or psychosocial. Our team of counsellors, all of whom have a university degree in counselling, welcome them. Our counsellors are perfectly bilingual, given the proportion English-speaking military personnel that we accommodate. We have a bed reserved for military personnel who are sent to us.

The service trajectory was implemented in cooperation with the 41 Canadian Forces Health Services Centre. All military personnel staying at a crisis centre must first go through this medical centre, which, after assessing them, contacts us to refer them to our services.

Rather than sending these service members to the hospital, it's much better to refer them to a crisis centre that can provide real psychological support, administer specific treatments to defuse the suicidal crisis and help them to regain some control over the situation and the suffering they are enduring.

The fact that we're not military ourselves really allows service members to take a step back and be open about what they're going through. From experience, I would tell you that these are very uprooted people. They generally leave their homes to spend 12, 13 or 14 weeks in Saint-Jean-sur-Richelieu in an environment completely different from the one they know. This often generates crises, and going to a non-military crisis centre helps them regain some control over their situation.

The relationships we have with the military base are smooth, necessary and significant. They work well. Over the past two years, we've had a number of military personnel stay with us. We keep them on a weekly basis in their stay can last anywhere from 3 to 10 days until the crisis is resolved and they are able to return to the base or are released from the base if the military is just not for them. So during their time in the centre, they can really step back and see what's best for them, and then make the best choice they can, being fully aware.

That's what I wanted to say to you. I would be very comfortable answering any questions you may have.

● (1625)

[*English*]

The Chair: Thank you very much.

Colonel Pucci, you have five minutes.

Some colleagues were wondering what our finish line would be. It's a six o'clock hard stop.

Colonel Pucci, you have five minutes, please.

Colonel (Retired) Richard Pucci (Senior Health Care Executive, As an Individual): Mr. Chair and distinguished colleagues, good afternoon.

My name is retired Colonel Richard Pucci. I'm a health care executive. I had the honour of serving in uniform for 30-plus years. I retired in 2016 out of the position of Deputy Commander, Canadian Forces Health Services. Prior to that, I served as the chief of staff to the Canadian Forces surgeon general.

Since retirement, I've had the pleasure of working with a multitude of veterans and veteran groups from coast to coast to coast.

One of the primary challenges facing veterans seeking health service is the lack of access to care. In many cases, veterans must travel long distances to access health facilities, which can be tiring, expensive and, of course, time-consuming. Additionally, the waiting times for appointments are often long, leading to delays in treatment and to increased risk of health complications.

Addressing this challenge requires a paradigm shift in how primary care delivery is available to our veterans. What veterans want and need is access to care upon retirement. We need in place an independent body to help facilitate a smooth transition to the civilian health care continuum.

Working with strategic partners, I am ready to launch a proof-of-concept trial here in the Ottawa area. I have developed a network of two health care facilities that are ready to be part of this revolutionary veterans health care multi-site trial.

The first site is Beechwood Physical Medicine, which is an interdisciplinary clinic where clinicians use the best practices, evidence and innovative solutions to assist our veterans experiencing physical and psychological pain and distress.

The second site is the establishment of a veterans' primary care clinic at the Tay River Reflections location in Perth, Ontario. I would like to reiterate that both locations are ready to take part in this innovative shift in delivering health care to our veterans. Both sites have generously offered up their infrastructure to support this most important shift in health care delivery for our veterans. The proof-of-concept trial would run over a six-month period with a goal of expanding to key sites across the country.

I have the following four recommendations.

Number one is to establish a veterans health services task force. Initially, the task force would work independently and have no affiliation with Veterans Affairs Canada or the Canadian Armed Forces transition group. However, a level of synergy would be developed once the task force rolls out the proof-of-concept trial. The task force would report directly to this body or to another entity, as deemed appropriate by the chair. This task force would be made up of veterans with expertise from the health care sector, as well as representatives from across other health authorities and jurisdictions.

Recommendation two is that the veterans health services task force develop a governance structure that would support the rollout of this model across the country.

The third recommendation is for the allocation of funds to launch one of our program sites forthwith. As you may be aware, the program has been developed to cater to the needs of the veteran community, and we have completed extensive planning and groundwork to make it a success. The funding would primarily be used to cover the necessary expenses to launch, including logistics, medical equipment, consultants and staffing.

The fourth recommendation is that the veteran health services task force complete a detailed review of the veteran primary care models of our allied nations.

In conclusion, I want to express my gratitude to the members of the Standing Committee on National Defence for studying health and transition services, and for their leadership and commitment to our military members and, of course, to veterans.

Let us work together to strengthen these essential services and ensure that our men and women in uniform and out of uniform receive the care they need and deserve.

Thank you.

● (1630)

The Chair: Thank you, Colonel Pucci.

Colleagues, the bells are not ringing yet, but I'm anticipating that they will be ringing.

I intend to launch into our first round of six minutes each and then to ask for unanimous consent to proceed.

I'm rather hoping that we have unanimous consent. Then, at some point, we'll figure out what the timeline needs to be to actually vote.

With that, Ms. Kramp-Neuman, you have six minutes.

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

I'll start with you, Madam Tam-Seto.

The impacts of serving on the mental health of CAF members have often been studied. Can you speak to whether or not there's much attention being paid to the impact this may have on the children and families of CAF members?

Dr. Linna Tam-Seto: There is emerging research within Canada, particularly research being done within DND, around the impacts on children. However, we continue to look, quite often, stateside and internationally on that. We know access to mental health care looks different here in Canada, because there is a dedicated health care system for family members down in the States. We're just beginning to look at that here in Canada.

There is some indication...and there's some preliminary research being done, but there definitely need to be more dedicated research resources for that.

Mrs. Shelby Kramp-Neuman: Thank you.

To complement that, as it stands, do you think there are sufficient specialized mental health supports for the children and families of CAF members?

Dr. Linna Tam-Seto: Absolutely not. I'm going to be very blunt about that, simply because I worked in child and adolescent mental health care prior to becoming a researcher myself. I know, in terms of our training, what we have and don't have. I speak passionately about military cultural competency and the work I've done around that.

We know that there are unique stressors for military families and military-connected children. What we don't know is how good the quality of care is that they are getting in the community.

To answer your question, no, they are not sufficient. Children's mental health care is not great at the best of times, for all Canadian children. However, for specialized populations, there's definitely a gap.

Mrs. Shelby Kramp-Neuman: Thank you.

Do you think the challenges and barriers to health care and other basic services for CAF members and their families could serve as a barrier to new recruitment?

Dr. Linna Tam-Seto: I think that is something people probably don't realize as they are joining.

When we are recruiting folks, we need to provide them with an opportunity that...this is a career that will span the lifetime. Quite often, new recruits who come in are not thinking about themselves at retirement or as having families. I think, throughout the process—as people are going through the ranks and training—that we in the Canadian Armed Forces should provide people with that insight and support...as they consider.

Mrs. Shelby Kramp-Neuman: Thank you.

Colonel Pucci, could you address how readily available you feel mental health treatment modalities are made to former CAF members? How do they transition to other supports following their time with CAF, in order to ensure long-term support for veterans?

Col (Ret'd) Richard Pucci: First of all, I'm not a clinician or a mental health care provider. I'm a health care executive and an operational planner.

I can mention that there are a lot of issues, and this is from personal experience in meeting with our veterans out there. There is a huge gap from the time a member releases and goes out the back door of the Canadian Armed Forces and the time they enter, as a civilian, the continuum of health care. That gap is very hard. As for all Canadians, there's a gap out there regarding mental health providers, unfortunately. I've talked to many veterans and worked with many companies that are trying to put in place capabilities to support our veterans in the mental health realm.

● (1635)

Mrs. Shelby Kramp-Neuman: Thank you.

Given the unique forms of stress and challenges experienced by those in positions of leadership within the military, can you think of any specific or specialized resources that currently exist for their mental health?

Col (Ret'd) Richard Pucci: Within the civilian sector, I think there are a lot of new, up-and-coming companies trying to bring forward new, innovative clinical capabilities to support the mental health challenges out there. Unfortunately, at this time, Veterans Affairs Canada is not allowing access to some of these new, innovative technologies.

Mrs. Shelby Kramp-Neuman: How do we support them? How do we support our veterans with potential burnout? What is currently being done to support them in that regard?

Col (Ret'd) Richard Pucci: Each veteran has a case manager within Veterans Affairs Canada. I had a case manager for the first two years of my retirement. I no longer have a case manager, so I'm on my own at the moment. However, clearly, when I retired, I had access to a clinical psychologist. I had access to a care team before I retired. I was quite fortunate.

Many members retiring today do not have the same level of access I had. There are gaps. However, there are capabilities now being developed out there to further support the men and women who retire.

Mrs. Shelby Kramp-Neuman: That's excellent. Thank you.

Madame Lafond, with regard to your experience working on the hotline, could you address whether you currently receive frequent calls from CAF members reaching out to you on the hotline for continuous support?

[*Translation*]

Mrs. Myriam Lafond: Unfortunately, that's not the case. We get a lot of calls from the clinic wanting to refer people to us, but military personnel can't seek out our services directly.

[*English*]

Mrs. Shelby Kramp-Neuman: Okay.

To complement that question, how much awareness or training is provided to hotline workers surrounding the resources that would be unique to CAF?

[*Translation*]

Mrs. Myriam Lafond: All our counsellors complete three days of accredited training. One part deals with treating people who are suicidal and the other deals with crisis management. The training is recognized by the ministry of education. In addition to their academic background—

[*English*]

The Chair: I am sorry. I am going to have to interrupt. The bells are ringing.

Are these 15-minute bells or half-hour bells? They're half-hour bells.

Can we get 15 minutes or 20 minutes?

Mr. Pat Kelly (Calgary Rocky Ridge, CPC): Say that again, Chair.

The Chair: I was going to run it for another 15 minutes anyway, and then we'll suspend to vote and do it that way. Is that agreed?

Some hon. members: Agreed.

The Chair: That's very impressive.

You have about 15 seconds left.

Mrs. Shelby Kramp-Neuman: I'll ask quickly, is there a crisis response available for CAF members after hours on the hotline?

[*Translation*]

Mrs. Myriam Lafond: Our services are available 24-7. No matter when, they are always available.

[*English*]

The Chair: Madame Lambropoulos, you have six minutes, please.

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

I'd like to begin by thanking our witnesses for being here with us today.

I'm going to start with Mrs. Tam-Seto. You mentioned that there is no consistent way for files to be transferred to the civilian system once the military signs off and a member retires.

Based on what you've observed in your time observing and being in that system, what are specific things you would change in order to put in place a better system for transition? How would you make it flow better and make sure there are no gaps, so that everyone receives the same transition?

Dr. Linna Tam-Seto: I don't think we have enough time today for that.

I have a couple of things off the top of my head. The responsibility currently lies at the doorstep of the member, which I don't think is fair. A lot of folks I've spoken to will take it upon themselves to do the groundwork before.

In the SCAN seminars that people attend, there needs to be much more emphasis on strategies, so that people can move forward and it helps with their transition. I think physicians right across Canada, but particularly those who are in military-connected communities should look at how they are prioritizing their wait-lists, which I know is a big ask.

Before people retire and before they attend SCAN seminars, they need to be given the heads-up that this is the process of transitioning out.

The federal government needs to be talking to the provincial governments to find a system to make accessing health care at the provincial level a lot easier for them, extending health services well beyond someone's date of release until they can find someone within the provincial government.

Like I said, these are just a couple of the strategies that I have off the top of my head.

● (1640)

Ms. Emmanuella Lambropoulos: Would you be able to put them down on paper and send them to our committee, so that we have access to them?

Dr. Linna Tam-Seto: Yes, I will do that.

Thank you.

Ms. Emmanuella Lambropoulos: Thank you.

Mr. Pucci, I appreciate your being here as well, and speaking about your own experience.

You mentioned that when you were released, you got certain services for a couple of years and you were seeing a clinical psychologist, but not everybody has access to this.

I am wondering, first off, what factors played a role in your receiving these services. Secondly, why don't all members have the same?

Col (Ret'd) Richard Pucci: I think all members have access. When they go out the back door, everybody is set up and they know exactly what their medical release data is. It's a 3B release, whether it's for a mental health disorder or a physical disorder.

It's been exactly seven years to the day since I retired, but at the end of the day there is an opportunity when the attending physician provides you with what you need to do when you release from the Canadian Armed Forces. It's up to the member and then the veteran to seek that care.

The problem is—and this is what my argument has been—that it's hard to get from that back door to the front door of a new clinic, because there are just not a lot of primary care providers out there. If somebody needs mental health care thereafter, they still need to have a primary care provider; hence my argument about setting up this primary care hub for our veterans.

Ms. Emmanuella Lambropoulos: I heard your recommendation loud and clear, and we're definitely going to be able to look at that and see if we can include it in the recommendations we submit.

If there were a health services task force, in your opinion and based on your own experience, what would be the main thing that it would recommend?

Col (Ret'd) Richard Pucci: I think the recommendation would be to look at a cross-Canada governance system to see how we can facilitate the smooth transition from being in the military to being a civilian. The veterans task force would look at each provincial health care system from coast to coast to see how we could better facilitate that move as well, so I think it would be setting up a governance structure to meet the needs of veterans and newly released members, but also at the same time to deal with provincial health care authorities to make sure they're aware of what we are doing.

Ms. Emmanuella Lambropoulos: Thank you.

I guess the last question is a bit broader.

Dr. Tam-Seto, I want to know if you can let us know what trends you've been seeing in mental health in the general Canadian population and how they compare to those you've seen in the military population.

Dr. Linna Tam-Seto: Unfortunately, I won't be able to speak to that. My research has been predominantly with military populations.

From what I understand, the rates are comparable; however, what is striking is that the rates in mental health are usually connected to military service, whereas, for most Canadians, it is not directly related to their career choice.

Ms. Emmanuella Lambropoulos: Have you noticed that things have gotten worse of late? What have the trends been in the time that you've been there?

Dr. Linna Tam-Seto: I think, generally speaking and speaking broadly around mental health reporting, it has increased over the years, just because of awareness and decreased stigma. I'll just leave it at that.

[*Translation*]

The Chair: Ms. Normandin, you have the floor for six minutes.

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

I'd like to thank all the witnesses for being with us today.

Mrs. Lafond, I'd like you to tell us about crisis management before the Canadian Forces called on your centre. To your knowledge, how well did the military base handle the situation when a member or a recruit was in a crisis situation?

Mrs. Myriam Lafond: Thank you for the question.

Prior to our agreement with the Canadian Armed Forces, the military at the base managed crisis situations with the green office. The green office is sort of the administrative centre for the St-Jean-sur-Richelieu base, which we actually toured. Someone was on duty 24 hours a day in the green office. Someone in a crisis situation would be set up there on a cot, and they were monitored at all times.

This is how crises were managed. They wanted to avoid sending them to the hospital if it wasn't an emergency. They preferred to wait until the 41 Health Services Centre would open. The centre is open weekdays from 7:30 a.m. to 4:30 p.m. Outside of those hours, the green office handled crisis situations.

● (1645)

Ms. Christine Normandin: Thank you very much.

In the early days of your partnership, how were people in crisis referred to you? Did it go through the green office or the clinic?

Mrs. Myriam Lafond: In the beginning, people were sent to us directly from the green office. It was really the military referring them to the centre; they avoided going through the clinic. Unfortunately, a suicide occurred. After staying with us, the member wanted to return to the base. However, we recommended that he be sent to the hospital and seen by a physician. It was a Saturday and there was no physician on the base. The suicide occurred at that time.

Based on the agreement we made as a result of that incident, all recruits and military personnel who stay at our centre must have been seen by a base physician, or alternatively by a hospital physician, prior to coming to the centre. Before coming to stay at our centre, they must be seen by either the base clinic or our city hospital. This process was put in place following the unfortunate suicide that occurred.

Ms. Christine Normandin: What I understand is that now, as part of your partnership, military personnel receive better medical guidance in crisis situations.

Is that right?

Mrs. Myriam Lafond: Yes, that's right. They automatically receive medical follow-up in these situations. So that results in better management and continuity of care after the crisis is over.

Ms. Christine Normandin: Can you describe how you cooperate with the military base clinic, in terms of sharing information when a recruit or service member is in a crisis situation, for example?

Mrs. Myriam Lafond: We have open lines of communication. We keep personal information confidential, but we waive that when someone's life is at stake. Sometimes it's a matter of life and death at our centre, and when we waive confidentiality, the lines of communication are open. We have a wonderful partnership with the medical clinic, because we give them the information they need while also informing the recruit or service member of what information we're giving out.

Ms. Christine Normandin: I'd like your comments on the system used to fund your services. What kind of partnership do you have with the military base?

Mrs. Myriam Lafond: We are a community organization funded by the provincial government. The Canadian Armed Forces have insurance through Blue Cross, I believe. Blue Cross pays us the same amount they pay when a service member is hospitalized in Quebec. Our accommodation services are billed on a per-night basis, and the insurance company pays for the bed for the person in crisis. That certainly provides a financial contribution to our organization.

Ms. Christine Normandin: For the same price, then, I understand that the Canadian Forces have access to much more specialized services to manage military mental health issues.

Is that right?

Mrs. Myriam Lafond: Yes, that's exactly it.

In Saint-Jean-sur-Richelieu, we're in a francophone environment, and service members and recruits are generally anglophones. We offer completely bilingual services, whereas according to recruits and service members, often no one speaks English at the hospital. This makes it hard for them to receive proper care and services. They are isolated. They get good physical care, but the psychological care isn't as good.

The crisis centre is therefore a safer and healthier environment for recruits and service members in crisis.

● (1650)

Ms. Christine Normandin: Thank you.

[*English*]

The Chair: Thank you, Madame Normandin.

Colleagues, Ms. Mathyssen's time will expire about halfway through the time we've agreed to, so if you don't mind, we can either not start, or we could do her six minutes.

Mr. James Bezan (Selkirk—Interlake—Eastman, CPC): I want to head over to the chamber.

The Chair: Do we agree to that?

Some hon. members: Agreed.

The Chair: We'll suspend until we return.

● (1650)

_____(Pause)_____

● (1725)

The Chair: I see quorum. We'll resume our meeting.

Ms. Mathyssen has six minutes. Then, colleagues, once her six minutes are done, we have about 25 minutes left. I'll probably have to shrink the second round to get within the timeline.

Ms. Mathyssen, you have six minutes, please.

Ms. Lindsay Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair, and thank you to the witnesses for their patience through all of this today.

I want to start with Ms. Tam-Seto.

You've done a lot of research, as I understand it, on the impacts of operational stress injuries and PTSD on women serving in the CAF. I'm wondering if you could talk about the differences that you see in terms of that research: how women are impacted by it, the service gaps that exist for women veterans in receiving the supports, and the trends that you see around OSI and PTSD.

Dr. Linna Tam-Seto: The majority of the work that I've been doing that would be classified as an operational stress injury acquired through work is related to military sexual trauma. Outside of that is less...has been outside of my scope. To be completely transparent, that's where the bulk of my research has been: around the impacts of military sexual trauma.

Broadly speaking, around the mental health challenges experienced by servicewomen, we don't have an understanding of how that impacts goals and how it impacts their identity, particularly around transitioning. I know that a lot of individuals who identify as women have difficulty accepting an identity as a veteran because of what society stereotypically sees veterans as. That's part of some of the stressors that women experience as they transition.

I know that doesn't specifically answer your question, but my work hasn't been specifically on operational stress injuries in women.

● (1730)

Ms. Lindsay Mathyssen: Okay.

In terms of PTSD, that has a huge impact. Could you get into a bit more around what you mean when you say that they find it hard to see themselves as veterans? Are there supports or programs? Is this seen more and more, and have the CAF, the DND and VAC dealt with this in any way? Has it been identified other than by some of your research?

Dr. Linna Tam-Seto: I examine a lot around identity and the change in roles and identities as people go through transition, so my work is around stages of change. As people are releasing from the military, they're changing from being from a military member to becoming a veteran and, essentially, a civilian. For a lot of women, that shift is different, because there is this social perception of what a veteran looks like, and that quite often doesn't match with how women appear in the world. There isn't, also, that acceptability. Quite often, I hear stories about women veterans with the veteran plates, and people will approach them and ask, “Oh, did your husband serve? Did your dad serve?” This is then compounded by the experience of military sexual trauma, where there is institutional betrayal. There is that difficulty for women to identify with the institution that has betrayed them, whether it be military sexual trauma or any other type of injury or illness that they may have acquired over the course of their career.

Ms. Lindsay Mathyssen: In the incredible work that I've seen done on the streets in my hometown of London, Ontario, with veterans who are facing homelessness, there was a lot of that conversation about veterans overall. These were mainly men, interestingly, but it was that identity and what they had in terms of their service, the institution that provided them with the structure of that service. Then, once they left service, it was what they weren't left with in terms of the identity that they had but also the structure that they had.

Is that the same for women, as well, in that role?

Dr. Linna Tam-Seto: It's essentially moving from one culture to another. I know that in London, in particular, they have an incredible operational stress injury clinic. I have colleagues who are there, and we are working on how to support health care providers to realize and to recognize these identity shifts that veterans are going through, particularly those who are coming into the clinic with work-acquired trauma and illnesses, and what that means to them. We are starting to develop those structures. My particular area is around military cultural competency and what that means for health care providers, particularly with regard to my colleagues at the OSI clinic.

Ms. Lindsay Mathyssen: We have also had previous CAF officials at this committee, and there's a bit of confusion, because they were talking about trying to get into the operational stress injury social support systems that are provided with the OSISS, but that is not covered. They don't work at all in terms of sexual misconduct and that trauma. Is that correct?

Dr. Linna Tam-Seto: People are going to OSISS clinics because of military sexual trauma. It is a subsection of a type of trauma that is unique, so that experience is unique, and we're just beginning to understand how it's different from other work-acquired PTSD from service.

There needs to be a concerted effort, and there has been. Again, I've been in communication with the OSI clinic in London, where they've identified that there is a subsection of people who are coming with trauma, but it's specific to military sexual trauma and about what supports and education we can give to these service providers in order to help them. It's very important for service providers to understand the nuanced contexts of what it means to have acquired military sexual trauma, which is very different from civilian trauma.

● (1735)

The Chair: We're going to have to leave the answer there, thank you.

Colleagues, if I do a second round and cut a minute off everyone, there's a good chance we'll be able to do it by six o'clock.

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

Mr. Pat Kelly: I think Mrs. Gallant is going to go.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Colonel Pucci, you referred to some technologies that were not being funded. To which technologies were you referring?

Col (Ret'd) Richard Pucci: I was speaking to treatment modalities that are currently out there. As I stated earlier, I'm not a clinician, and I feel very uncomfortable talking about treatment modalities, because they are outside the scope of my area of expertise; however, many companies have approached Veterans Affairs with new technologies and new modalities of treatment. They're currently being reviewed, but the process is extremely slow.

Mrs. Cheryl Gallant: What about EMDR? Is that still being utilized, rapid eye movement desensitization?

Col (Ret'd) Richard Pucci: Again, that's a very pointed, clinical question, and I'm here to speak about primary care functional capabilities; thus, a question about EMDR is not one I'd feel comfortable answering.

Mrs. Cheryl Gallant: We have heard from ombudsmen time and time again that we need this seamless transition from the forces to medically release. Your task force sounds good, but in reality, people are spread across the country, so they don't necessarily have the same people or even a link to the people who were dealing with them during the crisis stage after they release. They have no one, as a matter of fact.

Col (Ret'd) Richard Pucci: Yes, that's correct. That's the whole idea of the proof-of-concept period of six months. While that period is ongoing, the task force would look at nodes across the country, say, for example, in Edmonton, Valcartier, Quebec City and Fredericton, where we would create that network, that hub of wellness for our veterans, so—

Mrs. Cheryl Gallant: One of the insurers—I'm not sure if it was Veterans Affairs or a specific company—definitely dealt with all the veterans. They were receiving this EMDR from people who had qualified, but, all of a sudden, a certification was required, so these women and men lost their providers altogether, because the providers didn't have the new certification requirements. They had families; they couldn't stop working to go back to school.

Is there no way we can make the actual treatment they're getting seamless and not have to go to a layperson, because even having to explain what happened using regular military jargon.... If they have to explain their whole story over again, they become frustrated, and they find a quick and final solution to it.

Col (Ret'd) Richard Pucci: That's right. I've heard that story a hundred times in the last year from other veterans and their families out there. The decision to cease the modality of treatment came from Blue Cross and Veterans Affairs Canada. We need to pose those questions to them, not to people at my level who are dealing with setting up wellness hubs.

Mrs. Cheryl Gallant: Could you tell us what the steps would be under the task force for how someone has to medically release? What would it look like? What would, at best, a retiring or medically released soldier go through, especially if trauma was involved?

Col (Ret'd) Richard Pucci: It would be a seamless transition, so as they walk out the back door of the Canadian Forces, during their SCAN seminar, which my colleague mentioned earlier, they'd be aware of accessing these hubs. The first thing the soldier would do is contact the hub to say, “I'm retiring on June 15, 2023. I'm looking for a primary care provider. I'm moving to St. Albert, in the Edmonton area. Can you help me out?”

The task force would be able to dig into its database to determine, with its network of hubs in the Edmonton area, which physicians are looking after veterans, and if we have a specific veteran clinic there with a family doc and a veteran physician assistant ready to receive that patient.

Mrs. Cheryl Gallant: The Beechwood and Tay River clinics are the only ones right now. They're pretty well in the Ottawa vicinity anyhow. People from Ottawa already have access to providers.

It's the people out in Petawawa and southern Ontario—far from Toronto—who don't have access—

● (1740)

Col (Ret'd) Richard Pucci: That's right, but the people in Petawawa are quite willing to jump in their cars and drive to Tay River for treatment. We have veterans right now living in Petawawa who drive to Orleans, here in Ottawa, to see Dr. Hans Jung, who is the former surgeon general and runs a roster of 1,500 people.

The Chair: Thank you, Mrs. Gallant.

Mr. Sousa.

Mr. Charles Sousa (Mississauga—Lakeshore, Lib.): Thank you, Chair.

Thank you for your presentations.

I have a question, and I'm not sure to whom it should go. Madame Lafond, maybe I will start with you on this one, and maybe Ms. Tam-Seto can respond as well.

There is an emerging conversation on PTSD versus moral injury. How are these separate but closely related impacts of trauma experienced in the course of military operations?

Can you describe how these concepts differ and how treatment needs to differ?

[*Translation*]

Mrs. Myriam Lafond: Thank you for the question.

Our centre helps recruits who are experiencing suicidal crises, not those struggling with post-traumatic stress disorder.

So I will let a specialist answer that. Perhaps Ms. Tam-Seto can do so.

[*English*]

Dr. Linna Tam-Seto: I apologize, sir, but I don't diagnose. I could not, in my scope of practice, differentiate between PTSD and moral injury.

Mr. Charles Sousa: Colonel.

Col (Ret'd) Richard Pucci: That's way outside my scope, most definitely. I'm not a clinician, sir.

Mr. Charles Sousa: Chair, can you answer that question?

The Chair: I can answer pretty well any question. You might want some veteran information, though.

Mr. Charles Sousa: I'll go to something else then.

I will keep it more broad, then, in terms of how work is being done to support defence research and the Canadian Forces Health Services Group.

How can this research help improve the experience of service members, veterans and their families? Can the committee hear the steps to enhance this kind of research in the lives of military members and their families? Can you answer that more broadly?

Dr. Linna Tam-Seto: There is research being done internally. I worked with many of the wonderful colleagues within DND and DGMPRA who are doing this amazing research. Unfortunately, they don't have the capacity to answer all the questions that we need.

A lot of great research exists out there that a lot of health associations are going to in order to try to develop military cultural competency among their members—physicians and occupational therapists. However, they tend to be grounded within international contexts, which doesn't translate well over here in Canada. Despite the efforts of internal research, there's a whole network of us through the Canadian Institute for Military and Veteran Health Research who are trying to meet the demand.

That's just a very broad statement around research.

Mr. Charles Sousa: Colonel, if there's time, do you want to comment?

Col (Ret'd) Richard Pucci: No, I would just defer to my colleague here. That's more along her line of expertise and research.

Mr. Charles Sousa: We're talking a lot about mental health. There's this difference in trends that we see in the population of the military. Why is there a difference? Why is it more prevalent in the military?

Dr. Linna Tam-Seto: Why are mental health...?

Mr. Charles Sousa: Why are trends in the population...? We're seeing mental health in the Canadian population as a whole. It's more evident, and it seems to be even more so with the military.

Dr. Linna Tam-Seto: I just want to reiterate that my research isn't specifically on the mental health and well-being of serving members, so I can't speak to that. I can speak only to what my statement was before around increased awareness and decreased stigma in terms of reporting. There is more dedicated research looking specifically within the military.

Again, my research is predominantly around veterans and health services.

The Chair: Thank you, Mr. Sousa.

[*Translation*]

Welcome to the committee, Mr. Brunelle-Duceppe. The floor is yours for one and a half minutes.

Mr. Alexis Brunelle-Duceppe (Lac-Saint-Jean, BQ): Thank you, Mr. Chair.

I'll try to be as good as Ms. Normandin. I probably won't come close, unfortunately, but I'll do my best.

Mrs. Lafond, do you feel that service members open up more with the staff at your centre than they do with the military base clinic staff?

If so, I'd like you to tell me why and include some details.

Mrs. Myriam Lafond: Thank you for the question.

Yes, we've seen a noticeable difference when service members stay with us.

Our centre is not a military environment, nor is it staffed by military personnel. Therefore, the relationship is established on equal footing with the person staying with us. Moreover, since the person is no longer in the environment that led to the crisis situation, it's easy for them to confide in us about the events related to the crisis. They don't fear any repercussions on their career or their advancement. They let themselves be angry, unsettled and in a bad state so that they can then bounce back and feel better.

So we let people in crisis open up to us without them feeling judged and fearing repercussions for their future. When military personnel stay with us return to their base, they know that the information we share with the base clinic is only given out to keep them safe. So it's not connected to anything they may have said or reported during the crisis.

When an individual is in crisis, they have no control over what they say. However, the fact that we are not military personnel certainly has an impact on how much they confide in us.

● (1745)

Mr. Alexis Brunelle-Duceppe: Individuals who stay with you feel they can trust you more.

Is that it?

Mrs. Myriam Lafond: Yes, and we gain their trust quickly.

The Chair: Thank you, Mr. Brunelle-Duceppe.

[*English*]

Ms. Mathyssen, you have one and a half minutes.

Ms. Lindsay Mathyssen: Thank you.

Ms. Tam-Seto, I just want to finish up. Can you talk to this committee about what you see within your research in terms of missing data points, reporting for the CAF and reports that you would like to see? As an example, the veterans ombudsman made a comment about GBA+ policy discussions that had been done, apparently, and an analysis that had been done but not released and not made public.

Does that happen with DND and CAF? Are those some of the points that you would say are missing? Just give us an idea of what you'd like to see.

Dr. Linna Tam-Seto: I don't know if this committee can help out with this, but what we've been trying to do at McMaster is collaborate more closely and engage with DND to do research with active serving members.

The questions we ask are slightly different from what is asked within the research departments within the institution. There are systemic barriers for us, as researchers in the civilian world, in trying to access military members. I think it's really important for us to access active serving members to be able to do longitudinal studies, to follow them along, to see what that transition piece looks like.

From a research perspective, it would be great if we had free access to the great work being done within DND research departments. It would be great to get any information from Veterans Affairs to help inform some of the questions we have. I think the message that I hope everyone can hear from a research perspective is that if we can work together more collaboratively—providing information and some open transparency—with civilian researchers, we might be able to do better work together, and the work we do would inform us to ask the right questions.

The Chair: Thank you, Ms. Mathyssen.

Am I to assume that it's Mr. Kelly for four minutes?

Mr. Pat Kelly: Thank you.

We're just coming down to our last few minutes that we'll have, Professor Tam-Seto. After your opening statement, the first question to you was about the adequacy of medical supports for CAF members. You were quite emphatic in your responses and said that they were not adequate.

Do you want to take some of the time we have left to give the committee some more concrete or specific examples of the inadequacy of medical supports?

Dr. Linna Tam-Seto: Medical support upon release is definitely a challenge that we get. Before we can get into developing cultural competency and help providers in the civilian world, we need to be able to get people through the door. Right now, people are being dropped off. As we were saying here, people walk out the back door from the Canadian Armed Forces, and they're left on their own.

There need to be more people at this table discussing this issue. I spoke to the chair during the break and said that this is not a DND issue. It is a Veterans Affairs issue as well. It is also a provincial and federal government issue. We need people at the table to develop seamless transition.

It is not fair for veterans to have to go seeking out health care on their own, particularly for health issues they have acquired on the job. It is not fair for their families to have to advocate for themselves, because they did not sign up for this. As Canadians, we need to at least provide them with a support system that enables seamless transition.

Mr. Pat Kelly: Okay. In your research, do you know how many serving CAF members are discharged for different kinds of health conditions that could be treated with adequate resources? Let's talk first mental health and those who are discharged for mental health conditions that could be treated.

● (1750)

Dr. Linna Tam-Seto: I would like to believe that every health condition can be addressed and supported. Treated to what extent is really very subjective. I think what we need to do first is to be able to identify how many people are releasing, when and how. I think basic data points are missing—

Mr. Pat Kelly: Okay, so you don't have data points on that. What about for physical health conditions?

Dr. Linna Tam-Seto: To speed up the conversation, I don't have specific data.

Mr. Pat Kelly: Colonel, do you have any comments?

Col (Ret'd) Richard Pucci: I can provide a comment on that question. I currently sit on the City of Ottawa's veterans task force. Right now, the latest survey and numbers coming out of DND to us show there are about 800 veterans in the Ottawa area without a primary care physician.

Mr. Pat Kelly: Thank you. That's a response, I think, more to the first question.

Col (Ret'd) Richard Pucci: That's right. I didn't want to jump in.

Mr. Pat Kelly: Feel free. That's important information for the committee.

On the second one, then, I'm trying to assess, with the personnel crisis that we have in the forces, whether there are members who are discharging who could have had either a physical or mental disability treated to render them still able to serve.

Are people being forced out for lack of access to health care?

Col (Ret'd) Richard Pucci: When I was deputy commander of the health services, I was quite aware of all the capabilities, and we put our best foot forward. I think every man or woman who presented to a clinic across the country received the best medical care that was offered at the time.

While in uniform, I received outstanding medical care. I think it was very adequate; it met all my demands, as well as those of the men and women under my charge.

Mr. Pat Kelly: I can't get a question and answer in 15 seconds, so I will cede the floor.

The Chair: Go ahead, Mr. Fisher.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you, Mr. Chair, and thank you to all our witnesses for being here.

Colonel Pucci, thank you for your service.

I'm going to sound a bit all over the place here, because you have all made comments today that have interacted.

Colonel, you talked about your experience after you transitioned. I think you said you had two years of access to a care team.

Is there a level of service that every retiring and transitioning CAF member gets? I'm not suggesting that they take advantage of what's offered to them, but is everyone offered the same thing?

Col (Ret'd) Richard Pucci: It depends upon the terms of your release. If you have a medical release, you have access to Veterans Affairs Canada, which provides you with a case manager who helps you facilitate and manoeuvre through the health care system.

If you were released on a normal...I think it's a 5A release, which is just a normal release.... If you have no physical or mental health conditions, you're just put out onto the street, and you look after yourself.

Mr. Darren Fisher: Mrs. Tam-Seto, you talked about some type of relationship between provinces, territories and the federal government. I suspect you mean some type of bilateral agreement whereby a CAF member would transition out and there would be some type of partnership between each.

We talked about your trial projects in Beechwood and Tay River. We used the example when Madam Gallant was talking about examples from southern Ontario.

However, when you think about cities and towns across the country, and you talk about two trial projects—which I salute you for; it sounds like a great idea—what happens when it's somebody in rural Nova Scotia or northern B.C.?

Col (Ret'd) Richard Pucci: There would be access to technology through telemedicine. We could access that. We would have hubs within the provincial jurisdiction, where veterans could use telemedicine to connect with a physician.

Mr. Darren Fisher: What are your thoughts on...? Were you envisioning a bilateral agreement from province to province and territory to territory?

Dr. Linna Tam-Seto: There needs to be a mechanism whereby there's agreement across different jurisdictions and different ministries to be able to make that seamless. Right now, it's piecemeal, and the responsibility lies at the doorstep of the veteran.

Mr. Darren Fisher: Are there any provinces right now that give rapid access or front-of-the-line access to CAF members transitioning into veterans in provinces? Who does it well?

Dr. Linna Tam-Seto: I don't have an answer for that.

Mr. Darren Fisher: You don't have an answer for that. Okay.

Earlier, in your opening statement, you spoke about challenges, barriers and delays, but then your time for your opening statement ended.

Can you touch a bit more deeply on the challenges, barriers and delays—things that we may not have talked about yet today?

● (1755)

Dr. Linna Tam-Seto: I think I did touch on that somewhat, and yes, I will be providing a brief in which things are a bit more clearly articulated, because there are so many layers. It just needs to be a much more organized discussion than the one I can share right now.

Mr. Darren Fisher: Colonel Pucci gave us four recommendations. Do you have any recommendations? Is that something you're able to provide us right now, or is that something you'll put in your written statement?

Dr. Linna Tam-Seto: I'll put it in my written statement, but I think there needs to be this recognition that there is a system breakdown right now. That's the first piece. We need to get the right people at the table to have an initial conversation on what that pathway of transition might look like. Once they're in the door, we'll have different groups of people sitting around in order to ensure quality of care.

Mr. Darren Fisher: I'm going to ask all three of you whether you have a comment and if you wish to chime in.

I've heard it said that it would be better for CAF members to stay in the CAF continually as veterans, and never transition out into Veterans Affairs, basically combining the two.

Dr. Linna Tam-Seto: I don't have an opinion on how people should continue to get health services. I just feel that there should not be the gap that exists right now.

Mr. Darren Fisher: Colonel Pucci.

Col (Ret'd) Richard Pucci: I don't think there's a capability. It's all about capacity building. In the CAF's health services, when I was deputy commander, we would not have the capacity to support veterans while they were transitioning or when they had transitioned out of the military.

If you look at the U.S. model, it has the Tricare capability, whereby a veteran reports to the same sick parade as does a serving member. We don't have 300 doctors in uniform. We barely have a handful at times, so the biggest challenge is capacity, capacity and capacity.

Mr. Darren Fisher: Madame Lafond, I don't know whether you want to speak to that specifically, but I was also interested in your crisis beds.

Are crisis beds filled only with military members? I wasn't sure if there would ever be an instance in which a crisis bed was assigned to a veteran or somebody who is in the process of transitioning.

[*Translation*]

Mrs. Myriam Lafond: In our case, it's mostly Haut-Richelieu-Rouville residents. The military only represents a tiny part of our clientele. We mainly have recruits stay with us, but sometimes we've also had veterans or military personnel who were on “vacation” or “leave”—that's how they put it, unfortunately. They were training recruits on the military base.

The service member was a teacher or trainer who worked with recruits on the base. He was experiencing mental and physical health issues, and required certain services. He came to the centre for some guidance.

Veterans and active military personnel very rarely use our services; we mostly serve recruits.

[*English*]

The Chair: Thank you, Mr. Fisher.

Before I thank our witnesses, it was suggested to me that I should read this statement, given the subject matter of today's conversation.

Given that the subject matter of today's meeting dealt with issues surrounding suicide and self-harm, I want to take a moment to remind all those watching that resources are available if you or someone you know is experiencing thoughts of suicide or self-harm.

Staff can access the employee assistance program. Resources are also available online at crisisservicescanada.ca, or you can connect to the national suicide prevention lifeline at 1-833-456-4566, or the Kids Help Phone at 1-800-668-6868.

On behalf of the committee, I want to thank you. Time management is always a bit of a challenge in this committee, but you have very graciously accommodated the joys of democracy. I want to thank you for your contribution to our study. It was very helpful.

With that, colleagues, the matter is adjourned.