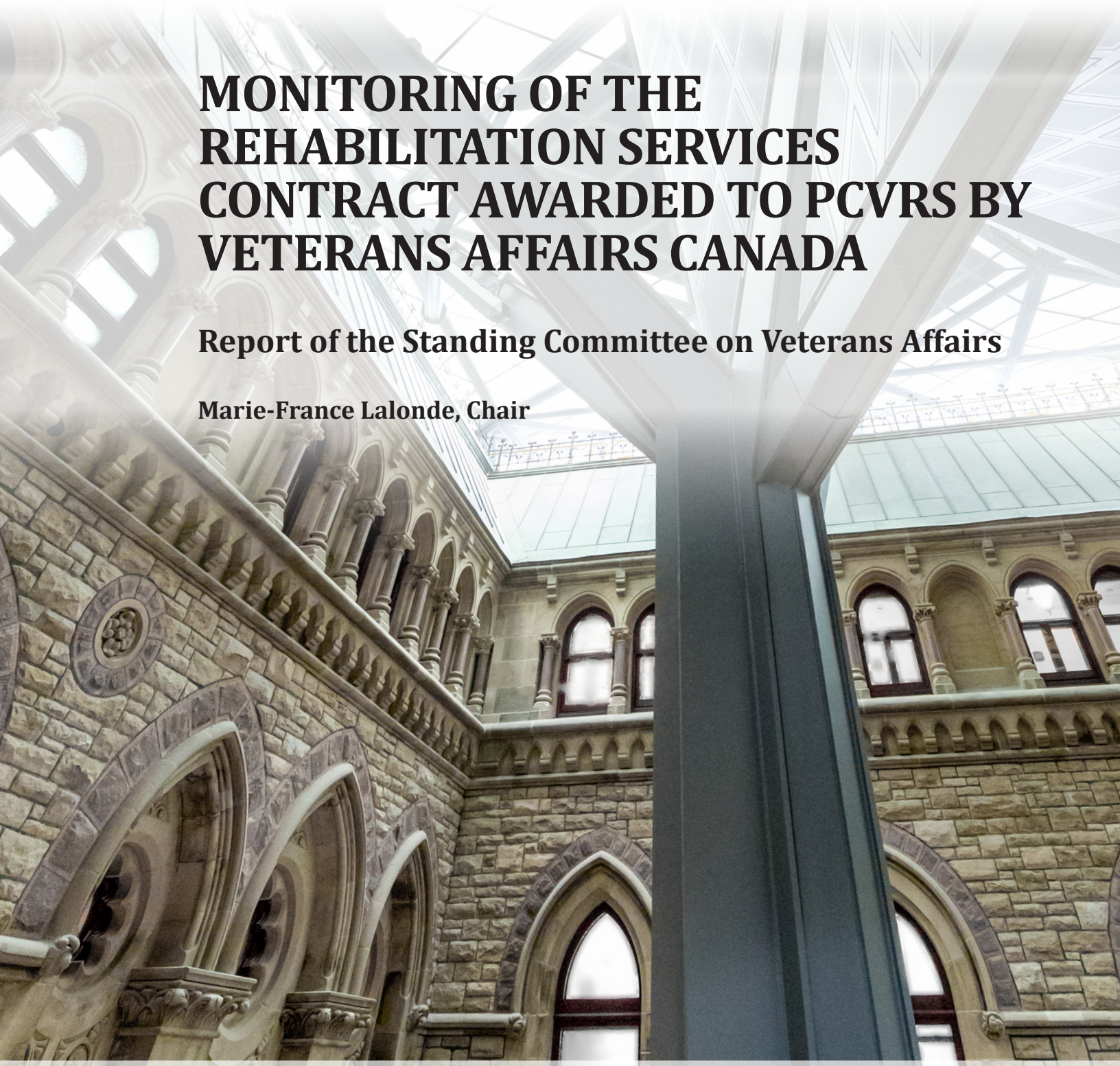
HOUSE OF COMMONS
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CANADA



MONITORING OF THE REHABILITATION SERVICES CONTRACT AWARDED TO PCVRS BY VETERANS AFFAIRS CANADA

Report of the Standing Committee on Veterans Affairs

Marie-France Lalonde, Chair

OCTOBER 2026
45th PARLIAMENT, 1st SESSION

Published under the authority of the Speaker of the House of Commons

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Reports from committees presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

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EIGHTH REPORT

Pursuant to its mandate under Standing Order 108(2), the committee has studied the monitoring of the rehabilitation services contract awarded to PCVRS by Veterans Affairs Canada and has agreed to report the following:

TABLE OF CONTENTS

LIST OF RECOMMENDATIONS 1

MONITORING OF THE REHABILITATION SERVICES CONTRACT AWARDED TO PCVRS BY VETERANS AFFAIRS CANADA 3

- Introduction 3
- The Veterans Affairs Canada Rehabilitation Program 5
  - What is Rehabilitation? 5
  - Major Program Components 6
  - Interaction Between the Veterans Affairs Canada Program and the Canadian Armed Forces Program 7
  - Differences Between the Rehabilitation Program and the Treatment Benefits Program 9
- The Contract Between VAC and PCVRS 12
  - Historical Background 12
  - Key Clauses 13
- Program Stages 15
  - Automatic Eligibility 15
  - The Initial Assessment 15
  - Diminished Earning Capacity 18
  - Rehabilitation Plan 19
  - Subsequent Evaluations 23
  - The Income Replacement Benefit 26
- Preliminary Assessment and Issues Identified After the Contract's Implementation 28
  - The Government's Position 29
  - Overall Judgement of the Witnesses 31
  - Fear of Losing the Income Replacement Benefit 34
  - Continuity of Care 38

Consideration of Military Culture 43
Conclusion 44

APPENDIX A: LIST OF WITNESSES 49

APPENDIX B: LIST OF BRIEFS 53

REQUEST FOR GOVERNMENT RESPONSE 55

SUPPLEMENTARY OPINION OF THE CONSERVATIVE PARTY OF CANADA 57

LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

Recommendation 1

That Veterans Affairs Canada clearly state in its rehabilitation program presentation materials and on the associated web pages that the program's objective is to restore veterans' ability to earn an income of at least two-thirds of what they earned in the Canadian Armed Forces. **12**

Recommendation 2

That, should the initial rehabilitation assessment reveal significant medical or psychosocial needs, the assessment of a Veteran's vocational capacities be postponed until rehabilitation professionals have determined that the Veteran's functional condition is stable. **17**

Recommendation 3

That, in cases when a Veteran is participating in both the VAC rehabilitation and treatment programs, the rehabilitation plans developed by rehabilitation service specialists be approved or updated by the VAC Case Manager in full consultation with the Veteran who may raise the opinions of other professionals involved in his or her treatment. **21**

Recommendation 4

That the VAC Case Manager, prior to approving a recommended rehabilitation plan, ensure appropriate and deliberate steps have been taken to ensure that Veterans know how to access their plan, have reviewed it, understood it and understand the objectives they are committing to work towards. **23**

Recommendation 5

That the Minister of Veterans Affairs publicly disclose the final report of the independent third-party review commissioned to examine the VAC rehabilitation program's outcomes since it was entrusted to PCVRS. **31**

Recommendation 6

That Veterans Affairs Canada provide a reasonable transition period to determine whether rehabilitating veterans have regained their earning capacity and whether income replacement benefit payments can cease. 37

Recommendation 7

That, in cases when a Veteran is participating in both the VAC rehabilitation and treatment programs, if health professionals participating in a Veteran's treatment believe the recommended rehabilitation plan will detract from the rehabilitation program goal of successful reintegration in the civilian workforce, VAC will conduct a review of the Veteran's supports and benefits. 43

Recommendation 8

That VAC ensure the rehabilitation program provider and the network of associated rehabilitation and medical service providers receive regular and ongoing training to raise awareness about and understanding for the unique aspects of military culture and experience in order to better support the recovery of Veterans participating in the VAC rehabilitation program. 44

MONITORING OF THE REHABILITATION SERVICES CONTRACT AWARDED TO PCVRS BY VETERANS AFFAIRS CANADA

INTRODUCTION

The Veterans Affairs Canada (VAC) rehabilitation program was created in April 2006 with the coming into force of the *Veterans Well-being Act*. The program includes medical rehabilitation, psycho-social rehabilitation and vocational rehabilitation components. All rehabilitation services have been delivered by authorized subcontractors in each of the three components since the program was created. Administration of the vocational rehabilitation component has been contracted out since 2009. For the medical and the psychosocial components, from April 2006 to July 2021, VAC administered the program itself, based on a list of certified suppliers responsible for service delivery.

In 2020, VAC announced its plans to delegate administration of its rehabilitation program's three components to a single supplier. On June 30, 2021, the department announced that the contract had been awarded to Partners in Canadian Veterans Rehabilitation Services (PCVRS) for five and a half years at an estimated cost of approximately $560 million. The transition phase started in November 2022 when PCVRS began taking charge of all new program participants. Back then and to this day, VAC is responsible for referring veterans to PCVRS, approving rehabilitation plans and verifying compliance with the contract and with the *Veterans Well-being Act*.

The Committee began studying the new contract in November 2022 and tabled its report in June 2023. The report focussed primarily on the call for tenders process, the scope of consultations and potential concerns raised by certain contract clauses. It was too early to weigh the positive or negative impacts on veterans. That was why the Committee recommended: "That Veterans Affairs Canada provide the Committee with a comprehensive update on the impacts of the rehabilitation contract awarded to PCVRS by November 2023." However, this date was apparently premature as well, considering that the update provided to the Committee by the department said that "full operations only began in October 2023, it is expected to take approximately twelve months to

measure the impacts the contract is having on service delivery and complete an analysis."[1]

Since this initial contract expires in December 2026, Committee members considered it worthwhile to study the effects of the contract awarded after 30 months of full operation. During her appearance, the Minister of Veterans Affairs, the Honourable Jill McKnight, confirmed that "With the contract approaching the end of its initial five-and-a-half-year term, I have instructed my department to conduct an independent review of the rehabilitation program and PCVRS."[2]

This report has four parts. The first part describes the main components of the VAC rehabilitation program, interaction with the CAF disability insurance program and the ways that this program differs from the VAC treatment benefits program. The second part provides background information on events leading up to the department's decision to seek a single supplier for the entire rehabilitation program, and on the main clauses of the contract signed with PCVRS. The third part provides a detailed analysis of the steps involved for veterans participating in the rehabilitation program, while highlighting certain problems related to the program's design and implementation that are independent from the supplier. The fourth part paints a partial picture of the program's results under PCVRS administration, and calls attention to issues related to or magnified by the supplier.

Three of these issues were addressed primarily by witnesses. The first issue concerns the pressure that rehabilitating veterans were under to make rapid progress and comply with PCVRS decisions or risk losing their income replacement benefit. Although this kind of pressure existed before the contract was signed, it seems to have worsened based on suspicions that a big company would be less likely than the department, despite its flaws, to put veteran well-being at the centre of its concerns.

The second issue relates directly to PCVRS and concerns continuity of care. Some tension seems to have developed between health professionals and rehabilitation professionals providing care to veterans under the treatment benefits program and other professionals employed by the PCVRS network before the contract was signed, who subsequently took on this new client population. The latter service providers believe that long-term disability treatment can occur together with a more intensive rehabilitation approach aimed at achieving results and getting veterans back to work sooner. The former treatment benefit

1 Veterans Affairs Canada, *Update on the impacts of the rehabilitation contract awarded to PCVRS on service delivery to veterans*, November 2023, p. 2.

2 ACVA, *Evidence*, 25 March 2026, The Hon. Jill McKnight (Minister of Veterans Affairs), 1730.

providers, however, perceive that these objectives are often incompatible, can damage long-standing relationships of trust cultivated with clinicians and, in some cases, can detract from the quality of veteran care. Even when these objectives are potentially compatible, the administrative red tape involved in standardizing evaluation procedures discourages some professionals from registering as PCVRS service suppliers. As a result, veterans run the risk that service providers they have come to trust could be replaced by PCVRS suppliers, a decision they feel compelled to accept for fear of losing their income replacement benefit.

The third issue concerns awareness of military culture. The major rehabilitation service suppliers usually gained their expertise through large, civilian employer disability insurance programs. A number of witnesses said that the standardization of procedures and of the associated expertise precludes the possibility of taking specific features of military culture into account.

For the purposes of this study, the Committee heard from 37 witnesses and received 18 briefs. Committee members are grateful to everyone who contributed to this study and have made every effort to ensure that this report accurately captures their concerns.

THE VETERANS AFFAIRS CANADA REHABILITATION PROGRAM

What is Rehabilitation?

Rehabilitation is usually understood as an intervention – often a multidisciplinary one – that addresses the consequences of a health problem, rather than the health problem itself. Instead of repairing an injury or relieving the symptoms of an illness through surgery or drugs, for example, rehabilitation focuses on the impact of the injury or illness on the individual's general ability to function in multiple areas of their daily activity.

When an injury or illness is expected to persist over the long term, it is called a 'disability.' The consequences of an injury or illness, whether or not it constitutes a disability, are referred to as 'impairments'. Rehabilitation aims to restore an individual's 'capacities' (sometimes called 'competencies') to an optimal level, regardless of how long any symptoms related to the injury or illness are expected to last. VAC defines rehabilitation as:

> (…) a process to restore a client's physical, psychological, social and vocational abilities to an optimal level that will result in a Veteran's ability to integrate and actively participate in their community. It is intended to be an intense, time limited intervention as close to the injury or onset of symptoms as possible. The outcome of rehabilitation is

> an improvement, as opposed to the outcome of treatment which centers on stabilization.[3]

Rehabilitation therefore involves assessing a person's optimal capacities, implementing the most appropriate measures to restore them, estimating the time it will take to achieve this, and drawing up a timetable to monitor progress. It is therefore a medium-term activity conducted over a finite period of time. This intervention is intensive and demanding. That is why individuals involved in rehabilitation are not deemed capable of holding full-time employment and therefore require a source of income in order to fully participate in their recovery.

Major Program Components

Year over year, from 11,000 to 14,000 veterans — about 10% of VAC clients — participate in the VAC rehabilitation program. Annually, VAC receives about 5,000 applications for admission to the rehabilitation program. About 96% of veterans in the program also receive a disability benefit, although it is not an eligibility requirement.[4] In addition, "78% of Veterans in rehabilitation have at least one mental health condition listed as a rehabilitation condition."[5]

Prior to April 2006, military personnel who left the CAF without a medical release or a VAC disability pension had a hard time obtaining rehabilitation services if service-related problems surfaced after their release. This was especially true in cases involving mental health issues. Without a medical release, they could not obtain disability benefits under the Service Income Security Insurance Plan (SISIP) administered by SISIP Financial or access the associated vocational rehabilitation program. After leaving the CAF, the timelines involved in applying for a disability pension prevented them from obtaining medical or psycho-social services that would have benefitted their recovery. The rehabilitation program, in operation since 2006, was largely intended to correct this weakness. Among other things, it enabled the creation of a network of clinics specializing in the treatment of operational stress injuries in partnership with the provinces.

The VAC rehabilitation program has three components: medical, psycho-social and vocational. These three components correspond to areas of daily activity that allow

3 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 1.1.

4 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1.

5 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1.

veterans an opportunity to improve their skills. Most of the services provided are not covered by provincial health insurance or drug plans. To ensure nationwide delivery, the Government of Canada relies on a network of provincially regulated health professionals.

To be eligible for the program, veterans must submit an application stating that they have a health problem, resulting primarily from their military service, which is impeding their ability to re-establish in civilian life.[6] VAC's policy on rehabilitation services and vocational assistance defines "barriers to re-establishment" in civilian life as a health problem "limiting the veteran's ability to perform their role(s) at home, at work or in their community."

Eligibility for rehabilitation services enables services to be provided promptly and opens up eligibility for the income replacement benefit whilst the department processes the accompanying application for disability benefits. The IRB benefit guarantees that veterans will receive 90% of their pre-release income for the duration of the rehabilitation program.

When the department determines that a veteran's capacities cannot be restored, the benefit can be paid in full up to age 65. In this scenario, VAC assesses whether the case involves "diminished earning capacity" (DEC). DEC is deemed to exist when the department finds a veteran unable to obtain a job with an income equal to at least two-thirds of the income that the veteran was earning in the CAF. To account for career progression, a 1% adjustment factor is applied annually for a maximum of 20 years. After age 65, the benefit amounts to 70% of what it was before the claimant turned 65 and is payable for life.

If a veteran dies from a service-related condition before reaching age 65, the full amount of the benefit is divided among the survivors until the death of the veteran's spouse and/or until orphaned children reach age 18 or age 25 if they are still in school. If death occurs before age 65 and is not service-related, survivors receive the equivalent of what the veteran would have received in a 24-month period. If death occurs after age 65, survivors receive 70% of the benefit that the veteran would otherwise have received.

Interaction Between the Veterans Affairs Canada Program and the Canadian Armed Forces Program

The CAF service income security insurance plan (SISIP) pays medically-released veterans 75% of their pre-release income over the 24 months following their release. After this

6 In the event of a veteran's death, or if the department decides that a rehabilitation program is not sufficient to allow the veteran to find suitable employment, professional support services may be offered to the veteran's spouse or survivors.

period, if the SISIP finds that the veteran is totally and permanently incapacitated, the benefit will be paid until the veteran reaches age 65. Between 2006 and October 2016, the VAC income replacement benefit was harmonized with the SISIP benefit and also guaranteed payment of 75% of the individual's pre-release income, but only to veterans who were not medically released.[7] In October 2016, the VAC income replacement benefit increased to 90% of the individual's pre-release income. Medically-released veterans receiving SISIP benefits could then apply for the VAC benefit as well, thereby obtaining the 15% supplement.

Veterans are not required to actively participate in the SISIP vocational rehabilitation program in order to receive SISIP disability benefits in the 24 months following their medical release. However, participation in VAC's program is required to obtain the 15% income replacement benefit supplement. The 2024 internal evaluation showed that this can sometimes create false expectations, considering that SISIP decision letters advise veterans to "go to VAC for the 15% 'top up".[8]

One initial objective of the VAC rehabilitation program was to support veterans who were not medically-released but were experiencing barriers to re-establishment. This objective remains relevant, considering that approximately 35% of rehabilitation program participants were not released for medical reasons.[9] For them, the income replacement benefit is not a 15% supplement, but rather the full 90% of their pre-release income. In their case, the active participation requirement is therefore crucial.

SISIP offers 24 months of post-release vocational rehabilitation services to veterans released for medical reasons. Veterans receiving these SISIP services are not eligible for the VAC vocational component of the rehabilitation program. If barriers to re-establishment persist after this time period, veterans may then qualify for the VAC program.

For the past fifteen years or so, the Committee has repeatedly called attention to the problematic duplication between SISIP and VAC vocational rehabilitation programs. The department's 2024 evaluation reached the same conclusion. However, it pointed out that the VAC program is more flexible. Unlike the SISIP program, the VAC program allows

7 The benefit can also be paid to a spouse or orphaned children if the veteran dies prior to reaching age 65 and if the cause of death involved a service-related injury or illness. For information about survivor transfer limitations, see: Amanda Anderson, Brief to ACVA submitted June 23, 2026.

8 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.3.3.

9 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1.1.

the possibility of tailoring eligible training programs to the veterans' abilities, regardless of their education or previous occupations.[10]

The problem persists, however, since veterans released for medical reasons can only be admitted to the VAC program 24 months after their release. They therefore have no choice but to accept the more restrictive SISIP criteria at a time when more flexibility would do them the most good.

Differences Between the Rehabilitation Program and the Treatment Benefits Program

When it acknowledges that a veteran has a service-related disability, the department pays out a disability benefit. All veterans who receive disability benefits are entitled to the VAC treatment benefits program to address any needs arising from the medical condition for which their disability benefit is paid. This program, similar to the health care plans provided by certain employers, enhances the services available under provincial and territorial plans without requiring veterans to pay any premiums and with fully refundable service costs. These treatment benefits are governed by the *Veterans Health Care Regulations* and are separate from the rehabilitation program.

The treatment benefits program is administered by Medavie Blue Cross under the Federal Health Claims Processing Service (FHCPS). The FHCPS administers all health services for Veterans Affairs Canada, the Canadian Armed Forces and the Royal Canadian Mounted Police through a contract with Medavie Blue Cross signed in January 2014 and implemented on August 1, 2015. VAC treatment benefits are organized into fourteen "programs of choice" and are subject to veteran eligibility based on the nature of the disability. About 80,000 veterans receive treatment benefits, while approximately 12,000 participate in the rehabilitation program. Most veterans enrolled in the rehabilitation program receive treatment benefits separately.

As the Committee explained in its 2023 report:

> With the signing of the contract with PCVRS, Medavie Blue Cross will no longer be responsible for the rehabilitation program but will continue to administer all health care claims under the treatment benefits program. VAC has withdrawn from FHCPS for the processing of rehabilitation program claims but has remained with FHCPS for the processing of treatment benefits program claims. As a result, there will now be two banks of authorized providers: PCVRS will cover the three components of the

10 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.3.3.

> Rehabilitation Program, and Medavie Blue Cross will continue to cover the treatment benefits program.

By the time the department determines that rehabilitation services may be useful in helping veterans overcome a disability, they may already be receiving rehabilitation services under the treatment benefits program. According to the Policy:

> If those services have a rehabilitation focus to achieve an identified goal, they will be incorporated into the Veteran's rehabilitation plan and funded at a predetermined rate through VAC's third-party service provider. If those services are not incorporated into the rehabilitation plan, they will continue to be funded under Treatment Benefits.

Conversely, once a veteran completes the rehabilitation program, any medical or psycho-social treatments required to treat the injury or illness for which the veteran obtained a disability benefit will continue, at no charge, for life.

These differing objectives have existed since the programs were first implemented in April 2006. According to the department, however, they remain poorly understood:

> Throughout project implementation it was discovered there is confusion and a lack of understanding of the legislated intent, scope and parameters of the Rehabilitation Program. The department will continue to provide information to stakeholders to clarify how the program both differs from, and complements, other VAC programs.[11]

Steve Burton, psychologist with Lifemark, tried to clarify this confusion:

> It's also crucial to understand that the definition of rehabilitation within VAC's program is distinct from what many clinicians might traditionally associate with long-term, diagnostic-focused care. In the VAC rehabilitation program, our approach is explicitly time-limited and function-based. We target specific impairments directly linked to a veteran's eligible health problems, with the overarching goal of restoring functional independence and improving quality of life. This differs from a primary focus on diagnosis alone, as our interventions are geared towards measurable improvements in daily functioning.[12]

These differences are subtle, and Mr. Burton says that they often go unnoticed by the health professionals responsible for implementing them. According to the department, clarification efforts seem slow to materialize. According to Ms. Hicks:

> (…) one of the things we're working on right now is clarifying the providers, the program and the messaging, so that veterans understand the expectations when they go into a

11 Veterans Affairs Canada, *Update on impacts of the rehabilitation services contract awarded to PCVRS*, November 2023, p. 6.

12 ACVA, *Evidence*, June 8, 2026, Steve Burton (Psychologist, Lifemark Health Group), 1205.

> program: when they can keep their providers, when they may work with other providers or rehab specialists and what the purpose of those providers is. Sometimes people don't understand the expectations when they go into the program, and obviously you're hearing that there is confusion as to when providers can be retained or not. However, that's something we will be clarifying going forward.[13]

The fact that such a vital program is still misunderstood twenty years after its implementation points to a problem that far exceeds an issue related to the quality of communication between VAC, its partners and veterans.

Mr. Burton of Lifemark may well say that "the overall objective is to restore functional independence and improve quality of life," and the Department may well state in its Policy that the goal of rehabilitation is to restore veterans to their "roles at home, at work, or in the community," the fact remains that the true criterion for rehabilitation—the only one that distinguishes success from failure, the only one that matters for the payment of the income replacement benefit—is veterans' ability to earn an income of at least two-thirds of what they earned in the CAF. All other criteria related to well-being, health determinants, or a smooth transition to civilian life are ultimately merely means to regaining that gainful employment. The program's objective is not the physical and mental recovery of veterans, but rather their return to employment. A veteran who has regained optimal functioning in all other areas of life but is unable to earn two-thirds of their military income would not be considered to have met the program's objectives. Conversely, a veteran who is able to earn two-thirds of their military income but whose physical and psychosocial abilities are diminished would be considered a success.

This central objective is never presented as such. On the homepage for VAC's rehabilitation services, it states:

> "You complete the Rehabilitation Program when:
>
> - you achieve, or mostly achieve, your rehab goals;
> - we don't identify any further rehab needs;
> - more intervention won't be effective."

Nothing on the page indicates that a program will be completed when the individual is able to earn two-thirds of their military income or when it is determined that the individual will not be able to achieve this goal. The application form itself makes no

13 ACVA, *Evidence*, March 23, 2026, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1235.

mention of this criterion. To clarify the objective of the rehabilitation program and distinguish it from the medical benefits program, the Committee therefore recommends:

Recommendation 1

That Veterans Affairs Canada clearly state in its rehabilitation program presentation materials and on the associated web pages that the program's objective is to restore veterans' ability to earn an income of at least two-thirds of what they earned in the Canadian Armed Forces.

THE CONTRACT BETWEEN VAC AND PCVRS

Since the rehabilitation program's creation in 2006, all services have been provided by subcontractors authorized by the department in each of the three components. In the vocational component, service delivery has been handled by a single subcontractor since 2009. Until the contract was awarded to PCVRS, services under the medical and psycho-social components were delivered by a network of health professionals and organizations named on a list managed, coordinated and administered by VAC. Once the contract with PCVRS was implemented, a single supplier has delivered all components of the program.

Historical Background

In April 2009, the department delegated responsibility for administering the national vocational component of the rehabilitation program to CanVet Vocational Rehabilitation Services, a joint venture between WCG International Consultants, March of Dimes Canada and Innovative Rehabilitation Consultants. After several renewals, the contract expired in December 2022. Between April 2006 and November 2022, for the medical and psycho-social components, VAC directly authorized services, managed a list of authorized suppliers and delegated the administration of payments and refunds to Medavie Blue Cross through the FHCPS.

During evaluations conducted prior to signing a new contract for the vocational component of the program, set to expire at the end of 2022, VAC chose to contract out management of the program's three components in their entirety.[14] On June 29, 2020, Veterans Affairs Canada (VAC) issued an initial request for proposals. In June 2021, the department announced that it had awarded the contract, valued at an estimated $560 million over an initial term of five and a half years, with the option of three, two-

14 ACVA, *Evidence*, November 17, 2022, 1640, Steven Harris (Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs).

year extensions, to the joint venture company Partners in Canadian Veterans Rehabilitation Services (PCVRS), comprising WCG International, previously a subcontractor under the vocational component of the program since 2009, and the Lifemark Health Group.[15]

Implementation of the contract began in November 2022. If not renewed at its expiry on December 31, 2026, a six-month phase-out period is provided at the end of the contract to allow PCVRS to gradually pull back and transfer the activities provided for in the contract "to VAC or an incoming contractor" (Annex A, section 9.0 of the request for proposals).

Key Clauses

The contract[16] states that VAC is responsible for determining the eligibility of veterans applying to the program. Once their eligibility is confirmed, "the VAC Decision Maker will initiate the referral process and identify the rehabilitation needs related to eligible health problems which are causing barriers to re-establishment." (contract clause 1.1.7).

On receiving the referral, PCVRS conducts a comprehensive assessment of the participant's medical, psycho-social and vocational rehabilitation potential. "Based on the outcome of the rehabilitation assessment(s), the Contractor must develop a Rehabilitation Plan to support the Participant in achieving optimal health." (contract clause 1.1.8)

VAC is therefore responsible for identifying barriers to re-establishment resulting primarily from a service-related health problem. PCVRS is responsible for taking the necessary steps to re-establish the individual's optimal capacities by developing a rehabilitation plan. PCVRS is also responsible for evaluating the participant's progress against the objectives identified in the rehabilitation plan, while making any necessary adjustments along the way.

15 WCG International was founded in British Columbia in 1994 and was acquired in 2018 by APM, an Australian multinational group offering health and employability services through its subsidiaries. Lifemark began as a division of the Canadian company Centric Health Corporation before it was purchased by the U.S. private equity firm Audax in 2015. In March 2022, Loblaws announced its acquisition of Lifemark through its Shoppers Drug Mart/Pharmaprix subsidiary.

16 Public Works and Government Services Canada, *https://canadabuys.canada.ca/en/tender-opportunities/contract-history/51019-184018/001/stj-004*, *operating as: Partners in Canadian Veterans Rehabilitation Services*, June 29, 2021 (hereafter, "the Contract").

Before the contract was implemented, VAC used a list of service providers updated by Medavie Blue Cross under the Treatment Benefits Program. They had to register with the administrator before veterans could be referred to them. One of PCVRS's important initial tasks was to replace this list and "develop and define their comprehensive network of Rehabilitation Service Providers depending on the business model for service delivery."[17] In other words, VAC delegates the management of all rehabilitation service providers to PCVRS.

If the rehabilitation needs identified by VAC involve operational stress injuries (OSI), PCVRS must first refer veterans to one of the outpatient OSI treatment clinics administered by VAC before any other supplier.

Even if VAC is responsible for the final decision, it is PCVRS that conducts veteran employability and diminished earning capacity assessments. If earning capacity has diminished, the income replacement benefit may be payable for life.

Based on the results of the evaluations conducted during the rehabilitation program, PCVRS must recommend to VAC "closure by completion of the Rehabilitation Program, or if warranted, suspension of a rehabilitation service and/or cancellation from the Program and providing closure reports." Again, VAC retains responsibility for the final decision, but it is PCVRS that provides VAC with the necessary information and a recommendation to that effect.

The contract also states that PCVRS is responsible for:

- administering, processing and paying eligible Rehabilitation Program Participant claims, related expenses and training costs;
- conducting quality assurance, performance management, outcome and management reporting and other relevant activities as required by program and/or benefit; and
- collaborating with VAC to identify and implement innovative improvements to service delivery throughout the contract.

17 Veterans Affairs Canada, "Answer 15" to questions from proponents, Annex K, Request for Proposal, October 2020.

PROGRAM STAGES

Automatic Eligibility

Under the terms of the Contract, VAC is solely responsible for determining rehabilitation program eligibility. The department must therefore assess any functional limitations arising from the service-related health problem to confirm whether a barrier to re-establishment exists. The Policy states:

> [I]f the Veteran has mental health and back problems (health problems established), it is important to determine the existence and degree of any associated symptoms (e.g. anxiety, chronic pain) and how those symptoms limit the Veteran's functioning (e.g. anxiety leads to difficulty with concentration, pain leads to difficulty with sitting and lifting). If these functional limitations prevent the Veteran from doing activities in relation to their roles at home, work and/or in the community (e.g. perform work, engage in interpersonal relationships) then it can be determined that a barrier to re-establishment exists.

However, the usefulness of this demanding activity seems questionable. As the evaluation covering the period from 2014 to 2023 showed, admission to the rehabilitation program is almost automatic, since "97% of applications are approved each year."[18] This departmental responsibility, carried over to the contract with PCVRS, has therefore been reduced to an administrative formality.

According to the evaluation, the main reason for the high approval rate is the fact that although the department must examine these applications, it cannot assess needs or functional abilities. In other words, veterans are admitted to programs even though the department is not able to determine their need for rehabilitation. The evaluation team developed a recommendation to address this weakness, and the department agreed to propose solutions by the end of June 2026.[19]

The Initial Assessment

Once eligible veterans are referred to it, PCVRS conducts a needs assessment based on the program's three components: medical rehabilitation, psycho-social rehabilitation and

18 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1.

19 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1., Table 5.

vocational rehabilitation. This assessment is crucial; it determines the entire sequence of events that follow.

Since the department almost automatically accepts veteran applicants before assessing their needs, the initial assessment has to confirm that the injury or illness for which the veteran is receiving or has applied for disability benefits does indeed constitute a barrier to re-establishment as specified in the admission application. Next, it must determine the severity of these barriers and the degree of improvement that the veteran can reasonably expect to achieve. The goal of rehabilitation is to close the gap between initial capacities and optimal capacities, and the "rehabilitation plan" sets out the steps involved in reaching that goal. The rehabilitation plan will include medical treatments, psychological counselling and appropriate training programs, objectives for each component, a timeline for evaluating progress, and a realistic completion date.

When the program was created back in 2006, the department expected that a standard rehabilitation program would last from 18 to 24 months. In its early years of operation, however, only about 10% of participants had completed the rehabilitation program in three years.[20] For the 1,210 veterans enrolled in the rehabilitation program at the time they were taken over by PCVRS in November 2022, and who completed their program without a DEC, the median duration was 4.5 years, and the average duration was 4.8 years.[21] For the 414 veterans who enrolled after PCVRS took over and who completed their program without a DEC, both the median and average duration were two years. While it is not possible to generalize, veterans who have completed their program since PCVRS took over have done so much more quickly than before. Although the Act provides no time limit for rehabilitation plans, a completion date is set when the plan is developed.

Witnesses reported that the intensive nature of the VAC rehabilitation program sometimes clashes with the needs of veterans struggling with mental health problems. Aaron Slingerland, from the Ottawa Hospital, performs a lot of these initial assessments and said that the process takes two days. After that, psychiatrists, psychologists and occupational therapists produce reports used to compile a summary report for submission to PCVRS.[22]

20 Veterans Affairs Canada, New Veterans Charter Evaluation: Phase I, December 2009, p. 12.

21 This data is based on the Department's responses to the Committee's questions. It is dated June 19, 2026.

22 ACVA, *Evidence*, June 1, 2026, Aaron Slingerland (Executive Director, Business Development and Strategic Partnerships), The Ottawa Hospital, 1135.

In these cases, according to psychologist Elizabeth Forbes, restoring functional ability must proceed gradually. Issues related to vocational success should only be considered once this functional state can be maintained:

> Vocational processes, such as the initial assessment and related meetings, are often described by PCVRS as neutral. However, clinically they involve evaluative and performance-based demands that can activate the nervous system in trauma-affected individuals.
>
> PCVRS […] is often introduced […] at a point when the individual may not yet have the capacity to tolerate these additional demands. […] In this way, the system is experienced not only as unsupportive but also as a recurring source of distress.[23]

This also raises concern that co-ordination of the two PCVRS partners' responsibilities may not always be optimal. During their testimony, Mr. Peddle and Ms. Forcier suggested that stress can spike when the vocational component of the program starts and WCG takes over from Lifemark:

> I struggled to apply for vocational rehab. I had issues with applying for university. I was given two weeks' notice before the university program started that I was approved. I was basically put on hold, since I wasn't able to get onto the program, because it only starts once a year. This is where I got threatened to get kicked off the program, because I wasn't in university as was expected of me.[24]

To limit any potential stress experienced by veterans involved in rehabilitation, the Committee recommends:

Recommendation 2

That, should the initial rehabilitation assessment reveal significant medical or psychosocial needs, the assessment of a Veteran's vocational capacities be postponed until rehabilitation professionals have determined that the Veteran's functional condition is stable.

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23 ACVA, *Evidence*, April 22, 2026, Elizabeth Forbes (Registered Psychologist, as an individual), 1740. See also comments from ACVA, *Evidence*, June 1, 2026, Natalie Forcier (as an individual), 1120; ACVA, *Evidence*, April 27, 2026, Dr. Line St-Pierre (Psychologist, as an individual), 6450.

24 ACVA, *Evidence*, June 1, 2026, Natalie Forcier (as an individual), 1155. See also: ACVA, *Evidence*, June 1, 2026, Joel Peddle (as an individual), 1125.

Diminished Earning Capacity

If the initial assessment reveals barriers to re-establishment but determines that a rehabilitation process is insufficient to overcome them, PCVRS will assess whether there is a diminished earning capacity (DEC) and will make a recommendation to that effect to the department. If the evaluation shows that the veteran appears unlikely to obtain a position providing an income equal to two-thirds of the income earned in the CAF, the veteran will then be entitled to receive the income replacement benefit for life. This two-thirds cut-off is the same as cut-offs prescribed under the disability insurance plan for the federal public service. This determination can be made at any time during the rehabilitation process if it becomes apparent that certain initial objectives cannot be met.

The Policy states that "A DEC decision is based on the Veteran's capacity to perform any occupation that would be considered suitable gainful employment, not on the Veteran's choices or preferences, or local labour market conditions." It also says that:

> Local labour market conditions, including but not limited to the unemployment rate, availability of certain types of jobs, salary levels and language requirements in the region where a Veteran resides, are not considered in the DEC decision.
>
> For example: A Veteran who has the capacity to work as a mechanic, an occupation which could be considered suitable gainful employment in Canada, would not be determined to have met the criteria for a DEC designation by virtue of the Veteran choosing to live in a region where mechanic salaries are lower and would no longer be gainful.

The Department can ask veterans receiving the lifetime income replacement benefit to undergo an examination or assessment to determine whether they still meet DEC criteria.

A high percentage of rehabilitating veterans have a DEC designation. Based on 2023 evaluation data:

> Approximately 88% of Veterans engaged in rehabilitation for both physical and mental health conditions eventually meet DEC criteria. This compares to 74% for those with mental health conditions only and 61% for those with physical ailments only. It should be noted that the average Rehabilitation plan contained 2.6 physical health conditions and 1 mental health condition. The file review showed that 95% of officers (including commissioned and non-commissioned officers) who had both a mental and physical condition met DEC criteria upon closure of their rehabilitation plan in 2021–22 versus 80% of junior members with a mental and physical condition.[25]

25 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1.1.

According to the most recent data provided to the Committee by the Department, approximately 85% of veterans who completed their rehabilitation program were designated as having a DEC. The plan was canceled for 6.8% of the veterans enrolled at the time of the transition to PCVRS in November 2022, and this proportion has decreased to 5.3% since PCVRS took over. With an initial admission rate of 97%, a cancellation rate of approximately 6%, and a DEC designation rate of 85%, this means that approximately 77.5% of all veterans who have filed a rehabilitation application will be designated as having a DEC and will receive the income replacement benefit for life.

According to the internal evaluation, the DEC designation is approved or withheld with no explanation of how the assessors determined that the individual is able to earn an income amounting to at least two-thirds of the income earned prior to release. What happens in the case of veterans expected to earn 70% to 75% of their pre-release salary? How was this limit determined?

Similar systems in other countries use different criteria to determine the extent of diminished capacity. In New Zealand, for example, the veteran's ability to work at least 30 hours a week is the deciding factor. Income replacement amounts to 80% of net wages and is paid through the workers compensation system. The Department of Veterans' Affairs pays the difference between this compensation and what veterans would otherwise have earned in the Armed Forces.

The evaluation of VAC's program recommended a review of the criteria used to determine DEC, and the department agreed to propose solutions by June 2026.

Rehabilitation Plan

A number of witnesses complained about ambiguity surrounding expectations at the different stages of the rehabilitation plan and the input that veterans and health professionals are able to contribute to developing it.[26] One issue seems to concern the co-ordination of ongoing treatment-related objectives in response to a medical or psychological condition, and the more demanding nature of rehabilitation objectives.

As mentioned earlier, the treatment benefits program operates outside the rehabilitation program. Most rehabilitating veterans receive treatment benefits at the same time for a

26 See, for example: ACVA, *Evidence*, April 22, 2026, Mackenzie Scharf (Manager, Clinic Services, Broken Squirrel Wellness Ltd.), 1725. ACVA, *Evidence*, April 22, 2026, Michelle Massunken (Clinical Director, Mindspa Mental Health Centre Corp.), 1725.

service-related disability. This opens the door to possible conflicting objectives between the two.

For example, one psychologist treating a veteran receiving treatment benefits could decide that the performance and progress requirements of a rehabilitation plan are contraindicated for someone who has not sufficiently recovered from a psychological condition. This creates a risk that clinical treatment recommendations related to the treatment of the illness or injury could deviate from recommendations related to the recovery of functional and vocational capacities as outlined in a rehabilitation plan. As confirmed by Mackenzie Scharf, Clinical Manager with Broken Squirrel Wellness:

> We have had opportunities where treatment requests are initially declined. We find that there's often a willingness to reconsider when additional rationale is provided. […] At times, when veterans are receiving updates about approvals or denials before the clinical team is informed or able to support, it can be unsettling, particularly for those receiving psychological care, as it can impact trust and leave the providers unable to support their clients in real time.[27]

According to Ms. Forbes:

> In my experience, there is very limited integration between rehab planning and an established psychological treatment plan, resulting in parallel processes that are not aligned in timing or priority. […]
>
> More broadly, there appears to be no clear mechanism for clinical recommendations to meaningfully influence rehab planning, even when clinical risks are clearly identified. […]
>
> Rehab frameworks emphasize activation and progression, while trauma-informed care prioritizes stabilization and readiness. What this looks like in practice is that individuals become overwhelmed. Their symptoms increase, they begin to withdraw and the progress made in treatment is disrupted.[28]

The medical and psychological treatment provided to veterans through the treatment benefits program can be incorporated into the rehabilitation plan, but the final decision is up to the department, through PCVRS. It seems unlikely that PCVRS rehabilitation service specialists (RSS) would be opposed to recommendations made by health professionals treating a veteran. There is, however, a risk that this could happen,

27 ACVA, *Evidence*, April 22, 2026, Mackenzie Scharf (Manager, Clinical Services, Broken Squirrel Wellness Ltd.), 1635.

28 ACVA, *Evidence*, April 22, 2026, Elizabeth Forbes (Registered Psychologist, as an individual), 1740.

particularly in cases where medical or psychological treatments are not included in the rehabilitation plan, or when clinicians are not part of the network of PCVRS providers.[29]

Sergeant Michael Perstinger aptly described the tension that sometimes surfaces during the transition from clinical treatment to a rehabilitation process:

> Now, I meet a bunch of strangers, who ask extremely invasive questions that took my therapist two years to pry out of me. I have to answer them because I don't know what happens when I say no. […] I sit in those offices, in front of complete strangers, for my little interview with them, and I am asked extremely deep, personal and traumatizing questions. Then my wife has to deal with me for three days afterwards, when there's a dark cloud over me and I can't get out of bed.[30]

A number of witnesses expressed the same thought and mentioned that veterans admitted to the rehabilitation program were not ready to engage in this kind of process. These comments primarily concerned the requirement to participate in a vocational rehabilitation process immediately, which seems premature unless medical and psychological treatments have produced results.[31] As Christopher Banks, a veteran of Bosnia and Afghanistan, put it: “Allowing a contractor to make a decision about which direction the rehabilitation should go should not fall on the RSS. It should fall on the medical professionals.”[32]

To ensure that all professionals involved in supporting veterans work toward the same goals, the Committee recommends:

Recommendation 3

That, in cases when a Veteran is participating in both the VAC rehabilitation and treatment programs, the rehabilitation plans developed by rehabilitation service specialists be approved or updated by the VAC Case Manager in full consultation with the Veteran who may raise the opinions of other professionals involved in his or her treatment.

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29 On the exclusion of service providers not registered with PCVRS, see: ACVA, *Evidence*, April 27, 2026, Dr. Alisha Henson (Clinical Psychologist, Pembroke Psychological Services, as an individual), 6615.

30 ACVA, *Evidence*, May 25, 2026, Michael Perstinger (Sergeant (Retired)), as an individual), 6630.

31 See statements by: ACVA, *Evidence*, June 1, 2026, Natalie Forcier (as an individual), 1105; ACVA, *Evidence*, June 3, 2026, Natalie Gillis (Licensed Counselling Therapist and Canadian Certified Counsellor, Valhalla Visions Counselling Clinic), 1820.

32 ACVA, *Evidence*, June 3, 2026, Christopher Banks (Sergeant (Retired)), as an individual), 1755.

Some of VAC's Acting Senior Assistant Deputy Minister's remarks created confusion about what exactly happens when veterans are not ready to participate:

> The rehabilitation program, as I've indicated, is a voluntary program. While veterans are participating in that program, they're eligible for the income replacement benefit. If they leave the program and they have a diminished earnings capacity, they might get income replacement long-term. However, if they're not actively participating in the rehabilitation program, then they may not get the income replacement benefit.
>
> We do have strict measures in place where we don't just kick people out of the program. We measure and assess, and we work with veterans to identify any of the challenges that they experience. Sometimes they are not ready for rehabilitation.[33]

One of the DEC determination criteria concerns whether rehabilitation measures will restore the veteran's earning capacity or not. The assertion that veterans are "not ready for rehabilitation" seems consistent with this criterion, which usually results in a DEC assessment and long-term payment of the IRB.

Issues were also raised about providing veterans with access to their rehabilitation plan. Retired Sergeant Michael Perstinger said he never had access to his rehabilitation plan, and that the best that his PCVRS rehabilitation service specialist (RSS) could do was send him screenshots of it.[34] This suggests that while there may be no guidance against disclosing rehabilitation plans, little effort is made to ensure that veterans clearly understand and feel satisfied with their plan.

Natalie Forcier, who served as a CAF medic for 14 years, pointed out the disconnect between initial expectations and the reality:

> When I signed my PCVRS contract in 2023, the process was presented as collaborative. It stated that my RSS would use my goals to develop a rehab plan […]. On paper, that sounds like I'm meant to be informed, involved and empowered in my own rehab. That has not been my experience.[35]

It seems insufficient to simply say that veterans participating in rehabilitation can access their rehabilitation plan through the department's portal. They should be involved in such an important and consequential process from the earliest stages of the plan's

33 ACVA, *Evidence*, March 23, 2026, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1150.

34 ACVA, *Evidence*, May 25, 2026, Michael Perstinger (retired Sergeant), as an individual), 6610.

35 ACVA, *Evidence*, June 1, 2026, Natalie Forcier (as an individual), 1105.

development. Otherwise, many veterans will feel as though they are being forced to undergo rehabilitation. For that reason, the Committee recommends:

Recommendation 4

That the VAC Case Manager, prior to approving a recommended rehabilitation plan, ensure appropriate and deliberate steps have been taken to ensure that Veterans know how to access their plan, have reviewed it, understood it and understand the objectives they are committing to work towards.

Subsequent Evaluations

A number of witnesses criticized the frequency and complexity of the assessments they were required to undergo during the rehabilitation process. Tim Laidler, Director of the Veterans Transition Network, described some of the issues:

> The number of assessments that veterans are put through is astronomical. The vocational rehabilitation assessment is three hours. The psychological assessment can be another three-hour assessment, including a questionnaire that has over 300 questions about trauma. It's 300 questions online with a therapist, going through them one by one. It is so excessive.
>
> I have a background in mental health. No counsellor would ever put their patient or their client through this sort of assessment, and there's no follow-up right afterward from the therapist. There's no lining up to make sure the veteran is not retraumatized. Quite often they're done on Zoom, and the veteran is sent right back into their family unit after being activated.[36]

Although Mr. Laidler is primarily referring to initial assessments here, a long series of assessments have to be conducted throughout the rehabilitation process to measure the veteran's progress. These subsequent assessments are less burdensome than the initial assessments. According to Mr. Burton, from Lifemark:

> It can fluctuate even day to day, but ideally, we're not assessing constantly. It's over three or four months that we would reassess with some of the outcome measures. They're not large psychological tests themselves but outcome measures that are just one page. They depict symptoms and other things that are part of day-to-day functioning for the veterans. The overall full assessment, as we'd probably call it, is done

36 ACVA, *Evidence*, February 23, 2026, Tim Laidler (Executive Director, Veterans Transition Centre), 1120. See also: ACVA, *Evidence*, February 23, 2026, Shawn Carter (Executive Director, Edgewood Health Network Inc.), 1145; ACVA, *Evidence*, April 20, 2026, Dr. Simon Sherry (CRUX Psychology), 1130; ACVA, *Evidence*, April 22, 2026, Mackenzie Scharf (Manager, Clinical Services, Broken Squirrel Wellness Ltd.), 1635.

> once, and then that's pretty much it. We continue to use outcome measures to monitor progress or decline.[37]

Nevertheless, Marc-André Bernard, Psychologist with the Institut Atlas, said that these frequent assessments nevertheless interfere with clinical treatment and can cause the veteran's condition to deteriorate:

> Every eight sessions, I have to fill out a form on the patient's progress. It's a form created by PCVRS, and it has nothing to do with the kind of progress report I would normally write.
>
> […] I also systematically refuse to have my patients fill out progress questionnaires, even though PCVRS requires them to, because Veterans Affairs Canada already has PCVRS get veterans to fill out questionnaires every time they speak with them.[38]
>
> I'm thinking of one veteran in particular whose situation worsened under the program. I wrote letters to VAC and PCVRS asking that he no longer be subjected to the assessments, but they never agreed. He had to follow the program from start to finish, despite the documented deterioration of his symptoms.[39]

Jane Hicks, VAC Assistant Deputy Minister, defended the need for these assessments: "While assessments and documentation can sometimes feel repetitive, standardized tools are used to ensure consistent and equitable decisions, and to measure progress."[40]

According to Mr. Burton, from Lifemark:

> We recognize the importance of effective and targeted assessments to inform the treatment plans while also being mindful of avoiding over-assessment. This can burden veterans, obviously, with their diagnoses. Our goal is to conduct the necessary evaluations that yield actionable insights, ensuring that every assessment serves a clear purpose in advancing the veteran's rehabilitation journey.[41]

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37 ACVA, *Evidence*, June 8, 2026, Steve Burton (Psychologist, Lifemark Health Group), 1220.

38 ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1125.

39 ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1150. See also: ACVA, *Evidence*, April 20, 2026, Pascale Marier-Deschênes (Assistant Professor, Université Laval, as an individual), 1115; ACVA, *Evidence*, April 27, 2026, Michael Perstinger (retired Sergeant), as an individual), 6550.

40 ACVA, *Evidence*, March 23, 2026, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1100.

41 ACVA, *Evidence*, June 8, 2026, Steve Burton (Psychologist, Lifemark Health Group), 1205.

Sonya Lockyer, President and CEO of the Lifemark Health Group, said that improvements have already been made.[42] René Deschamps, from PCVRS, said that the frequency of assessments had been changed from one every four weeks to one every eight weeks for the medical component, and from every eight weeks to every 12 weeks for the psychosocial component.[43] Although this will probably lighten the load for the professionals providing treatment to the veterans, it remains to be seen whether it will positively affect the pressure that some veterans feel to make quick progress on achieving their plan's goals. Furthermore, even with a lower reporting frequency, the model remains standardized for all veterans and providers. As Michelle Massunken from Mindspa Mental Health Centre Corp. pointed out, the process is not very flexible.[44]

Opinion on these assessments also seems to differ between service providers involved on an ongoing basis in veteran treatment and those participating in the assessment portion only. The former are more likely to perceive potential conflicts between treatment objectives and rehabilitation objectives, while the latter only see veterans during assessments. Aaron North leads Vector Medical Corporation, a company that has conducted many initial assessments but whose providers are not regularly involved in treatment or rehabilitation. In a survey of the company's assessors, they identified veterans' perception of "[…] frustration over repeated assessments, complex questionnaires and retelling difficult military experiences."[45]

Colonel (retired) Nishika Jardine, Veterans Ombud, said that she has received few complaints from veterans about PCVRS and had advised service providers to encourage them to contact her office directly.[46] Toufic El-Daher, National President of the Union of Veterans' Affairs Employees, believes that the problem is structural.[47]

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42 ACVA, *Evidence*, March 23, 2026, Sonya Lockyer (President, Lifemark Health Group), 1215.

43 ACVA, *Evidence*, March 23, 2026, René Deschamps (Vice-President, Veterans Health and PCVRS Contract Manager, Partners in Canadian Veterans Rehabilitation Services), 1215.

44 ACVA, *Evidence*, April 22, 2026, Michelle Massunken (Clinical Director, Mindspa Mental Health Centre Corp.), 1720.

45 ACVA, *Evidence*, May 25, 2026, Aaron North (CEO and Director General at Vector Medical Corporation), 6455.

46 ACVA, *Evidence*, March 25, 2026, Colonel (Retired) Nishika Jardine (Veterans Ombud, Office of the Veterans Ombudsman), 1655.

47 ACVA, *Evidence*, June 10, 2026, Toufic El-Daher (National President, Union of Veterans' Affairs Employees), 1710.

The Income Replacement Benefit

An approved rehabilitation plan allows a participant to receive the income replacement benefit while the department is processing the disability benefit application that usually accompanies it. This benefit provides the veteran with 90% of their pre-release income for the duration of the rehabilitation program. Veterans who are medically-released, whether they participate in a rehabilitation program or not, already automatically receive from SISIP 75% of the income they were earning during the 24 months following their release. If they participate in the VAC program, their income replacement benefit entitles them to a 15% supplement along with the SISIP benefit. The pain and suffering compensation and all other VAC disability benefits are excluded from these calculations and paid regardless of the income replacement benefit or SISIP benefits.

The income replacement benefit is paid for as long as veterans are actively participating in their rehabilitation plan. If the plan's main objectives are reached, rehabilitation ends and the income replacement benefit is no longer paid. If the plan's objectives are not met because VAC, on the advice of PCVRS, deems that the barriers to re-establishment are too serious to be addressed through rehabilitation, PCVRS will then proceed to make a DEC determination (see next section).

If VAC, on the advice of PCVRS, decides that objectives have not been met due to a lack of active participation by the veteran, the plan could be cancelled, which would consequently cancel payment of the income replacement benefit. 655 veterans enrolled since PCVRS took over the program have had their rehabilitation plans canceled, representing 5.3% of the total. This aspect of the VAC policy elicited the most criticism from witnesses during the study.

Section 14 (1) of the *Veterans Well-being Regulations* lists three reasons for cancelling a person's rehabilitation plan:

a) the person does not participate to the extent required to meet the goals of the plan;

b) the person's eligibility for the plan or the development of the plan was based on a misrepresentation or the concealment of a material fact; or

c) the person, at least 6 months after the effective date of a suspension, continues to fail to comply with a request to provide the Minister with:

    a) attendance reports;

b) evaluations, assessments and progress reports; and

c) any other information or documents that are necessary to enable the Minister to assess the person's continued eligibility for the services or assistance

VAC Policy specifies that refusal by the participant "without reasonable cause" to undergo a medical examination or other assessment required for the purposes of an evaluation of a plan is cause for cancellation. "Specific expectations regarding participation in the plan will be based on the individual needs of the participant as outlined in their plan which was acknowledged by both the participant and VAC. In developing a plan, VAC is to make participants aware of their participation requirements." If a short-term cause interferes with participation, such as an illness or death in the family, the person is considered to be participating nonetheless.

Unless veterans can prove that they are actively participating, their program will be cancelled. Medically-released veterans continue to receive SISIP disability benefits for 24 months following their release, whether they participate in a rehabilitation program or not. They will therefore receive 75% of the income they were earning prior to release but will lose the 15% supplement available under the VAC income replacement benefit. Veterans registered in the VAC rehabilitation program but not medically released will lose the VAC benefit that raised their income to 90% of their pre-release income.

The principle involved here is that participating in a rehabilitation plan demands a level of involvement similar to that required by employment or full-time studies. The reason why the income replacement benefit is payable and taxable is precisely because rehabilitation demands such extensive involvement and therefore prevents veterans from engaging in any other remunerated activity at the same time. This is what distinguishes it from the pain and suffering compensation, which provides unconditional compensation for a service-related disability and is not taxable.

The condition implicit in such cancellation is that, when the rehabilitation plan was being developed, the department deemed the veteran fit to undertake the process on the advice of PCVRS. A problem arises, however, when service-related disabilities or barriers to re-establishment are the very factors obstructing such active participation. If veterans are experiencing serious clinical and service-related needs that prevent them from actively participating in rehabilitation, denying them the income replacement benefit would be absurd. These kinds of situations are precisely why the DEC exists.

PRELIMINARY ASSESSMENT AND ISSUES IDENTIFIED AFTER THE CONTRACT'S IMPLEMENTATION

The factors examined so far have related to the rehabilitation program's structure since its creation in April 2006. The challenges identified could have surfaced to various degrees in any organization in charge of the program's management. The issues now to be examined are those which witnesses claim have been exacerbated or caused by the decision to assign the entire program to a single supplier.

No public data are available to objectively compare the rehabilitation program's results before and after PCVRS's arrival on the scene. However, a 2023 rehabilitation program internal evaluation provides a relatively clear picture of the results before and after PCVRS started administering the program. For example, we know that:

> 68% of Veterans are satisfied with the rehabilitation services and vocational assistance they received from VAC. A majority (64%) say it helped improve their quality of life and benefited them personally and their supporters. However, only 24% agree that the program helped them enter the workforce or return to their main occupational activity and only 29% agreed that their barriers decreased after participating in the program.[48]

The evaluation also shows that "few Veterans progress through the Rehabilitation Program and successfully complete the vocational component. A combination of Veterans' severe disability, prolonged periods between injury and rehabilitation, and high IRB payments pose barriers to a successful program completion."[49]

The overlap with vocational rehabilitation delivered by the CAF, examined earlier, partly accounts for the long delay between release and eligibility for the VAC program. In 2021–22, data on veterans who completed the rehabilitation program showed that, on average, veterans became eligible for the rehabilitation program 5.7 years after release, and 80% of clients obtained entry after 11.8 years.[50] However, research shows that success rates are much higher when rehabilitation starts as soon as possible after the injury or illness that created the need for it: "[…] the longer the delay between injury and rehabilitation, the more likely it is that interventions become maintenance in nature, rather than

48 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 4.1.

49 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 4.1.1.

50 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 4.1.1.

rehabilitative."[51] As we will see later, the length of rehabilitation is one of the issues that the government tried to resolve by entering into a contract with PCVRS.

The Government's Position

When the request for proposals was published in 2020, the reasons given for this major change were non-specific and offered little insight into the problems that this decision was meant to resolve. The answer given in a Question Period note dating back to December 2024 was: "Having one national contractor to administer all medical, psycho-social and vocational rehabilitation services provides a consistent level of service delivery with improved performance measurement and quality assurance."

During her testimony, Jane Hicks, VAC Acting Senior Assistant Deputy Minister, Service Delivery, provided some clarification. She referred to "regional inconsistencies" that made case managers responsible for negotiating directly with individual providers. In her view, the contract freed case managers from the administrative burden involved in this coordination task, while "allowing VAC managers to focus on oversight, veteran support and rehabilitation outcomes."[52] Case managers are no longer required to find service providers.

According to Sonya Lockyer, President of the Lifemark Health Group, the case managers' referral role in this regard created a lack of cohesion among the professionals involved, who no longer coordinated together to develop the rehabilitation plan. Now, "With every rehabilitation plan, there's essentially the veteran, the case manager and the RSS who are meeting to sign off on that rehabilitation plan. That allows us to have a more individualized but also team-based care approach to how rehabilitation is provided, and to be accountable."[53] Government representatives reaffirmed that ultimate responsibility for any veteran care decision rests with VAC case managers. However, such responsibility seems highly theoretical if healthcare providers are no longer able to communicate with

51 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 4.1.1.

52 ACVA, *Evidence*, March 23, 2026, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1100.

53 ACVA, *Evidence*, March 23, 2026, Sonya Lockyer (President, Lifemark Health Group), 1140.

case managers directly. As a result, case managers have to make decisions based solely on information forwarded by the PCVRS RSS.[54]

The other advantage outlined by the government relates to standardized evaluations, reports and access to specialists, offering an opportunity to reduce rehabilitation times and improve outcomes:

> We have an approach such that veterans from coast to coast should receive the same rehabilitation services. We did not have that prior to PCVRS. It was a very different approach. It was fragmented. We did not have consistency of services, and veterans were not achieving the desired outcome. They were staying in the program much longer than they should have been. They weren't achieving the outcomes.[55]

During her appearance, the Minister of Veterans Affairs, the Honourable Jill McKnight, said that now, with the contract fully operational for the past two years, "we have seen significant progress in standardizing care, expanding access and implementing new tools and technologies to support both veterans and staff."[56] Ms. Hicks praised the outcomes achieved under the new approach: "Right now, with the current model, we are seeing that 74% of veterans are reporting positive outcomes and increased functional capacity, and 84% are reporting an improved satisfaction as well."[57] These data were challenged in an analysis published by the Toronto Star on May 18, 2026.[58] According to the raw data analysis submitted to the Committee by Stefan Eberspaecher, 37% of participants reported that their condition had deteriorated between the beginning and end of the program. Since the data and the supporting methodology were not made public, their validity cannot be assessed. It is therefore impossible to confirm or refute the government's findings concerning progress made after PCVRS's arrival.

However, the Department's responses to the Committee's questions have made it possible to tentatively draw the following conclusions:

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54 See, *inter alia*: ACVA, *Evidence*, April 27, 2026, Dr. Line St-Pierre (Psychologist, as an individual), 6515; ACVA, *Evidence*, April 27, 2026, Clea Corman (Consultant, Collaboration Strategies, as an individual), 6640; ACVA, *Evidence*, June 10, 2026, Toufic El-Daher (National President, Union of Veterans' Affairs Employees), 1630.

55 ACVA, *Evidence*, March 23, 2026, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1145.

56 ACVA, *Evidence*, March 25, 2026, the Honourable Jill McKnight (Minister of Veterans Affairs), 1730.

57 ACVA, *Evidence*, March 23, 2026, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1145.

58 Frédérik Plante, Internal documents cast doubt on officials' claims that most Canadian veterans are improving under controversial rehab program, Toronto Star, May 18, 2026.

- 5.3% of enrolled veterans had their rehabilitation plans canceled, a proportion slightly lower than it was before the arrival of PCVRS.

- Approximately 85% of veterans who completed their rehabilitation plan were granted a designation of diminished earning capacity, which entitles them to the income replacement benefit for life.

- Approximately 15% of veterans who successfully completed their rehabilitation plan did not receive a designation of diminished earning capacity and ceased to receive the income replacement benefit, without any criteria to determine why one veteran might be able to earn an income equivalent to two-thirds of their income while in the CAF and another might not.

- These 15% of veterans who successfully completed their rehabilitation plan did so more quickly since the arrival of PCVRS.

In the absence of public data to evaluate the health and well-being outcomes of transferring administration of the rehabilitation program to PCVRS, and while applauding the commitment by the Minister of Veterans Affairs, the Honourable Jill McKnight, to request an independent evaluation of these outcomes, the Committee recommends:

Recommendation 5

That the Minister of Veterans Affairs publicly disclose the final report of the independent third-party review commissioned to examine the VAC rehabilitation program's outcomes since it was entrusted to PCVRS.

Overall Judgement of the Witnesses

Among the veterans who testified, opinion is generally negative: "I'm not saying that the old system was perfect. […] However, with this new program, the term I would use is that it's their way or the highway."[59] Retired Sergeant Perstinger did not mince words: "My time with VAC and PCVRS has eroded my confidence that I will be well taken care of

59 ACVA, *Evidence*, April 20, 2026, Michael Parsons (Registered Psychiatric Nurse, as an individual), 1155. See also: ACVA, *Evidence*, April 22, 2026, David Morrow (as an individual), 1805; Samantha Wilcox, Brief to the ACVA submitted on June 29, 2026.

in a timely—especially timely—and simple manner. It's up to you to gain my trust back. I've done my part."[60]

A perceptible difference exists between what service providers involved in ongoing veteran treatment say and what professionals with more limited contact with veterans (usually during assessments) say. The former were highly critical of PCVRS, while the latter praised the quality of their business relationship with the company.

According to psychologist Line St-Pierre, "[o]ne of the most significant patterns I observed in my clinical practice was a regression in therapeutic progress, along with an intensification of psychological distress…among a majority of veterans involved in the program. (…) Conversely, I also observed improvement in most veterans in my practice once they had exited the program."[61]

On the other hand, Shawn Carter, Executive Director of a clinic that has conducted a large number of evaluations for PCVRS:

> The PCVRS program and the care we deliver are important in meeting these diverse needs across in-patient and outpatient settings. […] Programs like PCVRS, when paired with providers that are committed to trauma-informed, culturally competent and accountable care, play a vital role in restoring trust and supporting recovery.[62]

Dr. Simon Sherry is Chief Psychologist with a network of clinics that has become one of PCVRS's most important service providers in the Maritime provinces. During his testimony, he praised PCVRS rehabilitation service specialists.

> I'll highlight what I think are a few strengths of PCVRS. One would be that they provide timely care. They do a good job of connecting veterans to services. […] They will reach

60 ACVA, *Evidence*, April 27, 2026, Retired Sergeant Michael Perstinger (as an individual), 6620. See also: ACVA, *Evidence*, June 8, 2026, Richard Brown (as an individual), 1230; Retired Sergeant Garet Avery, Brief submitted to the ACVA on April 10, 2026; Retired Corporal John Meneray, Brief submitted to the ACVA on April 10, 2026; Erin Butler, Brief submitted to the ACVA on April 24, 2026.

61 ACVA, *Evidence*, April 27, 2026, Dr. Line St-Pierre (Psychologist, as an individual), 6450. For a more detailed analysis of this statement, see her Brief submitted to the ACVA on June 5, 2026. See also: ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1100. See also the brief submitted by Jessica Miller on behalf of an anonymous clinician, Anonymous Author, Brief submitted to the ACVA on April 10, 2026; Clea Corman, Natalie Gillis and Alisha Henson, Brief submitted to the ACVA on May 1, 2026.

62 ACVA, *Evidence*, February 23, 2026, Shawn Carter (Executive Director, Edgewood Health Network Inc.), 1105. See also: ACVA, *Evidence*, April 22, 2026, Mackenzie Scharf (Manager, Clinical Services, Broken Squirrel Wellness Ltd.), 1635.

> out. They will drive action. This is a supportive work environment where a sense of collaboration is strong.[63]

Pascale Marier-Deschênes, professor with the Department of Anesthesiology and Intensive Care at the Université Laval and a chronic pain specialist, questioned the specialized expertise of certain RSS: "This can sometimes lead to an intensity of services being maintained although it may not be suited to best practices in cases of fibromyalgia, for example, exacerbating problems rather than promoting rehabilitation."[64] For Michael Parsons, Psychiatric Nurse, the same lack of awareness exists within the complex ecosystem of VAC and DND programs delivered by PCVRS staff, in contrast to the experience encountered with departmental case managers.[65]

Michelle Massunken, Clinical Director with Mindspa Mental Health Centre Corp., offered a nuanced opinion of the advantages and challenges involved in the transition to PCVRS. She mentioned shorter wait times, better access to specialized services in remote regions, better coordination between providers and a more standardized approach to reporting and outcome monitoring. These were all among the service standardization objectives that the government wanted to achieve by awarding the contract to a single supplier.

However, she criticized the ambiguity of the rehabilitation program's parameters, which created fears among veterans that they could be removed from the program: "While the structured, time-limited nature of rehabilitation is intentional and important, it's not always clearly communicated. As a result, some veterans experience the program as rigid and high stakes."[66]

As many of the witnesses testified, concern about the possibility of being cut off related closely to the tie between admission to the rehabilitation program and access to the income replacement benefit.

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63 ACVA, *Evidence*, April 20, 2026, Dr. Simon Sherry (CRUX Psychology), 1105.

64 ACVA, *Evidence*, April 20, 2026, Pascale Marier-Deschênes (Assistant Professor, Université Laval, as an individual), 1110. See also: ACVA, *Evidence*, April 27, 2026, Dr. Alisha Henson (Clinical Psychologist, Pembroke Psychological Services, as an individual), 6550; ACVA, *Evidence*, April 22, 2026, Anne Marie Pinard (Physician, as an individual), 1735.

65 ACVA, *Evidence*, April 20, 2026, Michael Parsons (Registered Psychiatric Nurse, as an individual), 1115.

66 ACVA, *Evidence*, April 22, 2026, Michelle Massunken (Clinical Director, Mindspa Mental Health Centre Corp.), 1645. See also: ACVA, *Evidence*, June 8, 2026, Steve Burton (Psychologist, Lifemark Health Group), 1235.

Fear of Losing the Income Replacement Benefit

The loss of financial security was the main complaint systematically raised in the testimony of veterans and rehabilitation service providers. Many of the veterans who testified said that the risk of losing their income replacement benefit put them under tremendous pressure. This risk was often perceived as a threat.[67] These veterans felt they could not afford to fail or succeed at rehabilitation. For veterans without a DEC, whether their rehabilitation was a failure or a success, it entailed a significant loss of income. Simon Parker, a veteran with 26 years of service, used the term “captive patients” to describe the sense of powerlessness caused by the power imbalance between veterans and VAC and PCVRS, who have the authority to impose their decisions:

> Simply put, as a veteran, you either work through VAC or you go without and you suffer.
>
> This creates what I would describe as a form of managed care captivity. Veterans like me become, in effect, captive patients in managed care.
>
> […] When veterans are financially dependent, medically dependent, psychologically vulnerable and have nowhere else to turn, rehabilitation stops being collaborative and starts to feel coercive.[68]
>
> […] The case manager and the RSS hold the keys to the kingdom, and if you don't conform, they can kick you out. They can deny services and they can hold back, which happened in my case a couple of times. They will actually collaborate in some instances to have you removed from the program just because you won't conform to what they want you to do.[69]

The testimony given by Natalie Forcier, a veteran of Afghanistan in rehabilitation for a knee injury and post-traumatic stress disorder, described this sense of powerlessness:

> The process often felt rushed in the short term, and there was a set timeline and an expectation that I should show a measurable improvement within that window, but 14 years of repetitive stress, joint degeneration, chronic pain and mental strain do not simply improve because the rehab plan says they should. That leaves me caught between two impossible choices. Either I try to force years of physical and mental stress into a rehab timeline that does not reflect my reality, or I admit that I cannot progress

67 See, for example: ACVA, *Evidence*, June 3, 2026, Christopher Banks (Retired Sergeant as an individual), 1735; Joel Peddle, Brief submitted to the AVAC, April 24, 2026.

68 ACVA, *Evidence*, April 27, 2026, Simon Parker (as an individual), 6445.

69 ACVA, *Evidence*, April 27, 2026, Simon Parker (as an individual), 6505. See also: Deep 6 Gear, Brief submitted to the AVAC on April 24, 2026.

> the way the program expects and risk being seen as non-compliant. If I'm seen as non-compliant, what happens to my IRB?[70]

When her physical knee rehabilitation plateaued, her knee treatments were transferred from the rehabilitation program to the treatment benefits program. Although clinical treatment of the injury continues, without a DEC, the income replacement benefit stops. Although Simon Sherry from Crux Psychology testified that PCVRS rarely denies extension requests,[71] the risk of a program interruption can discourage veterans from being transparent about their condition: "I also needed to feel that honesty about my limitations would not put my income or stability at risk," Ms. Forcier said. Mr. Laidler talked about the same tensions:

> When you are going through the program, you are told that participation is mandatory. It's not a voluntary program, you're told. It's mandatory if you want to receive your income replacement benefit. […]
>
> It's really hammered into the veterans: You have to go to all of your treatment programs or you're going to lose your benefits.[72]

It is not difficult to understand that the rehabilitation program, in some situations, will become a means to obtain the income replacement benefit rather than a means to achieve rehabilitation. As the 2024 evaluation had mentioned, "increasing monetary benefits attached to rehabilitation can have a detrimental effect on program completion rates and outcomes."[73]

The decisive criterion for determining whether a rehabilitation plan has been successfully completed is when a veteran regains their "earning capacity." This means that the person is able to hold "suitable and gainful employment." In other words, the purpose of the medical, psycho-social and vocational components of the rehabilitation program is to restore the participants' ability to hold a job that pays at least two-thirds of what they were earning in the CAF. VAC, however, guaranteed them 90% of their former income for the duration of the rehabilitation program, which sometimes takes several years.

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70 ACVA, *Evidence*, June 1, 2026, Natalie Forcier (as an individual), 1105. See also: ACVA, *Evidence*, June 1, 2026, Joel Peddle (as an individual), 1130.

71 ACVA, *Evidence*, April 20, 2026, Dr. Simon Sherry (CRUX Psychology), 1135.

72 ACVA, *Evidence*, February 23, 2026, Tim Laidler (Executive Director, Veterans Transition Centre), 1115. See also: ACVA, *Evidence*, June 1, 2026, Joel Peddle (as an individual), 1145.

73 Veterans Affairs Canada, *Evaluation of the Income Replacement Benefit and Rehabilitation Services*, April 2024, Section 3.1.

Mr. Bernard gave an example showing how successful completion of a program can lead to problems:

> One veteran found a culinary trades course. He was asked to work full time. It gave him a sense of camaraderie, kept him from using substances and allowed him to reinvest in his family.
>
> However, since it prevented him from meeting with his case manager and going to physiotherapy, PCVRS asked him to choose between his course and rehabilitation.[74]

Mr. Bernard aptly drew attention to the transition period between rehabilitation and a return to gainful employment. The example he gave represents a typical successful rehabilitation experience, but the "'my way or the highway' approach to the program and benefit payment makes a soft landing difficult."[75] Unsure where a new job will lead in a few months' time, the veteran is forced to make a choice with potentially serious ramifications and consequences.

If the job pays too little, it indicates diminished earning capacity and should result in lifetime payment of the IRB along with the $20,000 allowable exemption. If the job is sufficiently gainful, in other words, if it provides the veteran with the equivalent of two-thirds of his or her CAF salary, the IRB payment can be halted, but par. 45 of the Policy

74 ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1135. The Kafkaesque maze that two veterans had to negotiate during their rehabilitation offers insight in this regard: see, Christopher Banks, Brief submitted to the AVAC, June 3, 2026; Erika Belopotocanova, Brief submitted to the Committee on June 4, 2026.

75 The Evaluation published in 2024 notes that: "Veterans who accept employment before completing their rehabilitation plan (i.e., before a final vocational assessment is completed and a DEC determination is made) have their rehabilitation plan "cancelled" as per policy. Plans cannot be marked "completed" and the system will not show that *any* goals were met or partially met unless the Veteran undergoes final assessments. Thus, there are instances where Veterans with relatively good outcomes are lumped into the "cancelled" category normally reserved for Veterans who were removed from the program for failure to participate or non-compliance with the program terms, etc. A portion of the 1,193 rehabilitation plans that were cancelled between 2019 and August 2022 fall into this category. Quantifying the exact number of instances this happens would require an extensive file review."

provides that it ends on the first day of the month following this determination.[76] This cut-off seems too sudden.

The Policy's definition of gainful and suitable employment provides no information about timelines. Accordingly, no transition period between rehabilitation and the gainful employment is possible. Adding a reasonable transition period to confirm the veterans' earning capacity would gradually encourage a sense of financial security. This transition period could be fixed or variable, based on the veteran's circumstances, and other rehabilitation components could be transferred to the treatment benefits program without ending the rehabilitation program altogether. The Committee therefore recommends:

Recommendation 6

That Veterans Affairs Canada provide a reasonable transition period to determine whether rehabilitating veterans have regained their earning capacity and whether income replacement benefit payments can cease.

As Retired Colonel Jardine pointed out, the problem with the rehabilitation program "[…] primarily lies, in my opinion, in that it is connected to the income replacement benefit."[77] The very structure of the program seems problematic, considering that rehabilitating veterans are not convinced that their well-being is the program's main focus. Instead, the income replacement benefit is held out like a carrot to force them into an overly rigid rehabilitation process that puts undue pressure on them to achieve quick results.

This issue could have been addressed independently from PCVRS's arrival on the scene. However, in the evidence the Committee gathered in the past as part of its numerous studies that raised issues with the income replacement benefit, this frustration has

76 The wording of the Policy is: "The IRB ceases to be payable (unless the Veteran has a DEC) on the earlier of:

a. the first day of the month after the month in which a Departmental decision maker determines, as a result of an assessment of the Veteran's needs, that a rehabilitation plan should not be developed for the Veteran;

b. the first day of the month after the month in which the Veteran completes the part of their VAC Rehabilitation Plan that pertains to the health condition(s) for which they are eligible for IRB;

c. the first day of the month after the month in which the plan has been cancelled;

d. the first day of the month after the month of the Veteran's 65th birthday; or

e. the first day of the month after the month in which the Veteran dies."

77 ACVA, *Evidence*, March 25, 2026, Retired Colonel Nishika Jardine (Veterans Ombud, Office of the Veterans Ombudsman), 1710.

never been clearly expressed. While VAC was in charge of care, and despite the red tape, it was assumed that the department's concern for veterans' well-being was sincere. When that responsibility shifted to PCVRS, this assumption vanished. Veterans felt captive to decisions being forced on them by a large corporation, and suspected that its profit targets took priority over their well-being. Many of them felt that the risk of having their income replacement benefit taken away unfairly compelled them to go along with the company's requirements.[78]

We are therefore faced with two problems that amplify each other. The first concerns the program's structure. The coupling of the income replacement benefit with rehabilitation means that rehabilitation is no longer an end in itself, but all too easily becomes a means of obtaining the benefit. The second problem is that using the services of a large private corporation to administer and deliver services is heightening the perception that the pressure on veterans to achieve quick results is driven by profit-related objectives.

Continuity of Care

A number of witnesses mentioned the possibility that PCVRS may be pressuring veterans newly admitted to the rehabilitation program to switch from the professionals they are already seeing and use PCVRS-affiliated providers instead.[79] As explained earlier, the separation between the treatment benefits program and the rehabilitation program is partly responsible for this perception. Steve Burton of the Lifemark Health Group commented on this problem:

> It's important to clarify that veterans can absolutely continue with their existing health care providers in parallel with the treatment that they receive in the VAC rehabilitation program. We are not aiming to remove established therapeutic relationships. Instead, the program ensures that the assessments and treatments delivered within VAC's rehabilitation program are specifically function-based and are provided by clinicians who have received the VAC specialized training relevant to veteran care and the program's framework.[80]

Rather than solving the problem, the expert clarification provided in this answer masks it. For example, a veteran has been receiving treatment from a psychologist for the past two years and recently entered the rehabilitation program. For this veteran, it makes no

78 See, for instance: ACVA, *Evidence*, June 3, 2026, Retired Sergeant Christopher Banks, as an individual), 1805.

79 See also: ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1100; ACVA, *Evidence*, April 27, 2026, Dr. Alisha Henson (Clinical Psychologist, Pembroke Psychological Services, as an individual), 6550; ACVA, *Evidence*, June 10, 2026, Martha Josephian (Case Manager and Alternate Vice-President, Union of Veterans' Affairs Employees), 1745.

80 ACVA, *Evidence*, June 8, 2026, Steve Burton (Psychologist, Lifemark Health Group), 1205.

difference whether the psychologist is paid by Manulife, through the treatment benefits program, or PCVRS, through the rehabilitation program. If the veteran has a good relationship with this psychologist, why wouldn't he or she be surprised by the administrative hurdles involved in this psychologist enrolling in the rehabilitation program? If another psychologist affiliated with PCVRS is now required to evaluate that veteran, provide treatment, and monitor progress as part of a rehabilitation process, what exactly does a veteran's right to continue treatment with their current psychologist at the same time mean? Why change psychologists and why have two?

PCVRS would probably answer that rehabilitation is a separate process and that treatments offered during rehabilitation differ from treatments geared to maintenance or longer-term improvements. However, it does not solve the problem to say that the psychologist involved can simply become an affiliate and then the treatment they provide will be processed through the rehabilitation program rather than the treatment benefits program. If a rehabilitation approach based on measurable results achieved within a specific time period clashes with this psychologist's approach and the delicate work involved in building a trusting relationship, all progress made with this psychologist could be in jeopardy. As Ms. Forbes said:

> Individuals are often encouraged to transition from established community providers like me to providers within the PCVRS network. When a therapeutic alliance is already in place, disrupting that relationship, particularly in trauma treatment, can result in reduced engagements and many setbacks in progress. For some individuals, this may be experienced as a breach of trust, particularly in the context of institutional or relational trauma.[81]

Resistance to becoming a PCVRS affiliate is therefore entirely understandable. Some professionals might reluctantly register with the provider in order to maintain an established therapeutic relationship and to allow the veteran to obtain the income replacement benefit, but not because they support the rehabilitation plan objectives. This tension could complicate the rehabilitation process, and lead PCVRS to give preference to psychologists specializing in rehabilitation over traditional clinicians. Mr. Perstinger lost one provider over this situation: "[…] she refused to work with PCVRS because of other

81 ACVA, *Evidence*, April 22, 2026, Elizabeth Forbes (Registered Psychologist, as an individual), 1740. See also: ACVA, *Evidence*, April 27, 2026, Dr. Line St-Pierre (Psychologist, as an individual), 6510; ACVA, *Evidence*, April 27, 2026, Dr. Alisha Henson (Clinical Psychologist, Pembroke Psychological Services, as an individual), 6550; ACVA, *Evidence*, June 3, 2026, Natalie Gillis (Licensed counselling therapist and Canadian certified counsellor, Valhalla Visions Counselling Clinic), 1750; ACVA, *Evidence*, June 1, 2026, Natalie Forcier (as an individual), 1105; ACVA, *Evidence*, April 22, 2026, Mackenzie Scharf (Manager, Clinical Services, Broken Squirrel Wellness Ltd.), 1720.

patients. […] She had my full confidence, and her outright rejection to work with them was the canary in the coal mine for me."[82]

According to Mr. Bernard:

> The program is also very aversive and discouraging for professionals, who are relegated to technical tasks and given no room for maneuver. A lot of time and energy is spent on compliance with forms and reports, and very little on clinical needs. All of my colleagues who worked with military personnel in rehabilitation have stopped collaborating with the PCVRS.[83]

PCVRS has a different interpretation of the tension between the clinical needs identified by claimants and the rehabilitation needs identified by PCVRS. Eric Vila is a kinesiologist specializing in rehabilitation and employed by Lifemark. After explaining that he encouraged new patients to share assessments by past providers in order to limit the need for new assessments, he added:

> […] when veterans are referred to the rehabilitation program, their VAC case manager identifies their eligible health problems. These are the specific areas we as clinicians are authorized to assess and address within their approved rehabilitation plan.
>
> While VAC's rehabilitation program is focused on these eligible conditions, we strongly encourage participants to continue receiving services from their existing providers for any non-eligible health problems. Those services would be outside of the rehabilitation program and covered by their Medavie Blue Cross benefits. This ensures comprehensive care while maintaining the program's specific mandate for functional rehabilitation.[84]

This testimony suggests that veterans can continue to receive services from their former treatment benefits program providers as long as the health problem involved is not included in the rehabilitation plan. Ms. Hicks's testimony mirrored the same ambiguity: "With respect to treatment, veterans are able to maintain the treatment providers they have in place, provided that there is a clinical need to do so. In many instances, they do keep those providers."[85]

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82 ACVA, *Evidence*, April 27, 2026, Michael Perstinger (Retired Sergeant), as an individual), 6625. See also: ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1100.

83 ACVA, *Evidence*, February 23, 2026, Marc-André Bernard (Psychologist, Institut Alpha, as an individual), 1100.

84 ACVA, *Evidence*, June 10, 2026, Eric Vila (Kinesiologist, as an individual), 1625.

85 ACVA, *Evidence*, *March 23*, *2026*, Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 1120.

The Assistant Deputy Minister's words are supported by comments from Mr. Burton, of Lifemark, that "when the relationship is established with a therapist already, and it's a positive relationship, obviously you maintain that relationship. […] If they are currently seeing someone and benefiting, and if they enjoy that relationship and feel that it's very productive, I recommend that they maintain that relationship."[86] However, maintaining that therapeutic relationship will not be part of their rehabilitation plan. It is a parallel process, and its objectives could potentially clash with the rehabilitation objectives.

As explained by Martha Josephian, VAC Case Manager:

> [Veterans] can access services through PCVRS for their eligible health conditions, the health conditions they are on the rehabilitation program for. Other health issues they would, as you say, in parallel seek assistance and treatment through their A-line benefits and also possibly through the public service health care plan. It becomes very fragmented, and it's very confusing for clients[87]

The other factor involved in provider resistance to joining PCVRS concerns the department's evaluation report standardization requirements. René Deschamps from PCVRS describes these requirements as follows:

> The direction from PCVRS is that every provider is encouraged to join the network. PCVRS providers, RSPs, have to complete VAC-approved mandatory training, as well as agree to utilize the VAC-approved report templates and agree to the reporting frequency, and they have to utilize the portal for secure exchange of information. If the participant's existing provider is unwilling to join the PCVRS network, then yes, they may be asked to switch to a PCVRS-trained clinician.[88]

According to Ms. St-Pierre, the exclusion of unaffiliated providers "raises ethical concerns."[89]

Service providers who choose to register may do so as "affiliated" or "out-of-network" providers. The Veterans Transition Network, a well-known organization actively treating

86 ACVA, *Evidence*, June 8, 2026, Steve Burton (Psychologist, Lifemark Health Group), 1205. See also: ACVA, *Evidence*, April 27, 2026, Aaron North (CEO and Director General, Vector Medical Corporation), 6455–6500.

87 ACVA, *Evidence*, June 10, 2026, Martha Josephian (Case Manager and Alternate Vice-President, Union of Veterans' Affairs Employees), 1730.

88 ACVA, *Evidence*, March 23, 2026, René Deschamps (Vice-President, Veterans Health and PCVRS Contract Manager), 1120.

89 ACVA, *Evidence*, April 27, 2026, Dr. Line St-Pierre (Psychologist, as an individual), 6510.

veterans for the past 25 years, decided to register with PCVRS after it obtained the contract. According to Oliver Throne:

> When we were finally given the option to register, a year into the process, we were told that we could do so either as an affiliate provider or as an out-of-network provider. The affiliate status came with administrative requirements that we were not confident we could meet, as a charity with a small team, and still maintain our client-centred focus. We chose to register as an out-of-network provider.
>
> Another year later, in June 2025, we were informed that the registration was complete, but that as an out-of-network provider, PCVRS was unable to refer any veteran clients to us. This was never disclosed during the registration process.
>
> In total, it took 28 months for PCVRS to inform our charity that they would not refer any veterans to our evidence-informed program, which has been serving veterans successfully for over 25 years. […]
>
> As a national service provider, we're preparing now for a future with greater demand, and the broader system of veterans' care in Canada needs to be prepared too. That means removing barriers to care, not building them.[90]

As we saw earlier, medically-released veterans are encouraged to apply for the VAC rehabilitation program at the same time that they apply for the disability benefit. Since they were already eligible for the disability benefit and 24 months of SISIP vocational rehabilitation, many of them applied in order to obtain the 15% supplement available through the VAC income replacement benefit. Since the SISIP benefit was automatic and involved no rehabilitation, many people were surprised by the VAC rehabilitation program participation requirements. In addition, program admission was practically automatic for anyone who applied. Actual needs were only assessed after admission.

At the time of this transition and before a rehabilitation plan is developed, it might be wise for VAC case managers to consult with the professionals already offering relevant services concerning the relevance and capacity of these veterans to fully engage in a demanding rehabilitation plan. If they determine that such a process could undermine existing progress, it may be reasonable to assume that rehabilitation would not produce satisfactory results. The department could perform a determination of the veteran’s earning capacity and limit rehabilitation plan development to participants deemed ready to undertake the process.

The Committee therefore recommends:

90 ACVA, *Evidence*, April 22, 2026, Oliver Thorne (Chief Executive Officer, Veterans Transition Network), 1640.

Recommendation 7

That, in cases when a Veteran is participating in both the VAC rehabilitation and treatment programs, if health professionals participating in a Veteran's treatment believe the recommended rehabilitation plan will detract from the rehabilitation program goal of successful reintegration in the civilian workforce, VAC will conduct a review of the Veteran's supports and benefits.

Consideration of Military Culture

Despite the many complaints leveled at VAC for many years, the employees seem to have retained the respect of a large number of veterans. Several witnesses said they appreciated the employees' willingness to do their best and the departmental culture, despite its bureaucratic slip-ups, still reflects a sincere concern for the well-being of veterans.[91] This openness shown by the department, which has certainly been underappreciated at times, is indirectly apparent in the way witnesses perceived PCVRS as less sensitive to military culture. Many witnesses complained that the company has borrowed procedures from general disability insurance programs that are ill-suited to the consequences of military experience.

As Simon Parker said: "Veterans are not simply civilians with employment barriers or health problems that can be treated and administered by civilian like insurance programs. To help veterans, one must understand (…) military culture".[92] According to Aaron North of Vector Medical Corporation, service providers also need to understand military culture. "It's about cultural competency, absolutely. It's also about excellence in the work they do."[93]

Steve Burton, a former police officer and later a psychologist with Lifemark Health Group, acknowledged that apart from military culture training, other needs include "more education, more training and making people more aware. We do have the training for military culture, but I think we can do a lot more. When I'm talking to a

91 See for example: ACVA, *Evidence*, March 25, 2026, Colonel (Retired) Nishika Jardine (veterans ombud, Office of the Veterans Ombudsman), 1655. ACVA, *Evidence*, April 20, 2026, Dr. Simon Sherry (registered psychologist, CRUX Psychology), 1130. ACVA, *Evidence*, April 27, 2026, Dr. Alisha Henson (clinical psychologist, Pembroke Psychological Services, as an individual), 1815. ACVA, *Evidence*, June 1, 2026, Joel Peddle (as an individual), 1120. ACVA, *Evidence*, June 3, 2026, Christopher Banks (sergeant (retired), as an individual), 1735. ACVA, *Evidence*, June 8, 2026, Richard Brown (as an individual), 1200.

92 ACVA, *Evidence*, April 27, 2026, Simon Parker (as an individual), 6445.

93 ACVA, *Evidence*, April 27, 2026, Aaron North (CEO and director general at Vector Medical Corporation), 6530. See also: ACVA, *Evidence*, April 22, 2026, Anne Marie Pinard (physician, as an individual), 1815.

veteran who has gone through just horrible things organizationally and also out in the field, I can relate to that. I can relate to the smells and everything, but others can't.”[94]

The committee therefore recommends:

Recommendation 8

That VAC ensure the rehabilitation program provider and the network of associated rehabilitation and medical service providers receive regular and ongoing training to raise awareness about and understanding for the unique aspects of military culture and experience in order to better support the recovery of Veterans participating in the VAC rehabilitation program.

CONCLUSION

When the rehabilitation program was created in 2006, it met a critical need: to provide more timely, structured support to veterans whose health posed a barrier to re-establishment and address well-documented weaknesses related to accessing services. The three-component approach (medical, psycho-social and vocational) was intended to foster lasting functional improvements and meaningful social and vocational participation. This need still exists, and Committee members are convinced that a rehabilitation program designed and delivered for veterans is necessary.

By its nature, a rehabilitation process is intense and demanding. In this regard, it differs from disability treatments, which aim for long-term stabilization and to mitigate the symptoms of an illness or injury. This distinction is vital, yet the department seems hard pressed to adequately explain it. This rehabilitation requirement also implies that veterans can give it the necessary time, which makes it hard for them to simultaneously earn a living and participate in the process. The income replacement benefit was created for that very reason. However, as the 2024 program evaluation showed, increasing the benefit to 90% of the participant’s pre-release income, when it was previously aligned with the 75% CAF disability benefit, may have made rehabilitation a means to obtain the benefit, rather than the benefit serving as a support for rehabilitation. Unlike CAF benefits, which are automatic and do not require participation in rehabilitation, VAC benefits were designed to incentivize active participation in rehabilitation. The risk of losing the benefit for poor participation was possible, but seemed somewhat offset by

94 ACVA, *Evidence*, *June 8*, *2026*, Steve Burton (Psychologist, Lifemark Health Group), 1250.

trust that VAC, as a department keenly aware of its public service role, would not use it as leverage to pressure veterans.

The decision to award the contract to PCVRS as the sole supplier of the entire rehabilitation program has cast doubt on this presumed trust. Although the department remains responsible for the rehabilitation program under the contract, the company's rehabilitation services specialists (RSS) are the first to conduct a detailed assessment of rehabilitation needs. Since the department's case managers did not perform the assessment, they are in no position to challenge the recommendations of the RSS. This initial assessment, which covers the three components of rehabilitation, can be stressful for veterans whose medical and psycho-social condition has not yet stabilized, because it forces them to set vocational objectives at the start of the process. For that reason, the Committee recommends that, when the initial assessment reveals serious medical and psycho-social needs, the vocational component of the assessment should be postponed.

The same rationale applies to development of the rehabilitation plan, provider co-ordination, progress monitoring, the recommendation to cancel services and, lastly, the recommendation to grant or not grant diminished earning capacity (DEC) status, which would allow veterans to receive the income replacement benefit for life. The criteria for determining whether a veteran has regained his or her earning capacity are unclear, and the rules do not allow a transition period when veterans are notified that their program, along with their income replacement benefit payments, have ended. The Committee therefore recommends that these rules be made more flexible.

Although it retains this authority in theory, the department lacks the information needed to assess the appropriateness of PCVRS's recommendations. The department's dependency in this regard is compounded by the fact that VAC case managers, contrary to practice under the previous system, no longer communicate one-on-one with the service providers working directly with veterans. Instead, these service providers forward information to the RSS, who then pass it on to the case managers. To limit the risk of PCVRS gaining sole control of this information, the Committee recommends that all rehabilitation plans, prior to implementation, be expressly approved by the service providers, including those working with veterans under the VAC treatment benefits program. The department must also ensure that veterans participating in this process fully understand and expressly agree to the requirements involved, free from any pressure by the supplier that they reach certain objectives or risk losing their benefits.

Committee members acknowledge that standardized tools can support coherent decision-making and measure progress. However, this requirement should not create

administrative complications or rigidity that discourage service providers from participating because they view it as an unnecessary stress for veterans.

The issue that witnesses described as most important concerns the feeling that rehabilitation holds veterans captive. The risk of losing the income replacement benefit over unsatisfactory participation is perceived as a threat that transforms rehabilitation from a collaborative process into a performance requirement. For veterans, this emerges in a fear of admitting to personal limits, which detracts from the transparency needed to build therapeutic trust. It can also lead to a pattern of conforming to requirements rather than making a sincere therapeutic commitment.

Continuity of care was the other issue most frequently mentioned. On paper, veterans can keep their providers, but in practice, the distinction between “eligible health problems” covered by the rehabilitation plan and “non-eligible health problems” referred to the treatment benefits program fragments the process and obscures an overview of the veteran’s condition. A lot of clinicians are put off by the affiliation requirements, report templates, assessment frequency and the online portal. Being sidelined, these clinicians can no longer offer insight into potential conflicts between the clinical treatment they provide and what the rehabilitation plan proposes. One danger of excluding them is to overlook that, in some cases, active participation in a rehabilitation program can jeopardize the stability of treatment. Veterans may want to keep participating despite clinical contraindications in order to keep receiving their benefit. If the veteran’s medical and psycho-social condition stands in the way of beginning a demanding rehabilitation process, it seems inappropriate to deny them their benefit yet continue providing it to veterans who are feeling better. For that reason, the Committee recommends that when the clinicians treating veterans prior to the initial assessment advise that the intensity of the process could be detrimental to sustained progress, a determination of the individual’s earning capacity should be conducted immediately.

The assumption that VAC case managers are more concerned about the well-being of veterans and open to understanding the unique factors inherent in military service does not easily carry over to PCVRS rehabilitation service specialists, or to service providers hired by the company to conduct the veterans’ initial needs assessments. However, this aspect is key to creating a climate that allows veterans to begin their rehabilitation process with full trust. For that reason, the Committee recommends enhancing the military culture training offered to service providers.

Insufficient public data exist to allow an objective comparison of the rehabilitation program’s outcome before and after the contract with PCVRS took effect. Benefits identified by the government include a standardized assessment and monitoring

process, better access to services, better technological tools and greater veteran satisfaction. However, the data supporting these claims are either unavailable or disputed. For that reason, Committee members applaud the department's commitment to conduct an independent evaluation of the contract's impacts. The Committee also asks that all aspects of the methodology used and the results of this evaluation be submitted to the Committee and made public before any decision is made to renew the contract.

Through this report, Committee members hope to reaffirm the fundamental importance of the veteran rehabilitation process, which is a vital lever in supporting the healing process, maintaining independence and fostering full and lasting participation in civilian life. However, the process must follow an approach centred on due respect for veterans, commensurate with the honour and dedication they displayed in serving Canada.

The Committee also wants to thank all witnesses for their valuable contributions, especially the veterans who courageously shared certain painful experiences. Their openness clarified how the issues were experienced on the ground and led to a better understanding of the human consequences involved in administrative decisions.

Committee members would like to assure veterans and their loved ones that the concerns expressed throughout this study remain foremost in their thoughts. It is by drawing on these concerns—and on the respect they deserve—that the Committee continues to formulate its recommendations to improve service delivery and strengthen the trust that must continue to be placed in the rehabilitation program.

APPENDIX A:
LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

Organizations and Individuals	Date	Meeting
As an individual	2026/02/23	22
Marc-André Bernard, Psychologist, Institut Alpha		
Edgewood Health Network Inc.	2026/02/23	22
Shawn Carter, Executive Director		
Roxa Development Institute	2026/02/23	22
Tim Laidler, Executive Director, Veterans Transition Centre		
Department of Veterans Affairs	2026/03/23	26
Jonathan Adams, Director General, Finance		
Jane Hicks, Acting Senior Assistant Deputy Minister, Service Delivery		
Nathalie Pham, Director General, Field Operations		
Lifemark Health Group	2026/03/23	26
Sonya Lockyer, President		
Partners in Canadian Veterans Rehabilitation Services	2026/03/23	26
Sylvie Bourgeois, Medical Director, Mental Health		
René Deschamps, Vice President, Veterans Health and PCVRS Contract Manager		
WCG Services	2026/03/23	26
Tania Bennett, Chief Executive Officer		

Organizations and Individuals	Date	Meeting
Department of Veterans Affairs	2026/03/25	27
Hon. Jill McKnight, Minister of Veterans Affairs		
Mitch Freeman, Acting Assistant Deputy Minister, Strategic Policy, Planning and Performance Branch		
Nancy Gardiner, Deputy Minister		
Jane Hicks, Acting Senior Assistant Deputy Minister		
Pierre Tessier, Assistant Deputy Minister, Chief Financial Officer and Corporate Services		
Office of the Veterans Ombudsman	2026/03/25	27
Col (Ret'd) Nishika Jardine, Veterans Ombud		
Duane Schippers, Deputy Veterans Ombud		
As an individual	2026/04/20	30
Pascale Marier-Deschênes, Assistant Professor, Université Laval		
Michael Parsons, Registered Psychiatric Nurse		
CRUX Psychology	2026/04/20	30
Simon Sherry, Registered Psychologist		
As an individual	2026/04/22	31
Elizabeth Forbes, Registered Psychologist		
David Morrow		
Anne Marie Pinard, Physician		
Broken Squirrel Wellness Ltd.	2026/04/22	31
Mackenzie Scharf, Manager, Clinical Services		
Mindspa Mental Health Centre Corp.	2026/04/22	31
Michelle Massunken, Clinical Director		
Veterans Transition Network	2026/04/22	31
Oliver Thorne, Chief Executive Officer		

Organizations and Individuals	Date	Meeting
As an individual	2026/05/25	34
Clea Corman, Consultant, Corman Collaboration Strategies		
Alisha Henson, Clinical Psychologist, Pembroke Psychological Services		
Simon Parker		
Michael Perstinger, Sergeant (Retired)		
Line St-Pierre, Psychologist		
Vector Medical Corporation	2026/05/25	34
Aaron North, President and Chief Executive Officer		
As an individual	2026/06/01	35
Natalie Forcier		
Joel Peddle		
The Ottawa Hospital	2026/06/01	35
Aaron Slingerland, Executive Director, Business Development and Strategic Partnerships		
As an individual	2026/06/03	36
Christopher Banks, Sergeant (Retired)		
Valhalla Visions Counselling Clinic	2026/06/03	36
Natalie Gillis, Licensed Counselling Therapist and Canadian Certified Counsellor		
As an individual	2026/06/08	37
Richard Brown		
Lifemark Health Group	2026/06/08	37
Dr. Steve Burton, Psychologist		
As an individual	2026/06/10	38
Eric Vila, Kinesiologist		
Union of Veterans' Affairs Employees	2026/06/10	38
Toufic El-Daher, National President		
Martha Josephian, Case Manager and Alternate Vice President		

APPENDIX B:
LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's webpage for this study.

1, Anonymous Author – Auteur anonyme

Anderson, Amanda

Avery, Garet

Banks, Christopher

Belopotocanova, Erika

Butler, Erin

Canada House

Corman, Clea

Deep 6 Gear

Eberspacher, Stefan

Gillis, Natalie

Henson, Alisha

Meneray, John

Miller, Jessica

St-Pierre, Line

Vector Medical Corporation

Wilcox, Samantha

Wood, Johanna

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 22, 26, 27, 30, 31, 34 à 38, 40 and 41) is tabled.

Respectfully submitted,

Marie-France Lalonde
Chair

Supplemental Report: Conservatives Call for Accountability and Improved Outcomes from PCVRS to Veterans

Introduction

It is with the extensive feedback from Veterans that the Conservative members of the Standing Committee on Veterans Affairs submit this supplementary opinion to emphasize the need for stronger accountability, transparency, and independent oversight of the rehabilitation services contract awarded by Veterans Affairs Canada (VAC) to Partners in Canadian Veterans Rehabilitation Services (PCVRS).

The transition to a national rehabilitation services model was intended to improve consistency, access, and outcomes for Veterans. However, the Committee's evidence show that the Government must do more to demonstrate, with independently verifiable evidence, that the contract is delivering the outcomes for Veterans and the value for money that were intended.

Throughout the study on the Rehabilitation Services Contract Awarded to PCVRS, the most common issues presented deal with the assessment, rehabilitation, and decision-making processes affecting Veterans.

Ensuring that Veterans receive decisions based on complete, accurate, and appropriately considered evidence is essential to maintaining confidence in the systems designed to support them. Where inconsistencies, gaps in communication, or procedural shortcomings exist, there may be unintended consequences for Veterans seeking assistance and rehabilitation.

The Conservative members therefore urge the Government to strengthen contractual oversight, increase transparency, ensure independent verification of performance and make demonstrated Veteran outcomes the central measure of success.

Transparent and Measurable Outcomes for Veterans

VAC has told the Committee that a Performance Measurement and Quality Management Framework provides information concerning contractor and departmental performance and that participant feedback is collected during the rehabilitation process. Government information also reports measures such as assignment of rehabilitation service specialists, intake timelines, assessment timelines and the commencement of rehabilitation services.

However, the Committee must be able to determine whether these measures accurately capture the experience and outcomes of Veterans.

The Conservatives therefore believe that VAC should provide the Committee with comprehensive, disaggregated and independently verifiable information concerning the PCVRS contract. This information should be provided in a manner that protects personal health

information while allowing Parliament to meaningfully assess the administration of public funds and the quality of services provided to Veterans.

The Committee heard questions concerning performance bonuses under the PCVRS contract. The evidence also raised broader questions about whether contractual performance measures adequately demonstrate whether Veterans are achieving meaningful rehabilitation outcomes. The Veterans Ombud specifically identified questions concerning whether Veterans are getting better, whether rehabilitation outcomes are improving and whether the contract is producing better service and value for taxpayers.

Measures such as processing speed, administrative compliance, and the completion of assessments cannot, by themselves, establish the success of a rehabilitation program.

Performance measures should not create incentives for a contractor to prioritize administrative throughput over the individual needs of Veterans. Conservatives believe that the Government should therefore ensure that any performance-based compensation is demonstrably connected to outcomes that matter to Veterans.

Maintain Access to Veterans' Existing Clinical Providers

The Committee heard evidence that Veterans' freedom of choice and access to specialized providers had been significantly narrowed with PCVRS, with non-affiliated providers or independent community clinicians being excluded from treating Veterans.

Veterans and clinicians had raised concerns about whether PCVRS was accountable for its clinical decisions and sufficiently guided by professionals who understand Veterans' care, and Veterans Affairs Canada should ensure stronger clinical standards and independent oversight are in place.

Clear and Effective Process for Complaint Resolution and Appeals

The Veterans Ombud told the Committee that 100 complaints concerning PCVRS had been received since implementation of the contract in November 2022. Of the cases investigated by the Ombud, six involved findings of unfairness; five were resolved following Ombud intervention and one was resolved by the Department before intervention.

Veterans may interact with multiple organizations during rehabilitation, including VAC case managers, PCVRS rehabilitation service specialists and community health-care providers. The Committee heard evidence concerning the complexity of navigating these systems and the importance of clear communication and access to support.

The Conservatives therefore recommend that VAC establish a clearly identified, independent, and accessible mechanism through which Veterans can raise concerns about PCVRS without fear that doing so will adversely affect their access to rehabilitation services.

Privacy, Consent and Control of Personal Information

The Committee heard evidence raising concerns about the collection, disclosure, and repeated use of Veterans' highly sensitive personal and medical information under the PCVRS rehabilitation model. Witnesses described Veterans being required to undergo multiple assessments and repeatedly disclose deeply personal information to access rehabilitation services. The Committee also heard that privacy requirements have resulted in Veterans using separate communication systems for Veterans Affairs Canada and PCVRS.

The Committee also heard from the Veterans Ombud that her Office had difficulty obtaining Veterans' files, reportedly because of privacy considerations, affecting its ability to conduct systemic reviews. At the same time, testimony raised the possibility of Veterans providing express authorization for access to their own records.

Maintain Veteran Affairs Canada's Ultimate Responsibility to Veterans

The use of a third-party contractor does not transfer the Government of Canada and Veterans Affairs Canada’s responsibility for ensuring that Veterans receive appropriate rehabilitation services.

While VAC has indicated that its case managers remain responsible for approving rehabilitation services, monitoring rehabilitation progress and coordinating the overall case-management needs of Veterans and their families, Conservatives believe this responsibility must remain clear to Veterans.

A Veteran should never be left uncertain about whether an issue is the responsibility of VAC or PCVRS. Where a Veteran encounters a dispute between the two organizations, VAC should remain accountable for ensuring that the issue is resolved promptly.

Recommendations

Conservative members of the Standing Committee on Veterans Affairs are proposing the following recommendations:

1. That Veterans Affairs Canada publish an annual accountability report for the PCVRS contract, and any other future contracts, to provide transparent information on contract performance, expenditures, performance payments, service access, complaints, participant outcomes and corrective measures, with appropriate redactions for sensitive and personal information.

2. That Veterans Affairs Canada establishes clear service standards for PCVRS, and future rehabilitation services contracts, that meet the needs of Veterans.

3. That Veterans Affairs Canada ensure that all performance-based compensation under the PCVRS contract, and future contracts are directly linked to outcomes for Veterans that meet service standards and does not create incentives that prioritize administrative volume over appropriate clinical care.

4. That Veterans Affairs Canada establish a clear, accessible and independent complaint and escalation mechanism for Veterans using PCVRS services, and publish information concerning complaints, resolution times, and corrective actions.

5. That the independent review of the Rehabilitation Services and Vocational Assistance Program and the PCVRS contract examine contractual compliance, Veteran outcomes, access to services, complaints, clinical independence, value for money, performance payments, and VAC's contract-monitoring practices.

6. That Veterans Affairs Canada obtain informed consent from each veteran before any personal information is disclosed to a rehabilitation contractor, informing the veteran of the recipient, the documents to be sent, their purpose, and the consequence of declining, and that Veterans do not lose program eligibility or the Income Replacement Benefit for declining to share specific personal information or document, and that a recorded restriction prevent transfer of the restricted document.

7. That Veterans Affairs Canada complete and publish a Privacy Impact Assessment and information-sharing agreement summary for the arrangement before any contract extension takes effect.

8. That, before renewing, extending, or substantially amending the PCVRS contract, Veterans Affairs Canada publicly demonstrate that the contract fulfills the service standards established and meets the needs of Veterans.

9. That Veterans Affairs Canada continue to ensure that VAC case managers retain clear responsibility for the overall rehabilitation journey and that Veterans have a single, clearly identified avenue for resolving disputes involving VAC and PCVRS, and other contracted service providers

Conclusion

Veterans who require rehabilitation services should not have to navigate uncertainty about who is accountable for their care, and they should receive the rehabilitation support and services they require with accountable and accurate communication from VAC and PCVRS providers.

The Conservatives believe that accountability must be measured in terms that matter to Veterans: timely access to appropriate care, meaningful rehabilitation outcomes, continuity of service, transparent complaint resolution, and responsible stewardship of public funds.

The Committee's study has provided an opportunity to examine not only the experiences of individual Veterans, but also whether the Government is delivering on the necessary care to Veterans and has established the oversight accountability necessary to manage a major public contract effectively.

The Government has commissioned an independent review of the program and the PCVRS contract. That review should be comprehensive, transparent, and focused on outcomes. Its findings should be used to strengthen the system and to ensure that any future contractual arrangement places the interests and rehabilitation needs of Veterans at the centre of service delivery.

The Conservatives therefore recommend that Veterans Affairs Canada use the independent review announced in August 2026 as an opportunity to examine not only administrative performance, but also the lived experience of Veterans, clinical appropriateness, continuity of care, accountability, and outcomes.

Most importantly, Veterans should not be required to navigate the government's contractual arrangements to obtain the care to which they are entitled. The system should be organized around the Veteran, with clear responsibility, independent oversight, and measurable outcomes.

The recommendations in this supplementary opinion are intended to strengthen those principles and provide Parliament with the information necessary to hold the department and its service providers accountable.