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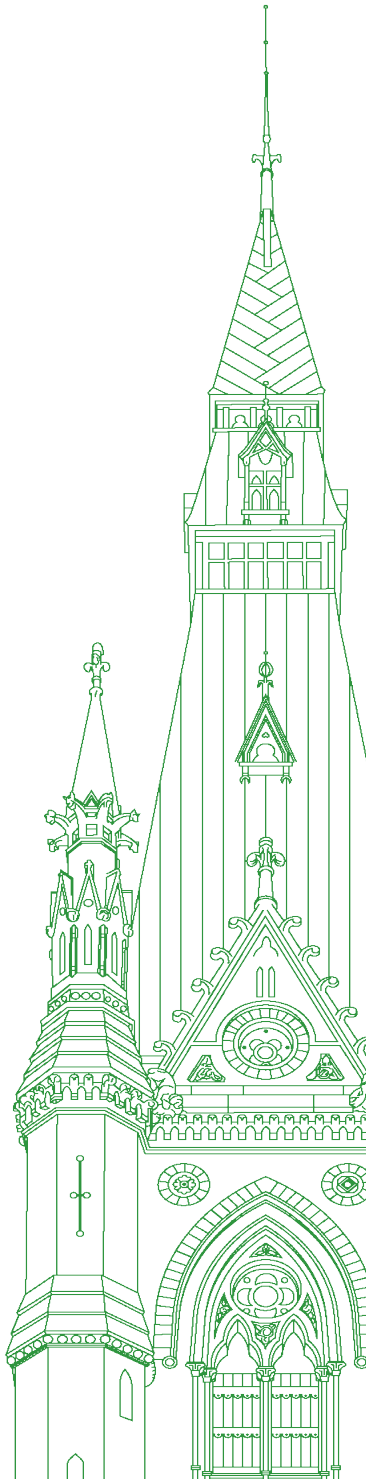
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Chair: Marie-France Lalonde

Standing Committee on Veterans Affairs

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● (1650)

[*Translation*]

The Chair (Marie-France Lalonde (Orléans, Lib.)): The meeting is now in public.

We're joined by witnesses for the study on the monitoring of the rehabilitation services contract awarded to Partners in Canadian Veterans Rehabilitation Services, or PCVRS.

I would like to introduce our first panel.

[*English*]

We have retired Lieutenant-Colonel Simon Parker, who is appearing as an individual, and Dr. Line St-Pierre, psychologist. By video conference, we have Mr. Aaron North, CEO and director general at Vector Medical Corporation.

You will each have five minutes for your opening remarks. Afterwards, we will proceed to a series of questions from the members of the committee.

Lieutenant-Colonel Parker, you have the floor for five minutes.

● (6445)

Simon Parker (Lieutenant-Colonel (Retired), As an Individual): Chair, vice-chairs and honourable members of the committee, thank you for inviting me here today. I sincerely appreciate this opportunity to share my experiences with all of you.

To provide some context, I'm a Canadian Forces veteran and an infantry officer with over 26 years of service. For 26 years, I faithfully served my country loyally and executed all tasks that were required of me, including operational service at home and abroad.

Like many thousands of serving members and veterans, I turned to Veterans Affairs when I needed support in rebuilding my life after military service.

I'm here today not as a policy expert or a procurement specialist. I'm not a political advocate. I'm here as a veteran directly impacted by the PCVRS contract and the rehabilitation system that it administers.

In my case, I was placed on the rehabilitation program twice and removed from it twice, unwillingly. During that time, I had three case managers and two PCVRS rehabilitation service specialists, so I have some knowledge and experience of the program, its delivery and the consequences.

To begin with a simple point, this study that you are conducting is not about a contract; it's much more. It's about trust, accountability, power and harm. As you work through your study, please keep those four things in mind: trust, accountability, power and harm. When rehabilitation services fail veterans, the consequences are deeply personal, long-lasting and often invisible to those outside the system.

I say this plainly: Veterans have nowhere else to go. We don't. Currently, there's no other organization or entity in Canada, private or public, that provides the same or equivalent services and support that Veterans Affairs Canada does. Unless veterans are able to pay significant out-of-pocket costs to various private entities, VAC is effectively the only option we have. Simply put, as a veteran, you either work through VAC or you go without and you suffer.

This creates what I would describe as a form of managed care captivity. Veterans like me become, in effect, captive patients in managed care.

As you know, the concept of a captive patient describes the helplessness and alienation experienced when people are denied meaningful choice in treatment pathways, providers or systems of care. Over time, repeated exposure to rigid bureaucratic systems can produce what psychologists call “learned helplessness”: the gradual erosion of agency, confidence and the belief that one's actions can meaningfully improve the outcome.

When veterans are financially dependent, medically dependent, psychologically vulnerable and have nowhere else to turn, rehabilitation stops being collaborative and starts to feel coercive. Veterans come to VAC already vulnerable and in pain. Many are coping with operational trauma, chronic pain, psychological injuries, family breakdown, moral injury, loss of identity, difficulty transitioning from military service and much more. They arrive seeking help from an institution they believe exists to support their recovery and restore dignity. Instead many, like me, encounter a system that appears fragmented, transactional and disconnected from military reality.

For me and many others I've spoken with, this becomes what clinicians call “sanctuary trauma”. I know you've discussed this term here in this group. As committee members have heard from previous testimony, sanctuary trauma occurs when an institution that is expected to provide care, healing and recovery instead becomes a source of distress, invalidation, fear and harm. Veterans come to VAC seeking rehabilitation support, yet many experience repeated retelling of traumatic histories, inconsistent care, dismissive interactions, poor continuity and systems that appear more focused on compliance and administrative processes than recovery and outcomes. I've experienced all of these.

At the centre of this experience is what I believe to be profound cultural blindness. Military service is not simply another profession; the military has its own culture, language, ethos of service before self, traditions and shared experiences that distinguish it from the society it protects. Military service shapes identity, trust, communication, leadership, coping mechanisms, relationships and even how injuries are reported, experienced, concealed or disclosed.

Veterans are not simply civilians with employment barriers or health problems that can be treated and administered by civilian-like insurance programs. To help veterans, one must understand the culture, because military culture matters, operational service matters and the trauma within military environments matters most, yet too often veterans interact with systems and administrators who appear to lack meaningful understanding of the military culture.

This is cultural blindness, and it has consequences: It affects credibility assessments, communication and expectations of behaviour, and it affects rehabilitation decisions.

When we feel misunderstood, pathologized or judged rather than understood or even respected, that trust deteriorates rapidly, but cultural blindness alone is not the greatest concern. The committee must also examine power imbalance and authority.

● (6450)

In theory, rehabilitation is supposed to be collaborative. Indeed, VAC and PCVRS frequently describe the rehabilitation program that way. They depict collaboration prominently in their materials, but veterans feel far removed from that. In practice, veterans often experience a profound imbalance of authority between themselves and the case manager and the RSS, and I experienced this.

As I'm running out of time, I will end now. I believe most of you have my opening comments, so if you have questions about anything in there, feel free to ask.

Thank you.

The Chair: Thank you very much, Lieutenant-Colonel Parker.

[*Translation*]

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

Dr. Line St-Pierre (Psychologist, As an Individual): Thank you, Madam Chair.

I want to thank the committee members.

My name is Line St-Pierre. I'm a psychologist in the Ottawa area. Many of my clients are veterans. Before going into clinical practice, I worked for the Department of National Defence. This work exposed me to military culture and to the realities faced by military members and their families. I'm also an affiliate provider with the Partners in Canadian Veterans Rehabilitation Services, or PCVRS. I'm here today as a clinical practitioner who meets with veterans on a weekly basis and who sees first-hand the impact of this system on their recovery.

One of the most striking observations that I've made in my practice is a regression in therapeutic progress and an increase in distress among veterans involved in the program. In contrast, I've also noticed an improvement in their condition after leaving the program. This pattern is hard to ignore.

In my opinion, a significant part of the problem lies in the fact that the program structure doesn't always sufficiently align with the psychological and cultural realities of veterans suffering from service-related injuries and trauma. A number of veterans dedicated their lives to the Canadian Armed Forces and experienced a deep sense of institutional abandonment upon their release. This is known as “sanctuary trauma”. As a result, they enter the PCVRS system with a deep distrust of institutions.

Unfortunately, certain aspects of the program often tend to amplify this distrust rather than lessen it. Veterans often report that they feel managed rather than supported. They describe it as a system based on ticking boxes. It's hard for them to trust rehabilitation experts and to feel safe discussing their condition with these experts. Yet recovery from trauma or psychological injury depends on a sense of security and trust and on veterans' ability to lower their defences. Veterans often see the rehabilitation process as a factor that reactivates their alarm system. This is incompatible with recovery.

I've also observed that frequent reassessments and progress reports can become quite demanding and, at times, destabilizing. They can also be a source of further trauma for veterans. I understand the need for accountability and to monitor progress. However, the program doesn't always seem to take enough account of the fact that deep psychological wounds often take a long time to heal and that progress is non-linear.

In addition to having to revisit their condition on a regular basis, veterans are also exposed to rating systems that assess their progress in treatment. For veterans trained for years to perform and meet expectations, being confronted for long periods with ratings indicating unsatisfactory or little progress can inadvertently reinforce shame, feelings of failure and despair.

Another major concern is the early emphasis on employability. Sometimes this happens before sufficient psychological stabilization. For a number of veterans suffering from major trauma, this leads to a significant increase in anxiety and psychological distress.

I also observed that certain clinical recommendations to avoid vocational assessments deemed destabilizing weren't always followed, despite the risk of significant distress for some veterans.

Taken together, all these dynamics mean that a large proportion of sessions are often spent managing the distress caused by the rehabilitation process itself, rather than pursuing the therapeutic work involved in the veteran's recovery. I invite you to look at the structure of the system to see whether it's really adapted to the realities of operational injuries and trauma, as well as military culture.

● (6455)

I look forward to answering the committee members' questions.

Thank you.

The Chair: Thank you, Ms. St-Pierre.

[*English*]

Mr. North, you have the floor for five minutes.

Aaron North (President and Chief Executive Officer, Vector Medical Corporation): Thank you, Madam Chair and members of the committee. Thank you for the opportunity to appear here today.

My name is Aaron North, and I'm the president and CEO of Vector Medical Corporation. I've worked in mental health services for nearly 22 years.

I co-founded Vector Medical in 2013 with two physicians. Our work was initially focused on medical and mental health assessments related to fitness for duty, return to work and treatment planning. In 2015, we welcomed a new physician partner to our board of directors. He had served in the Canadian Armed Forces as an aviator, medic and flight surgeon. His lived experience and perspective have helped shape our leadership's understanding of military culture and our work with the veteran population.

Vector began working with veterans' rehabilitation in 2017 as an affiliate provider of the CVVRS program, primarily in the vocational rehabilitation stream. When PCVRS was introduced, it brought together services that had previously been siloed across vocational, medical and mental health streams. It also created a clearer pathway for standardized assessments, functional goals, outcome measurement and tracking of treatment progress.

As an affiliate clinic of the PCVRS program, Vector does not set the design or strategic vision of the program, but our experience in both CVVRS and PCVRS gives us a unique perspective on how the model works and continues to evolve to meet the needs of veterans.

Since January 2023, Vector has completed 1,908 PCVRS assessments, mostly psychological and mental health-related. In July 2024, following an assessor safety incident, we introduced a mandatory post-assessment feedback form. This helps us identify participant distress, suicide risk, disengagement, frustration and assessor safety concerns. These concerns are immediately escalated to our clinical leadership.

A review of the combined feedback data shows that approximately 95.5% of records had no notable concerns identified by the assessor. Approximately 4.5% did raise a concern, and those concerns are significant. The concerns were patterned, however. There was frustration over repeated assessments, complex questionnaires and retelling difficult military experiences, as well as uncertainty, guardedness, distrust, and anxiety related to benefits or income replacement.

The records also show that approximately 85% of assessments were completed within three hours. Among the 4.5% of feedback forms that contained participant concerns, the average assessment length was not longer than it was in the feedback forms with no concerns.

Our director of psychological services for Quebec describes the key to good assessments very simply: Come prepared, review the background information provided by the RSSs, understand what the veteran has already told other providers, and show them that the work they've already completed is meaningful and will serve as the foundation for planning the next stage in their rehabilitation journey.

This insight matters because it reflects how Vector collaborates with PCVRS clinical and administrative leadership. When our assessors identify practical improvements to report templates, referral document packages, process flow or other items that are critical for assessment success, we bring those to PCVRS. Our recommendations are met with openness, and our leadership has ongoing opportunities for follow-up discussions on those matters. Most importantly, we've seen examples of our suggestions being included in system-wide innovations that improve participant experience.

Vector is also responsive to feedback from PCVRS, and we implement improvements to our processes and program quality whenever necessary.

Continuity of care is one of the most important issues raised at this committee about the program. In May 2025, Vector began an audit that sampled 211 psychological assessment records, mainly reports. Nearly half of the treatment pathways recommended in the reports involved participant requests for continuing with or being recommended to continue with a current or previous treatment provider. Where additional supports were recommended, they often supplemented the existing relationship with that previous provider, rather than replacing it.

● (6500)

One of the most important improvements now being introduced is interdisciplinary mental health assessments and treatment. In complex cases, for example, a physician, a psychologist and an occupational therapist are brought together around the same participant with the goal of completing all three assessment components sequentially, within approximately four hours.

The Chair: Mr. North, I apologize sincerely. I forgot to mention that I am the timekeeper here in this wonderful role that I have as the chair, and I have to interrupt you, sir.

I know there will most likely be a lot of questions coming to you in our first round. Thank you very much, Mr. North.

This will open our first round. We will start with Mr. Tolmie for six minutes.

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

Thank you to our witnesses for joining us today. I thank you for your service and for your care for the veterans who come to your clinics seeking help.

I do have a few questions that I'd like to ask, and I'm going to try to get to each witness here.

I'd like to start with you, Lieutenant-Colonel Parker.

You brought out a few terms. Some of them I'm familiar with, and then there's one that you brought in that I'd like to peel apart a little bit, because it seems like you're adding something to the trauma that veterans are suffering. You said you wanted to talk about trust, accountability, power and harm, and that's what we're here for. We're here for the veterans.

You mentioned sanctuary trauma. You mentioned institutional harm. Then you came up with a term that's new to me: “care captivity”. Is that the term that you used? Is that correct?

● (6505)

Simon Parker: Yes.

Fraser Tolmie: All right. I'm going to try to define these so that they're not the same and they're individual items.

Sanctuary trauma, in our understanding, is when the government betrays its responsibility of care for veterans. That's the way that I would define it.

Institutional harm is when a vet has to answer 300 questions and then is put back into the trauma that they're suffering because either they're feeling like they're being questioned about their honesty or they're being drawn back into the trauma.

As for care captivity, my understanding is that if you don't use Veterans Affairs, you don't get the care. You have to go through whatever program they have.

Would you say those are fair definitions?

Simon Parker: Within the time that we have, yes.

Voices: Oh, oh!

Simon Parker: If you want to have a separate discussion, we probably could go on a lot longer.

“Care captivity” means a captive patient. It's not a term I've invented, but certainly you are captive. When you think about the power dynamics, you see there's a power imbalance. The case manager and the RSS hold the keys to the kingdom, and if you don't conform, they can kick you out. They can deny services and they can hold back, which happened in my case a couple of times. They will actually collaborate in some instances to have you removed from the program just because you won't conform to what they want you to do.

Fraser Tolmie: I'd like to touch on that, because you brought up in your testimony that you were placed on PCVRS, removed, and then placed on it again.

Were you then removed again? Why were you removed from it? You don't seem a rebel to me.

Simon Parker: It was the rehabilitation program, not.... PCVRS is part of it. They coordinate, as you know. It was the rehabilitation program.

The first time I was removed, it was simply because the case manager decided that she wanted something from one of my care providers and couldn't get it. She tried to escalate the situation with me, made me responsible for it and then eventually decided, "Enough is enough. You're being removed from the program." She used language from the act that said, "You failed to participate as you should have."

VAC did an investigation and found that she shouldn't have done this. She wasn't supposed to do this. They put me back on the program about a month later and gave me a new case manager and a new RSS, and those two basically collaborated to remove me from the program within six to eight months. They waited for an opportunity and they found one. It happened to be around an out-of-service provider. This is important, and you've probably talked about this before.

There are in-service and out-of-service providers. Out-of-service providers are not given the same materials that in-service providers are given. In-service providers are ones who decide to sign on to PCVRS programs. Out-of-service providers do not get access to the portals. They do not get briefings on the timing of when the reports are supposed to come in and how to submit those reports. I had an out-of-service care provider who didn't know this and missed a report date. Then the RSS decided to let it slide for 30 days without doing anything about it and then ended the service.

● (6510)

Fraser Tolmie: That was unfair treatment.

Dr. St-Pierre, I have a constituent who's a vet and is dealing with PTSD. One of the biggest complaints he has is that although he had a relationship with his care provider, PCVRS came along and said that he can't use that one and he has to use one of theirs. Then he was retraumatized. He's fought so hard because he feels that he was getting so much work done with his care provider.

You have talked about regression within the program. Could you share a little bit about that before we run out of time?

Dr. Line St-Pierre: First of all, that's unethical. Not accepting the provider is unethical.

Fraser Tolmie: Okay. That's all I needed.

Dr. Line St-Pierre: Yes, it's unethical.

The Chair: Thank you.

We will go to Ms. Hirtle for six minutes.

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

Good afternoon, everyone, and thank you for being here today.

Dr. St-Pierre, I'd like to address my questions to you, please.

Based on your combined experience in government and clinical practice, what observations would you offer regarding the continuation of care during transition?

Dr. Line St-Pierre: Are you talking about the transition centres?

Alana Hirtle: The transition from active duty to....

Dr. Line St-Pierre: It's a very long road. It's a very difficult transition. Even for members who were looking forward to getting out—those who were not released medically—the transition is very hard.

We have to understand that many of them grew up in the military. Their whole identity is the military. A lot of them have gone to war zones. Coming back to the civilian world is extremely difficult.

Alana Hirtle: Thank you.

Are you saying that there are challenges around coming from a structured organization, such as CAF, into more community-based care, where it's not as structured?

Dr. Line St-Pierre: Life itself becomes very difficult for them because they have been told since they were 17 or 18 how to dress, where to go and what time to be there. They've been hand-held. They're very functional, but it's a very different reality. I think that's why it hits so hard when they feel, "I've left the military and now I'm on my own. The organization is not there for me."

I'm not sure if I'm answering your question.

Alana Hirtle: That's sufficient. Thank you.

From a clinical perspective, what supports engagement in mental health care among veterans and serving members? How do you build trust to shape willingness for them to engage?

Dr. Line St-Pierre: It's through me and through therapeutic alliance. It's through validation, building a rapport and building trust before we actually start doing anything. Sometimes that can take a long time.

I don't think PCVRS understands that sometimes it will take a while before we're actually starting to deal with the trauma. Maybe we have to help this person to just get out of bed. Before we get there, I have to build trust with this person. Sometimes it's quick and sometimes it takes a long time.

Alana Hirtle: Thank you.

Having gone through therapy myself after my partner's sudden death seven years ago, I can appreciate a bit of what that looks like.

You mentioned "therapeutic alliance". Can you expand on that a little bit for us?

Dr. Line St-Pierre: Yes. It's creating the space for the veteran to feel at ease, to feel that with me in the space that we create, it's a safe environment and there's no judgment. I am there for that individual, and there's no pressure. I don't put any pressure. I'm trying to build where they could feel truly themselves and not be on guard. Sometimes veterans will be on guard with a civilian therapist because they think, “We don't speak the same language. She won't understand me.” We get over that with the therapeutic alliance.

● (6515)

Alana Hirtle: That's interesting. Thank you very much.

Based on your clinical and assessment work, what have you observed about how veterans and serving members access psychological care?

Dr. Line St-Pierre: It's through word of mouth. What I've often heard is that they didn't even know they could go to VAC for help. You would think, by now, that people would know. We're way past Bosnia, but it's still the case. It's often through word of mouth.

Was that...? I'm not sure if I'm saying the right....

Alana Hirtle: No, that's correct. We understand. Thank you.

What aspects of the system appear to help individuals access care more easily? What's working?

Dr. Line St-Pierre: I think it's getting a case manager. I've always had good experiences with case managers, which is....

I'm going to use my time to say this: Before, with the older program, we had direct access to VAC case managers, and we don't anymore. It's a shame. We have access to the PCVRS RSS. It's something that's missing. It was highly valued, because in the end, the VAC case manager has the power as the decisional...which most veterans don't know. I instruct them on this.

[*Translation*]

The Chair: Thank you.

As noted, Ms. Gaudreau will be speaking to the witnesses in French. Make sure that you can access the interpretation in order to hear the questions in English. I hope that everyone can hear the interpretation.

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

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

First, I would like to emphasize the importance of these testimonies. We're at a crossroads in terms of the contract's renewal. This study will give us the opportunity to assess the situation and make any necessary adjustments. It's important. I would like to express my sincere gratitude to the witnesses.

Ms. St-Pierre, since the start of this study, we've heard a number of witnesses describe how the system is highly structured from an administrative standpoint, but poorly adapted from a clinical standpoint. We heard earlier about the need for a therapeutic alliance, which takes time to build. It bothers me to hear you say that some veterans regress rather than improve when they leave the program.

Are we looking at an operational challenge, or does the rehabilitation model require adjustment or adaptation on a fundamental level?

Dr. Line St-Pierre: I went through the transition from the Blue Cross rehabilitation program to the PCVRS program with a number of veterans. Of course, it's always a transition. As soon as a change takes place, no matter what type of change, we expect to see a slight increase in distress among veterans. Change does this. However, we quickly discovered many issues with PCVRS's operations.

● (6520)

Marie-Hélène Gaudreau: As you said, the program sometimes applies a performance approach to people who can't function with this approach given their trauma. A number of witnesses explained the objectives of the assessments. You told us.

My question is for both of you. When veterans no longer trust institutions and a system that constantly requires justification, assessments and proof of progress, can this ultimately directly exacerbate their symptoms?

Dr. Line St-Pierre: Yes.

Marie-Hélène Gaudreau: What do you think, Lieutenant-Colonel Parker?

Simon Parker: Certainly.

[*English*]

Absolutely, in my case, that happened many times as I progressed through. Just the interactions alone with the staff members, because they didn't understand the military culture, frequently, we would get into disputes over treatment. My goals were not what their goals were. They would talk about a plan, but I never saw the plan. In fact, I had to ask them one day if I could get a copy of the plan. They said it was in the PCVRS portal. I told them I looked, but it wasn't there. Then they said it must have been an IT problem, and then one appeared.

There are all these functional problems with the organization because it functions more like a civilian insurance company dealing with a slip and fall at work. They don't understand what we go through. They don't understand how to communicate with us. We have our own separate language. We have our own separate needs. We have our own separate requirements.

As we heard earlier, we don't transition well out of our system, which we have been developed inside and have operated inside. As we move into this world and are now engaged with a civilian insurance company, the two don't meet. There's no collaboration. There's no partnership. We are not at the centre of their work; we are peripheral.

In my last case, I was actually at odds.... It felt like a wrestling match, where they were tag-team partners, and I was alone in conflict with them. When you go through that and look for help from them, you regress. You get triggered, and you suffer more trauma. You go home and don't get out of bed the next day because you feel overwhelmed with everything they've done. You put your trust in them to help you navigate the system, and it's not repaid.

[*Translation*]

Marie-Hélène Gaudreau: Basically, regardless of the quality of the services that we want to provide, I gather that the right people aren't in the right place. Clearly, a contract is needed in another place. We need to encourage the therapeutic alliance and avoid the repeated involvement of administrative managers. That's what causes the most harm.

I would like you to talk about the bureaucracy issues that you're facing. I'll ask you a quick question, since I have 30 seconds left.

Have you been surveyed by the organization about how things work? We're told that many surveys have been carried out. Have you been assessed?

Dr. Line St-Pierre: I don't think that I was assessed. Before I became an affiliate, I looked at the memorandum of understanding. It wasn't the one from Veterans Affairs Canada, but the one given to me. I told the people in charge that it wasn't reasonable.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

The Chair: Thank you, Ms. Gaudreau.

[*English*]

We will start our second round with Ms. Wagantall for five minutes.

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

Thank you for being here today. It's really appreciated.

Mr. Simon Parker, you're a bit of an oxymoron because you are very articulate about the challenges of coming out of service, and then I see words like “commanding officer”. You obviously have huge responsibilities with other people, yet when you're coming out, what I'm seeing here is that the majority of the stress from what you're experiencing is due to the system and the sanctuary trauma of trying to deal with your other issues. Is that correct?

● (6525)

Simon Parker: I would say it encompasses all four of these aspects. The captive patient, the sanctuary trauma, the cultural blindness.... They are all part of it.

Cathay Wagantall: I appreciate that.

I'm just trying to think through the dynamics of being in command of other members and what that would take. Then you're made to feel like you don't really know what you need when you come out of service. Would that be accurate?

Simon Parker: That's right.

We were speaking in the hallway, and I used the example of a child's toy that has different shaped holes. The child is given different shaped objects and has to put the right shape in the right hole. As a veteran, if you're not the right shape for that hole, you don't get....

Cathay Wagantall: That's so sad.

Simon Parker: You're out of the program, or you don't get the benefit. You need to fit within the parameters that they tell you. In my case, because I refused to do that—I refused to change service providers when I was told—I was labelled as volatile. I was labelled as difficult. This became a big—

Cathay Wagantall: Okay. I hear—

Simon Parker: I'm sorry.

Cathay Wagantall: No, I'm sorry to interrupt you.

This is what we've heard a great deal about during this study. These veterans had a system and a provider, but now, all of a sudden, because VAC decides to do things differently, it has created a great deal of turbulence for those providers.

Also, in having to go through a reassessment again, were you able to see the assessment and sign off on what you were given to become part of the PCVRS program?

Simon Parker: No. The first time, I was rolled over into the program when it started, probably in the beginning, and I was just told that my file was going over and that was it. When I was eventually called by the RSS, it was just a conversation on the phone. The second time, the case manager said that an RSS would contact me. There was no assessment. There was no sort of—

Cathay Wagantall: There would have had to be some kind of assessment by them to be able to move forward. No...?

Simon Parker: No. This goes back to my comment that there's no plan.

In my case, in both situations, there was no assessment. There were no goals established. They're supposed to be. If you go to the websites, it's all there. There are no goals. There's no plan. None of the services are coordinated. They're all basically run independently.

Cathay Wagantall: I'm going to ask you a question: Was there nothing, or was there nothing shared with you as to what they were?

Simon Parker: That's a good question, because nothing was ever shared with me.

I did say that in the update phone calls I would get with the RSS and the case manager, they would literally have conversations with each other on the phone about “changing this in the plan” or “updating that in the plan”. I never saw it. I had no idea what it looked like.

Cathay Wagantall: Thank you. That's very revealing and very disturbing.

Mr. Aaron North, you indicated something that I thought was really interesting. You said that it was important to come prepared to assess. You're not talking about the veteran being prepared. You're talking about the assessor being prepared, having gone through everything the way they should to make that assessment they're doing as simple and as painless as possible. Am I understanding that correctly?

Aaron North: Yes, absolutely.

Cathay Wagantall: You are an affiliate provider. What does that mean? Are you one of—

Aaron North: Vector Medical is an affiliate clinic.

Cathay Wagantall: I'm sorry. Say that again. I interrupted you.

Aaron North: We're an affiliate clinic.

Cathay Wagantall: Okay. When they talk about out-of-service providers, that is something different.

Aaron North: Yes, as far as I know. We're not out-of—

Cathay Wagantall: You're able see all the reports and do everything. It sounds like out-of-service providers don't have access to what they really need to do the job, and that others are given preferential treatment in how they provide services.

The Chair: Excuse me. I have to—

Cathay Wagantall: I'm five seconds over. I apologize.

The Chair: That's okay.

Thank you very much, Mr. North and Ms. Wagantall.

We will now go to Mr. Clark for five minutes.

Braedon Clark (Sackville—Bedford—Preston, Lib.): Thank you very much, Madam Chair.

Thank you to all of our witnesses for being here this afternoon.

Mr. North, I want to continue with you, if I may. I just want to make sure that I understood correctly what you said in your opening statement. You said that Vector Medical did a little under 2,000 assessments since 2023. I believe you said 1,908. You said that about 95% of those assessments did not report any concerns and that 4.5% reported concerns.

Could you flesh that out? Who is reporting those concerns and how do you classify them? Are all 1,900 of those assessments recorded in that way, with concerns or not, or what was the sample of that group?

● (6530)

Aaron North: The sample was about 1,000 of the assessments. It's not an audit. It's an ongoing integrated part of the program.

We started the feedback forms after there was an incident with one of our assessors. A lot of the data that I've been able to glean has to do with our having a clear understanding of what happens within the assessments. The concerns that are raised are not categorized. The assessor will report back: Was this experience essentially a positive experience for the participant?

Braedon Clark: Those assessments are coming back from the assessors, not necessarily from the participants—or is it from both?

Aaron North: It's not a participant feedback summary. It's an assessor evaluation of how this assessment went clinically.

Braedon Clark: Do you collect any feedback from participants or anything from that side of things?

Aaron North: We address the concerns that are brought up by the assessors and we bring them up with the RSSs.

Braedon Clark: From an improvement standpoint, when you're dealing with programs of this scale and complexity across the country, it's always really important to have continual improvement.

Mr. North, you have a large sample size of assessments that have been done here. There are almost 2,000. From your point of view, what are one or two things that stand out to you as practical areas of improvement?

Aaron North: I would say it's making sure that the assessors who are doing the work really understand the culture and the complexities of an assessment that's specifically geared towards a population that experiences trauma but also has to deal with something that no one else really does, which is that transition back to civilian life. It's about cultural competency, absolutely. It's also about excellence in the work they do.

We have directors of psychological services for all of Canada, as well as for Quebec, and we constantly review the process as well as the work that's actually being done by those assessors in our network.

Braedon Clark: Okay. That's great. Thank you.

If I can, I'll move to you now, Lieutenant-Colonel Parker. Mr. North touched on a word that I wanted to ask you about. Actually, it was a good segue into culture. In the previous round, you said, “They don't understand”. That's a quote from you. With the problems you've experienced and others may experience, how much of that do you think is perhaps the administration and the structure of the program, and how much of it is cultural and more intangible things? The sense I got from you, and correct me if I'm wrong, is that it seems like that's a really important piece of it.

How do you balance that out and make sure that both of those pieces are actually getting improved? If you don't do both, my feeling is that you're not really getting where you need to.

Simon Parker: Those are good questions.

We could talk for hours on different models and different ideas. Mr. North mentioned something about how they brought in a former military member to advise on culture. I think it's helpful if you have someone there.

When you're bringing in new employees, you're onboarding them with whatever your business model is, your policies and all of those sorts of things, like regulations, how you want them to operate, their phone number and all of that kind of stuff, but you also need to have somebody there to say, "This is an understanding of the clients you're going to be dealing with and this is the kind of environment they operate in." For example, if you're in a civilian insurance agency and you're dealing with a slip and fall.... The person slipped and fell inside the warehouse. That was it. There's nothing else going on. They just slipped and fell—

● (6535)

The Chair: I'm so sorry, sir. I apologize. I mentioned to you personally that I would have to interrupt you. I'm very sorry about this.

[*Translation*]

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

I'm familiar with the insurance business. Property damage is nothing like human damage. Human damage involves dealing with another person. I call it taking the time to dance with the other person. Honestly, let's face it. This program—which is supposed to be people-centred, decentralized and adaptable—remains unpopular. I'm told that everything is fine. However, we're hearing more and more reports such as the ones shared by the witnesses. I want them to know that their voices are being heard. People keep coming back to tell us that they aren't the only ones.

I have a question for Ms. St-Pierre regarding the sessions, which sometimes involve efforts to soothe the veterans' distress resulting from the program itself. Some people say that they don't get a call back and that they can't even obtain their file. These people come to my office. I'm told that I have a direct line and that I could do something. However, I can't handle 100 cases a week.

Is this something considered marginal, or is it nonetheless quite rare?

Dr. Line St-Pierre: Are you asking me whether my sessions rarely focus on trying to regulate—

Marie-Hélène Gaudreau: Yes.

Dr. Line St-Pierre: This happens when veterans know that they'll be getting a call from a rehabilitation services expert. We talk about it the week before and the week after. So it's at least twice a month. Often, if a progress report is issued, the topic will be addressed there as well. Moreover, if they received emails or other correspondence from PCVRS in the meantime, it's back to square one.

It isn't my role. However, to make the whole thing easier, I try to build their trust in the program. Yes, the program has issues, but the veterans aren't targeted personally. I at least try to establish that separation.

That said, yes, I waste a great deal of time.

Marie-Hélène Gaudreau: Clearly, what veterans are experiencing doesn't meet their needs. Do you agree?

Dr. Line St-Pierre: Absolutely.

Marie-Hélène Gaudreau: Thank you.

The Chair: Thank you, Ms. Gaudreau.

[*English*]

We will now have a brief two minutes from Mr. Tolmie and Mr. Casey.

Mr. Tolmie, you have two minutes.

Fraser Tolmie: Thank you.

When we left off, Dr. St-Pierre, you were saying it's unethical to break the relationship when someone is going through counselling and then move them to a different provider. Could you unpack that for me? I think you had a lot more to say on that point.

Dr. Line St-Pierre: It takes so long to build that trust and that therapeutic alliance. You're dealing with somebody who's fragile—I hate using that term, but you know what I mean by it—and then you're going to take away security from that person and a space where he or she can finally express themselves without fear of being seen as weak. We're going to take that away from them and send them to a stranger. It should not happen.

I have to say that one of my clients just transitioned from the forces into PCVRS and it was his biggest fear, because I had been working with him for three years. He said, "I don't want to, but I know I'll be forced to". I found out—

Fraser Tolmie: What was his biggest fear about going to PCVRS? Was it that he was going to lose the relationship with you?

Dr. Line St-Pierre: It was that he would lose that secure place. He felt good with me. He felt like I got him. We speak the same language. We've worked together. He's grown. He's doing better than he was. For him, it was a big fear.

I managed to find out who his VAC case manager was. We spoke together and we ensured that it was not going to happen, and it didn't. I still see him.

● (6540)

Fraser Tolmie: Okay. Thank you.

[*Translation*]

The Chair: Thank you, Ms. St-Pierre.

[*English*]

Mr. Tolmie, thank you.

Now, for two minutes, we have Mr. Casey.

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

Mr. North, I'm going to direct my questions to you. If I understood you correctly, you started with the rehabilitation program in 2017 with the predecessor to PCVRS, and since 2023, you've conducted 1,908 psychological and mental health assessments.

Do I have both of those things right?

Aaron North: That's correct.

Sean Casey: Sometime after January 1993, you instituted a post-assessment form. Is that right?

Aaron North: It was in 2024, yes.

Sean Casey: That would have been after 1993 as well.

Why did you institute this form under PCVRS?

Aaron North: We had an assessor who was threatened in one of her assessments. She was very concerned, and we were very concerned. We brought the issue up and we developed a strategy to make sure that the assessors were safe. However, by extension of that endeavour, we also wanted to institute something to make sure that the participants were safe, and that the participants' experience was not too distressing for them or putting them in that position, which a lot of the witnesses at this committee have explained is sometimes the case.

Sean Casey: How long have you been using these post-assessment forms?

Aaron North: It's been nearly two years now.

Sean Casey: Have you noticed any trends over those two years? Has there been any change in what they've been telling you?

Aaron North: Again, about 4.5% of the assessments include some concern, so I want to emphasize that 95.5% of the assessments don't.

The Chair: Thank you. I apologize, sir. I know you cannot see me. I sincerely apologize, Mr. North.

This will conclude our first round. I would like to say thank you to everyone for coming forward today.

Thank you for your service, Lieutenant-Colonel Parker.

Thank you to all of you.

I will be suspending the meeting to welcome our next round of witnesses.

● (1740)

_____(Pause)_____

● (1745)

● (6545)

[*Translation*]

The Chair: Good evening. I call the meeting back to order.

I would like to welcome our second panel of witnesses, who will be speaking as individuals.

We're joined by Clea Corman, a consultant at Corman Collaboration Strategies.

[*English*]

We have Dr. Alisha Henson, clinical psychologist from Pembroke Psychological Services. We also have Mr. Michael Perstinger, a retired sergeant.

Thank you for your service, sir.

You will each have five minutes for your opening remarks. Afterwards, we will proceed to a series of questions from the members of the committee.

I will invite Mr. Michael Perstinger to start for five minutes.

● (6550)

Michael Perstinger (Sergeant (Retired), As an Individual): Good day.

I am retired Sergeant Michael Perstinger. I served in the Canadian Armed Forces infantry as a primary reservist from 1998 until my medical release in 2021. I deployed to Afghanistan twice and suffered from physical and mental health conditions directly related to those deployments. I served honourably throughout my career and was entrusted with significant responsibilities during my military service. I also hold two CEGEP diplomas and a bachelor's degree. I worked successfully as a 3-D animator in the gaming industry until my mental health no longer allowed me to continue.

Following my release, I spent two years stabilizing my mental health through therapy and medication, while also receiving treatment for permanent physical injuries through VAC-supported care. Two years after my medical release, I entered the PCVRS program. PCVRS spoke constantly about being needs-based, tailored and built around care and compassion, but almost immediately, my therapist refused to work with the program because of previous patient outcomes. That should have been my warning sign.

During my time with the program, I was repeatedly forced through redundant assessments for permanent conditions VAC already recognized. Again and again, I was required to justify and relive deeply personal trauma to strangers I would never see again. Instead of rehabilitation, the process often felt like institutionalized retraumatization.

At one point, I was assigned to a rehabilitation clinic located an hour and a half from my home, and I went there twice a week for treatment for a permanent back injury. Spending three hours in a vehicle for back rehabilitation is absurd on its face, yet when I questioned it, I was effectively told that convenience for the contractor network outweighed practicality for the veteran.

I was also subjected to additional psychological and vocational testing despite VAC's already possessing years of medical and employment records. Throughout the process, I was repeatedly forced to reprove what VAC already knew.

After a career of honourable service, I often felt treated with suspicion rather than trust. Throughout all of this, I never had proper access to my own rehabilitation plan through the participant portal. Over the course of the program, that plan was revised seven times, yet due to an unresolved and known IT issue, I never saw it directly myself. On a half-a-billion-dollar contract, that's bureaucratic malpractice, in my opinion. It is equivalent to sending a soldier on patrol without orders, a map or a compass, for that matter.

There's also a clear pressure to not resist the process too much. Among veterans, there's a widespread fear of being labelled “difficult” if you push back against the arrangements that don't benefit you. I would go along to get along, to accommodate, to avoid trouble and to hope that compliance would buy safety. Even the professional opinion of my therapist—that I was no longer employable because of my mental health condition—was effectively overridden by more bureaucracy, more assessments and more procedural hurdles.

Nothing about this process felt individualized. I felt like I was being forced into a pre-existing administrative template. It will always astound me that veterans who were held to the highest standards while in service would accept such mediocrity after their release.

By the end of my time with PCVRS, I found myself understanding exactly what Franz Kafka warned about: systems so bureaucratic and perpetuating that the individual trapped inside them becomes secondary to the process itself. Eventually, I found myself asking why the folks tasked with helping me were actively trying to hurt me.

Recently, Prime Minister Carney, speaking in Davos, talked about societies where “the strong do what they can, and the weak must suffer what they must.” That feels like an accurate description of the relationship between PCVRS and me at times.

Veterans are expected to navigate opaque processes while repeatedly justifying already-recognized conditions. After experiencing the program first-hand, I would find it obscene to commit another half a billion dollars to it without major reform.

The government has demonstrated over the last year that when there is political will, decisive action is possible. This committee truly believes in the government's stated values of honesty and accountability, and I believe you should honestly recognize that this program is failing veterans and requires fundamental redesign, because although I am currently sitting at the table, throughout this process I often felt like I was on the menu.

Thank you.

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

I would like to now open the floor for five minutes to Dr. Henson.

Dr. Alisha Henson (Clinical Psychologist, Pembroke Psychological Services, As an Individual): Good evening, Chair and members of the committee. Thank you for the opportunity to appear today.

My name is Dr. Alisha Henson. I'm a clinical psychologist working in Renfrew county, which houses one of Canada's highest concentrations of veterans. I'm here to speak to you about PCVRS and the need for stronger accountability, transparency, clinical standards and independent oversight.

These concerns are not new. They reflect years of advocacy by veterans, family members and experienced clinicians who have raised concerns about how rehabilitation services are designed, delivered, monitored and evaluated. In 2022, colleagues and I warned about the changes to the contracted rehabilitation model, and that it would increase administrative burden, reduce transparency, disrupt therapeutic relationships and limit veterans' access to experienced, community-based clinicians. In 2024, we approached McGill University to examine these concerns through an independent third party analysis, which we believe is critical to unbiased research. My colleague Clea Corman will speak more specifically to that project.

My focus today will be on strengthening the clinical side of PCVRS: whether the program is grounded in evidence-based, trauma-focused treatments and veteran-competent care, and the role of community-based, participatory research in the program's design, evaluation and rehabilitation planning. The brief submitted before this committee reflects evidence from frontline clinicians and veterans, an unpublished manuscript that surveyed 51 mental health clinicians from across Canada, and outcomes that are now supported by over 150 veterans, clinicians and community stakeholders.

The central concern is this: PCVRS serves veterans with complex, service-related rehabilitation needs, yet veterans and clinicians report that the program is not consistently transparent, clinically accountable or guided by those who understand the veteran's care. Veterans programming requires clinical judgment informed by operational stress, the relationship between mental and physical health, military and veteran cultural competency, identity disruptions following release and the readiness for change. Decisions about treatment and rehabilitation readiness must be clinically and culturally informed, transparent and not expressed as threats to essential supports.

However, veterans and clinicians report that some decisions are administratively driven, creating pressure and uncertainty. As previously noted, for veterans with trauma histories, systems experienced as unclear or coercive can become a source of distress rather than recovery. This is sanctuary trauma—harm that occurs when systems meant to provide safety become a source of threat, coercion and loss of trust, leading to the exacerbation of symptoms.

Furthermore, continuity of care is also essential. If a veteran has found a therapist who is safe, effective and trusted, the veteran should have meaningful choice in maintaining that relationship. Provider changes should be based on clinical need, not administrative convenience or program affiliation.

I offer three recommendations.

First, I applaud the veterans affairs minister's call for an independent third party evaluation. A program of this scale, involving public funds and clinically complex veterans, should not rely primarily on internal quality assurance by the contractor. The evaluation must include veterans in a meaningful way, along with psychologists with experience in program design and evaluation, and with the clinicians who work with the veterans. This must follow the principle of “nothing about us without us”. Veterans must help shape the evaluation, not simply become subjects of it.

Second, Veterans Affairs should establish a national standard for veteran treatment competencies for all mental health deliveries. Basic licensure is not enough. Providers should demonstrate competency in trauma-focused assessments and treatments—treatments that are easily identifiable in the literature as among the most effective psychotherapies for PTSD. They should demonstrate cultural competence with veteran and military populations. At minimum, mental health providers should have three years of postgraduate, clinically supervised experience in trauma and related evidence-based interventions working with military and veteran populations. The providers who do not meet that standard should have supervision and continuing education requirements.

Third, VAC programming should require meaningful collaboration with veterans, experienced clinicians, diagnosing psychologists and, where appropriate, family members. Unbiased clinicians have the clearest understanding of clinical status, readiness for change and treatment trajectories. Veterans must also have clear access to their assessments, goals, recommendations and rehabilitation plans. Veterans should not be forced to work with PCVRS providers if they already have a skilled clinician. However, PCVRS is continuing to force affiliate providers.

● (6555)

The issue is whether Canada is providing veterans with rehabilitation that is safe, transparent, clinically informed and worthy of their service. I have sat with veterans and their families for over 17 years, and I have seen the importance of transparency and safe space. I have also witnessed culturally competent and evidence-focused therapists walk away from this work, because their ethics and values in their work with veterans outweigh the financial benefits.

Thank you.

The Chair: Thank you, Dr. Henson.

As I mentioned, please look at the chair. I apologize sincerely.

We now have Ms. Corman for five minutes.

● (6600)

Clea Corman (Consultant, Corman Collaboration Strategies, As an Individual): Good afternoon, Chair and members of the committee.

My name is Clea Corman. I'm a public policy consultant and a Ph.D. researcher at McGill University. My research explores how communities and institutions can better collaborate to support at-risk populations.

Over the past decade, I've specialized in designing human-centred solutions and driving data-based advocacy for vulnerable groups across multiple sectors, including mental health, education, social pediatrics, employability and homelessness.

Earlier, my colleague Dr. Henson spoke powerfully about the severe clinical realities unfolding on the ground. My objective today is to provide the structural road map to address some of those realities.

The solutions I'm presenting are grounded in a comprehensive 2025 policy report entitled “Veterans First: A Policy Roadmap to Support Veterans’ Mental Health” developed through McGill's Max Bell School of Public Policy. It includes the policy brief that was submitted in April 2026 on behalf of over 150 clinicians, veterans and veteran advocacy groups.

To ensure our recommendations reflect the actual needs of the community, our findings synthesize survey data from 51 frontline mental health clinicians and integrate insights from 16 in-depth consultations with stakeholders across the veteran care ecosystem. These are not simply testimonials from outlier cases, this is an ecosystem raising the alarm and suggesting alternatives.

We recognize that the federal government has made a substantial half-a-billion-dollar investment to consolidate services under the PCVRS contract. Our goal today is not to advocate for scrapping this program entirely or starting from scratch with a new provider. Instead, we are suggesting viewing the last few years as a pilot phase.

Pilots are designed to reveal structural gaps. This one has clearly shown us where the system is failing our veterans. As we look toward the next iteration of the PCVRS contract, it is time to pivot from basic implementation to meaningful optimization and positive impact on the veteran community. We must treat this as an opportunity to build a system that actually improves the lives and mental health outcomes of veterans and their families.

To achieve this, we recommend three structural solutions to the next phase of the PCVRS.

First, a secure, centralized and trauma-informed data management system must be implemented. Currently, fragmented data practices are forcing veterans to endlessly repeat their stories and relive their trauma to multiple administrators and clinicians, thus increasing the likeliness of sanctuary trauma. We have a system with excessive access in some areas and complete blind spots in others. The next iteration of PCVRS must mandate the use of a secure platform with strict role-based access controls that protects patient confidentiality while ensuring seamless continuity of care and allowing for different care professionals to work together, not in silos.

Second, case management must be standardized and peer support formally integrated. Right now, a veteran's postal code and their knowledge of how to work the system too often dictates their level of care. We need a standardized system for assessment and referral across all jurisdictions, so that veterans receive timely wraparound services whether they live in an urban centre or remote community. Furthermore, international models in the U.S., the U.K. and Australia have proven that integrating veteran-led peer mentorship into clinical frameworks drastically improves recovery outcomes. Peer mentorship allows veterans who have already navigated the difficult journey of re-entry into civilian life to help others find their path.

A veteran struggling with mental health challenges should not have to go digging for services to connect the dots between service providers and push the system forward. This is the current reality and it is unrealistic. Canada relies heavily on fragmented, grassroots peer support initiatives, and there is currently no list of local resources that case managers can direct patients towards. The next iteration of PCVRS should formally recognize and fund peer support pathways to bridge the gap between clinical treatment and community reintegration.

Third, structural transparency and continuous accountability must be established moving forward. We strongly support the call for an independent third party evaluation, but accountability cannot be a one-off event. The next PCVRS contract must eliminate the conflict of interest inherent in allowing a contractor to evaluate its own efficacy. We recommend establishing an annual independent evaluation framework that includes publicly available performance indicators and a formalized feedback loop with the community it serves. Veterans and clinicians must have a direct and transparent mechanism to report service issues and influence program adaptations as they evolve.

I ask the government to consider the following questions: What is the quality of services we are offering our veterans? Is it enough for the sacrifice they have made for our country? Is the support accessible right across the country? Are we proud of our policies?

We currently have the data, the clinical expertise and the international models to get this right. The well-being of our veterans demands that we use this pilot phase of PCVRS as the foundation for immediate and meaningful change.

● (6605)

Let us put our veterans first.

Thank you for your time.

[*Translation*]

I'll be happy to answer your questions in English or French.

[*English*]

The Chair: Thank you very much.

We'll open our rounds of questions.

Mr. Richards, you have six minutes, please.

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

First of all, thank you to Mr. Perstinger and to any other veterans in the room today for your service.

I want to start with you, Ms. Corman, because you asked a good series of questions at the end. I would argue that the answer to those questions is “no”, unfortunately. I think that was your take on it as well.

You concluded with we must put veterans first. Some of the things we've heard through the course of the study would say that's not what's happening. Would you agree with that and why?

Clea Corman: Thank you.

“Veterans First” is also the name of our policy report. Here's some product placement—

Blake Richards: We're not allowed to use props, but you can.

Voices: Oh, oh!

Clea Corman: I'll take full advantage of that.

What we were tasked for at McGill when we reviewed this topic was to see how we could make recommendations to the federal government to improve the mental health outcomes of veterans who are making the difficult transition from service to civilian life.

I've listened to some of the previous meetings that this committee has held, as well as listening earlier to the previous witnesses. We've talked a lot about process and how the process itself is kind of failing our veterans. My work that I've done in the last decade often shows that process takes more space than is necessary, and we forget about the human that's at the centre of all of this. This idea of creating—

Blake Richards: I'm sorry. Do you mind if I interrupt you there?

Clea Corman: Go ahead.

Blake Richards: It's just because we're limited on time and I have a couple of other things that I wanted to ask you about. I think you've given me a pretty good sense that it's about process, rather than the individual, which is a real problem, obviously.

You also mentioned the idea that there's an inherent conflict of interest in the fact that you have a provider that's being told to essentially review themselves and determine their.... We've heard this data that they and VAC have quoted from, and I wanted to ask you about some of that. Can you speak very briefly for me to the importance of exit interviews for an organization that's trying to improve a program?

Clea Corman: Do you mean exit interviews of the people who are the patients or the veterans, or exit interviews for PCVRS, Lifemark as a contractor—

Blake Richards: Actually, it's exit interviews for the veterans in this case.

Clea Corman: Yes. I liked how the previous witness was talking about how they do assessments at the end of most of their interviews. I thought that was an interesting thing to implement, and I think that could be something that PCVRS could implement across the board with all of their clinics: the ones that are considered in-service providers and out-of-service providers.

There is a lack of continuity here, but I think it's clear that you know the clinics that are officially affiliated with PCVRS have a different way of operating, which affects care, and that shouldn't be the case. If you're a vet that's being plunked into PCVRS, you should have the same type of care regardless of whether you're keeping your current provider or you're switching to one that's affiliated by PCVRS.

Blake Richards: I couldn't agree more with that.

There's another thing we've heard about that's been an issue with the practices they have now. We've heard it from numerous veterans who didn't complete the program for various reasons. It seems that they're not being interviewed. How important is it that someone who's not completing the program is interviewed as part of that process to ensure we're getting a proper sample?

Clea Corman: Exactly, and I think the previous witness had a great system. However, 2,000 veterans are not the entirety of the veteran population. Those who are exiting the PCVRS program of their own accord because they're frustrated, because they don't feel like they're being supported or because they're being removed like a previous witness was...we're not hearing those stories. We're not hearing those voices.

It's excellent that you're able to hear some of them here today, but again, I think there needs to be a third party evaluator to come in and capture some of these stories, not to nix the whole program but to implement changes moving forward so that the program evolves with the needs of the veteran community.

● (6610)

Blake Richards: Okay.

Mr. Perstinger, where are you at currently? Have you completed the rehabilitation program with PCVRS or are you still in it?

Michael Perstinger: I am free and clear.

Blake Richards: You're free and clear. Okay.

Were you asked to do an exit interview of any kind?

Michael Perstinger: The first time I saw the face of my RSS was during my exit interview. Everything else was done over the phone. Finally, the last meeting I had with her was by video conference. It was a bit of an odd experience.

Blake Richards: There might be a bit of a problem in that, as well, I would argue. I'm sure you would too.

Outside PCVRS, what has your experience been when dealing with Veterans Affairs?

Michael Perstinger: I'm known to be smarter than your average bear. I have some schooling—a bachelor's degree.

It's a labyrinth. It became a full-time job for me to sit down, read policy and see where I fit into that.

Blake Richards: How did you find that experience with PCVRS? We hear a lot about duplication of bureaucracy, essentially, between the two. Has that been your experience as well?

Does that make it more complicated, and does it lead to sanctuary trauma for you or other veterans?

Michael Perstinger: It's already complex enough to.... I guess I'm not answering that.

The Chair: I'm so sorry, sir. Just say that sentence, and that will be it.

Michael Perstinger: It's already complicated enough to navigate the VAC labyrinth. To then be thrown into the PCVRS labyrinth as well is just duplicating everything.

The Chair: Thank you very much, sir. I apologize again.

Now, we'll go to Ms. Royer for six minutes.

Zoe Royer (Port Moody—Coquitlam, Lib.): Thank you, Madam Chair.

Thank you very much for the testimony we've received so far. I'd like to begin my questions with Sergeant Perstinger.

I'll begin by saying that my husband served 22 years with the Canadian Forces. He also received a university education during his time. His longest tour was 14 months in Bosnia, so I have a bit of a sense of what this world is.

Thank you for your incredible, extraordinary service to this country.

It sounds like you've been retired from the military for at least five years. What was the thing that was missing right away that might have made a world of difference when you started your transition into retirement?

Michael Perstinger: I was medically retired because of my physical and mental health issues. I no longer met the bar for universality of service for my trade. I had some sessions with a VAC representative at Saint-Jean, but once you're out, VAC isn't calling to tell you what is available to you. Nobody's calling, in fact. To then have to contact VAC to see what was available to me.... There's only so much the portal can do. After that, you are led to the policy pages, and good luck reading those.

I'm sure the people who work at VAC receive training on what the policy means, but to people who aren't in that world—who aren't bureaucrats dealing with this every day—it's gobbledygook. That's the best word to describe it.

Zoe Royer: Thank you.

If you were to redesign the program, what are some of the key things you'd look for?

Michael Perstinger: Are we talking about PCVRS or VAC?

Zoe Royer: It's both, actually.

Michael Perstinger: Basically, have a liaison officer—someone who's going to be there to answer any of your questions.

The RSS is there to book your appointments and keep up on certain things, but they're certainly not the person I'm going to ask, “Hey, what exactly is the road map here?” As I mentioned, I didn't have access to my rehabilitation plan. When I asked about it, the best she could come up with was sending me screenshots from her computer. That struck me as odd, especially given the largesse of the budget of this program.

It's about having a liaison officer who's there like a duty officer in the military. Break that glass in case of emergency. You could call them and say, “Hey, this is happening. What are my options? Do I have to say yes to this?” Again, we don't live in a vacuum. Veterans talk to one another. There are whole Facebook groups dedicated to this program, where horror stories—quite frankly—come out and people are panicked.

There should also be recognition of the fact that at the same time that I'm going through all this, I'm trying to stabilize my mental health. It's not as if I'm a regular human being who's completely stable. I'm ramping up on medications, ramping off other medications and trying to find the secret sauce. Now you're throwing me into this bureaucratic quagmire that I can barely read. Who is that helping?

● (6615)

Zoe Royer: Thank you, Sergeant. I really appreciate your candour.

I'd like to shift to Ms. Henson.

In that same vein, if you were to redesign the program, what are some of the best practices you might cite that are already happening around the world? Sometimes, we don't need to reinvent the wheel. What are some of those best practices that you would like to see implemented, which are already working very well in other places?

Dr. Alisha Henson: To speak to my own experience, I've been very lucky over time because I have had the opportunity to work with some veterans as they're releasing from the military. There's so much uncertainty. The more experience and the more knowledge you have in working between the different systems.... Often, veterans turn to their clinician to help be a guidepost.

We are often working from the perspective of other experiences with other veterans, but prior to PCVRS, we had very skilled VAC case managers whom we had connections with. We were able to turn to them and help our veterans navigate this system. With the onset of PCVRS, most clinicians I work with said they were just cut out of the system.

I know there has been some opportunity when veterans are coming on to the program for a bit more communication and collaboration, but if you're an out-of-network provider, PCVRS does as much as possible to remove you from the program as the clinician and, often, the person who has known the veteran for the longest on the other side of the system. Truly understanding the working alliance and the importance of that therapeutic relationship.... If Veteran Affairs and PCVRS could work with that model, they would have way better outcomes.

Zoe Royer: That's amazing.

I think there are just 15 seconds left. Thank you.

The Chair: Thank you very much.

[*Translation*]

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Ms. Corman and Ms. Henson, I hope that you know that you contributed to this study. It's enlightening. I spoke earlier about starting all over again, but that's too easy. There have been good moves and cases where things worked. I've also seen them in my office. However, it's unacceptable to have cases piling up.

Madam Chair, I would like to know whether Ms. Corman's document was sent to the analysts. The recommendations cover all this.

● (6620)

The Chair: It was sent for translation.

Marie-Hélène Gaudreau: Perfect. That's what I was expecting because we could talk about cases for a year.

Ladies, you have done phenomenal work. It's clear that a 180-degree shift is needed to provide services worthy of veterans. Let's be frank: This is a political decision. Veterans are following our proceedings and are telling us that we have everything we need. The report even includes the associated costs. We pat ourselves on the back when we talk about the defence agency, but we must not abandon those who have served their country. Everything is there. At the same time, there must also be an impartial assessment conducted upstream, and we can rely on your research. You are scientists.

If we don't listen, if we carry on as though nothing has happened, if we don't implement your recommendations and move on to something else—perhaps because there may be an election, for example—what will happen to veterans and future veterans?

That's my final question. It's for all three of you. I'd like to hear from each of you.

Clea Corman: Thank you.

If nothing is done, veterans and future veterans are sure to suffer. Right now, the government is investing more in defence because the global order is somewhat precarious. If we want people to be willing to enlist in our armed forces in the future, it would be good to treat service members properly when they leave.

It's possible that other recommendations may emerge from your meetings or elsewhere, but this is a good starting point. As you said, I myself calculated the implementation costs because I know that researchers often write lengthy reports full of findings and overlook the implementation aspect. I didn't want to overlook that.

So, I think the first step is to conduct a formal evaluation of the program. This isn't an unreasonable thing. A new program needs to be evaluated to ensure it is properly implemented and evolves in line with the needs of the community it serves.

Marie-Hélène Gaudreau: What will happen if all of your recommendations aren't implemented?

[*English*]

Dr. Alisha Henson: I agree with Ms. Corman that it doesn't look attractive for veterans to not be taken care of when we're asking people to step up.

I think the other concern, which is a constant from a clinical perspective, is how many veterans we are losing to suicide, addictions and various other things. From the last project, we don't know how many people we lose. We don't have the data on that. If we don't include veterans in the program design and evaluation who have been through the program and who are willing to come forward.... They're often very burned out, but there are a lot of people who really want to be strong advocates for their community. If we don't take the time to hear their voices and properly implement the changes, we're going to be making mistakes over and over again and putting this community at risk, and it's not fair.

[*Translation*]

Marie-Hélène Gaudreau: What do you think, Mr. Perstinger?

[*English*]

Michael Perstinger: I'm not here for me.

[*Translation*]

Marie-Hélène Gaudreau: Please answer in French, though!

Voices: Oh, oh!

Michael Perstinger: I'm a little better in English, madam.

[*English*]

I'm not here for myself. I'm here, hopefully, helping to plant a tree that I will never see the shade of.

If you look around the battle spaces of new drone warfare and whatnot, I think we're going to see mental health numbers go way up in the next conflict we encounter. If the system isn't ready for that, it's going to be a disaster for our community.

[*Translation*]

Marie-Hélène Gaudreau: Mr. Perstinger, I have a few seconds left.

On a scale of one to 10, how hopeful are you that things will change? We're among friends here. Tell us the truth. This is the moment. It's important to speak from the heart to bring about change. This has been going on for decades.

[*English*]

Michael Perstinger: My trust in the institution is gone. It's up to you guys to bring it back for me. I give it a two.

Honestly—

[*Translation*]

Marie-Hélène Gaudreau: We're calling on the government to take action, and we want to see change. That is also why we are here.

[*English*]

Michael Perstinger: These are all self-inflicted errors. My time with VAC and PCVRS has eroded my confidence that I will be well taken care of in a timely—especially timely—and simple manner. It's up to you to gain my trust back. I've done my part.

[*Translation*]

Marie-Hélène Gaudreau: So we need to regain your trust. We hear you, and we'll include this in our report. It's very valuable.

Thank you very much.

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

[*English*]

We will now start our second round. Again, we'll go for five minutes, five minutes, two and a half minutes, two minutes and two minutes.

Mr. Viersen, you have five minutes.

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

Thank you to our witnesses.

Thank you for your service, sir.

I was asking the minister about the purpose of PCVRS. I'm happy to see that two of you, in particular, have had dealings on both sides.

You just said, “the onset of PCVRS”, which sounded like it was a disease. I thought that was interesting.

What is the problem? Has there been an improvement in something with the onset of PCVRS?

Michael Perstinger: Are you asking me?

Arnold Viersen: Yes. I'm asking both of you.

Michael Perstinger: I only know PCVRS. I don't know what was there before, so I can't answer that with an informed comment.

● (6625)

Arnold Viersen: Okay, but you were dealing with a service provider and then you had to leave to go to PCVRS.

Michael Perstinger: No, I got to keep my service provider, but she refused to work with PCVRS because of other patients. She worked with veterans for 20 years at the hospital in Sainte-Anne-de-Bellevue, and that's how I came by her. She had my full confidence, and her outright rejection to work with them was the canary in the coal mine for me. I thought, “Okay. Behind the glossy pictures on the website of happy veterans, there might be something else behind this”, and I certainly wasn't disappointed by that opinion.

Dr. Alisha Henson: The concept of PCVRS, in centralizing care, sounds really wonderful, and it's definitely needed, but the way it has been implemented has not been effective whatsoever. The very few times I've been able to work with PCVRS, we're still completely siloed. It's almost like they're pushing that further and further so that they have complete control. We don't even have relationships with case managers to call and communicate with anymore.

Arnold Viersen: I made the accusation that it seemed like a “raise somebody's stock price” scenario, rather than trying to help veterans.

There's an exclusivity clause in the contract. My naive thinking was that if the government signs a contract with somebody, it signs a contract with an existing business to do an existing thing, but this seems like it signed a contract with a new concept business and it's billing the business off the money it got the contract for.

You've watched this grow. Can you explain that a bit?

Ms. Corman, as well, if you can, please comment on that.

Dr. Alisha Henson: As far as the research and communication that I've had so far are concerned, from what I can tell, the way the program was initially developed was very much done using a physical therapy model. They decided that with this massive amount of money, they could add mental health, but they didn't understand the complexities of adding the mental health component.

Without the consultation.... No one knows whom they consulted with. We don't know who actually got to sit at the table and help inform that practice. I think one of the biggest eye-openers was when they said, at the very beginning, they had all of these clinicians onboarded with them, but then there was never a list and they were frantically trying to collect us without ever having a lot of success.

I think it continues to be a barrier. They desperately wanted us and didn't expect that we would say no because our values outweighed the money and the financial benefits that we could potentially have.

Arnold Viersen: Ms. Corman, do you have any comments about that?

Clea Corman: I think PCVRS, again, had a good idea in having those three distinct facets of somebody's care united under one umbrella, but they didn't listen to all of the wealth of knowledge that already existed within the veteran ecosystem. Even now, there are alliances and associations banging down the doors to PCVRS and the government, saying, “Hey, we have all of this expertise. Could we share it? Could we collaborate?”

I think the standing committee did a report in 2023 and flagged a whole bunch of problems with PCVRS, yet there has been no update since then. There has been no update from the federal government or PCVRS. The alliances and associations, and everybody trying to help fix the problem and also serve incredibly vulnerable veterans at the same time, are left wondering what gives.

Arnold Viersen: On that, is there any reason why Veterans Affairs can't capture that by itself? It seems to make it so exclusive to PCVRS. We don't do this in any other kind of industry.

Is there a possibility of removing that exclusivity clause out of this?

Clea Corman: I think that's a question for Lifemark, VAC and PCVRS, but there are definitely always ways to collaborate with the communities you're trying to serve.

The Chair: Thank you very much, Ms. Corman. Good job.

Now, we will invite Mr. Fanjoy to take his five minutes.

Bruce Fanjoy (Carleton, Lib.): Thank you, Chair.

Thank you, witnesses.

Thank you, in particular, to Sergeant Perstinger. I am glad you're at this table. It's very important that you're at this table. I found myself writing down a number of the things you said. One, I believe, was about institutionalized retraumatization. That struck me because that's the opposite of what we're trying to accomplish. A foundational principle of bioethics is first, do no harm. We're failing that. That's what I'm hearing.

If we were to start from the beginning, what are the most important elements that you think a veteran needs to get out of a program such as this in order to successfully transition from active service to retirement and civilian life?

● (6630)

Michael Perstinger: I fall under a few Venn diagrams here. I live remotely, and I'm a reservist. My complexity is multiplied because of my type of service. I fought next to the regular force guys in Afghanistan, yet when I came home, I fell under a completely different set of rules and regulations around whom I can and cannot seek out for mental health or physical health issues.

It was already a whole process to get my medical release in 2021, and then I got punted over to Veterans Affairs, which I will reiterate is a very opaque maze that takes a lot of study to try to figure out. Then I got PCVRS.

Again, there needs to be some kind of.... As they mentioned, I live remotely, and I'm forced to go to in-network clinics. Why? I have a back problem, so spending three hours of my day in a car to get to my appointment is ludicrous. It's not helping me. I go there for an hour and do the physical therapy or what have you, and then drive for an hour and a half and have a stiff back by the time I get home. I had to raise the question: Why did you do this? The answer I got was, “It's not my department. That's the appointment department.”

You can understand that this is frustrating because as soon as I entered the PCVRS program, I was in administrative limbo. I got out of the military. I got certain conditions pensioned. Now I'm on IRB. Then I'm in PCVRS for I don't know how long, having to repeat myself. All this time, I don't know what my future holds, what my financial stability is going to be or any of this stuff, even though all of my medical professionals are telling me, “Tap out. You're done.”

Now, I meet a bunch of strangers, who ask extremely invasive questions that took my therapist two years to pry out of me. I have to answer them because I don't know what happens when I say no. If you come from the military, you know that if you make too many waves, you are thrown off the boat. We're coming into this with a culture of not making too many waves, going along with it, sucking it up and hoping we'll get through it. I sit in those offices, in front of complete strangers, for my little interview with them, and I am asked extremely deep, personal and traumatizing questions. Then my wife has to deal with me for three days afterwards, when there's a dark cloud over me and I can't get out of bed.

You tell me where we can start over here.

Bruce Fanjoy: Ms. Corman, you've had a lot of experience in human-centred approaches to complex challenges. I don't think we have a human-centred process here, and that gets to the root of the problem.

How do we change that? How do we turn that ship around?

Clea Corman: As I've said, the program evaluation is your first step. Pivoting a program like this, after the initial pilot phase, is not a fast process.

My concern, keeping the human-centred approach in mind, would be in the short term as the program is being evaluated, improved and rolled out in a different way. Put in place, for example, funding for peer mentorship opportunities so that veterans have an alliance of some kind during the messy waters that may ensue. That would be my recommendation.

The Chair: Thank you very much.

Bruce Fanjoy: If it hasn't been tabled already, could you table “Veterans First” with the committee?

The Chair: It's been shared with our clerk, and it's currently going through translation.

● (6635)

Bruce Fanjoy: Thank you.

The Chair: It will be shared with each of you, once we have the translated version.

[*Translation*]

Thank you very much.

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

Marie-Hélène Gaudreau: Thank you, Madam Chair. I'll ask a question and, after that, I'll make a comment.

Ms. Corman, it was mentioned that the professionals we were discussing, among others, could not continue a therapeutic relationship with a veteran within the PCVRS network. However, what about those who decide to leave the network? Is it because of the administrative burden, the conditions, or the operating model? Did you address this issue in your report? If so, could you summarize it for me?

Clea Corman: Are you talking about clinicians?

Marie-Hélène Gaudreau: Yes.

Clea Corman: Often, they leave because they know that patients who go through PCVRS do not have a positive experience. They withdraw from the network for ethical reasons.

Others leave because they aren't compensated according to their level of expertise. According to PCVRS criteria, clinicians and case managers working with veterans must have a bachelor's degree related to mental health.

[*English*]

You could have somebody with a bachelor's in sociology, or maybe a bachelor's in psychology, with a bit of experience handling the very complex trauma that a veteran's case would entail.

[*Translation*]

I think that's two reasons.

[*English*]

Perhaps you could add to why clinicians leave or don't participate in PCVRS.

Dr. Alisha Henson: As I said before, a lot of it has to do with the ethics of it. When the initial documents came out and they were looking for clinicians, they really hand-picked who they would reach out to. They got a lot of push-back.

[*Translation*]

Marie-Hélène Gaudreau: Now I'll make my comment.

Please know that I'm very frustrated. I am a parliamentarian who is here to represent my constituents. I'm not in pursuit of power. We have the opportunity to bring about massive change. It is being handed to us on a silver platter. I'm telling you: This is not compassion fatigue. Ask all the parliamentarians here. They'll say it doesn't make sense. The problem is that we're turning a blind eye. It's a matter of political will. If you keep pointing out the shortcomings, at some point, people will wake up, and it's thanks to testimony like yours that we can hope for that. Yes, there is a minister, but there is also a prime minister. That's why we undertook this study, and I thank you for it. You have courage.

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

[*English*]

We will be ending with two minutes from the Conservatives and then the Liberals.

Mr. Richards.

Blake Richards: I have a couple of things I want to touch on.

Mr. Perstinger, you've already touched on this a little bit. You live more remotely, and that's led to, as you mentioned, your issue with the appointments for your back. I can certainly understand how that would be counterproductive, essentially.

We've heard that from other veterans as well. You said you're on Facebook groups with other veterans and things like that. Is this issue that you're dealing with, where because you live further from a major centre you're being required to go places that make no sense, a pretty common story?

Michael Perstinger: I can't speak in terms of hundreds—these aren't exactly huge Facebook groups—but it is a theme. I had to fight VAC to get it moved to somewhere closer. This isn't in emails or anything, but when they called to tell me that they had found a new clinic for me that was only half an hour away, the tone on the phone was very much like they were doing me a favour.

Again, it's just frustration. I'm here doing a thing that I didn't ask for, and now I'm being shoved through this, even though I know it's not going fix my back—my back problem is permanent—for whose benefit?

Blake Richards: Essentially, I think I hear you saying that there is just a lack of common sense being applied here. Is that accurate?

Michael Perstinger: Bingo.

Blake Richards: Okay.

Dr. Henson or Ms. Corman, do you want to speak to sanctuary trauma and what the constant retelling of the veteran's story to be able to get help does to them?

Dr. Alisha Henson: A very simple way of saying it is that it just exacerbates the symptoms. They're telling their story over and over again. When they've just released and completed an assessment with a psychologist, the assessment gets sent to VAC, and then PCVRS picks it up and never even looks at the assessment. It doesn't make any sense. It's just retraumatizing and asking for way too much.

● (6640)

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

Thank you, Mr. Richards.

[*Translation*]

Ms. Auguste, you have the floor for two minutes.

Tatiana Auguste (Terrebonne, Lib.): Thank you very much, Madam Chair.

Since I don't have much time, I will direct my questions to Ms. Corman only.

If I understood correctly, in your report you don't throw the baby out with the bathwater. The purpose is really to identify what isn't working at the systemic level and what could be done to improve the program.

Could you speak to the systemic or procedural factors that truly contribute to the challenges veterans face in the program?

Clea Corman: Yes.

Essentially, that's what Mr. Perstinger just described. Right now, everyone is working in silos. There's a lack of collaboration and communication among PCVRS, clinicians and case managers. Too many people are working on a single person's case, and there isn't enough information sharing. That's why one of our recommendations is to create a database that can manage all this information.

Several people today said they didn't have access to their own PCVRS support plan. That's ridiculous. We are fully capable of meeting that need by putting in place measures that allow people affiliated with PCVRS, clinicians and case managers to communicate with one another and share best practices.

[*English*]

That's what human-centred is. Keep the human in the middle and figure out how to implement big policy.

The government and PCVRS had a great idea. They put a lot of energy into this great idea, but they didn't put as much energy into how to implement it. Now, we have to shift the focus to how to implement, how to improve and how to break down some of those silos. It's very doable. It's not crazy.

[*Translation*]

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

That concludes the second round.

Ms. Corman, do you have a French version of the report you mentioned? We've sent it for translation, but I'm asking anyway, in the interest of efficiency.

Clea Corman: No, I don't have a French version. I could translate it myself, but I think you'd be quicker than me.

The Chair: That's not necessary. Thank you. I was just asking in case you hadn't already been asked.

[*English*]

Clea Corman: We're working on a translation, so I can verify with McGill to see if its version is closer to being done than yours.

The Chair: I would encourage you to reach out to our clerk to verify. We'll make sure that through either our translation or the version being produced by McGill University, we can share it with the members of our committee.

Clea Corman: I'll also submit a brief this week summarizing the report in English and French. If anyone doesn't have time to read the full report, there will be a brief version.

[*Translation*]

The Chair: Our members will appreciate that.

[*English*]

I would like to thank our witnesses for being here with us.

Again, Mr. Perstinger, thank you very much, sir, for your service.

[*Translation*]

Our next meeting will take place on Monday, June 1. In the first hour, we'll hear from witnesses discussing the PCVRS and, in the second hour, we'll have witnesses regarding the study on the experience of Black veterans.

The meeting is adjourned.

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