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# Standing Committee on Veterans Affairs

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Chair: Marie-France Lalonde





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Monday, February 23, 2026

• (1100)

[*Translation*]

**The Chair (Marie-France Lalonde (Orléans, Lib.)):** I call this meeting to order.

Welcome to meeting number 22 of the Standing Committee on Veterans Affairs.

Pursuant to the motion adopted on November 25, 2025, the committee is meeting as part of its study on monitoring of the rehabilitation services contract awarded to Partners in Canadian Veterans Rehabilitation Services, or PCVRS.

[*English*]

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. Members are attending in person in the room, and I know that three of our witnesses will be appearing by video conference.

[*Translation*]

Before we continue, I would ask all in-person participants to consult the guidelines written on the cards on the table. These measures are in place to help prevent audio and feedback incidents, and to protect the health and safety of all participants, including the interpreters, whom I thank.

To ensure the meeting runs smoothly, I would like to give some instructions to the witnesses and members.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourself when you are not speaking.

[*English*]

For those on Zoom, at the bottom of your screen you have the choice of selecting the appropriate channel for interpretation: French, English or floor.

Finally, I have a reminder that all comments should be addressed through the chair.

[*Translation*]

For members in the room, if you wish to speak, please raise your hand. The clerk and I will manage the speaking order as best we can. We thank participants for your patience and understanding in this regard.

I would now like to welcome our witnesses.

We are welcoming, by video conference, Marc-André Bernard, psychologist from Institut alpha, as an individual.

[*English*]

We also have, from Edgewood Health Network Inc., Mr. Shawn Carter, executive director, by video conference; and from the Veterans Transition Network, Mr. Tim Laidler, executive director, by video conference.

For our witnesses, I am the clock keeper. We will provide you with five minutes for your opening remarks. If I see that you are running out of time, I may have to interrupt you. As we start the rounds of questions, I will do the same. I am apologizing in advance if I have to interrupt your comments if the time has passed.

[*Translation*]

I'd like to apologize in advance to the three witnesses in case I have to interrupt them because their time is up.

We will start the presentations with you, Mr. Bernard. You have the floor for five minutes.

**Marc-André Bernard (Psychologist, Institut Alpha, As an Individual):** Thank you to the committee for inviting me back to speak on this issue, which is of great concern to me.

I have been helping military personnel transition out of the forces for almost 12 years. I have seen probably a hundred men and women make this sometimes difficult transition, which presents many challenges and can exacerbate their difficulties. I consider myself to be in a privileged position, as I am the only professional involved in their cases who can follow them through rehabilitation, and then into civilian life through the Department of National Defence.

As you are no doubt aware, for the past three years, the PCVRS, or rehabilitation services and vocational assistance program, has been responsible for rehabilitation. There have been significant changes in the way things are done, and I don't believe they're for the better, neither for the health nor the well-being of veterans.

I could give you numerous examples of questionable program operations that push bureaucracy to the point of absurdity, but I would summarize by saying that the program seems to exist for the sake of it, piling on administrative requirements that make the process extremely cumbersome and painful for veterans, and irritating and suffocating for professionals. It does nothing to promote continuity of care, starting from the apparent premise that veterans want to abuse the system and that professionals are incapable of being objective or ethical. The repetition of improvement measures is also counterproductive, intrusive and invasive.

By comparison, despite the fact that the pre-2023 system may have lacked oversight for some veterans, rehabilitation worked better and was less aversive. One of your witnesses, during the suicide reflection days, compared the process to parole. I think that's a perfect image. Veterans must constantly prove their injuries, justify their limitations and document their efforts, or else they are penalized.

I have never talked so much about the rehabilitation process in my therapy sessions as I do now, with veterans who are distressed, irritated, or frustrated with the program. This is not normal.

Just recently, a veteran I've been seeing for three years, who left the forces last October, chose not to go through rehabilitation for fear of exploding with anger at the demands of the rehabilitation services and vocational assistance program, the PCVRS. As a result, he currently has no services for his physical injuries and is being penalized on his income. I find this terrible. Is it the goal of the program to have veterans give up on rehabilitation?

Veterans are people from a Canadian subculture, that of the military. They have made an immense personal sacrifice for the country, regardless of what one thinks of the military or its commitments, and for some of them, this sacrifice has led to a permanent loss of health. The agreement with them, when they enlisted as recruits, was that we would take care of them at the end of their service, and making post-service care a bureaucratic and punitive maze is an insult to what they were promised.

They can sometimes be difficult to help, it's true. They may struggle with self-determination, which can lead to passivity or immobility. And they sometimes carry very significant psychological and physical wounds. Their rehabilitation therefore remains a challenge. Faced with this inertia and suffering, it can be tempting to impose a very rigid and strict framework, providing a lot of structure and flooding them with services. This is the approach that Lifemark and the PCVRS seem to have taken, and in my opinion, it is a mistake. Veterans are leaving a very demanding service. They need space, time, a relationship of trust, and above all, continuity.

I would recommend that continuity of care be reviewed and considered as the cornerstone of treatment, that assessments made within the forces or during the period of service be taken into account, and that veterans not be systematically re-evaluated by four different bodies—National Defence, Veterans Affairs, the PCVRS, and Manulife—not to mention assessments by professionals. Having to repeat your story ad nauseam without any real clinical justification can cause shame, humiliation and anger. I recommend that continuity of care also be applied to therapy, where veterans are currently advised to change psychologists when one is already assigned to their file.

I would like to see the non-personalized aspect of the program reviewed, as it doesn't protect the most vulnerable and suffering veterans from the forced and humiliating stages of reassessment and justification.

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 col-

leagues who worked with military personnel in rehabilitation have stopped collaborating with the PCVRS.

In closing, I would say that helping people is first and foremost about caring about them and wanting to understand and love them. Do Lifemark and the PCVRS really care about veterans? The current program clearly answers "no" to that question.

• (1105)

**The Chair:** Thank you very much, Dr. Bernard. We are always happy to welcome you here at our committee.

[English]

I will now pass the floor to Mr. Shawn Carter, executive director of the Edgewood Health Network.

You have the floor for five minutes, sir.

**Shawn Carter (Executive Director, Edgewood Health Network Inc.):** Madam Chair and honourable members, thank you so much for allowing me to speak with you today.

My testimony is going to focus on providing a bit of context as to how veterans are treated in the environment that I support.

[Translation]

**Marie-Hélène Gaudreau (Laurentides—Labelle, BQ):** I have a point of order, Madam Chair.

Unfortunately, the poor sound quality doesn't allow the interpreters to adequately do their work.

[English]

**The Chair:** I will ask our witness, Mr. Carter, to say a few words about the weather, just to see if we can find a better network connectivity so we can interpret his comments here in Ottawa.

**Shawn Carter:** I'd like the weather to be spring. I am tired of the snow. Today it's quite sunny, so it was a nice drive into the office. We'll be getting some poor weather over the week, at least here in Ontario.

Is that better?

**The Chair:** Yes, I have the thumbs-up. I know we did the test earlier, so I apologize. I will ask you to start from the beginning.

**Shawn Carter:** Thank you again for the opportunity to speak with you today.

My name is Shawn Carter. I'm the executive director of EHN Canada and the head of one of our EHN Guardians treatment centres, which exclusively serve members of the Canadian Armed Forces, veterans and first responders. I also serve as national director of our treatment programs across the EHN Guardians network to ensure the standardization and delivery of clinical excellence in these important segments.

I'm here today on behalf of our organization and, more importantly, on behalf of the veterans we are privileged to serve through the PCVRS program.

EHN Canada is a national provider of in-patient and outpatient mental health, addiction and trauma treatment, with specialized programs delivered across the country in both English and French. Within EHN, our EHN Guardians programs are intentionally designed to provide culturally competent, trauma-informed care specifically for military members, veterans and first responders.

I hope this testimony provides a bit more information about how that's done and how that's done well. These are not modified civilian programs. They're purpose-built environments shaped by an understanding of service culture, operational trauma, moral injury and the realities of life after service.

One of the most important lessons we've learned as an organization is that how care is delivered is just as important as what care is delivered. Many veterans arrive in treatment, at least from our perspective, with prior experience in things like institutional harm or perceived institutional betrayal. When systems that are meant to protect or support instead feel unpredictable, opaque or dismissive, that experience can mirror earlier trauma and significantly undermine trust and engagement in care. This is sometimes referred to as sanctuary trauma. Preventing it requires organizational commitment, and not just at the individual clinical level or technician level.

At EHN Guardians, trauma-informed principles are embedded at a systemic level from intake to treatment to discharge and beyond. This includes predictable expectations of the care process, clear communication, transparency about decisions and respect for autonomy and veterans' voices. Veterans are actively involved in their care planning, and feedback mechanisms are built into programs so that concerns can be raised safely, without fear of negative consequences.

Consistency and transparency are particularly critical with the veterans we serve. Veterans are understandably sensitive to sudden changes in rules, staffing assignments or treatment plans. When change is unavoidable, we prioritize clear explanations and dialogue. When mistakes occur, as they inevitably will in any system, we focus on and acknowledge the impact. We take responsibility and make meaningful corrections.

Equally important is how we support our staff. Sanctuary trauma is far more likely to occur in environments where staff are burned out or unsupported by the system. We invest in the recruitment of culturally competent clinicians and in ongoing training in trauma- and veteran-informed care, and have reflective supervision structures that allow staff to manage the ethical and emotional weight of this work. We really do believe that healthy systems create safer care.

Our partnership with PCVRS reflects these same values from our perspective. We do not see ourselves as owning a veteran's journey. Instead, we see our role as one part of a broader continuum of care. Marc-André spoke to this being really important. We see this happening in collaboration with Veterans Affairs Canada, community providers and families.

That collaboration is operationalized through structured touchpoints within treatments, including introductory calls, medical assessments, midpoint progress reports, discharge planning confer-

ences and discharge summaries. These processes help ensure continuity, accountability and a shared understanding.

We also believe strongly in continuous improvement. When something isn't working as well as it should, we course-correct. One example is the recent collaboration that was initiated with PCVRS to strengthen step-down and transition supports, recognizing that a particularly vulnerable time for many veterans is when people are discharging out of intensive treatment. Another is the enhancement of our EHN Guardians family program, developed in response to the clear need to better support families, who are often carrying a significant and unseen burden alongside their loved one.

From a service delivery perspective, the veterans we support through PCVRS present with complex and overlapping needs. A significant proportion experience concurrent trauma and addiction, requiring integration and specialized care. Others require targeted trauma therapy and processing, addiction-focused treatment or structured outpatient interventions. The PCVRS program and the care we deliver are important in meeting these diverse needs across in-patient and outpatient settings.

In closing, I want to emphasize this: Veterans do not need perfection from the systems that serve them, but they do need consistency, transparency, respect and genuine partnership. 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. We are grateful for the opportunity to contribute to this work, and we remain committed to learning, adapting and constantly evolving to better serve our Canadian veteran population.

● (1110)

Thank you for your time and for your continued attention to the mental health and well-being of Canada's veterans and their families.

● (1115)

**The Chair:** Thank you very much, Mr. Carter.

Our last presenter, from the Veterans Transition Network, is Mr. Tim Laidler, executive director, by video conference.

**Tim Laidler (Executive Director, Veterans Transition Centre):** Hello, everyone. Thanks for having me.

I have a small correction. I'm actually with the veterans transition centre. I was part of the Veterans Transition Network's founding team. Oliver Thorne may have presented, or will be presenting, for the network. He is still a good friend of mine and doing very good work.

Coming here, my perspective is twofold. One is as a veteran. I served in Afghanistan in 2008. I went back to school and got a master's degree in counselling psychology, so I'm now a trained counsellor. I'm working with veterans on their journey back to civilian life and overcoming trauma.

I wanted to give a very veteran take on this. What we're talking about today is a contract that PCVRS received. I have the numbers: It's \$600 million that the Canadian government has given to PCVRS. From the veterans I've worked with and from my own experience.... We had one case manager at Veterans Affairs before this contract, and that was somebody you could go to to help you access your benefits. When you were applying for things, they helped you navigate the system. We now have two case managers. One is from Veterans Affairs and one is from PCVRS.

If that's not enough bureaucracy, because of privacy concerns, we're told that we're not allowed to be emailed by either of these groups, so we have to get a separate log-in for email communication with Veterans Affairs through the My VAC account. There is one password and email you have to remember and check frequently. You then get a second one from PCVRS, so you have a separate log-in and email there. Now you have two emails you have to remember passwords for and regularly check to make sure you're not missing any important information.

I want to try to highlight for the committee the experience of a veteran and the stress of going through this new program with PCVRS. 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.

Put yourself in the shoes of a veteran. Maybe you've had a response to some traumatic event. You've found your coping mechanisms, you're out of the military and you're looking for a new career. You are now thinking, "Okay, I'm getting government support through this income replacement benefit, but I'm also being told that I have to go to counselling a certain number of times and have to go to physiotherapy. What if there's a snowstorm and I can't make it to my session? If I miss this physiotherapy [*Technical difficulty—Editor*]"—

**The Chair:** Mr. Laidler, I'll have to interrupt you, as we're having some connection issues this morning.

I apologize to our interpreters.

Maybe go back to a few of the sentences you had shared with us.

**Tim Laidler:** I would like to highlight for the committee the experience of the veterans going through this new PCVRS program and the stress of potentially losing their income replacement benefits. These are the monthly benefits you receive while taking part in the vocational rehabilitation program that's now administered by PCVRS.

There is also the fear of missing an email from your VAC case manager. You're checking one email. You're missing the email from your PCVRS case manager. There was a snowstorm in Edmonton the other week, and a bunch of clients had to miss physio appointments. They were all worried that they were going to lose their monthly payments because they're being told by PCVRS case managers that participation is mandatory, that it's not voluntary. 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.

I'll also take a step back and talk a bit about trauma and PTSD. I've done a master's in counselling psychology at the University of British Columbia under Dr. Marv Westwood, who has done decades of work with veteran trauma.

The way PTSD is approved for benefits is that it has to have some sort of negative impact on your daily life. A veteran who has gone through a high-stress career, has good support mechanisms, is maybe having nightmares, is having hypervigilance, is avoiding things that remind them of military exposure to trauma.... These things can all exist, but if they're coping, if they have a job and if things are not getting in the way of their daily life on paper, they're not entitled to benefits and support.

As counsellors, we're trying to work in those supports and get people to overcome their traumas. That's part of the goal of trauma therapy. However, with the Veterans Affairs program, if you get healthy in the PCVRS journey and go back to your case manager and say, "Oh my gosh, I think I'm doing really well. I'm feeling really good. I had some great counselling sessions. I'm feeling confident again. Things are starting to look up", they will say, "Fantastic. You're now employable, and you're also kicked off the program." There's a negative incentive for veterans to worry about reporting being healthy for fear they're going to lose their monthly benefits.

There are lots of solutions we could put forward here. We're counselling veterans and trying to get them to feel positive about the future. We're trying to get them into career training. They're always concerned about their financial health and stability, because there's no clear, certain point you hit to go off your benefits. It is always this unknown area and this fear that triggers PTSD, and it keeps veterans suppressed. It's not a good system. We need to change it.

The last and most important piece I want to focus on is in terms of the retraining itself. There's a policy that PCVRS has—and I don't know if it's coming from Veterans Affairs—that is potentially the most detrimental policy we have in the system, wherein you're only allowed to be retrained back to the salary you had when you released from the military.

• (1120)

**The Chair:** Mr. Laidler, you were cut off from our connection. I have to apologize, but you're taking a bit of extra time. I had allowed about 30 seconds. I will have to interrupt you. I'm sure that some of our colleagues will come back to you during questioning.

I hope we're able to get a proper connection with Mr. Laidler.

Thank you very much, sir, and thank you for your service.

During this round...the three of you are here by video conference.

[Translation]

It's important to respect the speaking time.

[English]

For our first round, each member will have six minutes. I will interrupt if you exceed that. I want to be very candid this morning and say that we'll be very respectful of our time.

Mr. Tolmie, you have six minutes.

**Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC):** Thank you, witnesses, for your testimony. It was very enlightening, and it was very disappointing to hear some of the things you brought forward.

I'd like to start off with you, Mr. Carter.

Mr. Carter, PCVRS claims that veterans have access to a broader network, but VAC's April 2023 bulletin says that new referrals will not go out to PCVRS providers. In some areas, there's only one PCVRS clinic.

How does limiting veterans' choice to essentially one provider improve access, in your opinion?

**Shawn Carter:** That's a great question. Thank you.

I'm speaking from our perspective as the provider. We have access to services across the country with a lot of different in-patient treatment centres and outpatient treatment. When people are referred to our organization, we are able to direct them to the place that makes the most sense. Sometimes it makes the most sense that it's geographical, and sometimes, perhaps, a veteran doesn't want to be treated in the community they live in. Providing that flexibility is really important.

I understand your point in terms of when someone has limited options, but from our perspective, we are able to offer flexibility. I absolutely acknowledge that in some cases, this wouldn't be the case and it would leave the veteran with not many choices or no choice over where they receive the care they're looking to receive.

**Fraser Tolmie:** Thank you.

Mr. Laidler, in your testimony, you mentioned the \$600-million contract. From the people who have reached out to me and my of-

fice, we're hearing they have to continually go in and are having numerous appointments. This has been brought up in each testimony.

Do you think the contract with PCVRS is trying to validate their contract with the government by showing the number of appointments, as opposed to the proper care that should be provided to veterans?

**Tim Laidler:** Yes, I do, absolutely.

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.

I don't know the motivation, but it seems highly suspicious that there are so many assessments being done. I'm very curious about how much money is being spent on a veteran just to assess them. I would compare how much is actually going toward treatment with what's going toward all of these assessments.

• (1125)

**Fraser Tolmie:** That's actually what I was looking for in your answer, so I appreciate that.

You mentioned consistency. I think that's important, but I also think competency is important. There seems to be a lack of competency in any care that's being provided to veterans who are struggling. I heard that in Mr. Bernard's testimony.

Mr. Bernard, you touched on institutional harm, and then Mr. Carter touched on it. We've been dealing with sanctuary trauma in Veterans Affairs testimonies for the four and a half years that I've been here. Now we're not only putting veterans through sanctuary trauma through VAC; we're actually contracting it out through PCVRS. I'd like to hear more of your thoughts on that.

**Marc-André Bernard:** Are you talking to me?

**Fraser Tolmie:** Yes. That sounds like a movie line: "Are you talking to me?"

**Some hon. members:** Oh, oh!

**Marc-André Bernard:** I agree that with the way things are being handled now, we are sometimes doing way more harm to veterans than we are helping them. I have a few recent examples of people who deteriorated during the program because of the incessant assessments by new people they didn't know. It touched on the absurd.

People have been known for years that they could have avoided a lot of steps. They were forced to be assessed by someone new who assessed something completely different from what I would have assessed, and the PCVRS has had to hire me again to assess them a second time because they could not go through the system with the recommendations of the new psychologist.

I feel it is borderline absurd to put people through this. I absolutely agree with everything Mr. Laidler said. I think those assessments have an administrative goal to them, certainly not a clinical one.

**Fraser Tolmie:** With just a short answer, would you agree that the PCVRS contract is just to get points rather than to provide care?

**Marc-André Bernard:** It does appear so.

**Fraser Tolmie:** Thank you.

[*Translation*]

**The Chair:** Thank you very much.

[*English*]

Now, for six minutes, we'll go to Monsieur d'Entremont.

[*Translation*]

**Chris d'Entremont (Acadie—Annapolis, Lib.):** Thank you, Madam Chair.

[*English*]

First of all, I just want to say it would have been great to have PCVRS here so we could have received some data from them prior to opening up the discussion, because now we're doing this a little backwards.

The presentations we're having right now are very good. They give us an idea of how the veterans accessing the program are experiencing it. It's important for us to understand how the 12,000 individuals accessing the program are actually seeing it.

[*Translation*]

Mr. Bernard, can you give us more details about the bureaucratic burden in the system and tell us how often you have had to conduct assessments and manage waiting lists?

**Marc-André Bernard:** 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.

The form is often sent back to me several times for terminology and compliance issues. I end up spending an enormous amount of time on these forms, which serve no purpose. 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.

I can give you an example. I know someone who works with veterans and is very concerned about suicide risk among them. Every time he sees them, he asks the same questions about suicidality, substance use and fear of violence.

After being asked the same questions, what do you think veterans are going to do? They're going to end up lying because they won't want to answer that kind of questionnaire again. Constantly reassessing a veteran's progress by making them fill out questionnaires that make no sense is going to end up giving PCVRS false positives, because veterans don't want their benefits reduced and they're tired of answering the same questions.

I think it's this form of bureaucracy that complicates everything and doesn't give a true picture of what veterans are experiencing.

• (1130)

**Chris d'Entremont:** Do you find that PCVRS provides bilingual or francophone veterans in Quebec or other regions of Canada with the French-language services they need?

**Marc-André Bernard:** No, because they absolutely want the services to be given by approved providers of their program. To be a provider, you have to jump through all kinds of administrative hoops.

A veteran I know—I was seeing him at the Department of National Defence—wanted to receive in-person follow-up in Quebec City. PCVRS refused, but they were never able to find him a service provider.

In the end, the veteran was sent back to me; I have to see him remotely, because they aren't able to find anyone to see him in person.

[*English*]

**Chris d'Entremont:** Thank you for that.

I want to go quickly to Mr. Laidler. He was talking about the issue of being retrained only to the level they were paid in service.

I want to give you 30 seconds or more to flesh that one out before we move on.

**Tim Laidler:** Thank you. I appreciate it.

It's a problem, and it's a major difference between the U.S. and Canadian programs. In the U.S., they see their military as a tool of social mobility. They encourage people to join the military, and there are robust education and training programs available to them through the GI Bill after service.

In Canada, if you're injured, they will pay for you to get retrained, but only back to the salary level at which you left the military. Let's say you have some PTSD symptoms, you overcome them and you pay to do your own schooling. If five or 10 years after your release you have some issues, lose your job and go back to the government for support, PCVRS will not pay for you to be trained, because they'll say you're already employable to a level beyond what you were making in the military.

This is that moral betrayal. You think, "The government is going to be there to help me, and Veterans Affairs is there to help me", but there is no help, because you've managed to cope on your own and get your own training.

**Chris d'Entremont:** In your presentation, you talked about the bureaucratic issues of having to have two systems when you're signing on to VAC and PCVRS. You have to have two sign-ups.

This leads me to a bigger question. We seem to lump all veterans into just being veterans, but there are veterans in rural Canada versus veterans in urban Canada, and veterans in the east versus veterans in the west. They all have different requirements and treatment programs.

I'm wondering if you can talk about those two issues.

**Tim Laidler:** As has been said, these assessments, especially, are very long. Not everybody has a room in their home they can go to. Not everybody knows how to use Zoom and video conferencing. These are all administrative issues that add stress and aren't necessary.

Phone calls with clients could be easier, but when they're so long, it is punitive to people living outside major urban centres, who maybe don't have the same Internet speeds or the same connections. They're all being forced to relentlessly check these email systems and log in. Heaven forbid you forget your email password and you have to go through IT.

Especially for veterans who are in their senior years and are losing their jobs in their sixties because of service-related injuries, it's very difficult to manage this system.

**The Chair:** Thank you very much.

• (1135)

[Translation]

Thank you very much, Mr. d'Entremont.

We're now going to turn it over to Ms. Gaudreau.

[English]

For those on video conference who are anglophones, Madame Gaudreau will be addressing you in French, so make sure your little button has the right option.

[Translation]

Ms. Gaudreau, you have the floor for six minutes.

**Marie-Hélène Gaudreau:** Thank you, Madam Chair.

Again, not only am I learning a lot, but I'm also hearing a lot about this, because veterans talk to me. I hear the word "absurdity". I hear that people are afraid of losing their income replacement benefits. I hear that they have to redo everything they've already done once every time, which is unnecessary.

Honestly, I'm starting to wonder why we're here.

First, we have to raise the problem.

Then, we have to act.

I'm very disappointed. I'm not pessimistic, but I think there's a heartfelt cry here. Can we, once and for all, focus on veterans, and use statistics and data to make a serious change for the sake of our veterans? I truly hope we're going to take action.

To the veterans listening, I want to say that the committee doesn't disagree that changes need to be made. Unfortunately, your presence is required for that, and I thank you for it.

I'll start with a question for Dr. Bernard.

I was talking about the fear of losing income replacement benefits. Is that apparent in your hundreds of meetings with veterans?

**Marc-André Bernard:** Absolutely.

This has become one of the most obvious issues in recent years since Partners in Canadian Veterans Rehabilitation Services, or PCVRS, took over. Not only does this fear exist, but it's also a reality.

I can give you a very concrete recent example.

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. I find that kind of request absurd. In other words, if you don't meet the program's requirements, even if the purpose of the program is to send veterans to a vocational course, they tell them to do something else, which ends up reducing their income.

Veterans are very afraid of this transition. It's not just about mental health; it's about the transition to civilian life. It's very difficult, and it requires a lot of adjustment. It seems as though PCVRS isn't very aware of what this means for veterans in terms of the burden of self-determination.

**Marie-Hélène Gaudreau:** What I'm seeing is that not only is it a matter of willingness... I'm just looking at Quebec. I worked for people in semi-skilled training. They were never subjected to cuts in the support provided to them.

You could say that there aren't enough people equipped to provide the services. Honestly, if we fixed 80% of the red tape problems, do you think we would have made huge progress? I'd like an answer from each of you in the two and a half minutes I have left.

Please begin, Mr. Bernard.

**Marc-André Bernard:** I think a lot of the suffering caused by the process would certainly be resolved.

As Mr. Carter said, services must be provided by people who know veterans well and are tailored to veterans.

However, I believe that the bureaucratic process makes veterans regress, even those who had reached a much better level of functioning in therapy through defence rather than through the rehabilitation process.

Yes, I think the bureaucracy causes a huge loss of trust and re-traumatization because of the system.

**Marie-Hélène Gaudreau:** I'm hearing the word "traumatization".

I'd like to hear from Mr. Carter.

[English]

**Shawn Carter:** I think everything being mentioned is absolutely fair. Again, I'm speaking from this very narrow window in the veteran's journey, when they're the folks who need the highest level of care for the most intense symptoms they may be struggling with.

Some of the feedback that's been shared is about the confusion on their part of who is PCVRS and who is VAC at that point. They're struggling with an immense level of symptomology, whether it's from an addiction standpoint, a trauma standpoint or a depression standpoint—or comorbidly all of those. There's a lot of confusion about what is the role of VAC versus that of PCVRS. Some of the feedback we get as well—

• (1140)

[Translation]

**Marie-Hélène Gaudreau:** Madam Chair, the connection isn't good. I did hear Mr. Carter, but I'd like it checked for the remainder.

Since I have a few seconds left, I would also like to hear Mr. Laidler's response.

[English]

**Tim Laidler:** Picking up on what Shawn was saying there, he asked who PCVRS is. I've thought about that before, so I googled it. It's a joint venture—and this maybe goes to the motivation—between Lifemark Health Group, which is owned by Loblaw, and another company, WCG International Consultants, which is owned by an Australian firm. It seems that this Australian firm was just acquired on the stock market in 2024. I don't know. Maybe getting a \$600-million contract helped this Australian company with this acquisition or something. I'm not an expert in this sort of field, but Loblaw is a big company.

I think somebody said that PCVRS is going to come present some data after. I'm sure it's going to be a very impressive, very well-researched and well-funded presentation. The three of us here are volunteering our time and putting things together the best we can. I know that other committee members are doing the same.

If you really wanted to compare things, I think some sort of funded review of PCVRS's contract is going to get you better answers than what we're trying to do here today.

**The Chair:** Thank you very much to the three of you.

We'll go on to our second round. We'll probably have about 12 and a half minutes, or maybe a bit more. I'll see.

For five minutes, we have Ms. Wagantall.

**Cathay Wagantall (Yorkton—Melville, CPC):** Thank you, Chair. I thought you were giving me 12 and a half minutes.

**Some hon. members:** Oh, oh!

**Cathay Wagantall:** First of all, Mr. Laidler, I'd like to ask you a couple of questions. On our sheet, it says that your organization is Veterans Emergency Transition Services. Is the word “emergency” in your name?

**Tim Laidler:** No, that's a different organization, VETS Canada. They do work with homeless veterans.

**Cathay Wagantall:** That's exactly what I thought.

Going back, that particular organization helps veterans in an emergency. It is interesting that when the government put out a \$1-million emergency fund for VETS Canada, it was taking two weeks to a month to get this emergency funding out to veterans. They came to the realization that they needed to cut around their own bureaucracy and just simply give it to VETS Canada, which got it out to veterans across the country in a matter of 24 hours.

I look at what's happening here. We're talking about bureaucracy and about the fear created by PCVRS before anything ever gets to those of you who are providing services. I will say that we are doing the right thing by having you here today, first of all. Our veterans, I'm sure, appreciate that as well, because they don't trust the system.

Would it be your analysis that we are basically creating a huge bureaucracy, when you as service providers could write up something about who you are, we could put it in a catalogue and distribute it to our veterans, and they could find someone nearby who does what they need and provides the service in a timely manner? What's your perspective on that, Mr. Laidler?

**Tim Laidler:** The service providers are there. If we just cancelled the contract—I think it's up for renewal later this year—we'd have \$600 million saved. It would not cost that much to go out to the private practices that are seeing veterans on a regular basis, give funding for some training and cultural competencies—I know that Marc-André and Shawn's groups are doing it—and ask them to provide a report. It could be simple. It could just say what retraining they recommend. I think we'd save ourselves a lot of time and a lot of money doing it that way.

**Cathay Wagantall:** This conversation around a policy that we're not sure who it's being put forward by that only allows our veterans to retrain to the level they were at when they left the service sounds incredibly discriminatory to me and based on rank, because obviously someone who leaves with a higher rank is going to be able to earn more money. Regarding the chain of command from the top to boots on the ground, those who are serving on the ground would suffer the most. What is your perspective on that?

Shawn, Marc-André and Tim, just very quickly, is this what's best for our veterans?

• (1145)

**The Chair:** Identify one, please, Cathay.

**Cathay Wagantall:** Can I identify only one at a time?

**The Chair:** Start with one.

**Cathay Wagantall:** Let's go with Shawn on the services that you provide, please.

**Shawn Carter:** With the services I provide, what's important to consider in their journey in the long term is that if there's a goal for them to retrain and to re-enter the workforce, we also have to factor in what may be potentially injurious to them in terms of the conditions they now struggle with because of the service and the things they've endured in the service.

A really key point is that if we're limiting them by income and things like that, it could have a really big impact on the type of work they choose. It could potentially cause more harm if they're forced into a particular category.

That's about all I can speak to on our end, because we're really early in the—

**Cathay Wagantall:** I appreciate that. I'm sorry, but I'd also like to hear from Marc-André, if possible.

**Marc-André Bernard:** I've had a few people recently who identified programs that were good for them and that they wanted to do, but it would take too long to be admitted, or they couldn't start before leaving the army. There are so many rules for applying to or starting them that it's almost impossible for people to start them at the beginning of the readaptation program. Then, if the time is exceeded, they're penalized and it's not authorized by the system. It's very limiting what they can actually do once they go out.

**Cathay Wagantall:** Tim, do you have any comments on that as well?

**Tim Laidler:** It's discriminatory because, remember, veterans are medically released from the military if they get injured. If they get injured as a private serving overseas and they release, their retraining can be only to the salary of a private. When I was in Afghanistan as a corporal, I was making \$42,000 a year in 2008. I released after that. The vast majority of people who leave the service early get the least amount of support.

**Cathay Wagantall:** On the distrust fact, veterans who have come to speak to us spoke of baring their souls because of the requirements to do this—otherwise they don't qualify for their funding—and I found out that their information has been shared by VAC without their consent—

**The Chair:** Thank you very much. I'm sorry, Ms. Wagantall. You're a few extra seconds over.

For five minutes, we have Ms. Hirtle.

**Alana Hirtle (Cumberland—Colchester, Lib.):** Thank you, Madam Chair.

Good morning, gentlemen. Thank you for being here today.

I'll start with Mr. Carter. Based on your experience working with veterans, can you identify the impact the centralized PCVRS service delivery model has had on veteran care, please?

**Shawn Carter:** There are three main things, and I'm really working hard to stick to the feedback that veterans have given us and what we've heard in terms of their voice.

One is the confusion I mentioned before: “Who is PCVRS and how are they supposed to be supporting me?”

Another is the approval process. Prior to 2023, there was a quicker, direct link to receiving approval for things like in-patient

treatment or other comprehensive mental health services. Now they describe it as an extra hoop to jump through, which can delay them from getting into the necessary treatment they require.

Then, as well discussed already, there's the assessment burden. The feedback we receive is that they've had to bare their souls and be assessed by multiple people to get access to treatment. While that provides us with a lot of detailed information to admit them and support them in our care, that has to be balanced against the amount of information we're asking of these folks and the risk of retraumatization as well.

**Alana Hirtle:** Can you explain your understanding of the trauma-informed approach and how you ensure that your programs are using it in your service delivery?

**Shawn Carter:** As I mentioned, it's in the hiring practices, and organizationally it's what we embed in policy in the ways we treat people.

We also follow the SAMHSA six principles that guide trauma-informed care, which really focus on safety, trustworthiness, benefiting from the peer support that's available, collaboration, and empowering them to make their own choices throughout the treatment journey. It's also about recognizing the cultural and historical contexts these folks come from, knowing that many of us ourselves have not served in the military, but being really aware of that history, with the goal of always trying to do little harm and in every way possible not retraumatize.

• (1150)

**Alana Hirtle:** Are any of your staff veterans?

**Shawn Carter:** We have a mixture of people with lived experience. We also serve people other than veterans, including community first responders in our Guardians programs, and we certainly have a robust alumni department, which has people who've served in the military or as community first responders. Even within our sites, I would call it more of a sprinkling than a robust inclusion of that, but centring the clients' voices while they're in treatment and learning from the veterans in our program are central to ensuring that we are doing as little harm as possible, of course.

**Alana Hirtle:** That's great. Thank you.

Earlier, you mentioned family programs. Of course, we all know that veterans don't serve alone in their service. Can you give us a bit more information about these family programs and what they entail?

**Shawn Carter:** Of course. It's something we recognized recently as critical, knowing that folks don't serve within a vacuum and that their families are really impacted by these individuals' service. We have this window during in-patient treatment, for example, where it's an added layer of stress for families to have their loved ones leave and potentially go geographically quite far away from home. They lose access to the support the veterans themselves provide to their families.

Our programs focus more on providing connections between family members and other family members who are struggling in similar ways. We provide access to individual therapy by people who are culturally informed and are able to provide those services. It's also about being able to provide them with the resources they need to understand the conditions their veteran loved ones may be struggling with, provide them with as many resources as possible and connect them to the community resources that exist.

**Alana Hirtle:** Thank you.

I'll direct my last question to Dr. Bernard.

Are there care needs, like trauma care, PTSD care and peer support, that are not receiving the level of attention or care that you feel they need in order to ensure that veterans are receiving a well-rounded and fulsome level of support?

**Marc-André Bernard:** From my perspective, I can speak to the idea of continuous care and the idea that building a trusting relationship is very hard. The system now encourages people to cut ties with current psychologists and start all over again. In the journey of the veteran, I think maintaining the person where there's trust would be much more beneficial.

I can assure you that as psychologists, we are not biased toward profiting from the system by having the vet not do better. I don't see any reason that vets should be cut from existing therapeutic relationships that they feel are good for them.

[*Translation*]

**The Chair:** Thank you very much, Dr. Bernard.

Ms. Gaudreau, you have the floor for two and a half minutes.

**Marie-Hélène Gaudreau:** Dr. Bernard, you spoke about the amount of time that has to be spent writing burdensome, even pointless, reports, in your opinion.

Have you assessed the quality and effectiveness of the services provided?

Have you been asked to do an assessment?

**Marc-André Bernard:** Are you talking about the services I provide?

**Marie-Hélène Gaudreau:** I'm talking about your relationship with the consortium. Did it ask you any questions? Are veterans satisfied with the service?

**Marc-André Bernard:** No, I've never been asked that question, but I have made sure to indicate in my forms when the program was harmful to veterans. In fact, I did that this morning. I've never been asked whether the program, in its current form, was beneficial. 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.

• (1155)

**Marie-Hélène Gaudreau:** So it would be worthwhile to look in to whether an assessment is being done. You may have missed it, or it may not be systematic.

How can we correct the situation if there's no assessment? At the Standing Committee on Veterans Affairs, we have to do the assessment that the department should have done in order to rectify the situation. So how can we show that the bureaucracy is too cumbersome, correct the situation for the practitioners, who need specific expertise in this area, and ensure continuity of services?

Thank you very much for your testimony, which is very helpful to us. If you have any statistics, we would be grateful if you could send them to the committee. Personally, I know I will need them.

**The Chair:** Thank you very much, Ms. Gaudreau.

On behalf of the committee,

[*English*]

Dr. Bernard, Mr. Carter and Mr. Laidler, thank you very much for participating. I know there was short notice for changing your schedule.

[*Translation*]

Thank you for taking the time to join us as we begin this study.

Colleagues, our next meeting will be on Wednesday, February 25, 2026. We will be resuming our study on the obstacles to entrepreneurship among veterans.

That concludes this meeting. As you know, over the next hour, the members of the Subcommittee on Agenda and Procedure will be meeting in camera.

The meeting is adjourned.







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