



HOUSE OF COMMONS  
CHAMBRE DES COMMUNES  
CANADA

45th PARLIAMENT, 1st SESSION

---

# Standing Committee on Veterans Affairs

EVIDENCE

**NUMBER 037**

Monday, June 8, 2026

---

Chair: Marie-France Lalonde





## Standing Committee on Veterans Affairs

Monday, June 8, 2026

• (1200)

[*Translation*]

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

Welcome to meeting number 37 of the House of Commons Standing Committee on Veterans Affairs.

Pursuant to the motion adopted on November 25, 2025, the committee is meeting on its study of the follow-up to the contract awarded to Partners in Canadian Veterans Rehabilitation Services, or PCVRS.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. Members and witnesses are attending in person in the room and remotely using the Zoom application.

[*English*]

Before introducing our witnesses, I would like to remind members of an email that was circulated on Friday. This is simply a friendly reminder that some members and employees may have sensitivities or allergies to scented products.

To ensure everyone's well-being, I invite everyone to avoid wearing heavily scented products in the committee room, such as perfume or cologne. I would also like to invite everyone to avoid smoking or vaping immediately prior to committee meetings as much as possible.

I would now like to introduce our panel of witnesses for the PCVRS study.

As an individual, we have Mr. Richard Brown. It's my understanding that you are attending by video conference. It's nice to see you.

From Lifemark Health Group, we have Dr. Steve Burton, psychologist, who's sitting in front of me.

Each of you will have five minutes to present your opening remarks. Once each witness has spoken, the rest of the hour will be dedicated to a period of questions and answers with the members of the committee.

Mr. Brown, I would like to open the floor for five minutes to you. Thank you.

**Richard Brown (As an Individual):** Thank you, Madam Chair. Good afternoon, members of the Standing Committee on Veterans Affairs, as well as to other distinguished witnesses and veterans in the crowd.

To start, I apologize for not being able to attend in person today, but my family and I have been working on helping our older daughter recover from a serious car accident that she suffered last weekend.

My name is Richard Brown. I enlisted in the Canadian Armed Forces in January 2003 at the age of 18. I served three and a half years in the Canadian navy as a TASOP and then as a sonar operator.

In May 2006, while on workups to get ready for the NATO flagship *Iroquois*, I suffered an injury that would eventually have me take a voluntary release from the CF. In October 2006, I was honourably discharged and relocated back to the southern Ontario riding of Niagara West.

Over the next few months, I struggled to keep employment as I tried to move on with my life, but in January and February 2007, I called Veterans Affairs for help. At the time, I had a great case manager by the name of Tracey Slade, who guided me through all the necessary steps to be diagnosed, along with Dr. Don Richardson from the London OSI.

In 2008, I decided to relocate to the Ottawa area, in Ottawa west, as well as Barrhaven. I was connected with Veterans Affairs worker Christine Filiatrault, as well as with Megan Lamarre at Billings Bridge. If I needed help, once again they were there.

In 2011, I attended the in-patient program at Sainte-Anne-de-Bellevue in Montreal. At that program, I was always told that if I needed assistance, it was there. That does not exist as I was told back then. Since 2015, the services have been garbage.

I relocated back to southern Ontario after two successful diplomas with vocational rehabilitation services. Then I was assigned to a case manager who was very unreachable. I was placed on the DEC program, the diminished capacity program, because they deemed that I had exhausted all vocational rehab services, and then I lost my case manager and wasn't even assigned a veteran service agent as part of the plan.

In 2021, I was reassessed for my mental health condition. It was completed by Dr. Dee Rajska over nine hours. She came back with two additional conditions, PTSD and alcohol use. Veterans Affairs denied those reports.

I took it to the BPA, and my lawyer there, Janet Chisholm, told me we had a case. It took 18 months of waiting for a review board for a five-minute meeting, and then another eight months after that for the report to come back as favourable.

Just recently, I was able to receive a favourable decision for a knee injury. I'm awaiting a knee replacement, but just like previous witnesses, I'm ineligible because of my age, and I have a level one denial letter in my hand that says that VAC has denied me treatments and benefits.

Over the past six years, I've yet to hear from a minister or even a parliamentary secretary, including the one on this panel, who received an email from me back in February. PCVRS, if I go through them, are telling me that I have to use their personnel. In the Niagara region, there is only one occupational therapist. I've had bad dealings with him in the past, and I've chosen not to use him; therefore, I am no longer entitled to occupational therapy. That's if I can even get onto the VRS program, because I'm DEC.

It is very insulting. In my spare time, I volunteer with the Navy League of Canada as a uniformed officer. I am currently the executive officer at the corps in Niagara Falls. Before I had all of these injuries, the physical injuries, I was active. I did equestrian riding. You can tell by the picture behind me. That's my therapy, a horse. Now I can't even do that, because of cuts.

Thank you very much.

• (1205)

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

Thank you for your service and your continuing services, sir.

I will now invite Dr. Burton to the floor for five minutes.

**Steve Burton (Psychologist, Lifemark Health Group):** Thank you very much.

Thank you, everyone, for allowing me to be here today in person.

My name is Dr. Steve Burton. I am a psychologist with Lifemark Health Group, where I have the privilege of providing services to Canadian veterans enrolled in Veterans Affairs Canada's rehabilitation services and vocational assistance program—the RSVP program we know about.

My professional background includes over 25 years of experience in forensic and clinical psychology. I work extensively in the areas of trauma, rehabilitation and psychological assessment. I'm accredited with the colleges of psychologists of Alberta, Saskatchewan and Manitoba. I'm a proud member of the Gitksan nation in British Columbia. I was a police officer in Alberta for 25 years. This experience has given me a deep understanding of the unique mental health and rehabilitation needs of the veteran population.

One of the foundational principles of effective rehabilitation is to thoroughly assess a veteran's current functional state. This is

paramount, because to develop the most effective and personalized rehabilitation plans, a comprehensive assessment is essential. While respecting the veteran's privacy and confidentiality, this assessment allows us to gain the specific, up-to-date, functional details and nuances required to accurately understand their current challenges and strengths.

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

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

This leads directly to the importance of outcome measures. These are not merely administrative tools. They are vital for demonstrating growth, allowing us to reanalyze and adapt a veteran's rehabilitation plan to best fit their evolving functional state. By systematically measuring progress, we ensure accountability, validate the effectiveness of interventions and can make adjustments to optimize the outcomes for each veteran.

A common area of inquiry that I receive involves the distinction between rehabilitation services within the VAC rehabilitation program and those available through general community services, such as those provided by Medavie Blue Cross providers. It's important to clarify that veterans can absolutely continue with their existing health care providers in parallel with the treatment that they receive in the VAC rehabilitation program. We are not aiming to remove established therapeutic relationships. Instead, the program ensures that the assessments and treatments delivered within VAC's rehabilitation program are specifically function-based and are provided by clinicians who have received the VAC specialized training relevant to veteran care and the program's framework.

At the core of our work are rehabilitation best practices. These include adhering to evidence-based approaches, fostering interdisciplinary care where various professionals collaborate around the veteran, setting clear and achievable functional goals, and maintaining a truly client-centred model. This holistic approach ensures rehabilitation that respects the veteran's unique needs and aspirations.

From my professional experience, the principles of clear communication, consistent functional goal setting and a collaborative approach with the veteran at the centre are paramount. The challenges often lie in navigating complex needs and ensuring integration of services, which we continually strive to improve.

Thank you for your time and for this opportunity to share my insights into the work being done to support our veterans.

Thank you.

• (1210)

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

Now, we will proceed with the first round of questions. Each individual will have up to six minutes.

As I mentioned, Mr. Brown is online.

I am also the clock keeper, as I have the pleasure of chairing this committee. I apologize in advance. I always say, please look. If you see me doing this, that means that we have to end the round.

We will now start with Mr. Tolmie, for six minutes.

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

Thank you, Mr. Brown. I'm sorry to hear about what you're going through with your daughter. I think this committee understands that you have to be there for your kids.

Mr. Brown, I'd like to start off with you. Thank you for your service. It looks like we signed up at about the same time. January 2003 was when I was taken in. We're of a very similar vintage in our service.

I'd like to talk to you and ask you about the nine hours of assessments that you had to go through. Can you share more about what you experienced and how that made you feel?

**Richard Brown:** Yes, sir. It was probably one of the best assessments I've ever had. It was with Dr. Rajkska. I'm sure the committee and former committees have heard of her. She took the time. She has that experience. We actually had to cut one meeting short, be-

cause she knew she was hitting hard and didn't want to stress me out. It was all based on what I was feeling—not on her agenda or on her timelines. If it took us 12 hours to do it, great. If it took us four hours to do it, great. There was no timeline, whereas when you go to the operational stress injury places, like in London, they give you only two and a half hours. That's it. They're coming up with an assessment on that. When I was at Homewood for the alcohol use reduction, it was the same thing. They have psychiatrists there coming up with a diagnosis within an hour. I'm sorry, but that's not proper medicine.

Dr. Rajka had everything from day one until the day of my release, and my feelings.... The report was something like 20 pages. VAC did not even want to accept it right off the bat. It was very good to go through Dr. Rajka, somebody who was outside of the VAC connection.

**Fraser Tolmie:** To be clear, you're saying you had a very good experience, although it was lengthy. You were able to share and they were able to come up with a proper diagnosis, but VAC rejected it. Is that what you're saying?

**Richard Brown:** That's exactly what happened. We put it in. I was supposed to get a decision. It went from step three to complete in 48 hours. I got notice. I was up at the Glen House for the Veterans Transition Network. I know they testified at committee. I was going on the five-day retreat up there when I got a letter saying it was denied. I was not too impressed about that. For something to be opened and closed in 48 hours.... Did anybody even read that report, or was it just, like, stamped? I waited a long time for it to go from step two to step three.

• (1215)

**Fraser Tolmie:** I recently had some meetings with veterans in my office. One of the things they've shared with me is that they have an assessment or they have a meeting with VAC and then they don't hear anything, or they have to wait on a decision by VAC, whether it's through the PCVRS or.... In that delay, they experience fear, trauma and numerous other feelings. It seems to be that the period of waiting does just as much damage as what has happened to them in service.

Can you share that? Is that something you've experienced?

**Richard Brown:** I have, sir. I'm not going to lie right now. I was admitted not once but twice for suicidal ideation. Once was when I lived up in Ottawa. I was admitted to the Queensway Carleton. Probably in 2021, I was admitted in St. Catherines at Niagara Health System on Fourth Avenue for suicidal ideation.

It is that deny, delay, die. It is the worst feeling I've ever experienced. I use the wine barrel version, being from the Niagara region. There are all these wine barrels. It's like sitting at the bottom of the barrel, and you have that lid on top. It is on top so tight, and you're just going deeper and deeper. It's like the mouse trying to get out of the bucket with butter or whatever that one is. It's the exact same situation.

When you call VAC, they're like, "We can't help you. Call the IRO." IRO calls you back and says, "Oh, yeah. Call the ombuds. We can't do much for you."

**Fraser Tolmie:** I'm going to switch over for a minute here.

Mr. Burton, we've had someone come before us and testify about the code of ethics that the psychotherapy association has to adhere to and say that it's unethical for an organization to come in and force someone to break a relationship they've already established with a psychotherapist.

Do you agree with that?

**Steve Burton:** I would agree. My practice and everything that I've ever adhered to has been that, when the relationship is established with a therapist already, and it's a positive relationship, obviously you maintain that relationship. That is part of the assessment I conduct, and it is a big question. We're looking at all the providers they've had throughout their service and post release. If they are currently seeing someone and benefiting, and if they enjoy that relationship and feel that it's very productive, I recommend that they maintain that relationship.

**Fraser Tolmie:** Okay, because it seems to be that—

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

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

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

Thank you to both of our witnesses for being here.

I'm going to start with you, Dr. Burton.

I think in your opening statement you indicated that you served as a police officer for 25 years before becoming a registered psychologist.

**Steve Burton:** I was a psychologist while I was a police officer.

**Sean Casey:** How did your experience as a police officer inform your practice?

**Steve Burton:** Well, the trauma informed it, really. I went through a number of experiences during my service, and I think that is the piece that.... I think, when I hear these issues, obviously the experiences that a lot of the veterans have, they are real. They have happened. This is not to come in and diminish anything like that. I experienced it as well. We didn't have VAC in those days; it was WCB, so I went through the same thing.

There are institutional traumas, and there are sanctuary traumas, which I'm sure the committee is well familiar with. With all these things that, again, Mr. Brown has just spoken of, the waiting, the anxiety, the self-doubt, self-worth... You feel as though you've been thrown away by the organization, by the CAF. Then you are feeling discarded or dismissed when you're trying to get this assistance and

help. I think there are things within my practice that make me more sensitive to these issues because I have been through them myself.

• (1220)

**Sean Casey:** Thank you.

One thing that you said in your opening statement was that the way you work now under PCVRS or Lifemark is in a manner to avoid overassessment. We've heard a lot about overassessment and administrative burden. I'd like you to expand a bit on what you mean or what you're doing in your work specifically to avoid overassessment.

**Steve Burton:** With the assessment itself, there's obviously the requirement to determine progress within the treatment protocols. How are they doing? How are they after three or four months of treatment? Are we on the right path? It's evaluating symptoms and determining if we need to change things up. Do we have to go in a different direction?

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

**Sean Casey:** You indicated that veterans can continue with their own provider even if that provider isn't within the PCVRS or Lifemark network. We've heard conflicting testimony on that, so could you clarify what you meant by that? Then I'm probably going to ask for Mr. Brown's view of it as well.

**Steve Burton:** Once again, I really have to reiterate that what the veterans have experienced is real. That's not in dispute.

From my perspective, again, this is something that I haven't personally done, because I know the value of that relationship. For me, it's never been an issue of saying, as an example, "You have either this or some other provider, but you can't have your own." That's not something I've ever done, and I've never received that push-back from PCVRS.

The idea of having a provider outside of PCVRS would be, I would say, in parallel to potential treatment or a therapist within PCVRS. I am referring to Lifemark primarily because that's where I operate, but that's the difference. Again, at least from my experience, there is nothing that is written or pushed back in regard to another provider not being able to be involved, and maybe that's a communication issue.

In all these programs... From policing, I know that it was never perfect, but in this instance, communication would definitely be a big thing. Whenever they come in, whether they're veterans for OSI or already seeing psychiatrists and psychologists at the OSI clinic, the recommendation is for them to just maintain that relationship. I don't get involved unless they want a change or they want to see me. Often we end up connecting. Just due to the experiences, we end up connecting.

**The Chair:** I'm very sorry, but the time is up. I apologize, Mr. Casey.

Now we will go to Madame Gaudreau.

[*Translation*]

Mr. Brown and Mr. Burton, please note that Ms. Gaudreau will be speaking to you in French. If you can hear me right now, it means that the interpretation is working properly.

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

• (1225)

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

This is our last study. Thank you to the witnesses for being here. I would like us to start by going back.

A large proportion of the people who appeared here and wrote to us talked about a lack of trust. It has nothing to do with jurisdiction. Maybe it's about communication, but veterans seem to have a problem with the program. The people who are victims of it are the whistle-blowers.

In your opinion, what are the main factors that lead to a lack of trust? Is it a matter of transparency?

Could it be the delays? Is there anything else?

[*English*]

**Steve Burton:** Again, when we're dealing with transparency, I do believe that's a part of it, because it's about communication. From the get-go, when I first meet a veteran, it is about outlining all of these things and even explaining some of the delays they might experience. Again, it's from a trauma-informed perspective, based what they've gone through, and there will be reactions to how the program is received or to delays and how those affect them. Once again, it's about education, combined with communication and transparency. I definitely believe that is the biggest piece to all of this.

I don't like the word "stories", but when you hear the recounting by veterans of their experiences, again, there's almost a human interaction going on, and it's not the veterans'. It's based upon the human interactions where, again, the education about the program and the knowledge or experiences of the veteran are missed.

[*Translation*]

**Marie-Hélène Gaudreau:** Mr. Burton, it is only right for veterans to receive a service that reflects who they are. I think you're someone who can demonstrate that clinical expertise is key to getting the information out and explaining the process.

Our veterans seem to have dealt with people who had general training and lacked the necessary empathy to support them.

You seem to have a connection with veterans, but other specialists have said that it doesn't work.

Is clinical expertise essential?

[*English*]

**Steve Burton:** Yes. I would be putting myself out of a job if I said that clinical experience was not necessary. It is, and you're exactly right. If I could ensure that every clinician spent time in the CAF, in policing or in some type of first responder work, we would have no issues whatsoever. It is a perspective that does come into play.

As for the clinicians I work with, we work together very well. The knowledge of what I used to do and who I am helps in guiding their practice and their response to veterans too.

I would have to say, definitely, yes—back to your question—clinical experience is necessary.

[*Translation*]

**Marie-Hélène Gaudreau:** I really want us to get an idea of what people are going through right now.

Since the beginning of the study, we've heard disturbing testimony from health care professionals. In another study, a number of veterans made the same observation. They feel that the system is too rigid and that the bureaucracy is removed from their basic needs when they return to civilian life.

The study leaves me worried, but also troubled. These may be isolated cases, but, in my opinion, this is a responsibility that Veterans Affairs Canada must honour.

I only have a few seconds left, but I really want to assure veterans that we will keep going.

Mr. Brown, I will personally commit to pushing as long as it takes with Veterans Affairs Canada to make sure that you can deliver the services that veterans need and that you don't get turned down.

As for the denials of treatment, difficulty and lack of proximity, I really hope that what we understand people are experiencing right now ends, especially when it comes to defence deployment.

• (1230)

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

That concludes our first round of questions.

I will now give the floor to Mr. Viersen for five minutes.

[*English*]

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

Thank you to our witnesses for being here today.

Mr. Brown, I would like to start with you. This fall, the government has an option to renew the PCVRS contract. Would you recommend that the government renew that contract?

**Richard Brown:** Thank you, Mr. Viersen.

I would recommend that the government not renew the contract with Mr. Galen Weston, because, after all, I used to work for a Loblaw's store when I released from the military, and I lost my job because of my injuries.

I was still under the three-month probation—in Ontario, that's what it is—so they can let you go anytime. I was having panic attacks. I was having flip-outs and stuff like that. I couldn't come to work, and they just said, "See you later." Ultimately, I'm still waiting to see when Mr. Weston will be sitting in the House of Commons. It shouldn't be a dictatorship. It does need to be studied properly.

When I went through VRS, it was with the March of Dimes in Ontario. It was the same crap then as it is now.

It's all on what the government wants. They want timelines, because the bureaucrats want it, or their buddies all want it. It shouldn't be based on that. It should be based on the veteran. That's the exact reason I did that second assessment with Dr. Rajska, and because she takes the time to listen and to do a proper report.

I'm not saying that Dr. Richardson is a bad guy. Dr. Richardson was great at the OSI and getting that going in Montreal. Once again, he's under the pressure of the government.

In Ontario, veterans fall under two systems. We fall under the feds, and we also fall under provincial health care. In Ontario—I know it's bad all across, but specifically in southern Ontario—you can't get help. With Medavie Blue Cross, they tell me, "Oh yeah, you can go get this person." I call them, and they say, "We haven't worked with Medavie in six years."

There's another problem that we have. Medavie needs to be held accountable—the transparency—because if you go on their website under licensed providers, half of those people.... There was one on there, Terry Semple, who was one of my psychologists. He hasn't practised medicine in almost five years, yet he's still listed on there as a provider. Try to figure that one out.

I hope that it won't just be Mr. Carney saying, "Hey, you know what, Mr. Weston? We're giving you the contract." It needs to be discussed further.

**Arnold Viersen:** Is it clear to you, at all, why the government signed a contract with PCVRS? What specific problem were they trying to solve?

**Richard Brown:** I'm not too aware of that, because, as I said, I'm just getting back into trying to get some help with my mental health and physical limitations.

I'm told that I can use only the one therapist, who is very pushy and has their own agenda. It's that level of care. In the new veterans charter, passed in 2006, the veteran is supposed to be able to call the shots, not everybody else, because we all have different tendencies. Every veteran is different. There is no status quo when it

comes to mental health or physical injuries. It needs to be looked at across a broader spectrum.

**Arnold Viersen:** In your opening comments, you mentioned that you had to hire a lawyer to get your benefits. Could you talk a bit about that? Was there legal aid involved or anything like that, or did you pay for it out of your pocket?

• (1235)

**Richard Brown:** No, I didn't pay for that. I've gone through the bureau of pensions advocates not once but twice. Both were for mental health. I was lucky both times. I had the same attorney at the bureau of pensions advocates. I hope she's not going to lose her contract, because she took cases only if she could win. She had a 94% success rate.

When she looked at my case, she said, "I'm not even going to send this back to the department, because I know it's going to be revoked. We're going right to VRAB." It took 18 months to get a hearing that lasted five minutes. They asked me two questions. I was in and out. He said, "Your attorney gave a good report. It's looking very favourable." That was in August 2022. I didn't hear back about the decision until Valentine's Day 2023.

**Arnold Viersen:** I don't know if you're aware, but the government is cutting the bureau of pensions advocates funding. It's good to hear that you've used them. That's a case in point for not cutting their funding.

I want to thank you for your service, sir.

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

Now we will have Mr. Fanjoy for five minutes.

**Bruce Fanjoy (Carleton, Lib.):** Thank you, witnesses.

Dr. Burton, I'd like to delve into Lifemark and its relationship with clinicians.

You mentioned that clinicians are a critical part of Lifemark. Are you an employee of Lifemark, or a contractor? Do you work outside Lifemark as well?

**Steve Burton:** Yes, I am an employee.

I was doing correctional work with inmates at Stony Mountain near Winnipeg. That was, again, another huge trauma point.

In the work I do, I have the opportunity to work privately as well—outside work time, so to speak.

**Bruce Fanjoy:** Thank you.

Given that you can work privately as well as with Lifemark, I'd be interested in your perspective on what value Lifemark is bringing to this program.

**Steve Burton:** Again, experiences vary, obviously.

Lifemark has a large number of clinics across Canada that can service a number of veterans out there. As far as scale goes, Lifemark is one of the largest. It can accommodate the majority of veterans. There are veterans who prefer to live rurally or outside populated areas. We do our best, but there is travel for them, obviously, if they want to do in-person or physio-related work. It combines everything in one place. I think that's the biggest plus when we're talking about a clinic like Lifemark.

If you're experiencing anxiety about being in public places, you really have to just tolerate it for one visit. You could see your physiotherapist, occupational therapist or massage therapist and me, potentially, at the same time. I always liken it to.... I do the mental sort of massaging, with the physical massaging coming afterwards. That is the benefit of the Lifemark model.

My own experience in the clinic I work at has been one in which the interdisciplinary team works very well and closely together. I communicate with the physiotherapist—not outside confidentiality, of course—regarding what behavioural barriers or physical obstacles the patient is experiencing now. This could relate to something like, “Okay, they're experiencing a lot more stress and anxiety now, because they're feeling less worthwhile,” or, “Their self-esteem is lower because they can't mow the lawn.” These things keep coming up. Sharing that information and seeing how the person is doing are another benefit of the model.

**Bruce Fanjoy:** Health care professionals are used to working together, even when they function privately. It's your testimony that they're better able to deliver those benefits for veterans under the Lifemark corporate umbrella.

• (1240)

**Steve Burton:** Again, with the general statement, it is applicable when, for example, a physiotherapist will follow a veteran down to see me with hot packs and things for their physical pain while I'm addressing and working with them. It's literally just down the hall. We have that proximity, but we also have the relationship that makes things easier.

**Bruce Fanjoy:** A number of veterans live in rural communities. That's where their families and support networks are. It's not always the case that this is where there's ready access to health care professionals. How does Lifemark bridge that gap so that veterans can access services they need when they live in rural communities?

**Steve Burton:** Most of the time they can access providers in the community. That comes back to not restricting their ability to access those people. In addition, there are technological abilities, like virtual therapy, etc., so that we can communicate online like this. We do our best to accommodate, for sure.

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

[Translation]

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

**Marie-Hélène Gaudreau:** Thank you.

Doing the best we can is what our veterans deserve.

Seriously, I'm really embarrassed. It's like telling people to enlist, but then figure out how to live in a rural community while having to drive two hours with back pain. As we know, there are rural areas in Canada, not just in Quebec.

I can give you a list of names. They all call me at my office. To me, that's unacceptable.

Let's say that we consider this and conduct an independent study to see what worked and what isn't working. Let's face reality and not just say that we are good despite everything.

Mr. Brown, while reform is needed, if there were one thing to do, one major thing that could change the game, what would it be?

[English]

**Richard Brown:** There are actually two that I believe could happen. Veterans Affairs, VRS and all of them need to start listening to veterans. Hire veterans to be case managers. They have the experience. Veterans help veterans. It's proven with the social media sites, with everybody online. It's crazy.

On top of that, I live 25 minutes from Niagara air force base in Niagara Falls, New York. That's how close I am to Buffalo. I talk to American veterans all the time through Facebook, social media or whatever. Their system is messed up like ours is, but it's getting better. The wait times are getting better. Case managers in the States can approve stuff.

In Canada, we have to put it through the rigmarole, and everything goes and sits on somebody's desk in Charlottetown, because that's where the Veterans Affairs head office apparently is.

That's how things can be fixed—hire veterans to work as case managers, and if they speak out, don't punish them.

[Translation]

**Marie-Hélène Gaudreau:** It's duplication.

I just want to thank all the witnesses for coming. I'm genuinely distressed. You are very brave to come here and testify.

I'm thinking of everyone who came here, those listening to us and our veterans. We will not give up. That's why we're here.

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

[English]

Next is Ms. Wagantall for five minutes.

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

Thank you both for being here.

Dr. Burton, I would like to pursue this conversation around a parallel service. This is the first time, regardless of whether those who came were part of Lifemark or were on that other tranche that didn't quite qualify, that this has not been an option. It's been made very clear to veteran after veteran that unless they do it this way, they will lose their IRB. Please explain it to me. Would they have to pay for two different services, which to me would be two psychologists at the same time?

• (1245)

**Steve Burton:** In only the sense that if it's determined through whatever process.... The process is, again, assessment: determining that, okay, there are additional avenues of treatment. For example, if an individual is seeing a therapist, and they see them only monthly, but then I assess them and I'd like to see them more frequently, because they have—

**Cathay Wagantall:** How is that paid for?

**Steve Burton:** It's through PCVRS and VAC.

**Cathay Wagantall:** Okay. VAC will cover their parallel service.

**Steve Burton:** Yes.

**Cathay Wagantall:** At the same time, basically, VAC is paying for PCVRS to qualify....

**Steve Burton:** That is my understanding.

**Cathay Wagantall:** How many veteran patients would you see in the course of the times...? When were you first recognized as a provider?

**Steve Burton:** It was in December 2022.

**Cathay Wagantall:** Okay. Can you give me an idea of how many veterans you've served over the course of this time?

**Steve Burton:** It would be hundreds, yes—several hundred.

**Cathay Wagantall:** Hundreds have made it through the entire process of being assessed and then getting the vocational care they need and then....

**Steve Burton:** Yes, but here, I guess, is the other piece. It's that not all make it to the vocational step. That is where, from my perspective, and this is where I've had a lot of support.... Sometimes the veteran isn't going to be returning to work. There's so much that they are experiencing, and what we want to do is have them have a good quality of life, just to improve their....

**Cathay Wagantall:** Then, in that case, you would say that this person, from your perspective, can't return to work, so they're encouraged to realize they can't. Then they move off from that whole opportunity at that point in time. Can you give me some feedback on that?

I get the impression that they feel like they're being churned through the mill way too quickly and that they maybe don't qualify, as I'm hearing here, due to a lot of dynamics, as mentioned by Mr. Brown on his assessment outside of this program versus the process within it.

**Steve Burton:** Again, it's really disheartening to hear stories like Mr. Brown's.

My own experience has been that people have worked through the program, and it has been something where it's been literally

years. We continue to work through the program. I've never personally been pushed. I've never been pushed to—

**Cathay Wagantall:** What's the longest term you've spent with one particular veteran to get from A to B through the program?

**Steve Burton:** I'm still ongoing with some from 2022 whom I'm still working with. It's a transition, where the program has allowed for extensions of treatment and also the progression into DEC, this diminished earning capacity—

**Cathay Wagantall:** That's the difference that a lot of times I hear from vets. They just want.... A number of veterans have come to me wanting alternatives to that, and they just get pressured to finally just accept that. In your mind, they are misguided in thinking that they can do more.

**Steve Burton:** No. I don't think they are misguided. I think it's just from the time the program is set up for, which is two years—

**Cathay Wagantall:** That's my next question here, because you talk about a comprehensive assessment and how the program is time-limited and function-based. What is the time limit, regardless of that? You have some who have been there since 2022.

**Steve Burton:** Yes, and that's where the flexibility comes in, because I've experienced the fact that the extensions of treatment for the veterans have continued, and I know—

**Cathay Wagantall:** I'm sorry for interrupting you. Who decides that they get to continue?

**Steve Burton:** I would imagine it's through the VAC case manager and the RSS, the rehabilitative service—

**Cathay Wagantall:** They don't, in my mind, get to make those kinds of decisions. It's coming from somewhere else.

**Steve Burton:** I'm making a decision, obviously, that they need to continue on with treatment, and then whoever approves it.... I don't know that process.

**Cathay Wagantall:** That's something we need to know and that the veteran needs to know very clearly, because I hear often as well that they go into these situations and are told that it's interdisciplinary and it's collaborative, and they don't find it that way at all. They're told, "This is it. This is what you need to do, and no, you can't use your previous provider if you want to get your IRB." This is what we face.

• (1250)

**Steve Burton:** Yes, and this is again, I think, coming back to the communication and transparency, yes.

**Cathay Wagantall:** Thank you, Madam Chair.

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

Our next speaker—and our last one for this round—is Mrs. Hirtle for five minutes.

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

Good afternoon, gentlemen. It's nice to have you both here.

Mr. Brown, I'm relatively new to the committee, and I'm trying to understand all of these terminologies and how it all works. You mentioned, I believe, that you had been approved for diminished earning capacity. Is that correct?

**Richard Brown:** Yes, ma'am, I was. That was in 2018, I believe. It was offered to me because VAC pretty much deemed that I was not worth taking more time with.

It was just a level of care. They were like, "Yeah, you should take this, because it's going to be harder if you don't take it. If you don't do it now, the wait times...and we've exhausted all of your options. You've received your four years of post-secondary, one with an honours diploma in legal office administration." They said, "Well, yeah, there's the door. See you later."

There were promises made in 2014. I believe it was in Kingston. Mr. Trudeau was there with Ms. McCrimmon and Mr. Lehoux from Petawawa. All of them were there. They promised changes within Veterans Affairs: reopening the offices. Okay—big deal—they reopened them, but they didn't bring back case managers. They brought back veterans service agents, and veterans service agents cannot approve funding.

When I went to VTN, I had to wiggle, wiggle, wiggle. When I call VAC now and say, "I would like to talk to somebody in my Hamilton district office," which is 45 minutes from me, I never get to talk to anyone there. I can't even go in person, because they do not have anybody working in person. I'm talking to people in Trenton. I'm talking to people in North Bay. I'm talking to people in Windsor. They don't help. When I did ask to speak to somebody, I was told I wasn't allowed to, because it's a conflict of interest. I voted for a caseworker's husband in the last municipal election, and that's considered a conflict of interest. Wow.

That's what I mean. It's bullying. You get bullied. If a veteran like me stands up, eventually they do say, "Do you know what? We're going to cut you off. That's enough. We're doing this." I get it; they have pressures. The case managers, God love them, take so much brunt. I can't even verbally express my anger at times, because if I swear... It's not aggressive; it's just the way military people speak, because we're expressing an emotion, and now we're being told no, we're not allowed to do that.

Yeah, the DEC is nice, but once you get on DEC, you're a dead veteran. That's the way I feel, and my wife jokes about it too. She says, "Make sure you don't die before you're 65," because if that happens, she gets next to nothing.

**Alana Hirtle:** Okay, thank you for that clarification. I appreciate that.

In my remaining time, I will switch to ask Dr. Burton a question.

From your experience, what elements of the program would you say are working and should be strengthened?

**Steve Burton:** From the treatment perspective of getting the veterans in, the actual on-the-ground work is working. It's the other pieces in getting to that point that need work. Again, the reduction may be in delays from the point that they are admitted into the pro-

gram to the point when they are actually getting treatment. Usually, it's about 30 days, but I would like to see it happen sooner.

Resourcing, of course, from an RSS perspective—like, the people who are doing those intakes and some of those preliminary sorts of assessments of the needs before they come to me for the full psychological assessment.... That, I think, would be much more beneficial, but those are the things I think are working well.

It's the other parts that I think are more important that can be addressed through more education, more training and making people more aware. We do have the training for military culture, but I think we can do a lot more. When I'm talking to a veteran who has gone through just horrible things organizationally and also out in the field, I can relate to that. I can relate to the smells and everything, but others can't. I think that's where we need to really focus some of our energies.

● (1255)

**Alana Hirtle:** That's my time. Thank you so much, both of you.

**The Chair:** Thank you very much, everyone. This will conclude our round of questions.

Mr. Richards, I understand you have your hand up, but please bear with me.

I want to say thank you to Dr. Burton for joining us.

Mr. Brown, thank you very much for participating. I understand this is not only from a personal perspective, but you also have a family dynamic that prevented you, and you still took the time. Sir, I wish you the very best for your daughter and her recovery, and I hope that things are okay. Thank you for spending the last hours with us, and thank you for your service again, sir.

This has concluded our round of questions. Just from a logistical point of view, we will have our next meeting on Wednesday, June 10. For the first hour, we will have witnesses to complete our motion for the first hour of our study on PCVRS, and for the second hour, we will go in camera, as prescribed in the motion that was adopted by our committee, for the instructions on the redaction of the report of PCVRS and our Black veterans' experience.

Mr. Richards, I have a minute left, and then I will ask for adjournment. How can I help you, sir?

**Blake Richards (Airdrie—Cochrane, CPC):** I move:

That the committee invite the Minister of Veterans Affairs to appear before the committee for no fewer than two hours on the supplementary estimates (A) 2026-27, on or before June 17, 2026.

**The Chair:** Thank you.

Mr. Casey.

**Sean Casey:** Thank you, Madam Chair.

I'd like to propose an amendment to the motion to change two hours to one, and to delete everything after the comma. That would be something that the Liberal side would be able to support. The rationale for it is this.

First, the supplementary estimates (A) are going to be approved by the House of Commons tonight, so there's no urgency.

Second, the amount in the supplementary estimates with respect to Veterans Affairs is less than \$2 million, which is relatively minor when looking at the full amount in the supplementary estimates and the full budget of Veterans Affairs.

Third, a timeline of nine days for the minister is not something that she can do, and she would be able to make time to speak to this before the committee in the fall.

For all those reasons, I propose that amendment to the motion, and if that's agreeable to everyone, then we can support it.

**The Chair:** Do I have...? As I say, I know I have an important meeting on June 10, and everyone wants to see those witnesses.

We have about 45 seconds left, so I just want to make sure we can agree.

Briefly, Madame Gaudreau.

[*Translation*]

**Marie-Hélène Gaudreau:** I would like a recap. Even though we have 40 minutes left, we should reread the amendment. I want to know whether it allows us to meet with the minister before the end of our work.

**The Chair:** The floor is yours.

**Sean Casey:** The amendment seeks to remove the deadline for completing the work, the reason being that the minister can't make it before the summer break. However, she's willing to come in the fall, in September or October.

• (1300)

**Marie-Hélène Gaudreau:** Then let's say as soon as we come back in September, since we know that she's not available before the work is completed.

It will be postponed indefinitely, let's face it.

**Sean Casey:** We have to respect the minister's obligations and her schedule. I have no problem with the end of October, which is six weeks after Parliament resumes.

I simply suggested removing the deadline. However, if you want something more specific, that's not a problem.

[*English*]

**The Chair:** If I understand this, there was an amendment and possibly a subamendment to, hopefully, finalize a friendly way of addressing the motion of Mr. Richards asking the minister to appear. I understand she's been quite good about appearing in front of this committee, and I have to say thanks to the minister and her team.

At the same time, we would be open to prior to October, if I understood—just for everyone to understand—or in the first six weeks....

Mr. Casey, I just need language.

[*Translation*]

**Sean Casey:** It would be the end of October.

[*English*]

**The Chair:** Okay, so it's before the end of October. I see some nodding. Are we comfortable?

**Blake Richards:** On division.

(Amendment agreed to on division)

[*Translation*]

**The Chair:** That's great.

[*English*]

Again, thanks to our witnesses.

**Blake Richards:** Pardon me, but I have a point of order, Chair. I think we would still have to vote on the main motion now. That was on the amendment.

**The Chair:** We were trying to get everything on division, but we are more than happy to vote on the new motion.

**Blake Richards:** No, Chair, I'm not suggesting that we need a recorded vote. I opposed the amendment, so we were on division on that, but we obviously support the main motion, so I wanted to make sure there was a distinction there.

(Motion as amended agreed to)

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

[*Translation*]

Is it the pleasure of the committee to adjourn the meeting?

**Some hon. members:** Agreed.

**The Chair:** The meeting is adjourned.







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

---

### SPEAKER'S PERMISSION

---

The proceedings of the House of Commons and its committees are hereby made available to provide greater public access. The parliamentary privilege of the House of Commons to control the publication and broadcast of the proceedings of the House of Commons and its committees is nonetheless reserved. All copyrights therein are also reserved.

Reproduction of the proceedings of the House of Commons and its committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the Copyright Act. Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.

Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the Copyright Act.

Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this permission.

---

Also available on the House of Commons website at the following address: <https://www.ourcommons.ca>

Publié en conformité de l'autorité  
du Président de la Chambre des communes

---

### PERMISSION DU PRÉSIDENT

---

Les délibérations de la Chambre des communes et de ses comités sont mises à la disposition du public pour mieux le renseigner. La Chambre conserve néanmoins son privilège parlementaire de contrôler la publication et la diffusion des délibérations et elle possède tous les droits d'auteur sur celles-ci.

Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la Loi sur le droit d'auteur. Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre des communes.

La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la Loi sur le droit d'auteur.

La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.

---

Aussi disponible sur le site Web de la Chambre des communes à l'adresse suivante :  
<https://www.noscommunes.ca>