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Chair: Marie-France Lalonde



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• (1100)

[*Translation*]

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

Hello everyone. It's a pleasure to welcome you to this meeting.

Welcome to meeting number 26 of the House of Commons Standing Committee on Veterans Affairs.

Pursuant to Standing Order 108(2) and the motion adopted on November 25, 2025, the committee is meeting as part of its study on the monitoring of the rehabilitation services contract awarded to PCVRS.

[*English*]

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. This morning, all our witnesses and members of Parliament are here in person. I will ask all participants to consult the guidelines written on the cards on the table. These measures are in place to help prevent audio feedback incidents and to protect the health and safety of all participants, including the interpreters. We thank them all the time.

[*Translation*]

Thank you, dear interpreters.

[*English*]

You will also notice a QR code on the card, which links to a short awareness video.

[*Translation*]

To ensure the meeting goes smoothly, I'd like to provide some guidelines to the witnesses and members.

Before speaking, participants must wait for me to recognize them by name.

As I mentioned, I don't think anyone is joining via Zoom today. Those in the room can use the headset and choose the desired channel to listen to interpretation. All comments from members and witnesses must be made through the chair.

[*English*]

Before introducing our witnesses, I would like to briefly discuss a supplementary budget that was distributed to the committee on March 16. The purpose of this budget is to fund the last few meetings for our study on suicide prevention among veterans.

Is it the will of the committee to adopt the budget?

Some hon. members: Agreed.

[*Translation*]

The Chair: Thank you very much.

We will now start the study on the monitoring of the rehabilitation services contract awarded to PCVRS.

I'd like to welcome our witnesses, who I thank for being here.

We have officials from the Department of Veterans Affairs: Jane Hicks, acting senior assistant deputy minister, service delivery; Jonathan Adams, director general, finance; and Nathalie Pham, director general, field operations.

[*English*]

From Lifemark Health Group, we have Sonya Lockyer, president.

[*Translation*]

We're also welcoming officials from Partners in Canadian Veterans Rehabilitation Services: Dr. Sylvie Bourgeois, medical director, mental health; and René Deschamps, vice-president, veterans health and PCVRS contract manager.

It's a pleasure to have you here.

[*English*]

From WCG Services, we have Tania Bennett, chief executive officer.

[*Translation*]

Witnesses, we'll start with your opening remarks. Then we'll proceed to a series of questions from the members of the committee.

I'd like to invite the acting senior assistant deputy minister, Ms. Hicks, to speak first.

[*English*]

Jane Hicks (Acting Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs): Good morning, Madam Chair, and thank you to the committee members for the opportunity to appear today to provide an update on the rehabilitation services contract.

My name is Jane Hicks, assistant deputy minister responsible for the service delivery branch at Veterans Affairs Canada. Joining me today are Nathalie Pham, director general of field operations, and Jonathan Adams, director general of finance.

[Translation]

The Veterans Affairs Canada rehabilitation and vocational assistance program plays a central role in supporting veterans and their families as they transition to civilian life.

The program offers personalized support to veterans who are ill or injured to help them overcome barriers to reintegration by providing medical, psychosocial and vocational services designed to improve their health and well-being.

[English]

It has now been over two years since VAC transitioned to a new rehabilitation service delivery model, working with Partners in Canadian Veterans Rehabilitation Services, or PCVRS. Under the previous model, case managers coordinated services directly with individual providers. This often led to inconsistencies regionally, fragmented care and significant administrative burden to case managers.

The current model moves to a nationally coordinated, interdisciplinary approach. Rehabilitation specialists coordinate services through PCVRS, allowing VAC managers to focus on oversight, veteran support and rehabilitation outcomes. The new model also ensures standardized assessments, reporting tools and access to specialized rehabilitation expertise across the country. This is particularly important as veterans' needs become more complex, especially in the area of mental health.

[Translation]

Veterans have experienced changes during this transition. They continued their rehabilitation while new processes and specialists were being put in place. Our priority has been to ensure continuity of care throughout this period.

[English]

Throughout the rehabilitation journey, we have actively sought feedback from participants and monitored program outcomes. While it is still early, results are encouraging. More than 70% of participants have reported improvements in functional capacity or overall health and well-being.

At the core of this approach is teamwork. Rehabilitation services are delivered through integrated teams and consider veterans' medical, psychosocial and vocational needs together. VAC case managers, PCVRS rehabilitation service specialists, and rehabilitation service professionals work with the veteran as a coordinated team. Each discipline brings specialized expertise, and decisions are made at the appropriate level to ensure clarity, continuity and coordinated support for the veteran.

Through a partnership between Lifemark and WCG, PCVRS currently supports about 11,700 veterans across Canada. These participants, who represent about 6% of VAC's client population, have complex needs. Approximately 74% are experiencing mental health conditions alongside physical health challenges.

The needs are reflected in program spending. In 2024-25, approximately \$184 million was invested in rehabilitation services, with the majority supporting psychosocial rehabilitation, followed by medical and vocational services. Importantly, these investments

are delivering results. Veterans completing the program report improvements in functional capacity, overall health and well-being, and life satisfaction.

We recognize that access to services can be challenging, particularly in rural and remote communities. PCVRS continues to expand its national provider network, which now includes close to 15,000 clinicians, more than 50 Lifemark clinics and over 600 affiliate clinic locations. Approximately 30% of providers offer services in French, and efforts are ongoing to strengthen bilingual capacity. Hybrid and virtual options are being expanded where appropriate to improve access.

It is important to emphasize that VAC case managers retain full decision-making authority regarding veterans' rehabilitation plans. PCVRS provides clinical recommendations and delivers services, but it does not make independent decisions about veteran care. Outcome measures and ongoing performance monitoring allow us to identify trends, address service gaps and continually improve service delivery.

Rehabilitation is specialized and time-limited. It involves assessments, participation, services and engagement. While assessments and documentation can sometimes feel repetitive, standardized tools are used to ensure consistent and equitable decisions, and to measure progress. When veterans require ongoing care beyond rehabilitation, they continue to have access to other VAC programs, benefits and treatment services. At the core of its program, the updated rehabilitation service delivery model is built on collaboration, specialized expertise and a strong commitment to supporting the health, well-being and successful transition of those who have served Canada.

Thank you, Madam Chair.

• (1105)

The Chair: Thank you very much.

I forgot to mention that I am the timekeeper. I have to apologize to our witnesses. I don't want to be rude, but sometimes I will have to maintain that order. Please bear with me. Look at me, and I will try to give you some insight when it's the last 30 seconds. Thank you very much.

I will now invite Ms. Lockyer to speak for five minutes, please.

Sonya Lockyer (President, Lifemark Health Group): I think Tania is actually going first.

The Chair: Go ahead, Ms. Bennett.

Tania Bennett (Chief Executive Officer, WCG Services): Good morning, Madam Chair and members of the committee.

My name is Tania Bennett. I'm the CEO of WCG Services and the executive sponsor for Partners in Canadian Veterans Rehabilitation Services, or PCVRS. I'm here today with Sonya Lockyer, CEO and president of Lifemark Health Group; René Deschamps, our PCVRS contract manager; and Dr. Sylvie Bourgeois, our medical director for PCVRS and national director of psychology and mental health services for Lifemark.

PCVRS was established to coordinate and administer the program on behalf of VAC. We are a partnership between Lifemark Health Group, a leading provider of health care assessments and rehabilitation services with over 28 years of experience, and WCG Services, a Canadian leader in the design and delivery of employment and vocational services for over 30 years. Our collaboration synergizes diverse expertise to enable a robust national framework for veterans' rehabilitation.

Our mission at PCVRS is to provide Canadian veterans and their families with best-in-class rehabilitation services, underpinned by compassionate care, dignity and respect. We support veterans' health and well-being through medical, psychosocial and vocational rehabilitation services. Through our nationwide bilingual and trauma-informed rehabilitative care, we enable improved access to quality services for Canadian veterans.

Our mandate, through the contract, includes assessing the rehabilitation potential of veterans for each of their eligible health conditions. We focus on maximizing restoration of function and providing psychosocial skills and strategies, so that participants achieve their individualized goals to improve their role performance at home, in their communities and at work.

PCVRS functions as the coordinator of rehabilitation assessment and treatment services operating within the framework and policies set forth by VAC. We deliver an interdisciplinary service, and our rehabilitation service specialists, or RSSs, play a central role. RSSs are health and vocational professionals who support veterans through developing their rehabilitation plans, coordinating services and facilitating their rehab progress. RSSs coordinate extensively with professionals who work within interprofessional programs and stepped-care models, including occupational therapists, psychologists, psychotherapists, physiotherapists, kinesiologists, and medical and vocational specialists. This integrated model supports veterans in receiving seamless care across their rehabilitation journeys. Our approach ensures that each veteran is supported by the right team of professionals, at the right time, using evidence-based rehabilitation approaches throughout assessment and treatment services.

Positive outcomes for veterans are supported through our performance and quality framework. We invite program participants to complete outcome measure surveys at three different points during their rehabilitation journey. This provides us with feedback that helps us adapt and continuously strengthen our service delivery. Since our services began, 74% of participants who completed their plan reported improved functional capacity or overall well-being, and 82% reported improved life satisfaction.

We also focus on ensuring that veterans receive timely service. In the last quarter, over 800 participants in the program received their first contact from PCVRS within an average of one business day of receiving the referral from VAC, and participants' initial rehabilita-

tion assessments with their RSSs occurred within an average of six business days. Intake occurred within 24 days, and assessments within 33 days. Rehabilitation services began an average of 21 days after the referral was completed. PCVRS metrics stand in contrast to wait times for specialized health services that are in high demand nationally, which can extend to many months.

I will now invite my colleague Sonya to elaborate further on how PCVRS delivers timely and effective care.

• (1110)

The Chair: You have five minutes.

Sonya Lockyer: Thank you, Madam Chair and committee members.

My name is Sonya. I'm president and CEO of Lifemark Health Group. It is a privilege to be here today to discuss our collective commitment to veterans.

Before we get into questions, I thought it would be helpful to push on three points that seem to come up in questions about the program. The first one is how it's different and distinct from other programs that veterans have access to. The second is the breadth and composition of the network itself. Last but not least is the governance structure that underpins the program itself, including the ownership structure of Lifemark.

As a proud Canadian veteran myself, I know first-hand the dedication and sacrifice it takes, for all of our veteran community. It is deeply personal to me.

The unique challenges that many face transitioning into civilian life are what we focus on. This personal understanding informs our work—Lifemark's work—and fuels our collective commitment to making sure Canadian veterans receive the best possible care, tailored and individualized where possible to their specific needs and expectations.

The RSVP program is distinct from other treatment benefits that veterans have access to. It's additive to other benefits programs and is solely focused on rehabilitation and function regainment. As Jane noted, prior to RSVP, veterans, through their case manager, engaged with individual practitioners, but not in a coordinated manner where practitioners were speaking to each other and the veteran was integrated in case conferences continually and regularly. The design of the program was meant to create improved care coordination. It does focus, as many have said, on three areas of rehabilitation: medical, psychosocial and vocational. This collaborative view of the program makes it different and unique, not only in Canada but internationally.

The program is voluntary. It is designed for veterans who are really interested in taking a more intensive and team-based approach that covers the full spectrum of rehabilitation.

In terms of the breadth and composition of the PCVRS network, PCVRS was designed to be national, a network of qualified rehabilitation professionals. While Lifemark is part of that network, we represent roughly 27% of the 1,250 clinics that are available to veterans across the country. Veterans are able to access care from both Lifemark and non-Lifemark providers within the network. To put a little bit more nuance on that, of the roughly 15,000 clinicians within the network today, 12,000 are independent community practitioners. All of our service providers are required to complete VAC-approved training, including standards for veteran-centric care and trauma-informed care. Sylvie can answer questions on that, if you're interested.

Our approach ensures that care is personalized and also accountable. What that means is that we have clear administrative and reporting requirements in place, including required collaboration between care providers and participants using VAC-approved reporting templates and defined timelines for reporting.

Finally, I would like to take the opportunity to address questions regarding Lifemark's ownership structure. We are a Canadian organization. As Tania mentioned, we have 28 years of experience in delivering rehabilitation services in communities across the country. Our leadership team is Canadian. Our clinicians are Canadian. The care that we provide is delivered locally in clinics embedded within the communities we serve. The PCVRS contract was awarded in June 2021 following a competitive federal procurement process. It is one of many national rehabilitation contracts that Lifemark has the privilege of delivering.

The acquisition of Lifemark by Shoppers Drug Mart occurred in May 2022. That change in ownership did not alter the structure of the contract, nor how services are being delivered to veterans today. Clinical decision-making, professional standards and service delivery are governed by our contractual obligations with health service providers, as well as the Canadian regulatory frameworks that govern our clinical providers.

In closing, the partnership between WCG and Lifemark under PCVRS exists for one reason: to serve Canadian veterans. This network was built to provide structured, accountable and clinically grounded rehabilitation services. We understand the responsibility that comes with delivering this program. We are accountable for the outcomes. We are accountable for the stewardship of public funds. Most importantly, we are committed to continuous improvement, and in collaboration with VAC, we hope to continue on that journey.

• (1115)

Thank you for your time and attention today.

The Chair: Ms. Lockyer, thank you very much.

Thank you for your service. On behalf of all of us, I want to say thank you.

We'll have a round of questions. The first round is six minutes.

I am the clock keeper. If I have to interrupt either a member of Parliament or a witness, I apologize in advance. Everybody knows this. You also have the time beside you so that you know.

It is a six-minute round. It will start with Mr. Richards for six minutes.

Blake Richards (Airdrie—Cochrane, CPC): In 2023, this committee released a report on the implementation of the PCVRS contract. There were several recommendations made in that report, essentially none of which were acted upon. I would suggest that this is at the heart of how this government is failing veterans. There's a failure to listen to and act upon concerns being heard from veterans and those who serve them.

I'd like to go through some of those recommendations and see if it will enlighten us.

The first recommendation of that report is to ensure that veterans participating in the program are directly informed about the changes, how that will relate to their work with their case manager and what kinds of changes are coming their way. I think there was some initial communication and things that happened, but there's clearly a lot of confusion that continues to exist about what is and isn't available for veterans and who they work with.

I see this meeting today as a visual representation of that confusion. There are so many people at the table that they wrap around the sides of the table. I'm not even sure where to direct my questions. You can only imagine how a veteran must feel when they don't have a clue who they're supposed to go to and who's in charge of what. That seems to be the problem.

I'll start with Veterans Affairs.

Are veterans supposed, under this contract, to be able to work with the service provider they wish to work with, whether an existing provider or a new provider they like? Are they supposed to be able to engage with the service provider of their choice, or is it mandated who they work with, under this contract?

• (1120)

Jane Hicks: Madam Chair, there are a couple of things.

The model differs a bit from the previous arrangement we had in place. We have a rehabilitation team in place that looks at the needs and the requirements of the particular veteran, and then we match the veteran with a provider based on those circumstances. It's not a provider of choice, as per Medavie Blue Cross in the past.

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.

Blake Richards: It doesn't really line up with what we're hearing from veterans. There was a really good article in the Toronto Star over the weekend that highlights all of this, but we certainly hear it all the time.

This is for PCVRS or whoever thinks it's appropriate to answer.

We hear all kinds of reports of veterans saying that they're being forced to try to work with people within your network. They say that they want to work with the person they were working with before. They feel that they're being pressured and forced to make a decision to go somewhere else, and they don't feel comfortable with it. Is that happening, and is it supposed to be happening?

René Deschamps (Vice-President, Veterans Health and PCVRS Contract Manager, Partners in Canadian Veterans Rehabilitation Services): 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.

Blake Richards: Okay. Well, I can tell you that there seems to be a lot of confusion around this and there seems to be a lot of concern around this. I would suggest to both organizations here today that you need to do better in this regard.

Let me turn to the second recommendation of that report. It was essentially indicating to the government that they need to maintain regular communication with the Union of Veterans' Affairs Employees and make sure they're consulted before making changes to programs of this nature. I know that the union expressed a lot of concerns about the confusion they had when this contract was implemented. I believe they would probably still tell you that, if they were here today. Certainly, we've heard that in relation to the cuts being made at the Bureau of Pensions Advocates and how they were not consulted by Veterans Affairs prior to those cuts being made, cuts that will massively impact veterans.

I guess I don't even know what question to ask in regard to that recommendation, because it's clearly not happening. Does anyone want to suggest otherwise?

Jane Hicks: I can tell you that there is regular and ongoing communication with the Union of Veterans' Affairs Employees. Certainly I and my predecessor, Mr. Steven Harris, meet regularly, at least monthly, with the union. We've also had working groups where we've engaged the union to make service improvements.

• (1125)

Blake Richards: It's interesting, because that's not the story we heard from them.

The Chair: Thank you very much, Mr. Richards.

I will now pass the floor for six minutes to Mr. Casey.

Sean Casey (Charlottetown, Lib.): Thank you, Madam Chair.

I didn't intend to go there, Ms. Hicks, but I think you probably need the full six minutes to respond to Mr. Richards' assertion that the 10 recommendations made in the 2023 report of this committee have not been adhered to. Let's work through them.

The first recommendation was that VAC "directly inform veterans about the changes resulting from the new contract". Have you done that?

Jane Hicks: Yes.

Sean Casey: I think you have responded to the one with respect to the Union of Veterans' Affairs Employees.

The third was this: "That veterans, VAC employees and service providers be informed of any change to the delivery of rehabilitation services." Have you done that?

Jane Hicks: Yes.

Sean Casey: This was the fourth one: "That VAC commit to meeting regularly with the veterans, advocates, and experts who make up the ministerial advisory groups."

Jane Hicks: We have met with the advisory groups periodically.

Sean Casey: The fifth recommendation was as follows: "That VAC acknowledge the gaps in its initial case manager communications strategy and specify which of the responsibilities will be transferred to PCVRS' specialists." Have you done that?

Jane Hicks: Yes.

Sean Casey: This was the sixth one: "That VAC hire more permanent case managers to limit the number of cases assigned to each case manager to a maximum of 25."

Jane Hicks: Go ahead, Nathalie.

Nathalie Pham (Director General, Field Operations, Department of Veterans Affairs): Madam Chair, since 2016 VAC has had temporary resources added to case management. As of today, we have not reached 25:1, but we're getting closer to 25:1.

That is the situation right now. We do have additional resources, temporary resources, to support case management.

Sean Casey: Thank you, Ms. Pham.

I'll go to the next recommendation: "That VAC ensure that the conditions offered to providers registering with PCVRS will support the retention of health care professionals who have experience with the unique services provided to veterans."

Jane Hicks: We have seen a significant growth in the provider network with the PCVRS contract. There are approximately 15,000 clinicians in the network at this point in time.

Sean Casey: This was the next recommendation: "That VAC specify the mechanisms that will allow it to oversee the implementation of the rehabilitation program management contract, and to ensure the quality of services delivered by PCVRS and its providers."

Jane Hicks: VAC has a robust quality performance and quality assurance framework in place to oversee the management of the contract.

Sean Casey: I'll go to the ninth recommendation: "That VAC provide the Committee with a comprehensive update on the impacts of the rehabilitation contract awarded to PCVRS by November 2023."

Jane Hicks: That was completed and submitted to the committee.

Sean Casey: Thank you.

The final recommendation was as follows: "That the Office of the Veterans Ombud be asked to publish a report in one year's time on the [effects] the contract has had on veterans, VAC employees and service providers."

Jane Hicks: The ombudsman has not published a report, but that is not within the purview of my responsibilities.

Sean Casey: When you're accused of not fulfilling any of the 10 recommendations, in summary, how would you respond?

Jane Hicks: We have fulfilled the recommendations. There have been numerous improvements since we were last at committee. We've provided additional training and information to case managers and communications to veterans. We've worked extensively with PCVRS to improve the contract in place.

Sean Casey: Thank you.

How much time do I have?

The Chair: You have two minutes.

Sean Casey: Thank you.

On February 23, we heard from one panel of witnesses in connection with this study, and there were several items that were raised in that testimony. I trust that you've all had an opportunity to review it. I'd like to raise some of these things.

I'm going to stay with you, Ms. Hicks, but feel free to invite others to chime in. If there are specific things that were said on February 23 that you wish to address, just ignore my question and go ahead and do it.

I'm going to start with the testimony that was offered by a psychologist, Dr. Bernard, with Institut Alpha. He maintained that continuity of care should be the cornerstone of the program.

Could you respond to that?

• (1130)

Jane Hicks: Continuity of care is really important as part of the rehabilitation program. Based on the relationship that we have with veterans, case managers take the information that we have and provide it to PCVRS, to the rehabilitation service specialists. That information is then provided to the rehab service professionals to build the rehabilitation plan.

I'll turn it over to my colleague at PCVRS, Madam Chair, if that is okay.

The Chair: You have 30 seconds.

Sylvie Bourgeois (Medical Director, Mental Health, Partners in Canadian Veterans Rehabilitation Services): The continuity of services includes coordination of services. When participants are referred to the rehab program, we, through various assessments, are conscious of their circle of care and their existing providers. More so, we try to understand what these providers are doing in order to see where rehab-focused care fits. For some, it may be in parallel, where these providers will remain, while rehab-focused providers will come—

The Chair: Dr. Bourgeois, I'm so sorry, but I have to be fair to everybody. I sincerely apologize.

The next person will be addressing you in French, so make sure, for those of you who do not have the pleasure of knowing our two official languages, that you have the little earpieces.

Madame Gaudreau, you have six minutes.

[Translation]

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you, Madam Chair.

I'll continue on the topic of care.

Earlier, I heard mention of training. I don't know which witnesses could explain what specific training employees receive in order to become service providers.

Sylvie Bourgeois: Thank you for your question.

We have two categories of providers: rehabilitation specialists and professionals who provide rehabilitation care. In addition to ensuring that providers are carefully selected, we offer mandatory training.

Marie-Hélène Gaudreau: Excuse me, but I'd like to understand what makes this training program unique. My question is: Does the training cover military culture, among other things?

Sylvie Bourgeois: The training sessions cover military culture, trauma-informed care, mental health challenges when they co-occur with physical health issues, suicide prevention and risk management protocols. We also offer training focused on data management and confidentiality.

These training sessions are provided at the start of the program, when employees or suppliers join our organization. We also offer ongoing training.

Marie-Hélène Gaudreau: For example, *Out Standing* is a film we'll ask students to watch to try to understand Captain Perron's reality after what she went through in 1995. Is that correct?

Sylvie Bourgeois: We have lists of resources, such as the Atlas Institute, for veterans and their families. The medical directors who work with us also provide training sessions on mental health and substance abuse, including how these issues can manifest themselves.

Marie-Hélène Gaudreau: Ms. Lockyer, I heard you say that you've experienced this first-hand. How can service providers as a whole deliver services if they don't consider or understand the lived reality of fellow service members?

[English]

Sonya Lockyer: I think the reality is that if you work with veterans without understanding military culture, you are not setting up the program accordingly.

There are about 12 mandatory training courses that RSSs have taken, and a little bit more for our service providers as well.

To your point, there are videos, and there's intervention. If we receive a complaint from a veteran about a clinic, about our front desk staff, anyone, we immediately go in and retrain and have performance mechanisms in place to address situations. As the program scaled, of course, things were moving quickly. We did have some challenges and complaints, and we dealt with them. I think that's the key. We are identifying gaps and dealing with them very quickly. Mandatory training is in place. Not everyone takes training at the same pace, of course.

• (1135)

[*Translation*]

Marie-Hélène Gaudreau: We wouldn't be here talking about this if we weren't highlighting the 25%, 30%, or 40% of people affected. We're talking about numbers, but we're not just talking about numbers—we're talking about real people who are falling through the cracks and who are suffering. When support begins only after 21 days, and it then takes six more days to establish a relationship, for someone who decides to reach out to us at the last minute, it's like a hotline: If no one answers at night, the person might act on those thoughts.

So it's clear that I need to hear from the people who came to meet with us, because even if three-quarters of the services may be adequate, we're focusing on those who are struggling.

As for service delivery, I've obtained the June report, which I imagine you're very familiar with. It's titled "Veterans First" and was produced by McGill University's Max Bell School of Public Policy. It states that although Lifemark requires its mental health service providers to hold a relevant professional degree as well as a licence to practise in the field of mental health, there are no universal standards regarding cultural competency or specialization for practitioners contracted by Lifemark who are specifically called upon to work with the veteran population.

I find this really troubling. I'm thinking of all the veterans who tell us they don't know where to turn anymore and how exhausted they are from feeling misunderstood. What's your response to that? It's included in a report.

The Chair: You have 30 seconds left.

Sylvie Bourgeois: Since 2022, we've developed a training program to try to standardize, at a minimum, certain aspects related to care providers. We also continue to support our providers with various resources. It's important to remember that this program combines cultural competencies with rehabilitation skills, which helps improve how our providers function in their roles. Our providers must strike a balance between these two skill sets, and they must recognize that there need to be minimum requirements across Canada, and—

The Chair: I'm sorry, Dr. Bourgeois. This is the second time I'm interrupting you, so I'm truly sorry.

Ms. Gaudreau keeps very good track of the time, so she knows I have to keep the meeting moving and interrupt you. Please forgive me.

Mrs. Wagantall, the floor is yours for five minutes.

[*English*]

Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Madam Chair.

Thank you for being here today. You are clearly prepared.

I have a question about something I heard that is deeply concerning to me in response to the number of veterans who have come—very apprehensively and under a lot of duress—to share their stories with me.

I think it was Ms. Bennett who indicated that this program is voluntary. To me, that is kind of like this government saying that our law-abiding firearms owners have a voluntary opportunity to have their firearms confiscated. Quite honestly, this is not voluntary. I've had many come to me who want to continue with the care they've had or who simply want a bit of direction. They are told that they cannot get any help, care or funding unless they go through an assessment. This assessment is, once again, another challenge for them, because they've done these assessments. I'm talking about individuals who are already in programs and getting care. Now they have to flip over and adjust to a new system.

Why is it that an assessment is required of individuals who are already getting care and who are very happy with the care they're getting? Why are they being told that they have no choice if they want to continue with care?

Who would like to answer that in 30 seconds?

• (1140)

Jane Hicks: I'll answer the question very quickly.

In the program we have, there are treatment benefits for veterans with service-related injuries and illnesses. That program is in place, and veterans can continue with it.

The rehabilitation program is separate. It is a voluntary program and—

Cathay Wagantall: Excuse me. I'm asking about the individuals who are already involved in rehabilitation.

Jane Hicks: As part of the rehabilitation program, the first step is an assessment to understand—

Cathay Wagantall: They're already involved. They're already getting rehabilitative care. VAC is way behind in dealing with all of its files, and here we are creating more complications for veterans who are happy and content, and getting the care they need. It's being provided through VAC, and they have to go through this again.

Can we see the paperwork that has gone into determining what qualifications, experience and performance metrics are required of those who are providers through this new program? Can the committee get a copy, yes or no?

Jane Hicks: Yes.

Cathay Wagantall: Thank you so much.

It says, "for providers to join or to remain in PCVRS". How many providers who were already serving veterans have remained in this program?

Sonya Lockyer: I can definitely go back to look and get a precise number for you.

Cathay Wagantall: That would be great.

Sonya Lockyer: The 12,000 independent community providers we brought into the network are generally coming in because they have an affiliation with, or previous experience in, veterans' care.

Cathay Wagantall: I would like to know the number of those who were already treating veterans and who can maintain their ability to treat those veterans, because I hear from them, as well. I appreciate that.

Would you provide that to the committee in the next week or so?

Sonya Lockyer: [*Inaudible—Editor*] precision.

Cathay Wagantall: Thank you. I appreciate that.

An assessment is required. When that assessment is done, who gets to see it? I have had veterans say that they've been assessed but they never get to see their assessment before it's handed out to other places. Do veterans sign off on that? Do they have an opportunity to see what was determined by the person doing the interview and assessment before it is shared within your organization?

Sylvie Bourgeois: Participants engage in an assessment to determine rehab potential, which is different from an assessment for disability and pension award. When an assessment is completed and rehab needs and potential are identified.... It is considered an independent assessment. Therefore, the report goes back to the RSS and case manager for review.

Our assessors are encouraged to provide verbal feedback at the end of the session.

Cathay Wagantall: Is that to the veteran?

Sylvie Bourgeois: It's to the veteran, yes, in terms of their—

Cathay Wagantall: Why does the veteran not see that assessment? From what I understand, when push came to shove, this particular veteran was able to sign off through VAC but found out afterwards that it had already been shared extensively. How—

The Chair: Thank you very much, Mrs. Wagantall. I apologize, but you're done.

Cathay Wagantall: Thank you.

The Chair: Thank you very much.

Now for five minutes, it's Mrs. Hirtle.

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

Good morning, everyone. It's nice to see you all here.

I was not a member when.... I'm a new member, so the contract was signed before I was even aware of it. I'm wondering if the Life-mark folks could tell me this. PCVRS was introduced to modernize and streamline rehabilitation and vocational services for veterans across the country. Can you give a very brief summary of the problem that this was designed to solve?

Sonya Lockyer: A very brief summary would be that there was essentially the case manager in the centre going to a physio, going to an occupational therapist, going to a mental health practitioner, but that team of care professionals were not coming together around a functional improvement plan in regard to rehabilitation. Very specific to rehabilitation, functional assessment and functional ability, what are their functional abilities and how do we bring a team-based approach together with the veteran at the centre? 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.

• (1145)

Alana Hirtle: That's lovely. Thank you.

Can you explain how this model is improving national consistency? I think that was one of the main goals. To add on to that, are you still keeping veterans' individual needs at the centre of this decision-making process?

Jane Hicks: We absolutely are. In terms of a standardized approach, we have standardized tools and standardized assessments. 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.

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.

Alana Hirtle: How has this been addressed to make the program work better for veterans?

Jane Hicks: With the implementation of PCVRS, we've reduced the administrative caseload of case managers. With PCVRS, we have a dedicated rehabilitation team that works with the veterans to do the assessments and to follow the rehabilitation process. It's much more structured and formalized, and we're seeing more positive outcomes as a result.

Alana Hirtle: Thank you.

Obviously, for a contract of this size, there needs to be some accountability built into it. Can you describe the quality assurance and performance monitoring tools that VAC uses to ensure that the veterans are receiving timely, high-quality rehabilitation services through PCVRS?

Jane Hicks: Absolutely. As part of the contract, we built a strong quality assurance and quality performance measurement framework. That includes standardized assessments. We're monitoring service standards and the quality of the reports. We do file reviews. We monitor the time from assessment to intake. We have a variety of measures in place to measure the performance of the contract.

Alana Hirtle: Thank you.

Can you also speak briefly about what takes place when there are issues? If there are systemic issues identified, what takes place to address those?

Jane Hicks: We work very closely with PCVRS when we identify themes, trends or issues. Then we work with our colleagues in field operations and the case managers. We work with our PCVRS colleagues to address those challenges.

We've made numerous improvements over the life of the contract, from improved training to messaging for our case managers and additional messaging for veterans. We've put provider bulletins out. We've clarified some of the relationships with some of the providers we work with. We've made numerous improvements over the course of the contract, and we continue to do so.

Alana Hirtle: I see that I have 10 seconds left. I think that's probably it.

Thank you.

The Chair: Thank you, Mrs. Hirtle.

[*Translation*]

Ms. Gaudreau, you have the floor for only two and a half minutes, so please try to respect the time limit.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

I still feel like we're talking about the improvements we're making and the good work we're doing, and congratulating ourselves. Yet we've just completed a study on people who die by suicide. We fully recognize the value these individuals bring to our national defence, especially since we will be asking others to serve as well.

What am I supposed to tell the people in my riding in the Laurentians who call me and say they've been waiting and haven't heard anything, that they were told a shared file had been created, but that, in the end, they have to repeat their story four times?

Earlier, I mentioned that there is a report. This isn't just one person among 12,000 others. What are we actually doing for these people? Right now, they're listening to us and telling us that it all sounds good, but they're worried about their own situation. There are more and more people in this situation.

So, my question is this: What performance indicators should we be using to truly ensure that services are being delivered properly? How do we justify that the agreements with Veterans Affairs Canada are targeting the right services?

• (1150)

[*English*]

Jane Hicks: Madam Chair, there are numerous ways in which we look at the satisfaction. At the beginning of the program, we survey the veterans to see how they're doing. We do it at the mid-point. We do it at the end-point. We are getting feedback from veterans throughout their rehabilitation journey. We take that feedback very seriously.

What I would suggest is that anyone who is suffering and not getting the feedback has to let us know, speak to their case manager and report it, because it's not acceptable. Sometimes people do slip through the cracks. We do not want that, but it does happen. They need to let us know.

I'm very appreciative that they're contacting you, but they need to let us know so that we can react and respond immediately, because we are committed to doing so.

[*Translation*]

Marie-Hélène Gaudreau: I think thousands of people are watching us now, or will be watching us, so make sure you have

plenty of people on hand, because veterans contact us after they've knocked on many doors and haven't received any response. I'd be grateful if something has been resolved.

At this time, are you satisfied with the performance standards for service delivery? Are you satisfied with the contract?

The Chair: I—

Marie-Hélène Gaudreau: Oh, it's over. I completely forgot.

Thank you, Ms. Hicks. I truly care about what veterans are going through.

Thank you for your vigilance, Madam Chair.

The Chair: I'm really sorry.

[*English*]

Mr. Viersen, you have five minutes.

Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair.

Thank you to the witnesses for being here today.

This is for VAC. We've heard from a number of witnesses on this. We've read the news articles about this. It appears to me that this whole system has a trust deficit. The public is concerned about Lifemark being bought by Shoppers Drug Mart, by Loblaws. You hear that come up more often.

Your service providers, who have worked with veterans for years, are now being told that they have to become a Lifemark partner. There are trust issues there. They're saying, "We've worked very hard to build a system of care—that's kind of our thing—and now Lifemark wants us to fill out all these forms explaining our trade secrets, essentially." There's a trust deficit there.

Then we have a trust deficit from veterans as well, who are going through the system and have been working with a service provider, and you're saying, "No, you can no longer go to that service provider. You have to go to a Lifemark one." There seems to be some pressure in the system pushing veterans and pushing service providers in one particular direction, and there isn't a line of sight back to say, "Oh, that makes sense. We understand why that is."

Maybe there's been a failure to communicate, but I guess the question is, how are you addressing that trust deficit? How do we get over that hurdle? Now that we've been in this for five years and this contract is up for renewal, the chaos looks like it's about to start all over again. How do we alleviate all of that trust issue?

Jane Hicks: Certainly, the information we have.... We're working with PCVRS. We're working with our case managers to address some of the issues that we hear of. We have provided additional training and additional communication, and we're working with veterans. Certainly, we have enhanced processes. We've streamlined processes. There is a lot of work that we've done to improve.

I think the outcomes that we have right now.... When we measure, we're hearing from veterans that 74% have improved functional capacity and improved outcomes. Those are scientific. Those are outcomes that we measure. Also, 84% have improved satisfaction. We can't underestimate that. Certainly, there are veterans and providers who don't have a positive experience, and we're working with them to look at how we can address the concerns they have raised.

Arnold Viersen: One of the other alarming concerns that I heard was around veterans who perhaps didn't want to participate in the new program. I'm not sure that it's actually true, but they felt like the financial benefits they were receiving from VAC were being threatened because they were being administered by PCVRS. That is the perception. Is that a real perception? How do we alleviate that? Why are we getting that noise coming out of the system?

Jane Hicks: 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 veterans are not ready for rehabilitation.

• (1155)

Arnold Viersen: Okay. That didn't make it any clearer to me. A number of them have come forward saying that they were in a program and they had to move to a new program. They were told that if they didn't go to the new program, their benefits would be gone.

Can you try one more time for me there?

Jane Hicks: PCVRS is a rehabilitation program. We changed our model from providers through Medavie Blue Cross to PCVRS. It's all the rehabilitation program. In order to receive the income replacement benefit, veterans have to be participating in the rehabilitation program. If veterans choose not to participate, then they would not—

Arnold Viersen: I'm getting it. You can see how that doesn't feel very voluntary, when you're saying that they must move from the program they're in to this current program, and if they don't move to this program, they lose their benefit. They feel that—

The Chair: Thank you very much, Mr. Viersen. I sincerely apologize that I have to interrupt you.

[*Translation*]

Mr. St-Pierre, you have the floor for five minutes.

Eric St-Pierre (Honoré-Mercier, Lib.): Thank you, Madam Chair.

If I may, I will speak and ask questions in French.

I'd like to thank all the witnesses for being with us today. I know that two hours is quite a long time, so I thank them for their patience.

Ms. Hicks, the PCVRS was established to modernize and streamline rehabilitation and vocational services for veterans on a national scale. Could you briefly summarize the problem this initiative was designed to address?

[*English*]

Jane Hicks: Yes, absolutely.

There were many challenges that we had with the old system, prior to PCVRS. For example, services were not consistent. It was not rehabilitation-focused or specialized. Veterans were in the program for an inordinate period of time.

We also have case managers. There was a lot of administrative burden on our case managers. They had to find the providers, coordinate the appointments, and follow up with progress reports and other things. There was a lot of burden on our case managers with all of this.

There was an evaluation that was done approximately 12 years ago on rehabilitation and case management services, and they recommended that we needed to make changes. As a result, we looked at the model, and we decided to develop a new one that specializes in rehabilitation, where veterans have access to rehabilitation specialists, as opposed to just general providers. This reduces the burden on our case managers. It was intended to be a more intense model, with standardized processes so that when veterans come into the program, they would have the same experience coast to coast.

[*Translation*]

Eric St-Pierre: Do you think this model improves consistency at the national level? Do you think it meets the needs of individuals, of veterans? I'd like you to talk a little about the national strategy.

Jane Hicks: There have been a lot of improvements.

[*English*]

I think it has made a big difference, certainly in terms of standardized tools and standardized processes. We're seeing better outcomes. Certainly, it's not meeting the needs of everybody. Veterans come to us with very complex needs. Many of them have complex physical and mental health needs. It takes time to work through this, and it doesn't work for everybody. That being said, we have a robust issue-reporting process in place, and we respond to the concerns expressed by veterans. Certainly, we work with them to resolve any issues they encounter.

We are seeing more positive results, more positive outcomes, and certainly satisfaction as well.

[*Translation*]

Eric St-Pierre: Concretely, does this change things on the ground? Can you speak to the tangible impact on the ground?

I'm also wondering about the timeliness of services. Do you think services are better adapted and delivered more quickly?

● (1200)

Nathalie Pham: I'll answer that question.

We obviously hear a lot of things on the ground. I want to point out that people aren't satisfied, and there is dissatisfaction being expressed.

That said, if we look at the facts, there has been improvement. Ms. Hicks spoke about the administrative tasks that case managers used to have to handle, including coordination and the search for service providers. Now, through Partners in Canadian Veterans Rehabilitation Services, or PCVRS, they work with a single point of contact, and it is the service provider's responsibility to coordinate the multiple providers. As a result, case managers no longer have to do that themselves.

When the program was implemented, one of the things case managers said was that they felt they didn't spend enough time with veterans, and wanted to have more contact and spend more time with them. When we compare the period since the start of the contract with the six-month period prior to its implementation, we see a 25% increase in direct contacts with veterans.

For us, these are concrete facts that need to be taken into account when assessing the improvements made possible by the program.

Eric St-Pierre: My colleague from the Bloc Québécois represents a riding in the Laurentians, which is a more remote region than mine, Montreal. Very briefly, could you speak to how care is delivered in more remote regions?

Nathalie Pham: As you know, remote regions pose challenges for the health care system and for all related systems. Together with the service provider, we've identified more than 15,000 providers, so there is a commitment to finding providers in veterans' local communities.

The Chair: Once again, I'm really sorry to interrupt you.

With that, let's take a break for about five minutes.

Dear witnesses, you'll be with us for two hours. You might want to drink some water and take a moment to experience the more human side of our nature.

I'll suspend the meeting.

● (1200)

(Pause)

● (1205)

The Chair: I call the meeting back to order.

[*English*]

We have Mr. Tolmie for five minutes.

Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC): Thank you, Madam Chair.

I would like to piggyback on some of the comments that were made earlier. When I'm sitting here in this chair, I cannot tell the difference between VAC, PCVRS and Lifemark. I want to know where the line of accountability is for veterans.

I'd like to thank my colleague across the aisle for going through all the recommendations and getting one-word answers, but I'm going to dig a little bit deeper.

Ms. Hicks, earlier you said that we received a copy of a report. I'd like to know why we haven't seen that report. When was that report delivered? I'm being told the previous minister did not receive that report on time. That was flagged with her, and we haven't received it.

Jane Hicks: My understanding is that it was tabled with ACVA. It was recommendation number nine, and a report was tabled with the committee.

Fraser Tolmie: Your understanding is different from saying that it was tabled and that we received it. I'd like to have an answer.

The Chair: I will allow a few extra seconds.

Our clerk is verifying this, Mr. Tolmie, so please continue.

I can suspend if you want to check.

Fraser Tolmie: No, I'll continue on. I have other questions.

We have heard from veterans who have gone through sanctuary trauma, now institutional harm. I'm going to argue that hearing the witnesses today... It is survivor bias. The reports that you're getting are from people who have gone through the system and not from vets who have had challenges because they're being threatened with losing their benefits. They're not getting the quality of service that is due to them.

I'm going to ask a few more questions. Mr. Deschamps, you said that veterans are encouraged to use those providers. Could you define "encouraged"? What I'm hearing from veterans is about being threatened.

● (1210)

René Deschamps: What I said is that providers are encouraged to join the PCVRS network. By joining the PCVRS network, they agree to four things, which are to complete the VAC-approved training, to use VAC-approved report templates, to report at a specified frequency—

Fraser Tolmie: What other choices do they have?

René Deschamps: I'm not sure I understand the question.

Fraser Tolmie: Okay. I'll continue on.

We have veterans who are being threatened that if they change providers, they will lose their benefits. There is no continuity of care, as Ms. Hicks brought up, because veterans are being forced to leave care providers with whom they already have relationships and established care programs to go with something through PCVRS or Lifemark. That relationship is broken, so there is no continuity of care.

Ms. Bennett, you brought up compassionate care. That's not compassionate. You're now severing relationships for veterans who are fragile and who have suffered from PTSD. Could you please explain your view of compassionate care?

Tania Bennett: Madam Chair, thank you for the question.

The member raises a very good point. Compassionate care, from the perspective of PCVRS, is supporting veterans based on their needs and understanding their needs—

Fraser Tolmie: That's the essence of the problem: It's your view. I want the veteran's view of care, and I'm not hearing that from this panel.

I'll let you continue on.

Tania Bennett: The first thing that happens when a veteran is referred to PCVRS is that they're assigned a rehabilitation service specialist, who meets with them, becomes their trusted point of contact and supports them through their whole rehabilitation journey. That process involves in-depth conversations and interviews to understand what the veteran's needs are from their voice and their perspective. That philosophy and that level of care and concern for the veteran, from their perspective, continues with them the entire time they are with PCVRS.

The Chair: Thank you very much.

Now, for five minutes, we'll go to Mrs. Fancy.

Jessica Fancy (South Shore—St. Margarets, Lib.): Thank you very much, Chair.

I would love to thank all the witnesses we have here today, especially those on our witness panel—and also those colleagues with us today—who have served in the past and are veterans themselves.

I have a family where my ex-husband was in the service and did tours in Syria, Lebanon and Israel. I'm very well aware of some of those traumas that come after having served, as well as different streams of care that can be administered. If this had been available many years ago, maybe we would still be together.

I'm also a former high school administrator, and I am very well aware of continuous improvement and always trying to do better by our kiddos. I'd like to go along this line in terms of our veterans, continuous care and improvement indicators for success.

First, Ms. Lockyer, I was wondering if you could share with us on the committee what kinds of success indicators you look at as preparations to progress or the completion of rehabilitation plans, etc.

Thank you.

• (1215)

Sonya Lockyer: Absolutely.

Tania and I meet with the committee to review progress against feedback. I have a paper in front of me right now on all of the feedback that we've gotten from veterans, some of it positive and some of it critical. We take every piece of feedback that we get extremely seriously, and we use it for continuous improvement.

A good example of this—and Mr. Deschamps can weigh in on this as well—is that on the assessment templates, we got feedback that they were a bit too long and a bit too comprehensive. Providers weren't liking them. Veterans thought there were too many questions. We adapted them. We worked with VAC. We adapted the assessment templates, and we are moving forward based on providers' preferences as well as veterans' preferences. That's a good example of continuous improvement.

We have two major IT changes that are coming to reduce the administrative burden on the RSSs so they can spend more time speaking with veterans directly and be available when they call and have that one-on-one contact.

Continuous improvement is actually a big underpinning of this program. As with any new large, national program rolling out, we learned a lot over the first two years of implementation, and a lot has changed.

Jessica Fancy: In terms of learning a lot, could you—or your associate beside you—give us an example of those course corrections, seeing as how you have that whole sheet in front of you? What is the feedback you've received? Is there an example of that course correction when something wasn't going well? What do those newly developed criteria look like?

René Deschamps: Absolutely. In the feedback we received from providers, one of the complaints was about the reporting frequency. For phys med, progress reports were due every four weeks, and med psychosocial reports were required every eight weeks. After feedback from providers—they were reporting that the frequency of reporting was too much—we recently updated our reporting frequency to eight weeks for phys med and 12 weeks for the med psychosocial portion.

Jessica Fancy: Thank you very much.

Do you have any examples or indicators from veterans? That was from your service providers. As my colleague across the way mentioned earlier, veterans are at the heart of what we're doing, so I want some examples from actual veterans.

René Deschamps: One of the complaints was about the participant portal. In the participant portal, they have access to a calendar where appointments are displayed. Currently, the Lifemark appointments are displayed for all future treatments but not necessarily for all the affiliates. The calendar therefore creates confusion for participants. Multiple appointments show up on the same day.

There's an improvement to the calendar going up in the next deployment of our IT release.

Jessica Fancy: Thank you.

I'd now like to turn my questioning to Veterans Affairs. It's a similar line of questioning.

Could you let our committee know the kinds of success indicators that VAC looks at, such as participation progress, completion of rehabilitation plans and client experiences?

Jane Hicks: Approximately 23,000 veterans were referred to the PCVRS program. We work with PCVRS, our field operations staff and our case managers to receive regular feedback in terms of how the program is going. We met a year and a half ago to talk about some of the pain points that were happening—some of the veteran experiences and some of the case manager experiences.

We developed a plan focusing on communication, service delivery, data and some training. There were things we needed to do. Sometimes it was about expectations. We were not communicating what was required as part of the rehabilitation program, so we enhanced our communications.

The Chair: Thank you very much, Ms. Hicks.

To answer Mr. Tolmie's questions and to help, we were able to find that information. The documents and questions were shared on December 4, 2023, by the former clerk, so it was a while ago. They were sent to all committee members through the correspondence and reference documents in the e-binder. That's how it was done. That was before I assumed the chair and before our clerk. They were distributed to all members on December 4, 2023, at 3:50 p.m., exactly.

Thank you. I wanted to make sure. I like exact things to be said.

Our clerk will now share.

• (1220)

The Clerk of the Committee (Eric Glavin): Thank you.

To add to what the chair mentioned, the e-binders from previous legislatures—this would have been in the previous legislature—are not available. It's much more difficult to find documents from previous legislatures.

The Chair: That's something we can talk about.

[Translation]

I just wanted to clarify that for the members of our committee.

[English]

It's also for the VAC team here.

[Translation]

Ms. Gaudreau, the floor is yours for two and a half minutes.

Marie-Hélène Gaudreau: Thank you very much.

Let's get back to basics, namely, the fact that we all want to do a good job. We're not pointing fingers at anyone. We don't wake up in the morning saying that we're not going to do our jobs properly. That said, we often find ourselves having to say that we're doing the best we can with what we have.

Deputy Minister, my question is this: What is missing to move beyond having only 74% of people satisfied or reporting an improvement, and instead reach 100%? What resources are you lacking? Be frank with us about what's really missing.

[English]

Jane Hicks: I think we have the resources in place to actually deliver a solid rehabilitation program. There are things that we can do ourselves to improve, and we are improving our communications, our training and our interactions with veterans.

We will be embarking upon a consultation with veterans and employees in the next month to seek their feedback specifically on the program, so it's not the quantitative data, but the qualitative perspective. They'll be asked to complete a survey, and they'll also be offered an opportunity to provide a one-on-one interview regarding the rehabilitation program.

[Translation]

Marie-Hélène Gaudreau: In fact, our role is also to assist you in making requests to the appropriate authorities. We will be meeting with the minister, and we'll be asking her the same questions. Is this cabinet's responsibility? Is it the Prime Minister's responsibility? At some point, if we say this is important, we'll have to walk the talk. If you don't tell us that you're lacking funding and resources, and if you say everything is fine while still having concerns about veterans, then we could turn around and criticize you, saying that you're not doing your job. Otherwise, please, we need to know.

Since I have only 15 seconds left, I'll ask my question again in the next round: In your view, what are you missing?

The Chair: There are 20 seconds left, so someone can answer the question. Otherwise, we can come back to it later.

[English]

Sonya Lockyer: I can respond, Madam Chair, in 10 seconds.

We are still early in the program, and with the 25% of veterans who are not progressing the way we want them to progress, the way we expect them to progress and the way we're trying to get them to progress, we need to lean in there, and we will lean in there. We need to understand where the gaps are, and we are learning them. This is still an early program, and we're committed to filling them.

The Chair: Thank you, Ms. Lockyer.

For five minutes, we go to Mr. Richards.

Blake Richards: There seem to be two versions of the story here. We're hearing today that everything is wonderful, that it's all great, that things are going great and all these improvements are happening. Then there's the story we hear from veterans.

Even some of the veterans in the room with us today expressed, during the break, how frustrating it is to listen to this today, because it's not the reality they're seeing or hearing about from their colleagues in the veteran community. It's why this committee needs to extend the study and hear from more veterans, because we're hearing that everything is great, but veterans aren't getting a chance to have their voices heard here.

I'd like to touch on a couple of things that we hear consistently from veterans.

The first one is that they feel just buried in bureaucracy. This is a general thing when they're dealing with Veterans Affairs. They feel like wait times are too long, and there's a constant need to re-prove things that everyone is already well aware exist. There are delays and denials. It just seems to be never-ending. Then this contract came about, and now it feels like they have two overlapping bureaucracies that they're dealing with. They're suffocating in bureaucracy. They don't even really know where they're supposed to turn.

I'm just going to reference a couple of things from a Toronto Star article over the weekend that highlights this, because it at least gives a little bit of a voice to veterans. The Star talked to 30 different veterans and 11 different health care professionals. The article says, "They described a bureaucracy rife with delays and redundant assessments." Then it talks about the testimony we heard from a clinician on a different study, who called it "bureaucracy to the point of absurdity". That's how he described it under PCVRS. He said, "The program seems to exist for its own sake by piling on administrative requirements that make the process extremely cumbersome and painful for the veteran, irritating and suffocating for the professional."

The article continues:

An experienced VAC case manager said that while the previous iteration was based on veterans' needs, this program "is all geared around feeding the system, feeding the money into PCVRS."

The final thing I'll mention from the article really says it all:

Under the rehabilitation program, eligible veterans are assigned a VAC case manager and an RSS working for PCVRS. While case managers are dubbed "decision makers" in the contract, PCVRS staff are responsible for developing rehabilitation plans and conducting assessments, including of veterans' ability to hold a job and eligibility for benefits. Decisions related to benefits are made by VAC, the department said.

When you listen to that, it's like.... I don't even know. It's clearly telling everyone that no one has a clue who's making the decisions

about what. I think that even exists among the workers themselves who are expected to do these things, so how are veterans supposed to figure it out?

I guess my question for the Veterans Affairs folks with us here is, do you acknowledge these problems and these concerns, and what are you doing about them?

• (1225)

Jane Hicks: First, Madam Chair, I want to acknowledge that the experiences described in the Toronto Star are serious and concerning. Certainly, we take those very seriously and we will be following up.

We do have veterans who have concerns—

Blake Richards: I want to interrupt you for a second, because it's not just about some things that were expressed in the Toronto Star. These are things we've been hearing from veterans for the last few years. I'm sure you've heard them as well.

It's great to say you're going to follow up on these things we read in the Toronto Star, but we've been hearing these things for a few years, and nothing seems to be changing. If anything, things seem to be getting worse.

Do you acknowledge there are problems here? Do you agree that there are some things that need to change so that veterans can have a better experience?

Jane Hicks: I acknowledge that there are certainly challenges in the system, and if I had been allowed to continue, I would have indicated that we do hear from veterans that there are concerns, and when we do, we work with them 100%.

It's early days. We are working to improve the system. Veterans Affairs is accountable and responsible to deliver the rehabilitation program. We work with PCVRS, our partner in delivering the services. The case manager is the pivotal individual who makes the decisions with respect to rehabilitation and eligibility for VAC programs and services.

The Chair: Thank you very much.

You have a second left, Mr. Richards. Thank you.

Now we go to Mr. Casey for five minutes.

Sean Casey: Thank you, Madam Chair.

I want to go back to the testimony of February 23. This is for our guests from Lifemark and PCVRS, and anyone among you is free to respond as you wish.

When Dr. Bernard completed his testimony, the last thing he said to us in his opening statement was, “Do Lifemark and the PCVRS really care about veterans? The current program clearly answers ‘no’ to that question.”

In fairness to you, you should have a chance to respond to that. Please do.

Sonya Lockyer: Thank you.

I think we definitely care about veterans. I can tell my personal story.

When I was approached to take the leadership role at Lifemark, the reason I joined Lifemark was for this program. I knew it was just kicking off. It was roughly a year and a half into implementation, and from day one, I brought the veterans' voices to the table. We have been pushing on and talking about what you guys hear at the table. What you read in the Star, we live every day. Yes, we've had complaints, and yes, we've addressed them. We've become really good as well.

Right now, my call to action for everyone who's listening is to please tell us. If you're given a satisfaction survey, fill it out. We can only react and respond to the information that's presented to us. At roughly three years now into the program, 74% of participants are reporting good functional gains from the program. That's actually the industry standard.

I'm not reacting to it in a negative way, but I'm also not saying that our work is done. This is an early program and it's an important program, and to say that we don't care about veterans is actually an insult.

• (1230)

Sean Casey: Thank you.

Is there anyone else?

Sylvie Bourgeois: If I may, from a clinical perspective, this program has clinical leadership—chief psychiatrist, chief psychologist, occupational health medicine—and we are constantly looking at quality, at standards, at risk mitigation and at safety in terms of oversight, serving to develop constant training ultimately for ethical care, compassionate care and trauma-informed care.

Yes, we do care about the veterans, which is ultimately why we're all here doing what we do every day.

Sean Casey: Thank you very much.

Shawn Carter, who is a provider contracted by you, testified on that day as well. We've had a bit of a discussion here today around continuous improvement, and he pointed to two specific examples that I'd like to share with you in case you have anything to add to what he said. He talked about continuous improvement and specifically that there was something “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.” He also referred to the EHN Guardians family program.

Could you expand a bit on those improvements, on how they came to be and what impact they had?

Sylvie Bourgeois: The rehab program, ultimately, is about removing barriers to functioning at home, in the community and at work, when it is negatively impacted by a service-related health condition. We have built clinical pathways that support the veterans where they're at, in terms of whether they require clinical stabilization from a medical rehab perspective or whether they're at the phase of needing to learn to live with a certain amount of symptoms and chronicity while empowering them to function better in the roles that are important to them at home, in the community and at work.

Through continuous improvement, we've built pathways to look at more high-needs clients, more moderate needs and low needs. We have pathways that start where they need to start and support handovers when one phase leads to another, until veterans reach their own goals of functioning at home, in the community and, for some, at work. Our network has specialized intensive in-patient care, right down to an individual provider in the community, who will wean them off and ultimately discharge them and close the file in rehab.

Sean Casey: Thank you, Dr. Bourgeois.

The Chair: Thank you very much, Dr. Bourgeois.

Mr. Richards, go ahead for five minutes.

Blake Richards: Thank you, Chair.

I mentioned there were a couple of things I wanted to touch on. Here is the other one.

It came up a few times already today, but we hear this all the time from veterans: They're being forced to work with the providers within the PCVRS network. It has been described today as “optional”, but the option is, essentially, that a veteran can give up their IRB or utilize the providers they're being told they have to utilize. It's not really much of an option. That's a really terrible option, if that's the option they're being given.

I'll just refer to a couple of quotes from this Toronto Star article. Then I have a question about how we can proceed in the future.

It is described in the article that program staff “frequently ask veterans to cut ties with clinicians who do not affiliate with the PCVRS network, disrupting treatments.” Then, at another spot, the article says, “A retired sergeant alleged that a PCVRS staffer repeatedly used her hard-earned benefits as leverage to make her switch providers.”

Also, there is a psychologist who indicated that there seems to be a bias in PCVRS against out-of-network providers. She said, “How on earth can they formulate treatment plans without talking to the primary provider?”

I'll just close with the comments of the veteran I referred to earlier:

When she objected to leaving her psychologist, the RSS's tone then “turned highly aggressive”, she said. “The woman threatened to cut off all benefits I was receiving from Veterans Affairs unless I agreed to change doctors and follow PCVRS's treatment plan.”

The upsetting threats went on for weeks, the veteran said, until her psychologist intervened to request that PCVRS only contact her by email.

“I gave over 40 years of my life to my country, and to have [someone] threaten me to cut off my benefits for all that work I did for my country, that just makes my blood boil.”

I mention that one because it's the kind of thing we've heard from veterans time and time again. There's this.... It's presented as a choice, but it's not really a choice. Veterans aren't really given the choice. There are so many service providers who have done good work, and they're being told they can no longer work with our veterans, so clearly there's a problem.

Rather than focusing on debating that problem, I'd like to talk about the solutions and what we can do going forward. Ms. Hicks or whoever from Veterans Affairs, maybe you could indicate... This contract is coming up for renewal. What could be done differently, when we set this up the next time, to make sure that veterans are able to work with the providers they want to work with?

● (1235)

Jane Hicks: Madam Chair, 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 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.

Blake Richards: I appreciate that, but I don't think it's just confusion. There seems to be.... We hear all the time that their benefits are being threatened, and things like that. There's obviously an issue there. Is that something that's considered acceptable under this contract? What can you do to put a stop to that?

Jane Hicks: First of all, threatening a veteran is not acceptable, and that needs to be escalated so we can deal with it. That being said, in order to receive the income replacement benefit, you have to be participating in the rehabilitation program, and that is based on the VAC legislation and our policy. It doesn't have anything to do with PCVRS. They're delivering based on the rules we have in place or the framework we have in place.

Blake Richards: I'm certainly not suggesting that it is a PCVRS thing. This is obviously a problem within the system, and that's what I'm getting at here. What can we do to fix that? We hear this repeatedly from veterans, all the time—

The Chair: Thank you very much, Mr. Richards. I apologize sincerely. Next round, you will have a chance.

We'll go to Mrs. Hirtle for five minutes.

Alana Hirtle: Thank you, Madam Chair.

One of the stated goals of PCVRS was to free up case managers at VAC to deal with other issues. What does that look like in practical terms for case managers?

I'll go to Ms. Hicks or Ms. Pham.

Nathalie Pham: Since we introduced PCVRS, they can spend more time with veterans, as I stated before. Also, for a lot of the administrative tasks, as you can hear, case managers were saying that they had to spend a lot of their time coordinating, from finding providers to billing issues. It all went through the case managers. With PCVRS, those are tasks they no longer need to handle.

We could talk about all the bureaucracy that is associated with their job, but there are a list of things that we have removed: sending out letters, coordinating providers, following up with the providers, getting reports. In terms of the billing issues, now they only have to deal with PCVRS. The other providers have to deal with PCVRS if there are billing issues.

For all of that, the main purpose is to allow them to do their case management job: to spend time following up with veterans. We will hear that they still find they might have administrative issues, but there is evidence that we have reduced them. Of course, now some may say, “we still have to follow up with PCVRS”, but they're not following up with 12 providers anymore.

● (1240)

Alana Hirtle: Thank you for that.

Ms. Lockyer, this one might come over to you. I'm wondering about mandatory training for your RSS folks. Is there training on military culture, trauma-informed care and service-related injuries?

Sonya Lockyer: I can read the list for RSS if that would be helpful. We have it right here.

As I mentioned, there are over 10: understanding veterans; fundamentals and service delivery parameters; mental health awareness; discussing suicidal ideations with participants; suicide risk protocols; program orientation; caregiver considerations for women veterans particularly; RSS clinical approach; privacy security, which is obviously increasingly important these days; process and procedural training.

All of that goes to say that there is a big effort when we onboard our staff to get them oriented and ready to serve. That being said, as I mentioned before, sometimes we have to retrain. We do watch quality and performance. We do terminate when things aren't going well. We also celebrate some of our RSSs. I'm deeply aware right now that the Toronto Star article has actually impacted them as well, because a lot of our RSSs are doing extremely good work and go above and beyond. Again, I'm happy to share some of the positive testimonies where veterans are saying that their relationship with their RSS was one of the most meaningful and that it finally felt like rehab to them.

It's easy to make a good news story about bad news, but there is good news as well. I think we have to acknowledge that there are both. I'm not here to say that we have it all right. I don't think anyone at this table thinks that. That's not the nature of the meetings that we have. We actually don't spend enough time talking about what we have right. We're often asking, "How are we feeling?" and "How do we do better?"; and that's why we're here today. We want to listen, and we want the voices of veterans at my table and at our table so that we can respond.

Alana Hirtle: How were those 10 areas identified? How did you come up with those?

Sonya Lockyer: I wasn't here when the contract was made, so I'll pass it over.

René Deschamps: That was developed in collaboration with VAC in terms of the areas that required specific training for the RSSs.

Alana Hirtle: Was feedback received from veterans as part of that process?

Jane Hicks: Yes. We work with our field colleagues to determine the training. As part of the implementation or development of the new contract, we also consulted with our ministerial advisory group on some of the contract parameters, what we were moving forward with, why we were doing it and how we were doing it.

Nathalie Pham: Our staff and our case managers were also consulted on what would be some of the training that PCVRS would need. I think some of this training is part of our own onboarding. That was taken into consideration as well.

Alana Hirtle: That's my time. Thank you very much.

The Chair: We will now invite Madame Gaudreau.

[Translation]

You have two and a half minutes.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

What I heard from the witnesses is that they lack some things to improve services or to properly identify their needs. That's what I took away.

If we don't know these things, we won't be able to do anything. We need to hear about the cases. We're happy when things are going well, but what concerns us is what's not working as well. I heard my colleague ask if the meetings were sufficient. Since you need testimony to make a 180-degree shift, perhaps, in the end, what's needed is funding or recognition.

Madam Chair, I would like to give notice of the following motion:

That, in light of the testimony heard during the course of this study and the need for the committee to hear additional witnesses, including health professionals, researchers and veterans, regarding the Partners in Canadian Veterans Rehabilitation Services program, the committee add at least three additional two-hour meetings in order to continue its study on Monitoring of the Rehabilitation Services Contract Awarded to PCVRS.

• (1245)

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

I just want to know something. We had already added a meeting. You're suggesting three more meetings, right?

Marie-Hélène Gaudreau: Yes, Madam Chair.

The Chair: I wanted to make sure I understood.

Marie-Hélène Gaudreau: I'm proposing at least three meetings. Obviously, we'll proceed based on the responses we receive. I've received too many responses. We're all politicians, and I've received responses from politicians. We need to go a little further to provide what's necessary so that people can knock on the right door. Veterans are suffering, and some are dying.

The Chair: Okay.

You have 20 seconds left.

Marie-Hélène Gaudreau: I'd like to tell the witnesses that I'm very grateful for their work and for what they are trying to achieve. As for me, I have a duty to speak on behalf of the people who elected me. I know that compassion fatigue can sometimes hit us hard.

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

[English]

We now go to Mrs. Wagantall for five minutes.

Cathay Wagantall: Thank you so much, Chair.

Thank you for persevering with us today.

It was commented that we're in the early days of this program. I think that for some of you, it's been a shorter amount of time. This contract is set to expire or be reconsidered in December 2026. In 2021, in the years preceding its start with PCVRS, there were 14,377 participants in the VAC rehabilitation program. As of March 31, 2024, that dropped to 12,554. That's a drop of 1,823 veterans. I'd like to think it's because everything was good.

Can you very briefly tell me why? For the number of individuals who dropped out, did they lose their income replacement benefit?

Sonya Lockyer: When the program started—you mentioned 2021—we had a two-year implementation period when we were getting all our processes in. We actually had to build a net new IT system to govern and shape this. There were 10,000 veterans waiting the day we turned the program on. Right now, we're seeing about 300 veterans a month entering the program.

It's natural that we would have had a large number of veterans enter the program at one point. It's now at a steady state. If you think about it, with 300 a month, we should see the numbers come down in roughly 12 to 18 months.

Cathay Wagantall: What happened to the 1,823 who were no longer part of the program at that time? Did they opt out? Did they not get their income replacement benefit?

Sonya Lockyer: I can hand it over to Mr. Deschamps to explain.

Cathay Wagantall: Perhaps you could just briefly clarify it for me.

René Deschamps: Most likely, rehabilitation potential was identified but no rehabilitation was further required, and the participant would have moved. That's when we would recommend file closure. That's when they would move to another VAC program, like DEC.

Cathay Wagantall: It's been two years now since that drop. How many veterans are currently enrolled in the rehabilitation program?

Sonya Lockyer: There are 11,700.

Cathay Wagantall: Are they all receiving the care they need at this point in time? Have they been processed through VAC to PCVRS, and are they now seeing providers?

Sonya Lockyer: They would all be at different stages of their rehabilitation journey. Some may be currently in the assessment phase and some may be in the treatment phase. Some may be in graduation.

• (1250)

Cathay Wagantall: Do you have an idea of how many are in each of those phases?

Sonya Lockyer: We do.

Cathay Wagantall: If you could provide that for me, I would really appreciate it.

Sonya Lockyer: For sure.

Cathay Wagantall: Thank you.

We talk about “rehab specialists”. What I hear from veterans who have received care previously is that they see the people who have been serving them as specialists. I'm sensing that there are the experts and then there are the providers. I struggle a little bit with

what that means. Really, it's the providers who have that relationship ability and all those things already in place.

Do you try hard to keep those who were previously part of the service providers? How many of them actually chose, because of the complications of the process, to drop out? Can you tell me how many quit?

Sonya Lockyer: I can't tell you that precise number, but maybe I can give a little bit more nuance on how it works.

The spirit of the program is that you are now transitioning into a specialist program. You can think of it like going from a general program into a specialist program. The continuum of care.... It hurts me when I hear that the providers they currently have were not consulted and that no one from PCVRS reached out to them. That is not how the program was designed. We can share more about that, if you're interested.

The idea is that we're now moving to a specialist, based on function and based on rehab. We're actually just looking at function in this program and improving function for veterans. It should be an “and” situation, not an “or” situation. Somehow, I'm feeling that we've created an “or” situation here, where you can't continue to receive maintenance care and you can't continue getting the treatment you wish. It needs to be “and”.

Cathay Wagantall: In 20 seconds, I'll just say that I have loved ones who provide that care. They are incredibly qualified. I'm concerned about the dynamics around this, making it more difficult for veterans to get the care from the people they would choose to get it from. I would recommend that whatever you do to determine whether or not they qualify, veterans be able to see those providers and why they qualify when others don't—

The Chair: I'm sorry, Mrs. Wagantall. I have to interrupt you. Thank you.

[*Translation*]

Mr. St-Pierre, you have the floor for the last five minutes.

[*English*]

He will be addressing our panellists in French, so please make sure you have your earpiece in.

Eric St-Pierre: Maybe I'll proceed in English with Ms. Lockyer, and then in French with Madame Bourgeois, just to switch it up.

I want to keep my friends on their toes.

Voices: Oh, oh!

Eric St-Pierre: First, thank you, Ms. Lockyer, for your service. I think it's probably unanimous here that Canada needs a lot more people like you. Thank you for the service you've provided to Canada in defending our great country.

I also appreciate that earlier you mentioned that generally the messaging you're receiving is quite positive. It's easy to focus on the negative. That's something that I'm seeing is quite common in the House of Commons these days, but I appreciate that you mentioned that overall the messaging is quite positive.

I'm wondering if you could speak a little bit about what you've seen so far. What has actually improved? Are veterans getting services faster or seeing better outcomes? I'm wondering if you could speak to the better outcomes that veterans are receiving.

Sonya Lockyer: Absolutely. Access timelines alone speak for themselves. Ms. Bennett mentioned that referral to a first assessment is roughly 30 days. If you think about that for a mental health appointment in Canada right now, that is nowhere available. Within the PCVRS network, we have allowed that to happen by bringing clinicians to the table who are like-minded and committed to veterans. I think access alone has improved.

Again, coming back to the inception of the program, there were definitely communities that.... When we first started the program, we didn't really know where the veterans were going to need care, so as they were coming, we were building. We've been building quickly. If you think about 15,000 today, we started with 4,000. If you think about 300 affiliates, we now have 600 affiliates. We continue to build the network based on where the veterans are and based on their needs. That's number one.

The second piece is, how do we continue to focus on improving the network? I get what you're saying in regard to positive.... We want to be positive, 100%, but that's not where I want to spend my time, especially with the Toronto Star article and everything that I'm hearing here today.

I hear the call to action. We need to understand the gaps, and we need to focus on how we're going to fill them.

Eric St-Pierre: Thank you for that.

Sometimes this discussion feels a little bit high-level. Can you provide some concrete examples and maybe speak to a story or two of what you're hearing on the ground in terms of the positive support that veterans are getting from this program?

Sonya Lockyer: Absolutely. If you'll bear with me, I'd love to read some feedback given to me that veterans allowed me to present in one of our town halls where we generally celebrate all wins.

One stated, "The program has changed my life, and I am very grateful for the opportunity to participate fully in chasing my dreams to start a new career. Thank you to my VAC case manager and my PCVRS RSS for walking this journey with me these past few years. They always went the extra mile to help me achieve my goals. The impacts of my PTSD on my working career in the military and afterwards in the corporate world weren't understood by me and had grave impacts on my career choices." I'll skip the middle part. It continues, "I am not just managing my symptoms any-

more; I am recovering. My life has changed. It's been a godsend to be eligible for this support. I threw myself into the program wholeheartedly, and I'm proud of all I've achieved."

There are pages with feedback. It's important to know that we have gaps. I want to understand those gaps so we can have more people writing these stories, but we can't negate that this program is working for some veterans, though not for others. It is important to stay focused. These are heartwarming testimonials. Again, I'll take it. Maybe I was only listening to that. My ears are different today, and I appreciate your patience with that.

• (1255)

Eric St-Pierre: Thank you.

I really appreciate your sharing those personal stories.

[Translation]

Dr. Bourgeois, could you briefly, in about a minute, talk about access to mental health services? Can veterans get help more quickly? Can you, in 45 seconds, comment on these services and their positive impact on the mental health of veterans?

Sylvie Bourgeois: Access to services depends on an assessment. This program focuses on improving an individual's ability to function in daily life. That functioning can be compromised by mental health challenges. For us, access to resources is often interdisciplinary: Mental health resources are needed, but so are occupational therapy and physical therapy resources. These resources focus more directly on the individual's daily functioning, even where the underlying issue may stem from a chronic mental illness.

So, yes, access to mental health resources is necessary, but access to biopsychosocial resources is also needed to improve an individual's functioning. I think that would be an asset.

Eric St-Pierre: Thank you.

[English]

Lastly, Ms. Lockyer, earlier you mentioned links to some of the reports and testimony. Could you provide those reports or testimony to this committee, if you have a chance?

Sonya Lockyer: As long as we can de-identify them and ensure privacy, I will, absolutely.

The Chair: Thank you very much.

[*Translation*]

I'd like to thank the witnesses.

[*English*]

I know it was two hours, so thank you for joining us. Thank you for your contribution to our veterans community.

Certainly, Ms. Lockyer, thank you again for your service.

[*Translation*]

Our next meeting will take place on Wednesday, March 25, 2026. We will resume our study on the monitoring of the rehabilitation services contract awarded to PCVRS. In the first hour, we will hear from the veterans ombud and, in the second hour, the Minister of Veterans Affairs will appear.

The meeting is adjourned.

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