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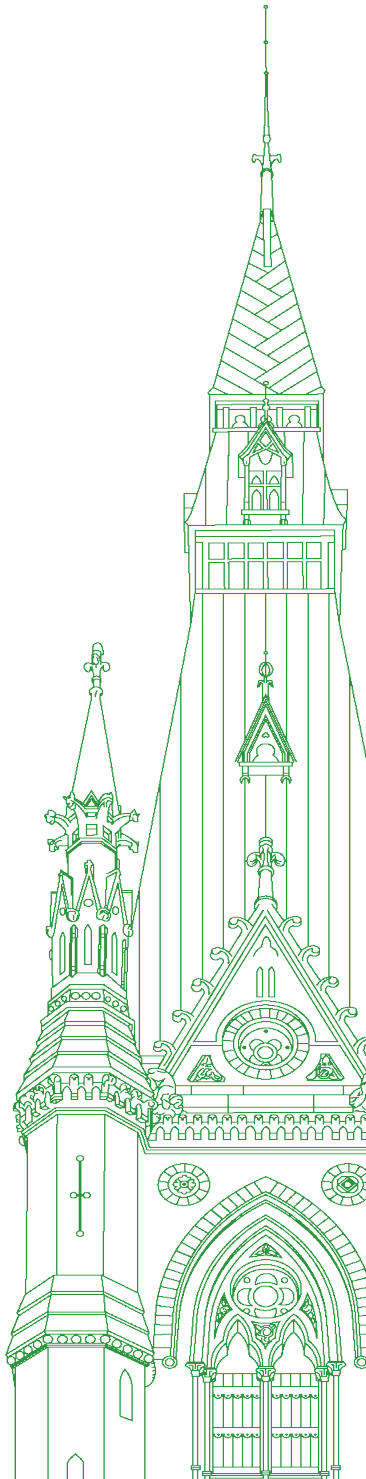

Chair: Marie-France Lalonde

Standing Committee on Veterans Affairs

Wednesday, April 22, 2026

● (1630)

[*Translation*]

The Chair (Marie-France Lalonde (Orléans, Lib.)): Good morning, everyone.

Welcome to meeting number 31 of the 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 the organization Partners in Canadian Veterans Rehabilitation Services, or PCVRS.

[*English*]

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

I would like to make a few comments for the benefit of witnesses and members.

[*Translation*]

Please wait until I call on you before speaking.

If you are participating in the meeting via video conference, click the microphone icon to unmute your microphone. Please mute it when you are not speaking.

[*English*]

To those on Zoom, at the bottom of your screen, you can select the appropriate channel for interpretation: the floor audio, English or French. Those in the room can use the earpiece and select the desired channel.

Before introducing our witnesses, I would like to touch on a bit of housekeeping.

Earlier this week, a draft budget was distributed for our upcoming study on the main estimates for 2026-27.

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

Some hon. members: Agreed.

The Chair: Thank you.

[*Translation*]

I would now like to welcome our first panel of witnesses.

[*English*]

From Broken Squirrel Wellness, we have Mackenzie Scharf, manager, clinic services, by video conference. From Mindspa Mental Health Centre, we have Michelle Massunken, clinical director. From the Veterans Transition Network, we have Mr. Oliver Thorne, chief executive officer, by video conference.

Each witness will have five minutes to give their opening remarks. We will then proceed to a series of questions with the members of the committee.

I would like to invite Ms. Mackenzie Scharf to go ahead.

The floor is yours for five minutes.

● (1635)

Mackenzie Scharf (Manager, Clinical Services, Broken Squirrel Wellness Ltd.): Good afternoon, everyone.

My name is Mackenzie Scharf. I'm the clinical services manager here at Broken Squirrel on Vancouver Island, where we have been providing services with a PCVRS contract to veterans in our area. My role is overseeing the clinical programming, supporting the referrals and supporting the providers and veterans as they navigate the rehab pathway.

I'd like to start by acknowledging a few aspects that, since working with PCVRS, are working well. In our experience working with the case managers, they've generally been very responsive, collaborative and open to the clinical input from our team. We have had opportunities where treatment requests are initially declined. We find that there's often a willingness to reconsider when additional rationale is provided. We believe that this demonstrate a level of flexibility and respect for the clinical judgment of our team, which is extremely important when it comes to complex care.

Additionally, in working with PCVRS, we have seen a level of adaptability in the scheduling and the service delivery. We're in a smaller area on the island with limited access to clinics that also hold the contract. They have been quite flexible in allowing us, with our interdisciplinary rehab programs and single services, to schedule in a way that meets the needs of our community and our veterans.

We really do believe that these strengths are important and worth preserving in any negotiations going forward.

At the same time, we would love to take this opportunity to share some challenges that we see at the clinical level, with the intention of contributing to ongoing improvements in the system for the veterans that we're supporting. Our intention is that by identifying these areas, we can continue to work together to reduce barriers and better support the veterans that we're here to serve.

One of the most pressing challenges we see is inconsistency and a lack of clarity in the standardized processes. There's often some confusion around workflow requirements, such as when approvals require VAC involvement versus when decisions can be made within the PCVRS level. We see that this uncertainty can create delays and administrative burden for the clinics. It can also make it difficult for the veterans to understand and navigate their own care.

We see opportunities to strengthen the communication between PCVRS, Veterans Affairs and the treatment providers. At times, when veterans are receiving updates about approvals or denials before the clinical team is informed or able to support, it can be unsettling, particularly for those receiving psychological care, as it can impact trust and leave the providers unable to support their clients in real time.

Another area of concern that we see is delays in care. The process of submitting recommendations, undergoing review, requiring VAC approval and then returning decisions through the system can sometimes take several weeks. During this time, veterans may be left without active support. In some cases, they're encouraged to use alternative benefits such as Medavie, even when those benefits are intended for maintenance rather than active rehabilitative care. From our perspective, this raises important considerations around continuity and appropriateness of care.

Particularly from our counselling team, there's concern around the reassessment process for psychological conditions. It can be demanding and, at times, counterproductive. Frequent reassessments can contribute to withdrawal from care or worsening of symptoms. Many veterans are already experiencing anxiety related to evaluation, and the repeated assessments can reinforce fears of losing support if they are perceived to be improving, which makes it challenging to celebrate the great progress that they make while under our care.

Additionally, the timelines associated with rehab and vocational programming don't always reflect the complexity of the individuals we're supporting. Many veterans present with multi-faceted physical and psychological conditions that require longer-term, flexible approaches. Rigid timelines can unintentionally increase the stress and overwhelm rather than support their recovery.

We also observe some variability in the level of support veterans receive from their case managers. While many provide excellent guidance and advocacy, the differences in approach can lead to inconsistent experiences for the veterans, with some feeling well supported and others feeling uncertain about the next steps.

The administrative complexity can be an ongoing challenge, with many veterans experiencing difficulty navigating paperwork and processes independently due to cognitive or mental health concerns. Without adequate support, this can delay care, interrupt the continuity and increase their feelings of isolation. Greater clarity around the available supports for these administrative requirements would be beneficial in helping the veterans remain focused on their recovery.

Streamlining our communication pathways, reducing delays in approval processes and clarifying the rules are some areas of improvement that we would love to see happen going forward with PCVRS.

● (1640)

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

We'll go to Mr. Thorne for five minutes.

Oliver Thorne (Chief Executive Officer, Veterans Transition Network): Hello, and thank you for the opportunity to speak today.

[*Translation*]

I apologize. My testimony today will be in English only, due to time and language constraints.

[*English*]

My name is Oliver. I am chief executive officer of the Veterans Transition Network, a charity that provides group counselling programs for veterans of the Canadian Armed Forces and RCMP.

For over 25 years, our programs have helped men and women in uniform address the challenges of service-related mental health and the transition to civilian life. Today, we offer these programs across Canada in English and French for men and women, always free of charge.

As Canada refocuses on recruitment, supporting veterans' well-being and successful reintegration, services like ours will be more important than ever in providing trusted, community-based support where it's needed most.

We have been a registered service provider to Veterans Affairs since 2012. This means that Veterans Affairs Canada will cover the cost of eligible clients who attend our program. Historically, this eligibility and funding approval process has been complicated and inconsistent, meaning we often serve Veterans Affairs clients without Veterans Affairs funding, so when it was announced that Partners in Canadian Veterans Rehabilitation Services would take over this program administration, we were optimistic that the problem might improve. My testimony today will focus on why it did not and why that matters for veterans' care more broadly.

When PCVRS was contracted to administer the vocational rehabilitation program, we were instructed by Veterans Affairs to register with them as a service provider. We initiated that process in February 2023, and it took two years and four months to complete. Over that period, we sent 16 messages to PCVRS, 14 of which received no response. Our point of contact changed five times, and with each change, no information was handed off, meaning that we essentially restarted the process every time.

When we were finally given the option to register, a year into the process, we were told that we could do so either as an affiliate provider or as an out-of-network provider. The affiliate status came with administrative requirements that we were not confident we could meet, as a charity with a small team, and still maintain our client-centred focus. We chose to register as an out-of-network provider.

Another year later, in June 2025, we were informed that the registration was complete, but that as an out-of-network provider, PCVRS was unable to refer any veteran clients to us. This was never disclosed during the registration process.

In total, it took 28 months for PCVRS to inform our charity that they would not refer any veterans to our evidence-informed program, which has been serving veterans successfully for over 25 years.

The flaws in this process are not just administrative inconveniences. They have real consequences for two important issues related to veterans' care in Canada.

The first is accessibility. We've appeared before this committee many times, and our message is always consistent: Veterans are a unique population, and supporting them requires programs that are specialized, culturally competent and accessible. Based on all of our conversations with veterans and other service providers, PCVRS has significantly narrowed veterans' freedom of choice and their access to available programs. Instead, they favour lengthy assessments and a structure that funnels veterans toward their preferred affiliate providers. We would be interested to know if there's any reason PCVRS has favoured or streamlined the process for some providers and not others, and whether that's a previous relationship, formal partnership or terms and conditions that weren't clearly communicated to all.

The second reason this matters is preparedness. Canada is significantly increasing defence spending, and the Canadian Armed Forces is expanding recruitment and operational activities domestically and overseas. The downstream consequence of this is predictable: More Canadians will come home from service needing effective and accessible supports.

This challenge is not new. We have seen it before. Following Afghanistan, tens of thousands of men and women came home to a system that was not fully prepared to meet their unique needs. That gap was a driving force behind the creation of our charity.

This challenge is not theoretical—it is happening now. We are already working with veterans who served on Operation Unifier and Operation Reassurance—men and women with exposure to trauma and moral injury from those operations.

As a national service provider, we're preparing now for a future with greater demand, and the broader system of veterans' care in Canada needs to be prepared too. That means removing barriers to care, not building them.

This committee has an opportunity to correct a serious structural problem before it compounds, so I ask the committee to do three things. First, investigate if there are previous professional or financial relationships among PCVRS's affiliate providers and its parent companies.

Second, review whether the out-of-network designation is excluding proven, independent service providers, and if so, why?

● (1645)

Third and finally, act on that information and ensure that the system governing veterans' care allows access to specialized, culturally competent supports without unnecessary barriers.

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

Now, for five minutes, we will go to Ms. Massunken.

Michelle Massunken (Clinical Director, Mindspa Mental Health Centre Corp.): Thank you.

Good afternoon, Madam Chair and members of the committee. Thank you for the invitation to be here today.

To briefly situate my perspective, I am a trauma therapist who has been working with veterans, CAF members and RCMP members for the past 17 years. I'm also clinic director at Mindspa Mental Health Centre, an affiliate within the PCVRS network.

Since joining the network, we have supported nearly 100 veterans across Quebec, Ontario and parts of Atlantic Canada, both virtually and in person, with services being offered in French and English. Our virtual model has also expanded access to veterans in rural and remote communities, who might otherwise face barriers to care.

Over the course of my career, I have seen the rehabilitation program evolve from a system that was coordinated directly by case managers, to the current PCVRS model. Today, I'd like to offer a balanced perspective of what's working well and where there are clear opportunities to improve.

To start with strengths, I have seen improved access to care, particularly for veterans in remote regions. Many are now able to connect with appropriate providers more quickly, without having to navigate the system on their own. This has reduced barriers and allowed veterans to engage in treatment sooner.

For example, I recently worked with a VAC case manager to coordinate care for a veteran who was not yet in the rehab program. Scheduling that initial appointment took several weeks. In contrast, under the PCVRS model, once a rehabilitation specialist is involved, appointments can often be arranged within days. That difference in timeliness is significant, particularly for veterans who are in acute need of support.

We also saw this early in one of our first PCVRS participants, a veteran who was incarcerated and who would typically face significant barriers accessing care. Through the program he was able to engage in treatment while serving his sentence, and we saw clear, measurable improvements in his mood and his overall functioning.

When the model is working well, I have seen strong multidisciplinary collaborations with coordinated care across providers. I also see standardized reporting practices and the use of outcome measures to track progress and to inform the care.

That said, one of the most significant challenges I experienced early on, and one that continues to be echoed throughout the committee and in some of the testimony we heard today, is a lack of clarity and education around the nuances of the program. This lack of clarity, if left unresolved, has real clinical consequences. In response to that, I have made it a priority to maintain open lines of communication between our team and the PCVRS team, including Peter Adams and Karen, and Dr. Bourgeois. We have received support when clarification is needed.

Closely tied to this is a fear among veterans of being cut off from the program or losing access to services. While the structured, time-limited nature of rehabilitation is intentional and important, it's not always clearly communicated. As a result, some veterans experience the program as rigid and high stakes.

I want to emphasize that the system can work well when flexibility and clinical judgment are applied. For example, I worked with a veteran medically released for PTSD, who had already completed a comprehensive assessment. A reassessment was not clinically indicated, as it could have risked destabilizing her. Through collaboration with her VAC case manager, we readjusted the plan and moved directly towards a determination of diminished earning capacity.

This is an example of the system working as intended, but it required advocacy and a level of clarity that isn't always made available to veterans or providers.

At its core, what I'm observing is a model with strong foundations and clear impact, with opportunities to enhance how it's actually experienced on the ground. The program is already working for many veterans, so the opportunity now is to build to that success and ensure that it works consistently for all.

In closing, PCVRS represents an important evolution in how rehabilitation services are delivered. It has improved access and introduced greater structure and coordination. For it to reach its full potential, it must be clear, consistent and well understood. When those elements are in place, the program has the capacity to be truly transformative for the veterans it serves.

Thank you for your time.

The Chair: Thank you very much.

We will now start our first round. Each of our members will have six minutes.

As I said to those online, I apologize in advance if I have to interrupt you. I'm going to be very strict on the six minutes for each of our members of Parliament.

We will start with Mr. Richards, for six minutes.

● (1650)

Blake Richards (Airdrie—Cochrane, CPC): Thank you.

First of all, I'm looking for a yes or no response on this.

I'll start with you, Ms. Massunken, and work on to those on the screen.

Prior to the contract with PCVRS, did you or your organization provide rehabilitation services to veterans? Provide just a yes or no on that, please.

Michelle Massunken: No.

Blake Richards: Okay.

Ms. Scharf?

Mackenzie Scharf: Yes.

Blake Richards: Mr. Thorne?

Oliver Thorne: Yes, the majority of our Veterans Affairs clients are in the vocational rehab program.

Blake Richards: I'm having trouble hearing them.

Okay. The next question I have is for you, Mr. Thorne.

I was struck by your testimony regarding your efforts to become a provider or to continue to be a provider: that it was two years and four months, 16 messages—14 of them unanswered—and five changes in your point of contact, and that, at the end of all of that, essentially what you found out was that what you were applying to become was meaningless because you couldn't actually serve veterans as a result.

I guess what I'd like to ask—and maybe I'll ask Ms. Scharf as well, to follow up following this—is this: What kind of effect does it have on veterans when they've worked with someone, a trusted provider, and then are told, "Do you know what? We're going to have to change you to someone else"? Obviously, this process that you had to go through, Mr. Thorne, is so difficult to navigate for these service providers. In some cases, no matter what they do, they're not even able to get approved, as you've experienced.

Let me actually ask this first: If it was that tough for you as a pretty significant veterans services organization—you guys are pretty significant—what is it going to be like for a small clinic somewhere to try to go through that process? It has to be even more difficult for them. It took you two years and four months. That's the first question.

The second one is this: What kind of an impact does it have on a veteran when they're told that they're going to have to switch providers just because this program doesn't seem to have a process to enable the provider they had before?

Oliver Thorne: There are a couple of points there to address. I think the first is what it is like for a small clinic.

The Chair: Stop the time.

Mr. Thorne, I'm just going to ask you to hold for a second. We are having some technical problems hearing you, unfortunately. We're just going to see....

What you didn't hear is that Mrs. Gaudreau is getting great sound, unlike some of us who are listening to you in English, unfortunately. We're having a lot of.... Maybe tell us a little bit about the weather where you are, please.

Oliver Thorne: Sure.

We started off the day with sunny skies and decent temperatures, but it's getting cooler. I'm told there's rain coming later on in the day.

How's that?

The Chair: Okay, that's a bit better.

I apologize for having to interrupt you. Maybe start your answer as Mr. Richards was asking you the question.

Oliver Thorne: Okay. Thank you very much.

Maybe I'll address three points: the impact on us, the impact on small organizations and the impact on veterans.

First, I should be clear that this does not mean that we can no longer receive Veterans Affairs funding. We still can apply for that approval process through Veterans Affairs and Medavie directly. It remains challenging and inconsistent. Our hope was that the involvement of PCVRS as the organization managing the administration of vocational rehabilitation—and the majority of the Veterans Affairs clients we serve are on the vocational rehab program—would streamline.... It has not. It's been difficult, if not often impossible, to speak to them. The majority of that period of two years and four months is just extended periods of silence where they were not responding to any of our messages. Over that period of time where PCVRS took over the contract, I can say that our approval rate for Veterans Affairs clients dropped by 30%, even though we continued to see the same number of Veterans Affairs clients.

The impact on the veterans for our organization, in a sense, is minimal, because we will never turn them away if they are not funded by government funding. We will draw upon the generous donations that we receive from Canadians, foundations and charitable institutions to make sure that the program stays accessible. However, the result is that we can run fewer of these programs, because the systems that the government has in place are not sending the money to us for the government clients we treat. We'll never turn them away, because we know that two-thirds of the folks coming to our programs have considered suicide very recently.

The impact, then, on small organizations, particularly the impact on mission-driven organizations like ours, which spends only 15% of every dollar on administration.... We don't have a large administrative team that can focus on a two-year application process and going back and forth with these folks. We spend 85¢ of every dollar we have on veterans' care, because that's what our donors expect and that's what, as a charity, we should be doing, but we are then not able to contend with this massive process of administration that some other providers may be better able to contend with. As a mission-driven organization that has to keep a lean overhead, we cannot. I believe that would be the same impact on other charities, nonprofits and mission-driven organizations.

● (1655)

Blake Richards: Before I go to Ms. Scharf with that same question, can you, Oliver, give us a sense of what the fix would be? How do we fix this?

Oliver Thorne: It seems to me that this is perhaps an extension of the problem that we have seen in Veterans Affairs as well, that the systems are not well established to recognize a wide variety of different types of service providers. They're pretty astute at recognizing what a counselling clinic looks like. However, with a national organization that is registered in eight or 10 different provinces, with various colleges, and all of the differences that come with that—the fact that we deliver an in-patient program that doesn't occur on a weekly basis—this is where it seems to be challenging for us to be integrated into the existing system. They're good at recognizing clinics; they are bad at recognizing specialized services like ours. That is my admittedly limited take, because we have received so little information from PCVRS. That's about it.

Blake Richards: Thank you.

Ms. Scharf, what's been your experience in terms of the difference—

The Chair: I'm so sorry. I was just reminded that you're 15 seconds over time already. You'll have to get to it in the next round.

Blake Richards: Okay. Hopefully, I'll get a chance to ask that in a future round.

The Chair: Next is Mrs. Hirtle for six minutes, please.

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

Ms. Scharf, I'd like to start with you, please. I understand that you worked for several years at 19 Wing Comox, in recreation and fitness roles. Can you tell us what you observed during that time about the wellness needs of serving members and their families?

Mackenzie Scharf: Absolutely. I was PSP staff while I was there, so I will admit that I was limited in my knowledge of what was available for members following their release from the military.

I can speak, again, to being in the fitness area with them. There was a lack of.... At the gym, we had opportunities for veterans to come in and use the services at 19 Wing after they released from the military. We found that there was a disconnect and that, once members did leave, coming back into the gym was triggering. It was very challenging for them to feel a part of the active serving community. As a PSP member, we would get questions, while administering the force tests, for individuals who were not meeting the requirements to continue, or who were exploring medical release.

Personally, I had a lack of knowledge of what was available ongoing after they released, but I certainly saw that there was a disconnect from that community and more of a social isolation once they released from the military.

Alana Hirtle: Thank you.

While you were at the base then, what were the day-to-day issues that you saw coming up for both mental and physical health?

Mackenzie Scharf: The physical health perspective was probably what I had the most experience with. We would have members who were completing their force test, who were also recovering from chronic injuries from their time in service. We would see them for remedial PT to help support them back to meeting the physical requirements of the testing that we had to administer. Past that point, though, I didn't have any support ongoing with them in that process. It was strictly from the personal training perspective, my time there....

● (1700)

Alana Hirtle: That's completely fair. Thanks.

What supports were readily available on base? Were members able to find help off base? Are you aware of that? Do you have any idea?

Mackenzie Scharf: In my role, I was not. It was strictly with the personal training programs and the remedial PT. We did have a PES—a physical exercise specialist—who would support members who had more chronic or complex challenges going on. Again, outside of that physical training role, I was not aware.

Alana Hirtle: That's great. Thank you so much.

I'll switch now to Ms. Massunken. I have a couple of questions. Based on your clinical experience, ma'am, including your work at the Department of National Defence, what has your experience been while working with veterans seeking mental health care?

Michelle Massunken: I've noticed that the transition piece is one of the things that come up most often—identity, adjusting to life as a civilian, navigating the health care system as a civilian, versus those who were working as active service members. That's one of the main things that I would see, navigating the nuances of being a civilian.

Alana Hirtle: I can appreciate that, for sure.

Did you notice similar needs among veterans you had been working with?

Michelle Massunken: Absolutely. I think one of the biggest things we explore is grief around identity—"Who am I now?"—and having to navigate simply getting a family doctor, for instance, or even the health care system. Those are things that I have often seen with those I worked with before and that I see with those I work with now.

Alana Hirtle: Okay. Thank you.

You also mentioned a virtual program, I believe. Can you explain the differences? What are the differences between an in-person session or program and the virtual program that you would have offered?

Michelle Massunken: We're in a stage now where virtual mental health care can be as effective as in-person mental health care. At this point, it's about being able to realize that having access to the support is the most important piece versus no support at all. There are some interventions, perhaps, like EMDR, that are preferably done in person but can be still offered virtually as well.

There are a lot of similarities between virtual and in-person care.

Alana Hirtle: Was the acronym EMDR? Can you explain what that means?

Michelle Massunken: Yes. EMDR is eye movement desensitization and reprocessing. It does use a couple of different tools, like light bars, but the idea is to engage in bilateral stimulation, and that can be done virtually, by showing the client how to do that on their own.

Alana Hirtle: Okay. That's really cool. It sounds cool. I'm more of a meditation kind of gal.

You talked a lot about some of the challenges. In the 30 seconds we have left, are there one or two suggestions you could make that would improve the service?

Michelle Massunken: One would be having clear expectations and outlining those clearly to the veterans who are entering the program, in terms of what to expect as you enter or if you decide to enter the rehab program. Managing those expectations, I think, will be very important, as it is on the case manager side, because they often have the initial contact with the veterans before they are entered into the program. Inform the case managers and the veterans very early on what the program is and what the expectations are of the program.

The Chair: Thank you very much.

This is for the benefit of our witnesses. The next person, Madame Gaudreau, will address you in French, so I would invite each of you to make sure you use your earpieces and set the audio to the proper language.

[*Translation*]

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

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

I heard Mr. Thorne say that veterans are a unique population.

Ms. Massunken, is that statement true?

[*English*]

Michelle Massunken: I would absolutely say they are a unique population. They have a culture of their own, and their experiences are different from those of civilians. I would definitely agree that they are a unique population for many reasons.

[*Translation*]

Marie-Hélène Gaudreau: Thank you.

Ms. Scharf, what do you think?

[*English*]

Mackenzie Scharf: I would agree as well. From what I see with the veterans we support in the clinic, they are a group of folks who have become incredibly resilient in the job they have done to support our country. What I see is that the resiliency does not directly translate to the workings of day-to-day civilian life, and that poses a lot of challenges for the reintegration back into their day-to-day life.

● (1705)

[*Translation*]

Marie-Hélène Gaudreau: Mr. Thorne, why are veterans a unique population?

Can you expand on that?

[*English*]

Oliver Thorne: There are many different ways to look at it.

First and foremost, veterans are a unique population, because they have these deeply unique experiences. The job we ask them to do is unlike any, or many, others that occur in civilian society. We see elements of similarity with culture between those who serve in the Canadian Armed Forces and those who serve as first responders, such as firefighters, paramedics and police, but perhaps where that path can fork is that veterans have a very unique culture.

The process of becoming a soldier is a deeply personal and transformative process of entering into the culture of meeting the needs and the demands of the job, the work they do as a team and the team spirit and collectiveness.

There's one quote I can think of where somebody said, “[W]hen we leave the [Canadian Armed Forces], we find ourselves in a society where the notion of 'we' hardly exists.” It's this idea of moving from a culture and environment where there are such clear expectations around how one behaves and how one interacts.

Another veteran talked about the idea that they could look at somebody's uniform and know everything about them just by looking at that uniform. They could tell where they could serve; they could tell what their rank was and what element they were in. They knew instinctively by looking at somebody's uniform what their relationship was to that person—where they sat within the structure, the hierarchy, the overall mission and the operation of the Canadian Armed Forces. Then they come into civilian life and they try to distinguish one blue suit from another.

Ms. Scharf and Ms. Massunken talked about the idea of transitioning from a highly specific culture and way of life to one that has none of those elements. Comparatively, it's one of absolute chaos and disorder from the perspective of someone who has served, and it is an incredibly difficult psychological and social process for anybody to navigate. Now, let's layer on top of that a traumatic or moral injury, depression, anxiety or PTSD because of the things they've been asked to do or have witnessed overseas in defence of our country or in defence of our freedoms.

Responding to natural disasters here in Canada is an incredibly difficult process, and culture is an enormously important part of connecting with and helping people to navigate that process. If they are not understood, they will not trust. They will not be able to go into those experiences and address the trauma and address what has happened if they do not feel they can trust the person sitting across from them. The trust can emerge only if there is a level of connection and understanding of their experience, which is why military cultural competency is so important.

[*Translation*]

Marie-Hélène Gaudreau: Thank you very much.

I'd like to hear your opinion, Ms. Massunken.

We're talking about trust and a unique population. We're told that, sometimes, veterans have to switch care providers.

How can we successfully support our veterans if the trust relationship is not tangible?

What can happen to these people when care providers pass the buck and there are delays or a lack of clarity?

What are the repercussions?

[*English*]

Michelle Massunken: I think the consequence of that is the lack of continuation of their care and support. Once they have established that trust with the provider, the likelihood of their symptoms improving continues to grow. When that's disrupted, then we'll see a disruption in their wellness, and that's a significant part of it.

In terms of building on that trust, because it's such a unique population, going back to the point Oliver made around competency, it's about ensuring that there is a level of cultural competency and understanding the uniqueness of the military culture. It's about understanding the importance that culture has in terms of how they're managing their symptoms, especially if it's a trauma symptom or a moral injury symptom.

Being able to understand the culture allows for there to be better engagement and better support offered to them as well, but that trust comes only when the culture is understood.

● (1710)

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Madam Chair.

[*English*]

The Chair: We will now start our second round with Mrs. Wagantall for five minutes.

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

Mr. Thorne, you've been here many times, and I would like to cut to the chase.

You made three recommendations that you felt needed to be addressed. So many veterans are struggling because they've lost their providers and they've had to do assessments again, and it's a very difficult environment. In your first recommendation, you said that in relationships between providers that exist now with PCVRS, there needs to be an investigation as to how and why those particular relationships are there.

Can you put that into words in the form of a recommendation we could give to this committee to send to the government?

Oliver Thorne: I think the recommendation centres around trying to gain a greater understanding of how affiliate providers who receive referrals are selected. We were presented with simply two options and not a lot of clarity as to what it actually meant to choose either one of those options.

In the experiences we've had, speaking with veterans in our network and with other providers, we have encountered a lot of confusion about how affiliate status is assigned and how it fits with the existing services that have been serving veterans for years and sometimes decades. I think our recommendation is to understand more clearly how that process occurs and if there's an existing relationship of some kind between PCVRS and some or many of those affiliate providers.

Hopefully, that offers a—

Cathay Wagantall: Okay. Thank you.

You spoke a bit about that “out of network” experience. I interpret that as meaning you don't fit. Is that basically it?

I will say about your particular organization that it is incredibly effective. Across the country, you also have an advantage that, yes, you can fund, and you would not turn someone away. When an organization like that or a PCVRS has that option, it concerns me that you aren't treated like all of the others. Is that what you're referring to, that this needs to be reviewed? Why in the world is that even there?

Oliver Thorne: Yes. My confusion is that a program that is research evidence-based, run by licensed mental health professionals, has a 25-year history and has been built from the ground up specifically to support the mental health of veterans from service-related injuries and transition somehow does not qualify for referral. Again, I think the model is a good fit for clinics. In a way, perhaps because we are built from the ground up to be accessible to veterans, to be national, to be bilingual and to be gender-specialized in our programs, those things almost make us a bad fit for the existing classification or taxonomy system of PCVRS. I think that's an issue. Because we're national and because we don't fit the model of a stand-alone clinic, we don't fit their criteria to be an affiliate provider. Well, those are the things that make us a specialist veterans' provider.

Cathay Wagantall: Thank you.

I have one more question. You mentioned that maybe the problem is that you are “mission-driven”. Does that also mean you are not profit-oriented, and maybe that's a problem? Why are you saying that being mission-driven seems to be a problem? It seems irrational.

Oliver Thorne: I think it's an issue because we keep a very lean administrative staff and a very lean overhead. That structure is part of the reason we felt we could not consistently meet the administrative requirements of an affiliate provider. We chose that as a network, but again, it was not made clear to us what that choice meant—that one option meant we would get no referrals whatsoever.

To answer your question, no, we are a non-profit. We are a registered charity.

● (1715)

Cathay Wagantall: Thank you very much.

In my last 10 seconds here, let me say that I'd certainly like to see your organization have the role it should have within VAC's prospective PCVRS.

Thank you for being here again today.

The Chair: Thank you, Ms. Wagantall.

[*Translation*]

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

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

I have a question for all three witnesses.

I'd like to build on my colleague's excellent question.

Was it appropriate to lump veterans and their specific circumstances into a single group?

I'll start with you, Ms. Massunken.

[*English*]

Michelle Massunken: Is it appropriate to group them into one single group? I think we always want to be able to look at each individual's presenting concerns and presenting needs and treat them accordingly. Despite there being some similarities and some common threads among the groups, there will always be differences among them. It's important to take those into consideration.

[*Translation*]

Eric St-Pierre: Ms. Scharf, do you have anything to add?

[*English*]

Mackenzie Scharf: Yes, I think there are definitely such differences, even when you start to narrow in on the population. Just as we are unique human to human, the experiences that these men and women go through are affecting them in different ways as they come home. You can look at the spectrum of mental health diagnoses that we see among our veterans who come into the clinic—how it presents, how they are moving through that and how it's impacting their lives. It's unique from case to case, and it can be so complex when you look at all the layers that go into it. I think that's really a challenge when it comes to trying to standardize rehabilitative care.

While I understand there is a place where it is helpful from a treatment team, as well as giving structure to the person receiving care, there needs to be an element of flexibility that honours the complexity and the depth to which these folks are affected, and care there to support them until they get back to that place where they feel they can integrate and have a quality of life.

[*Translation*]

Eric St-Pierre: Mr. Thorne, would you like to comment?

[*English*]

Oliver Thorne: The short answer is no. We cannot treat them as one population. I think if providers do not recognize military culture and the military population as a unique population in and of itself, they're doomed to fail. Within that, there are many considerations for the populations that exist within the Canadian Armed Forces and veterans.

Our women's programs across Canada are adapted programs, because 60% of the women we serve have experienced military sexual trauma. That is a reality of the population we serve—it is a reality of that population within the Canadian Armed Forces—so we must adapt to it both culturally and programmatically. Our French programs are not just translations; they are cultural and programmatic adaptations to specifically address the unique challenges that veterans in Quebec struggle with.

[*Translation*]

I'm going to say this in French, and I apologize in advance for that. We want to provide the same level of service to all veterans across Canada.

Eric St-Pierre: Thank you.

I'll turn to you, Ms. Massunken.

According to the MindSpa Mental Health Centre, what factors have a positive impact on outcomes for veterans?

[*English*]

Michelle Massunken: I didn't get all of the question. What types of factors influence...?

Eric St-Pierre: Yes, what kinds of factors positively influence the veterans?

Michelle Massunken: I would say having community would be a positive factor that influences their wellness from a mental health standpoint. Whether that's a social network or community network, it's something similar to what they were used to while they served, but that's a huge and significant part to their wellness. Having that social support and being able to lean on that support in different environments has been a significant aspect, I would say, to their wellness.

[*Translation*]

Eric St-Pierre: Are there any barriers to veterans accessing mental health services, such as those you offer in your clinic?

[*English*]

Michelle Massunken: I feel like we've done our best to work through and identify some of the barriers, whether it's a language barrier or a geographical barrier or a regional barrier. I think one of the biggest barriers that continue to exist for some would be the stigma around mental health and accessing mental health care—what this would say about me, whether this is a sign of weakness, or what this might bring up for me.

● (1720)

Eric St-Pierre: Very quickly, Mr. Thorne, you mentioned a review of network designation. Can you elaborate on that in 10 seconds?

Oliver Thorne: I can do my best. We would like a review of whether proven, established service providers are being excluded from veteran referrals because they have been designated as out-of-network providers. That's what we're requesting.

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

We will now go to Madame Gaudreau.

[*Translation*]

You have the floor for two and a half minutes.

Marie-Hélène Gaudreau: Thank you very much.

This week, I asked the minister whether an independent investigation was required before automatically renewing the contract for six years. The ultimate goal is to ensure that the services delivered are exactly what veterans need.

That said, time is racing by. You all have expertise. I don't know what your workload is, but we are here to listen. I will ask you to answer my questions in turn, starting with you, Mr. Thorne.

If we had to change just one thing as a priority, what would it be?

What do we need to do now before we get the investigation results and get PCVRS back on track?

[*English*]

Oliver Thorne: I think any policy changes that relate to an increase in the accessibility and the range of choice that veterans have in the programs they can access would be good, and that's input from the veterans, not only from their rehab specialists.

[*Translation*]

Marie-Hélène Gaudreau: Ms. Scharf, what are your comments?

[*English*]

Mackenzie Scharf: It would be access to care. Being in a small community, we see a very high volume of veterans. We do our best as a small team to support as many as we can. We are also in a community that has expert, incredible clinicians. We have clinicians these veterans are already attached to, where a therapeutic relationship and trust have been developed, and it is critical in health care to keep those relationships. Opening it up beyond just specific clinics and specific providers, then, is going to eliminate the number of veterans who are considered to go into gap while they are awaiting services and waiting for our caseloads to come down.

[*Translation*]

Marie-Hélène Gaudreau: Thank you.

Ms. Massunken, do you have anything to add?

[*English*]

Michelle Massunken: Yes, I would echo much of that. I think in addition to the access piece, there's the piece about flexibility: When it comes to assessments, are they required all the time, or are there flexibilities around what that might look like for individuals?

In addition to flexibility, I would say accessibility, and what that looks like for individuals entering the program.

[*Translation*]

Marie-Hélène Gaudreau: Thank you very much.

I appreciate your answers.

[*English*]

The Chair: Thank you.

In our last round, we'll go three minutes and three minutes, to stay respectful of the other panel.

[*Translation*]

Mrs. DeRidder now has the floor for three minutes.

[*English*]

Kelly DeRidder (Kitchener Centre, CPC): Ms. Scharf, I'll start with you on the first question.

Was it easier to intake veterans who need support before or after the implementation of this program, and what has changed?

Mackenzie Scharf: I have been with our clinic for two years. I was not working as the manager before the PCVRS contract was taken on, so I can't speak to that.

I can say that currently it is a lengthy process from the time of receiving a referral to veterans being connected to the supports that they need. It is a big administrative process for the reporting that the clinicians have to do. There are also certain parameters around the referral-booking process of how a psychologist, physician and physiotherapist need to be coordinated with respect to the schedules of a clinical team. Being able to meet the parameters can sometimes cause delays in the assessment process. That's kind of what—

Kelly DeRidder: I think that paints a clear picture. It's quite a complicated process.

I'll go to Oliver now.

Just quickly, what is your intake process?

Oliver Thorne: Sorry, are you asking about our intake process for clients, or specifically in dealing with PCVRS and funding approvals?

● (1725)

Kelly DeRidder: It's just with clients.

Oliver Thorne: Our intake assessment process is fairly simple. It's designed to be accessible.

First there would be a conversation with one of our program coordinators. That would be with a local program coordinator in their region to talk about the contents of the program and if they feel that it's a good fit.

If the veteran is interested and motivated to attend a program, they then do an intake assessment with the clinician psychologist who'll be running that program. It typically takes about 45 to 60 minutes over the phone, and that's it.

Kelly DeRidder: Then I'm going to ask you something, Oliver, because you have a lot of experience working with veterans struggling with crisis and injuries.

Do you believe adding this complicated bureaucratic process has been counterproductive to helping veterans who are suffering, as it stands today without implementing change?

Oliver Thorne: I can speak only to the specific veterans we serve and interact with, but I would say it has been counterproductive thus far, yes. We're seeing an increase in confusion, an increase in the burden of assessments on veterans, and a decrease in the choice and autonomy that they have in their care plan.

Kelly DeRidder: I have a very quick question—just a follow-up, then—because you believe it has been counterproductive. Do you think forcing veterans to change service providers after they've found a service provider they trust can actually cause more damage?

Oliver Thorne: One hundred per cent. Once again, trust is one of the biggest issues, the biggest challenges, for veterans coming forward and seeking help. We've heard from other witnesses about the stigma, the fear—the fear of being misunderstood, of not having their experiences and their culture understood—so yes, changing is bad.

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

For three minutes we go to Mr. d'Entremont.

Chris d'Entremont (Acadie—Annapolis, Lib.): I'm just trying to get some numbers to figure out how many veterans we are helping. The whole idea of this study is to understand the responsibilities of PCVRS.

Quite honestly, how many veterans are we actually helping? How many are coming for help? How many are we helping, and how many of them are running into problems? To try to understand that challenge, maybe I'll just go through our witnesses today.

Mr. Scharf, how many veterans are you helping? How many are in your group, and how many of them are coming in with challenges with PCVRS?

Mackenzie Scharf: Offhand, I can share that we have 23 folks who are currently in our interdisciplinary rehab program. One of our occupational therapists, on top of that, has a caseload of 20 single-service occupational therapy clients. Our physiotherapist has around 20 physiotherapy clients as well. That's just three of them off the bat.

I would say that the majority of folks coming in are expressing frustration with a lack of clarity on the direction they're headed in and what the next steps are, and are having challenges with the self-advocacy for the administrative pieces and having to do these parts on their own. We do our best to support them through that and be that bridge between them and PCVRS to soften that burden as much as we can, so that they can focus on their care.

Chris d'Entremont: Thank you.

Mr. Thorne, it's kind of the same question, even though I know you have a larger group of veterans you have been working with for a very long time.

Oliver Thorne: We serve about 220 to 250 veterans a year, depending on the number of programs we can deliver. About 2,500 to date have graduated through our programs.

We also consistently hear from the veterans we're working with of challenges in the process of approvals, assessments and options regarding PCVRS.

Chris d'Entremont: Thank you for that.

Madam Massunken, go ahead as well.

Michelle Massunken: We have approximately 100 veterans in the program. In total, we have close to 250 veterans. Some are in and some are not in the program. Of those who are in the program, we've had a few who have concern around the clarity or understanding the program and what the expectations are.

I meet with our clinicians every month, just to disseminate any information I receive from PCVRS to them, so that they're well aware of the changes or to clarify any questions they might have had from the clients.

Chris d'Entremont: When it comes to actually dealing with PCVRS, is it done through phone calls? I don't know much about the interactions. Is it emails? How is that interaction actually happening?

Michelle Massunken: It's usually a Teams meeting for me. I can speak only to my experience. I meet with the manager every eight weeks to give any updates or ask any questions the team might have about the program. Typically, it's a Teams meeting, but in between I can email, and they're quite responsive.

● (1730)

The Chair: Thank you very much to our three witnesses for your time this afternoon.

We will suspend for the next panel.

● (1730)

_____(Pause)_____

● (1735)

The Chair: I would like to make a few comments for the benefit of our new witnesses.

[*Translation*]

Good afternoon. We will now resume the meeting.

Before speaking, please wait until I call on you.

If you are participating in the meeting via video conference, click on the microphone icon to enable it. Please mute it when you are not speaking.

As for interpretation, those participating in the meeting via Zoom can choose between French, English and the floor at the bottom of their screen. Those in the room can use the headset and select the desired channel.

I would now like to welcome our second panel of witnesses.

We welcome Dr. Anne Marie Pinard, a physician, who is joining us via video conference and testifying as an individual.

[*English*]

In person, we have Mr. David Morrow.

Welcome back, sir.

By video conference, we have Madam Elizabeth Forbes, registered psychologist.

Welcome.

[*Translation*]

Each witness has five minutes for their remarks. Afterwards, we will have a round of questions with committee members.

Dr. Pinard, you have the floor for five minutes.

Anne Marie Pinard (Physician, As an Individual): Thank you for inviting me to participate in this study.

My name is Anne Marie Pinard. I am an anesthesiologist specializing in chronic pain at the CHU de Québec–Université Laval. For the past 14 years, I have devoted all of my clinical time to caring for people living with chronic pain. I am also a full professor at Laval University.

I have been actively involved at the provincial and national levels in several initiatives related to chronic pain, some of which involve veterans. Every year, I see 10 to 12 veterans at my clinic who are struggling with chronic pain. Over the years, I have come to understand and respect military culture. Veterans of the Canadian Armed Forces have often faced difficult situations, and not just while deployed. They are overrepresented among the population living with chronic pain. Roughly 20% of the general population suffers from chronic pain, but among veterans, the proportion exceeds 40%, and is likely 50% among female veterans. Mental health issues are also very common. Among veterans living with chronic pain, an estimated 60% also have mental health issues, whereas in the general population, that figure is around 30%.

In my work, I am extremely fortunate to collaborate with an interdisciplinary team. In the most complex cases, we develop an individualized treatment plan that is realistic, progressive, and, above all, developed in collaboration with the patient and their loved ones.

Chronic pain is not simply persistent pain; it is a complex phenomenon involving a hyper-reactive nervous system, cumulative fatigue, difficulty tolerating physical exertion, sleep disorders and past traumas that have left their mark. In this context, best practices rely on fine-tuning, gradual progression, respect for limits and the genuine integration of mental health considerations.

My experience with programs offered by private clinics is quite extensive. About a dozen years ago, programs with a rather rigid structure were very common. Patients with complex cases or mental health issues were often left feeling battered by this type of program. Such programs gradually disappeared because their effectiveness was fairly limited in complex cases. The mental health aspect was rarely taken into account. Often, there were no psychologists, occupational therapists, or social workers on these teams. What I have observed in recent years—I say this cautiously, but also with genuine concern—is a tendency to replicate this rigid, standardized approach in the care pathways of certain veterans.

Over the past few years, likely since the creation of Partners in Canadian Veterans Rehabilitation Services, I have observed a significant decline in the ability to collaborate—or indeed, an inability to do so at all. I am seeing long delays before assessment and access to initial services. Based on my experience with this program, I can say that the assessment is rarely conducted by a team that includes, among others, a physician with a good understanding of both military culture and chronic pain. Above all, once the program has started, it is very difficult to influence the content, intensity, or frequency of treatment, even when the clinical situation deteriorates. This one-size-fits-all approach is precisely what was abandoned, for example, by the Commission des normes, de l'équité, de la santé et de la sécurité du travail a few years ago.

We must return to what is effective in cases of chronic pain: collaboration and adaptation.

We must then seriously consider what secondary and tertiary care clinics may be doing concurrently. If a plan already exists, it must be integrated, not bypassed.

We must also integrate mental health in a structured way. Success often depends on linking mental health and physical interventions.

Finally, professionals working within these programs need solid training in both chronic pain management and military culture.

I also believe we need to improve transparency. Opaque decisions, a lack of feedback, and a flood of paperwork undermine trust and the quality of care.

I hope you will also have the opportunity to hear the views of those who work with veterans, particularly in clinics for operational stress trauma, as well as case managers, because they are the ones experiencing the concrete consequences of the system as I see it today.

I will conclude with a simple image. We wouldn't dream of offering the same size of clothing to all veterans, saying it is standard issue and they must adapt. Yet, my clinical experience sometimes leaves me with the impression that this is what we are doing when we impose a single, fixed and rigid model on people whose clinical realities are profoundly different.

● (1740)

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

[*English*]

Ms. Forbes, you have five minutes.

Elizabeth Forbes (Registered Psychologist, As an Individual): Thank you for the opportunity to appear today.

My name is Elizabeth Forbes. I'm a trauma psychologist. I work in both Alberta and British Columbia. I previously worked at the operational stress injury clinic here in Calgary. I now operate a private practice focused primarily on veterans experiencing post-traumatic stress and related conditions. I regularly support individuals who are navigating both psychological treatment and the rehab system under the PCVRS contract.

My comments today will focus on the clinical implications of rehabilitation timing, system structure and alignment with trauma-informed care.

Trauma treatment for PTSD and related conditions typically follows a phased model of care—stabilization, active treatment and maintenance, resulting in a gradual return to functioning. Then vocational success can be considered. From a clinical perspective, a key concern is how and when rehab services are introduced and whether or not they align with the current phase of treatment that the veteran is in. Vocational processes, such as the initial assessment and related meetings, are often described by PCVRS as neutral. However, clinically they involve evaluative and performance-based demands that can activate the nervous system in trauma-affected individuals.

PCVRS in my clinic is often introduced during the stabilization phase, when the therapeutic relationship between the veteran and me is already well established, and at a point when the individual may not yet have the capacity to tolerate these additional demands. In practice, this can result in treatment and rehab pulling in two different directions, which can be very difficult for the veteran to manage, as they are required to engage in destabilizing demands while also attempting to stabilize. This often results in increased distress, heightened suicidality and worsening of other symptoms. Over time, the rehab process itself can become associated with threat detection. The anticipation of contact or required participation may repeatedly trigger the individual's stress response. In this way, the system is experienced not only as unsupportive but also as a recurring source of distress.

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

Another concern relates to system coordination and accountability. In my experience, there is very limited integration between rehab planning and an established psychological treatment plan, resulting in parallel processes that are not aligned in timing or priority. When clinical recommendations are not integrated into a broader plan, care becomes fragmented. Veterans may receive conflicting directions, which can increase distress, reduce engagement and interfere with treatment progress.

More broadly, there appears to be no clear mechanism for clinical recommendations to meaningfully influence rehab planning, even when clinical risks are clearly identified. This creates pressure to engage despite clinical contraindications or limited capacity, and financial necessity overrides clinical readiness.

At a broader level, there is a mismatch in approach. Rehab frameworks emphasize activation and progression, while trauma-informed care prioritizes stabilization and readiness. What this looks like in practice is that individuals become overwhelmed. Their symptoms increase, they begin to withdraw and the progress made in treatment is disrupted.

In trauma-informed care, it is the system that needs to flex to the veteran, not the veteran to the system.

Thank you.

● (1745)

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

Mr. Morrow, you now have five minutes.

David Morrow (As an Individual): Thank you, Chair, for inviting me for a second time. Clearly, the first time around, I wasn't too bad.

I was on my way here from Montreal, and on the drive I had a nice speech that I shared with everybody here, but I realized it wasn't in the right tone. It didn't capture the language that I really wanted to discuss. I think there's an inability to really communicate with each other. I speak a language of duty, honour, respect, service. The government speaks a language that is based on policy and governance and laws.

The reason I bring this up is that I'm part of an exclusive group—a special minority, one might say—the 0.01%. I invented it myself. The 0.01% is approximately how many Canadians have actively been engaged in combat and fought an armed enemy. I'm one of those privileged few, along with my brothers and sisters and Arabs now. There might be more, but go with me on this.

The reason I bring this up is that when I was patrolling in Afghanistan, kids would come up to me. I was with an American unit, so I was the only one there with a maple leaf on my shoulder. They would say, “Canada good, America bad.”

When a kid came up, I would go, “Oh, man, wow. Okay, kid, like thanks, man.” That kid had no contact with the outside world, but he intrinsically knew that there was some added virtue to being Canadian, and that's the pride I had when I signed up. That's the pride I had going to war.

When I had to do Canada's dirty work, the expectation when I came home as a young buck in my twenties was that if I needed help, the government, VAC, Canada would provide the care that I needed. Unfortunately, I guess maybe out of naïveté, or just not having enough time in when it comes to life experience, that never really materialized when I took a knee and I needed help.

Now, “care” for me means something. I'm a father. I have two beautiful kids at home. When they hurt themselves, and they need help, I ask them, “Hey, what's going on? Are you okay?” Anybody here who has kids knows the rest. My expectation of care was like a father's care, a father's love, from his country, but since that never materialized, I believe the best way to describe it was, or is, a broken heart.

I love my country, or loved my country, fiercely. I was willing to die for my country. I did the country's dirty work, along with lots of my brothers and sisters. Now, through contracts like PCVRS, and being managed and processed through a company that is owned by American private equity and Loblaws, which sells us apples and oranges, to go through that process was demeaning and dehumanizing, to be honest.

I don't know where we stand right now, to be honest. There's an unwritten contract between soldiers and our country, and that contract is not being honoured. I'm not expecting this contract to be cancelled—I'm not expecting the government to really do anything more, to be honest. It's only because I recognize that this language difference hasn't been resolved. Not enough Canadians know who we are—0.01% is so few, it barely even registers.

That being said, my expectation is actually for my fellow veterans to start talking, to put their boots back on, to start fighting again, just not in a dusty war zone, but here. We need to advocate for ourselves with policy and good decisions. The easiest way to do that is simply to start talking to our friends, to get out there. Send a message to me. I'm easy to find. Let's start building this together. As far as I can tell, that's a responsibility—the care is not being met. They are bound by the veterans charter to look after us veterans, and it's not being done.

The issue is not PCVRS, in my opinion. It's not Manulife. It's VAC. Why doesn't VAC want to take care of its veterans? That's my only question to the committee.

Thank you.

● (1750)

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

We will start our round of questions with Mr. Richards for six minutes.

Blake Richards: Thank you.

Mr. Morrow, thank you for your service. I know sometimes those words can sound hollow and meaningless. Based on what we just heard from you, I want to just also say thank you for your willingness to be frank and the bravery that you've shown doing that. I know that for many veterans, it's a struggle to do that, because they're afraid of the consequences they'll see in their benefits and things like that. That was much appreciated, that you were willing to be that frank with us.

It's sad that you have to do that. As you said, when you went and served our country, our job is supposed to be to make sure that you're taken care of with what you need. As you say, for you and far too many veterans, that's not happening.

Let me start with this question. What would an ideal rehabilitation program look like in your mind for our veterans?

David Morrow: I don't know if we have enough time.

Blake Richards: That's fair enough.

David Morrow: I'll explain it as succinctly as possible. I know what it is, because I did it myself. I did it before PCVRS existed.

If it weren't for the VTN, I don't think I'd be here, so I'm glad that Mr. Thorne was here. That was part of the puzzle that I had to put together on my own. I had no help from VAC, and PCVRS didn't exist. It included getting the help that I needed. It's actually finding programs that work for you.

That's the stabilization phase. VTN is probably the best program in Canada. I talk about it all the time on my show.

After that, I focus 100% on fitness and health, because, unfortunately, the rehabilitation process does not incorporate fitness and health, which is absurd. We're not looking at the cellular problems that we have as veterans.

I'll give you an example. GWOT veterans, or global war on terror veterans, like me, experienced more combat load than any other generation in history, simply because we were exposed to war every day we were in theatre. We were on forward operation bases. We could have been rocketed, vaporized or shot at every day. We were always on alert, 24-7.

World War II veterans got pulled back to France. They got pulled back to England. They knew you could sustain only so much. I did one tour. Some guys did three or four tours. The amount of combat load on the central nervous system is way too much. The average Roman soldier saw only two to three days of combat a year. Those are the Romans. In my case, I experienced over 260 days of combat.

In a rehabilitation world that is actually effective, we need to look at the cellular issues. Veterans aren't broken; they're under-recovered. It takes a whole team of people to figure that out and make it individualized, and to focus not just on the psychology of veterans but also on the physiology of veterans. We can go into all the different modalities available to veterans at this point.

Blake Richards: I think I know the answer to this question, but do you believe that the Department of Veterans Affairs has ensured there's sufficient oversight on this PCVRS program? In anticipation of your answer, what does it need to do better?

David Morrow: Unfortunately, I don't know why VAC abdicates its responsibility to other organizations when it's mandated with the care of veterans. It's a slap in the face. I'll be honest. If it can't do the job, it should figure it out.

As I said, care is asking what we need and how we can be supported. We know it's not going to be perfect, but for it to be farmed out to a private equity firm that is American-owned, and to know that its goals are based on corporate policy and obviously not based on care of veterans.... We're not incapable of doing an Internet search. We know this exists, so we know this is disingenuous. They're not trying to make us better; they're trying to achieve their corporate goals.

The first thing would be to stop farming the care of veterans out to private equity firms and insurance companies. That would build a lot more trust within the institution, in my opinion.

Blake Richards: The other thing I'd like to ask you about is around the bureaucratic processes. Whether they are within VAC itself or in dealing with PCVRS and the coordination or lack thereof between the two, what does having to deal with all the processes, paperwork, bureaucracy and overlapping elements of it do to a veteran, especially one who's already struggling?

● (1755)

David Morrow: For me, it was emasculating. You have to constantly talk about your issues with people who are not really qualified to listen to them. You think, initially, that they're trying to help, and then it's just another step that you didn't do. You constantly feel like you're failing.

That's not rehab. That's not care. It's just one form after another. It's one individual informing you of one policy, but it's not correct, and you constantly have to go back and redo things. The amount of inefficiency in the system is absurd.

We're taking it upon ourselves as veterans to start figuring this out on our own. We've created our own groups to figure this out. The problem is that when we talk to VAC, they don't even know their own policies. They don't know the law. I would argue that most have never read the new veterans charter. That being said, what are we doing? Why aren't more veterans involved in the actual planning process and oversight? That is essentially why we have all these problems. It's because we're being told what we need, when in fact it should be the other way. It should be from the bottom up, not top down.

Blake Richards: Thanks again for your service, and thank you for your frank and excellent advice today.

David Morrow: It's my pleasure.

The Chair: Thank you very much.

For six minutes, we'll have Mr. Casey.

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

Thanks to our witnesses for being here.

Mr. Morrow, it's good to see you again. At the risk of it sounding hollow, thank you for your service, sir, and for your testimony, which was particularly compelling.

I'd like to start with you, Ms. Forbes. You drew a very clear distinction, I think, between trauma-informed care and a rehabilitation framework. I'd like you to expand a bit on that. It's my understanding that PCVRS is involved and engages you only if there has been a determination made that the client or the patient is someone who is seeking or is involved in a rehabilitation program. I understand the difference between trying to get someone better and trying to rehabilitate them: treating them, as opposed to the rehabilitation path, which ideally reaches a goal at some point, as opposed to stabilization.

I'd like to hear from you a bit more on Veterans Affairs Canada and PCVRS. Do they actually have a mandate for trauma-informed care or stabilization, as opposed to working through getting someone rehabilitated?

Elizabeth Forbes: I'm not quite sure I understand. I apologize. Do you mean the difference between a rehab perspective versus a trauma-informed care perspective?

Sean Casey: Yes.

Elizabeth Forbes: In PCVRS, the rehab often focuses on action—on taking action, getting going, getting back to work and all those kinds of things. There's nothing wrong with a rehab program. The issue I have is that these mandatory assessments, programs and engagements in PCVRS are often at times when veterans are not ready. They're not ready at all for another system.

In trauma-informed care, we talk about slowing down. We talk about not overwhelming your system. When they're introduced, especially early on in treatment in my clinic, it is so very destabilizing. What happens is that I'm pulling back, trying to stabilize my client, and I actually have to pause the treatment. What happens is that PCVRS is activating them: You need to do this. You need to have this assessment. We need to see where you're going. We need to know what you need to do.

They actually work against each other. I usually have to pause my treatment and deal with the fallout from what happens in this system. To a lot of the things folks mentioned today, I could just nod and say, yes, that's the case.

I hope that answers your question. As far as what their policies are on trauma-informed care, I can't speak to that. I know what I can speak to in terms of how I am trained and what my specialities are in this area.

● (1800)

Sean Casey: I would like to ask this a little more concisely. I understand what you said. You are addressing what I'm getting at. My question is about whether or not the rehabilitation framework and trauma-informed care are mutually exclusive. Can they coexist, or should they coexist, in your treatment of a patient?

Elizabeth Forbes: Understood. Thank you. That's a great way to reframe it.

Prior to this current model, VAC case managers functioned more as coordinators of care directly with treating clinicians, whether it was in the OSI or whether we were community psychologists. We determined timing and readiness together. Rehabilitation services were introduced more flexibly. We were typically aligned with wherever the client was. If I got a call from a case manager and they asked me, “How is this person doing? Can we move them on to this stage?”, it would be a conversation.

There are no conversations with PCVRS. They do not respond to any of my emails, faxes or phone calls...or I guess I should clarify that this is not quite true; I would say it's “most” of my communications. It's a timing issue, but also, they're not understanding that they're actually contributing to this veteran's distress. I've tried to have conversations and meet with higher-ups. I'm also an affiliate provider, so that creates an added barrier for me, especially being a community psychologist as well.

[*Translation*]

Sean Casey: Dr. Pinard, I will reiterate that I don't have much time for a conversation with you.

You are a medical specialist, and I'm sure you have a team.

Can you tell me what level of communication exists between you and the provider, Partners in Canadian Veterans Rehabilitation Services?

Anne Marie Pinard: Thank you for the question.

The answer is none. I had exactly the same experience as Ms. Forbes. When we follow patients who are enrolled in the pain clinic program, I am unable to have a discussion with the health care professionals who are treating them. For some patients, I had to stop what we were doing as a team at the pain clinic because they were completely exhausted. There is also a problem with—

The Chair: Dr. Pinard, I'm going to have to cut you off there. I'm so sorry.

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

Marie-Hélène Gaudreau: Thank you very much, Madam Chair.

I'll go to Ms. Pinard.

I understand, then, that not only do these vulnerable individuals need specialized care—because they are part of a unique population—but they also have to fight to access a continuum of care. On the one hand, we want every person to get better, but on the other hand, when they arrive at the ER in cardiac arrest, they're told there are forms to fill out first.

What happens when you meet clients who are struggling to receive PCVRS services?

Anne Marie Pinard: In fact, our patients are referred to the pain clinic either by their family physician or by a specialist.

I won’t hide the fact that access to specialized care for chronic pain—whether you’re a civilian or a veteran—is extremely complex. There are very long waiting lists, and currently, in Quebec, there isn’t really any way to get around this waiting list, even for veterans. I wish it weren't so, but that's the way it is.

First of all, most of the time, when a veteran comes to our clinic, we don't even know they're a veteran until we meet them. We find out at the first encounter. Sometimes I don’t find out for six months, because if people don’t tell me, I have no way of knowing. I’ve learned to ask, but sometimes we find out later than we should.

Then, sometimes the veterans we treat are already in a rehab program or are being treated by another rehab team, through PCVRS—even though we're already treating them. Plus, it’s siloed care. It’s done completely separately. It doesn't really account for the fact that they are already being treated by a pain clinic team.

Obviously, pain clinics aren't able to provide very long-term care. For example, they can't offer two or three sessions of physio or psychotherapy every week. However, in the past, we were able to collaborate, establish a shared plan, and take into account the challenges veterans sometimes face. Under the new approach, things have become extremely rigid. There is very little communication, as Ms. Forbes mentioned, and this sometimes hinders the work we’re doing with the patient.

I have had to stop what we were actively developing regarding medication or mental health care, for example, because my patient was completely exhausted by the program they were following. Moreover, we know military culture. When you’re told to do something, you do it. That’s really a distinctive feature. So people do it, and they burn out. I’ve had the same experience as Ms. Forbes. People burn out, and then it’s hard to find the energy to implement other strategies we suggest. Quite often, I’ve had to tell a patient that we were going to take a break for a few weeks and that they would have to call us back once they’d finished their program to pick up where we left off.

Moreover, access to mental health care is often very limited. Sometimes, patients are being treated by us, by the operational stress injury, or OSI, clinic and a third program is added. It becomes quite overwhelming.

Furthermore, as I was going to mention earlier, veterans often live a bit farther from major urban centres, for various reasons. Sometimes they have to travel 30, 40, 50, or 75 kilometres to attend their program. Driving places a significant cognitive load on them. That adds to everything else.

In addition, even though we don’t always have to fill out paperwork in our setting—at the pain clinic—the demands placed on us and the paperwork we’re given are extremely onerous. What I see represents only a tiny fraction of what needs to be done and filled out. For example, I was asked if my patient suffered from fecal incontinence. I’m a chronic pain specialist. How can I answer that?

It’s also difficult to access medical histories. I understand that this is “Protected B” information, but it’s extremely difficult to care for people because there are endless steps involved in obtaining, for example, what was previously done to avoid repeating something that didn’t work in the first place. So, it’s quite burdensome and, unfortunately, it ends up compromising the quality of care we’re able to provide.

● (1805)

Marie-Hélène Gaudreau: Yet again, I am at a loss for words. However, what reassures me—even though we're in politics, with laws and power struggles and all of that—is that everyone wants things to go well. Please understand that. In this case, everyone wants the situation to improve. Now, how will we achieve that? It takes resolve, and you're here.

I'd like Ms. Forbes to speak to us for a few seconds about the concept of "care" mentioned by Mr. Morrow.

In 30 seconds, do you think the program truly takes care of veterans?

[*English*]

Elizabeth Forbes: That's a tricky question.

Honestly, I don't. I see it as such a huge barrier. I feel as though there are just so few individuals who sign up for jobs in which they could potentially die as part of their role. Veterans do this so willingly for our country. That level of sacrifice just really warrants something much greater, a level of care that's responsive, care that actually listens to its providers—whether we're in big clinics or in community—and is respectful and really understands their needs. I just have not had that experience with PCVRS.

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

We'll go to Mr. Tolmie now for five minutes.

Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC): Thank you to the witnesses for joining us today.

Ms. Pinard, I appreciate your comment that one size does not fit all. We've brought that up in committee before.

Ms. Forbes, I really do appreciate that your experience bridges two provinces, Alberta and British Columbia.

Mr. Morrow, you've called for a full-scale independent audit of this program. The minister has now committed to an independent review. Based on what you've experienced, do you believe that a review overseen by VAC can be independent? Given that VAC designed the contract, set the KPIs, conducted no audits and has defended the program's performance figures at this very committee, what would independence actually require, and what should we be watching for to know if this review is genuine?

● (1810)

David Morrow: That's a good question. Thank you.

Fraser Tolmie: I always ask good questions.

Some hon. members: Oh, oh!

David Morrow: I think you already know the answer, but the reality is, how many veterans are forensic auditors? I ask because that would be the best way to get it set up. Get a team of veterans who are independent and on the outside. If Veterans Affairs constantly wants to do internal investigations, then how about we get a bunch of veterans to do this investigation?

Aside from that, no, I don't trust VAC as far as I can throw them. This is not going to be objective in any way, shape or form. We can see it for what it is. The veteran community will see it again as another dog and pony show, as we call it. We'll just shake our heads and let the politicians do their stuff, but we still won't have the care that we're actually looking for.

I won't have any faith in it if it's not independent, meaning that we have an independent body that is outside, at arm's length from the government.

Fraser Tolmie: Right.

You opened your testimony with the difference between the languages of military culture and politics, that is, between "duty, honour, service, respect" in the military world and "governance, law and policy" in the political world. Moreover, with VAC, there's also "administration" and the requirement that administration follow governance and a vision.

I would like to get your thoughts on that. What do you feel? Do you feel the tail's wagging the dog or the dog's wagging the tail here?

David Morrow: I don't know. Again, that's a good question.

If I could get my eyes on it and see what happens at VAC under the hood.... All I know as an end-user is that it just seems very chaotic. The reality is that things didn't get bad until it went to PCVRS.

VAC lost my trust at one point with an incident. As I mentioned in my last testimony, trust is so important for our community. I go back to my 0.01% analogy and that our whole job was to distrust literally everybody we came across, from little children to men. Whether they had a weapon or not, they could kill us. Therefore, coming home, we distrust everybody, including the government. As soon as you break that trust, it does a lot of harm.

To answer your question, I don't know. Is the tail wagging the dog? Maybe it is, but I don't have a good enough answer to point you in the right direction, to be honest.

Fraser Tolmie: We have no confidence in the review. We're not sure of the operation of this organization. Do you believe this is going to get turned around after audit, the independent review?

David Morrow: No. As I mentioned during my initial five minutes, I think the only way this gets fixed is like this: We—I mean veterans—need to take charge and organize, so that we can actually share our voices reasonably with government. It seems as though you're operating in a dark room. You don't know what you don't know, because you don't talk to us. There's nobody to talk to except me, individually. We don't have a room of 100 or so veterans, speaking through our spokespeople, saying, “These are the things that we need to fix now,” as they do in the United States. If we can start establishing that.... I know it won't be for our generation, but it will be for the next generation of veterans, who probably aren't even born yet. They could benefit from an advocacy arm of veterans.

Fraser Tolmie: Thank you, Mr. Morrow. I appreciate your time.

The Chair: Thank you very much.

Now, for five minutes, I have Ms. Hirtle.

Alana Hirtle: Thank you, Madam Chair.

[*Translation*]

Dr. Pinard, I'm going to ask my questions in English. I apologize for that.

[*English*]

I wonder if you had a chance to finish your response to my colleague Mr. Casey's earlier question.

● (1815)

Anne Marie Pinard: I guess I will answer in French, because it's easier for me.

[*Translation*]

Indeed, I was able to include those aspects in my previous answer, which focused primarily on the fatigue caused by the program and by distance. That's what I was going to mention when I answered Mr. Casey's question.

Alana Hirtle: Thank you.

[*English*]

Can you tell me a bit about the types of experiences you've had with veterans seeking care or assessments, please?

[*Translation*]

Anne Marie Pinard: As I was saying, people are generally referred to our pain clinic by their family physician or by a specialist. A great many veterans do not have access to a family doctor, at least in the province of Quebec. That is the first problem. The same is true for civilians, but it is particularly glaring among veterans. Access to primary care is therefore very difficult. Without access to primary care, it’s very difficult to obtain secondary and tertiary care.

Then there are the unfortunately very long waiting lists, as I also mentioned. Since our clinic is more geared toward the civilian community, when veterans come to us, they often find themselves in settings that aren’t very sensitive to the reality of veterans living with operational stress. We’re in the city, in crowded areas, with ill-suited waiting rooms, sometimes with staff who have no training in military culture. So that’s already a barrier.

Next come the assessment, the wait times and, sometimes, the difficulty in accessing rehabilitation and integrated mental health care. Currently, the integration of our services with care from the operational stress injury clinic, for example, depends on the knowledge we have of each other, much more than on an actual established link. We rely on personal contacts, emails, or text messages to communicate with each other, rather than on a truly integrated system. Unfortunately, the same is true for the PCVRS program.

[*English*]

Alana Hirtle: That's wonderful. Thank you.

Are there common needs among the veterans you've worked with?

[*Translation*]

Anne Marie Pinard: I think the first common need is recognition of this different culture, of this reality. I always tell my veteran patients that I’m just a civilian. I can try to understand their reality, but I haven’t experienced it. So, I think we need to approach this with a great deal of humility. We need to be better trained on military culture. I've been working for 23 years, so I’ve met a lot of veterans, and I think I’m better able to meet their needs. That's a common need.

The other common need is for patients to be told that we care about them or that we’re here for them. That was mentioned earlier. It's extremely important.

It's also important to have fewer administrative barriers, papers and pencils, and more human contact.

[*English*]

Alana Hirtle: Thank you.

Would you say there are still misconceptions around what chronic pain is?

[*Translation*]

Anne Marie Pinard: Whether you're a soldier or a civilian, it's very hard to understand what chronic pain is. It's still seen as a sign of weakness. I often say that chronic pain is where mental health was twenty years ago, back when it was shameful to suffer from depression or bipolar disorder. Now, it’s more widely accepted. Chronic pain is still perceived—among civilians, but even more so among veterans—as a weakness, a lack of willpower. That is so wrong. There is still a tremendous need to raise awareness about this among everyone, including health care professionals.

[*English*]

Alana Hirtle: Thank you.

I have 30 seconds left.

How would challenges related to chronic pain affect other areas of a veteran's life?

[*Translation*]

Anne Marie Pinard: Chronic pain affects personal life, family life and sexual life, as well as self-image. It impacts every aspect of a person's life, whether they are a civilian or a veteran. For veterans, this is often compounded by operational stress, mental health issues and a lack of understanding of both military culture and the importance of family and group unity.

The Chair: Dr. Pinard, thank you very much.

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

Marie-Hélène Gaudreau: Thank you very much.

I would like to draw a parallel. We are parliamentarians; we are democratically elected by the people. We enjoy privileges and are potentially entitled to a pension. One day, we will step down or will not be re-elected. Eventually, we'll be told: "Whatever you did is now forgotten. So forget about your pension. Go home." We'll then become anonymous. I understand that when I'm no longer an MP, people will ask me who I am.

Is that what veterans are experiencing? Personally, I wanted to help my fellow human beings, but they tried to save lives. That's called compassion. It's something I strive for. I want to stay very positive, despite everything. In my view, we need to think about future generations. In politics, if we look to the future and draw a connection between the urgent needs in defence and the fact that today's veteran community is telling their children not to enlist—even though it's an extraordinary experience in a person's life—and if we realize there will be concerns about the next wave of recruits, that's when we'll wake up. I hope that, by then, you will have been consulted and that corrective action will have been taken. I hope so, and I am confident that it will be.

I have one last question for Dr. Pinard.

Did I understand correctly that in Quebec, the Commission des normes, de l'équité, de la santé et de la sécurité du travail, or CNESST, made changes to the system early on to adapt?

In terms of culture, how did that contribute to a better understanding and to getting the work done?

● (1820)

Anne Marie Pinard: Several years ago, the CNESST had programs that were quite rigid and somewhat similar to what is currently in place, particularly regarding lower back pain. Patients suffering from lower back pain were presented with a program that dictated the course of action. The CNESST quickly realized that patients' health was deteriorating. There was no consideration for mental health. It was a program that operated according to a one-size-fits-all approach. People with more complex issues—

The Chair: I'm so sorry, Dr. Pinard, I have to cut you off.

[*English*]

For five minutes, we have Ms. DeRidder.

Kelly DeRidder: I have to say that in this room today a bit of frustration I've seen personally is that not one person on the government side has asked the veteran in this room what can be done better in serving veterans who have fought for this country. I'm going to do that.

Before I continue, thank you for your service.

You said in your opening statement that you're not expecting VAC to do more, but I think we can expect to do better. I think we can agree that there's an expectation to do better. With PCVRS, do you think it's designed to help veterans or just to check a box and put them through a program, regardless of whether that program works for them?

David Morrow: Yes, 100%.

Kelly DeRidder: Do you think a better way is to listen to veterans like you with the lived experience and the help that is required, take that guidance and turn it into systems that work for you through better management through VAC, so that we can serve you better?

David Morrow: Yes, 100%. I can do better than that. I've been working tirelessly for six years with veterans from across the planet, building programs—building recovery programs. I more or less fixed my chronic pain on my own. I've been to Mexico; I've been to the United States. They're significantly further ahead than us, and that's because they actually listen to their veterans. It's 100% the way forward. I don't understand how VAC isolates itself from the population that it's actually mandated to serve. Until we do that, we're not going to get the care that we're actually expecting, because how do you do it when you don't have input from the actual end-users? Yes, I 100% agree with your point there.

Kelly DeRidder: You also said in your opening statement that you're rallying veterans to put their boots back on and fight for themselves with the government that you yourself fought for. To me, that's incredibly disheartening. Moving forward, we need the government to put their boots on, listen to our veterans and make changes that better support the needs and services that you require when you come back into community. Can you give me your top two starting points to be able to do that for veterans?

● (1825)

David Morrow: Do you mean from the VAC perspective? I would say to start reaching out to the actual community. Show up to the events. We have events, and VAC doesn't show up. It's like they're scared of us. I've been to plenty of VAC events, and I don't see folks like me, meaning I consider myself that 0.01%. Tattoos on the neck...like we were war fighters. We weren't there to protect people per se, we were there to fight a war, so we're aggressive. We look scary. That's okay. That's who we are. But come to where we're at. That would be the first thing.

The second thing would be that the model of care is the wrong model. We're trying to solve the wrong problem. We're looking at the veteran like this precious China doll. As I said, it's emasculating. It is emasculating because I'm a war fighter. I will never not be a war fighter. What I did is what I did. I want to move on. I want to rebuild. I want to be stronger. I don't want to be put in this box of therapy and drugs and talk about my problems. How do I build back better? The model itself needs to be re-evaluated at VAC, and that model exists if you just look outside the box. Again, that comes down to talking with the community and talking with folks like me, who have been doing this for years. I'd be happy to share what I know with VAC, any time, any place.

Kelly DeRidder: Thank you so much. I'm going to take my last moments here to thank you for your service. To the gentlemen also in the room, thank you for your service, as well.

I think there's a better way, and I really do hope that the government takes what you have to say today—we'll put a report together in this committee—and decides to make better changes for veterans in our community. Thank you for your time.

David Morrow: Thank you.

The Chair: Thank you very much.

[*Translation*]

Mr. St-Pierre has the floor for the last few minutes of this round.

Eric St-Pierre: I'll take three or four minutes, if I may.

Mr. Morrow, I'm going to ask my questions in French, because you're from Montreal. I imagine you're a big Habs fan. I have to mention it, because we're in the playoffs. In fact, I'm wearing my pin.

[*English*]

The Chair: This is not going to start well.

[*Translation*]

Eric St-Pierre: Thank you for your service to Canada. Thank you for your podcast. I think it's so important to make the connection between physical and mental health. It's something that resonates personally. I know my colleagues tease me when I do push-ups in the House, but I do it because I believe exercise is important. It's a great way to manage stress. It makes us better MPs.

As my colleagues know, I'm an ultramarathon runner. It's a good way to stay in shape. I hope Mr. Richards and Mr. Tolmie will join me the next time I go for a run. Some runners are a huge inspiration to me. David Goggins was an ultramarathon runner. He ran the Moab Trail Marathon. He ran some incredible races. He was in the U.S. military, and he sets a good example of how to manage post-combat stress.

So I wanted to congratulate you on the work you're doing. On a personal note, this strikes a chord with me. I'd like to know if you can speak generally for the benefit of Canadians.

Why is it important to stay physically fit after combat? Why is it important to stay physically fit to remain mentally healthy?

David Morrow: Thank you for the question.

Quite frankly, it's a better way to heal. Instead of focusing on mental health, the Greeks and Romans invoked the maxim *anima sana in corpore sano*, meaning a healthy mind in a healthy body. Two or three thousand years ago, they knew that if you're not in shape, your mental health will suffer. So, for veterans who aren't necessarily in good physical health due to chronic pain, that's what happens.

From my perspective, I can say that veterans are uniquely in this position because they were all in shape. Now, because they are veterans, it is highly likely that they have gained 30, 50, or 60 pounds. Furthermore, they're in pain and suffering the repercussions of military life. So, the first step would be to promote physical health among veterans, which would be an excellent approach to improving mental health. To me, that is clear. However, the government will need a little guidance. The research is clear. Suicide rates will go down if we focus on physical health rather than solely on mental health.

● (1830)

Eric St-Pierre: Thank you.

Do I have any time left, Madam Chair?

I have one last question for Dr. Pinard.

The Chair: Yes.

Eric St-Pierre: What does a positive outcome look like for a veteran seeking treatment for chronic pain?

Anne Marie Pinard: When it comes to chronic pain, whether you're a civilian or a veteran, success in managing pain isn't necessarily measured by the absence of pain. Generally, we measure improvements in quality of life and functional abilities because, unfortunately, chronic pain often persists over time. We try to alleviate it and reduce it, and not just with medication or injections. I support the practice of physical activity. Good physical fitness is extremely important.

Generally, we focus primarily on improving functional abilities and resuming a meaningful activity—which can sometimes be as simple as attending your child's hockey game or a concert. Sometimes, that's what victory looks like. Then, gradually, they're able to resume activities. However, I often draw a parallel with weight gain if the pain has persisted for 20 years. You can't gain weight over 20 years and try to lose it in two weeks. That doesn't work. It's a very lengthy process, and we won't improve people's health by exhausting them. It's by listening to them and working with them to create a plan based on what matters most to them.

Eric St-Pierre: Thank you, Ms. Pinard.

The Chair: Thank you very much.

That concludes the time allotted to the witnesses.

I would like to tell Mr. Morrow that I was present at the launch of the national veteran volunteerism action plan along with some of my colleagues, including Mr. Casey.

[*English*]

One of our veterans who was on stage said to all of us, “We thank you for your service.” He also mentioned to all of us that the service continues to give.

I say thank you for your service, but also for all the service that you continue to give, sir.

Thank you very much.

[*Translation*]

Thank you to our other witnesses.

[*English*]

I do have one thing before we end.

[*Translation*]

Our next meeting will be on Monday, April 27, 2026. We will welcome the Minister of Veterans Affairs and officials from Veterans Affairs Canada for a study of the main estimates 2026-2027 and the subject matter of the supplementary estimates (C) 2025-2026

Is it the pleasure of the committee to adjourn?

The meeting is adjourned.