



HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

45th PARLIAMENT, 1st SESSION

Standing Committee on Veterans Affairs

EVIDENCE

NUMBER 012

Tuesday, November 18, 2025

Chair: Marie-France Lalonde



Standing Committee on Veterans Affairs

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• (1535)

[*Translation*]

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

Welcome to meeting number 12 of the House of Commons Standing Committee on Veterans Affairs.

Pursuant to Standing Order 108 and the motion adopted on September 18, 2025, the committee is meeting to continue its study on suicide prevention among veterans.

[*English*]

Before we welcome our witnesses, for people who are viewing I would like to provide a trigger warning. We will be discussing experiences related to suicide and grief. This may be triggering for viewers with similar experiences. If you feel distressed or need help, please advise our clerk.

For all witnesses and members of Parliament, it is important to recognize that these are difficult discussions. Also, for our witnesses, if you do not feel comfortable at any point, please let us know. We can pause our committee for you.

[*Translation*]

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

[*English*]

Before we continue, I would ask all in-person participants to consult the guidelines written on the cards on the table. These measures are in place to help prevent audio and feedback incidents and to protect the health and safety of all participants, including the interpreters. You will also notice a QR code on the card, which links to a short awareness video.

[*Translation*]

To ensure an orderly meeting, I would like to outline a few rules for witnesses and members to follow. Before speaking, please wait for me to recognize you by name. For those participating by video conference, click on the microphone icon to turn on your microphone, and please mute yourself when you are not speaking.

[*English*]

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

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

[*Translation*]

For members in the room, if you wish to speak, please raise your hand. That said, I do not believe any members are participating in the meeting via Zoom.

Thank you for your understanding.

[*English*]

I would like to welcome our witnesses. As individuals, we have Mr. Gordon Hurley, Madame Marie-Noël Duhaime, Mr. Justin McKay, Mr. Darren Simons and Mr. David Bona, and from Seven Edge Success Inc., Ernie Wouters.

We will start by inviting each witness to deliver their opening remarks for a period of about five minutes. As you can see, there are a few of you, so please try to stay within our five-minute mark.

Once all our witnesses have given their opening remarks, the rest of the meeting will be dedicated to a series of questions and answers with the members of the committee.

Mr. Gordon Hurley, the floor is yours for five minutes, please.

• (1540)

[*Translation*]

Gordon Hurley (Veterans Mental Health Advocate, As an Individual): Thank you, Madam Chair.

My French is not very good, I'm sorry.

[*English*]

I'll do this in English.

Thank you for this opportunity.

In 2015 I decided to cut my wrists on a course at Canadian Forces Base Wainwright, Alberta. Immediately, as soon as I drew blood, I knew it was a mistake. I got myself a course vehicle and drove myself to the hospital. When I got to the hospital, the nurse told me they would have to call the base, call the police, get my chain of command involved and bring up the suicide attempt through the chain of command. I was in the special forces at the time. I said I was working on kit. I smoothed it over as much as I could: I'm special forces. I slipped. I would never do that. Blah blah blah.

They believed it. The next day, I went on course. I finished that course. For the next five years, I used suicide and suicidal ideation as a coping mechanism for mental health.

I spent 15 years in the Canadian Armed Forces, half as an airborne light infantry reconnaissance patrolman and the other half as a special operator and joint terminal attack controller. I was deployed to Africa, Iraq and Afghanistan and trained globally, not only on the leading edge of combat operations but in the highest echelons of our military headquarters.

My name is Gordon Hurley. I am a retired veteran and I am a veteran advocate specifically for psychedelic-assisted psychotherapy. Right now, Veterans Affairs Canada is not fulfilling the requirement of giving veterans the care they deserve with ketamine-assisted psychotherapy. Veterans Affairs will pay for ketamine, for the drug itself, but they will not pay for psychedelic-assisted psychotherapy.

It's in the name. It's "assisted" therapy. It's psychedelic-assisted therapy. It is not being covered by Veterans Affairs at this time. We're putting veterans at extreme risk while in very, very fragile mental states.

I would like to let you know that in Australia not only is it legal, but on October 31, the Australian government's Department of Veterans' Affairs funded psychedelic-assisted psychotherapy within its own military for veterans. That's MDMA and psilocybin.

Our government is cutting approximately \$4 billion over the next four years for medical cannabis. Okay. That's in line with market value, but what are we going to do with this money? Are we just going to absorb it, and it becomes another talking point about how fiscally responsible we are as a government, or are we going to keep that money within Veterans Affairs proper and put it to research programs or new initiatives that our peer nations are well surpassing us on?

Veterans Affairs needs some help. Take our hands. All of us on this panel are trying very hard to make this loud and clear, and for you to listen to the veteran. Because I've been surrounded by the people I have in the last couple of years navigating the charity and veterans sector, my team has come up with something called the veterans accelerated access and research program.

The veterans accelerated access and research program proposes a structured model for safe, regulated access to psychedelic-assisted therapy. The pilot program—not study—would operate under both provincial and federal frameworks, leveraging such provincial leadership as Alberta's progress in regulated psychedelic-assisted therapy. We would be able to integrate this with a federalized pathway administered by Health Canada. This collaboration would align with Veterans Affairs Canada's ongoing interest in identifying a lawful mechanism for accessing psychedelic therapy and would also strengthen intergovernmental co-operation on innovative health solutions.

The proposed pilot would begin with 10 to 15 participants receiving MDMA-assisted psychotherapy at an approved clinic in Alberta under the supervision of a multidisciplinary team, including a psychiatrist, a nurse practitioner and a psychologist. This treatment would adhere to rigorous standards of safety, ethics and clinical

care. Future phases would expand to include additional compounds with therapeutic potential, such as psilocybin and ibogaine, pending regulatory approval and oversight.

Following completion, a systematic evaluation would capture feedback from participants, clinicians and administrators while analyzing safety, feasibility and efficacy data. A retrospective research review would then assess treatment outcomes and inform future program expansion to additional provinces.

This process ensures that the program remains accountable, evidence-based and aligned with the highest standards of medical and ethical practices. This initiative directly addresses the inefficiencies and delays currently associated with the special access program and the section 56 exemptions. By streamlining access through a regulated pilot, the veterans accelerated access and research program aims to deliver timely, effective and ethically sound care for veterans in critical need. This scientific evidence will guide future policy and improve long-term outcomes for those who have served Canada with honour.

I came here to tell, sure, a little story. You guys can hear about me more. You can go on the Internet and google me and you can get in-depth podcasts. I came here with a solution, so please take our hand.

Thank you.

• (1545)

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

[*Translation*]

Ms. Duhaime, you now have the floor for five minutes.

Marie-Noël Duhaime (As an Individual): Thank you, Madam Chair.

The first glass is never the problem.

O Canada, our home and native land.

[*English*]

O Canada, our home and native land.

[*Translation*]

Ottawa is built on the unceded territory of the Algonquin Anishinabe people, a nation that has paid for the ultimate violence and has managed to save some souls and save its people by tolerating the invaders: us.

Thank you, Madam Chair and members of the committee. Thank you, brothers and sisters in arms. Thanks to my dad and my big sister. I thank you lovely people for offering me your help. I have been asking to be heard for over 30 years. Ms. Gaudreau has arranged for it to happen.

[English]

Leave no man behind.

[Translation]

But I am a woman.

[English]

Lest we forget: Let's honour the service and sacrifice of all souls who have served in wars, conflict, and peace operations. *Vigilamus pro te*.

[Translation]

Thank you, dad and mom, for passing on your knowledge and your love of Latin to me.

[English]

We stand on guard for thee. The anthem changed recently to include all of us, to be more inclusive. The anthem started in Quebec in 1880. How many years did it take to realize that women were also worth it?

• (1550)

[Translation]

I think it was in 2018. It was on Saint-Jean-Baptiste Day, 1880. Two thousand eighteen, one thousand eighty, it's "mathemagic".

I'm still cold. I'm going to keep my coat on, because it's really cold outside.

[English]

You're my lady in red.

[Translation]

No, I'm going to take my coat off, because I'm hot all of a sudden.

I'm starting to accept help. My scarf is mauve. It's the scarf of hope. Thank you, Josée. Mauve is important.

Do you have your handkerchief, dad?

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): I have one here.

Marie-Noël Duhaime: No, I want my dad's.

[English]

I put him on the spot, but he is still there for me.

[Translation]

In Latin, there are two words for "handkerchief". The first is *mappa*, but I don't remember the other one. There is a little one, that you use to blow your nose, to keep your germs to yourself; COVID-19, we know about that. But there is another word that means a beautiful wrap. Those Romans were crazy, but not that crazy. They brought their handkerchief with them, and their hosts wrapped their gift in it. Every person left with something.

How much time do I have left, Madam Chair?

The Chair: You have gone a bit over the five minutes allowed.

Marie-Noël Duhaime: Thank you for your time.

The Chair: I'll allow you a few minutes more so you can finish your remarks.

Marie-Noël Duhaime: If there is time at the end, I will come back to it. For now, I will let the others continue. I will be respectful of everyone's speaking time. Their time is important, as is mine.

I have had my platform. If you want to know more, you know where to find me.

The Chair: Are you sure, Ms. Duhaime?

[English]

Marie-Noël Duhaime: Yes, ma'am.

[Translation]

The Chair: Okay. I just wanted to be sure. Thank you.

[English]

Mr. McKay, you have five minutes, please.

Justin McKay (Veteran, As an Individual): Thank you, Madam Chair. I won't take five minutes. I'll keep my remarks short.

I joined the reserves at 17 years old. Before I was 18, I became one of the 19,000 members of the military sexual misconduct lawsuit. I was sexually assaulted by an older soldier while I was sleeping at night.

I went on to serve two tours with 2nd Battalion, PPCLI in Bosnia. If I had kept drinking the way I was drinking up until 2011, I wouldn't be sitting here giving you these statements right now.

Right now, I'm the sergeant-at-arms at the Royal Canadian Legion in Amherst, Nova Scotia. In 2023, I hope I helped some Afghan veterans with some healing by unveiling an Afghan memorial in Nova Scotia.

I, too, almost took my own life, and I would have if it hadn't been for another service member helping me out. That's why I implore you to take all of our information—Mr. Hurley's information, Mr. Simons' information, Mr. Bona's information and Mr. Wouter's information—to Veterans Affairs.

I don't think that cutting the benefits that we get—i.e., the shock-wave therapy that some veterans get for chronic pain—is a good avenue to go down, because then you're going to push veterans to another avenue unless you give them something else to take away that pain.

I implore you to heed the recommendations at this committee and take them to VAC.

That's all I'll say. Thank you.

• (1555)

The Chair: Thank you, Mr. McKay.

For five minutes, we have Mr. Simons.

Darren Simons (As an Individual): Good afternoon. Thank you for the opportunity to speak today.

I'm an army brat and a veteran, having served just over two years in the Canadian Army and more than 33 years in the RCMP. I have lived in six provinces, one territory and Germany. With the RCMP, I served in 10 detachments throughout Alberta, the Northwest Territories and Saskatchewan. Many of those detachments were limited-duration posts and isolated posts.

My wife, Tracy, and I have been married since 1999. Our son, Nathan, is studying to be a chiropractor. I stay active and volunteer regularly. The physical and psychological challenges faced by veterans are also faced by their families. Spouses, children and loved ones see the changes, the pain, the outbursts and the silences. They are more perceptive than we think. They suffer too. Retirement or leaving the Royal Canadian Mounted Police or the Canadian Armed Forces doesn't erase these challenges; sometimes it makes them worse.

I did not know I could apply for veterans benefits until I had over 10 years in the RCMP. Many RCMP members and Canadian Armed Forces members don't even consider themselves veterans because they did not deploy. This lack of awareness is an education gap that must be addressed. If we were treated properly earlier, we would be healthier now.

My early experiences with Veterans Affairs were positive. My first claims were approved, but when I learned I was disabled, I panicked. I was afraid it was going to affect my career. Thankfully, a VAC employee reassured me. I thought, finally, an organization that is here to help me. Unfortunately, that feeling didn't last.

After applying for a psychological condition, I was denied. I was told to wait until the RCMP had completed their investigation, a process that took over nine years. Upon attending a hearing in 2020, I was finally approved and advised that my benefits would go back three years. I was told I should have appealed earlier. I was following the direction of VAC. I was waiting. Why did someone not follow up with me and tell me that?

For me and many veterans, it's not as much what we saw and did as it is how we were treated during and afterwards. Amongst many Veterans Affairs' clients, it is perceived that initial applications are often denied and appeals are often successful. It makes many veterans feel like VAC expects you to give up. One veteran told me that I need the cheat codes, like a video game, to figure out how to win.

Each delay, each denial, erodes trust and hope. I had a claim initially denied and when I phoned and requested further information, I determined that it was because they received the wrong X-ray. I was denied mileage, and when I called to inquire why I was denied mileage, I was told that I filled out the wrong form. Why not provide more input as to why there was a denial? Why not make it easier to get help, instead of harder?

I paid out of pocket for psychological care because Blue Cross and VAC would only reimburse part of the cost, even though the RCMP had been paying my psychologist in full when I was serving. I was told to find someone less expensive. After much back-and-forth trying to find a workaround, I gave up. Fortunately for me, my psychologist found a workaround. However, I was out hundreds of dollars. I can afford it, but many veterans cannot. I know

one who pays to take a taxi for treatment and has stopped trying to claim for it because it's too frustrating.

There are good people working for Veterans Affairs, but as my father said when I was a young child playing sports, seven "at-taboys" get wiped out by one "ah, crap". The negative experiences overshadow the good ones.

VAC and Blue Cross need to communicate better. Veterans shouldn't be passed back and forth between systems. We need one point of contact, someone who checks in, follows up and helps navigate the maze.

VAC should also be proactive. No one has ever asked if my wife or son needed support, even though they've lived through the same struggles I have. At a retreat funded by the Legion—not VAC—I was asked to bring my wife. This is where we met Ernie. It was a breakthrough for me and my wife for different reasons. That support worked and it helped my wife more than it helped me—which helped me.

I often ask why we are all treated the same, regardless of need or circumstance. If someone slammed a door right now in this room, we would all see, feel, hear and experience what transpired differently. That's because we are all different.

While I was preparing my speaking notes, my wife asked me a question that I still can't answer: How many people need to die before they get it?

● (1600)

People need help. When you're at your lowest, everything feels too hard and you want to give up. For some of us, it's just a financial loss. For others, it's their lives.

I truly hope this committee not only listens but also hears what veterans are saying. We're not looking for handouts; we're looking for help, fairness and respect. We want to heal, to be better for ourselves, our families, our communities and our country. We are the ones most likely to continue to serve. You can't afford to lose us.

Thank you for your time and for hearing the voices of those who have served, their families and their supporters.

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

For five minutes, we'll have Mr. Bona.

David Bona (As an Individual): Thank you.

My name is Dave Bona. I tripped and stumbled and fell into a role nine years ago when I discovered I was poisoned by the anti-malaria drug mefloquine. In my search for answers I inadvertently became a point of contact for injured veterans looking for assistance and very quickly I realized there's a quite a large problem.

I was on social media and I was watching the suicides come across my feed again and again, and it was like, someone's got to do something about this. I started going on veteran Facebook groups, chat groups etc., and talking about my own journey and my own symptoms and stuff like that. Whenever I'd get veterans commenting on it, I would literally pounce on them and would end up creating a situation where I would get these guys on the phone and I would educate people on their injury and point them in the proper direction to receive help.

Here comes the hard part: I started having the families reach out to me. I had to develop a technique for dealing with these people because it was suicide and there was a lot of strong emotion involved. I developed a system where, when I got the information from the individual, I would track down someone this individual had deployed with, to find out if they had taken mefloquine and, more importantly, if they had been having adverse reactions to the drug.

Once I established that, I reached out to someone who had intimate contact with this individual in the last two weeks of their lives. Then I could see what their state was, their mental health state. With that information, I was able to draw conclusions on whether they were poisoned by mefloquine and if their suicide was attributable to mefloquine poisoning.

I'm not a doctor. I've lived with suicide. I know what CLP tastes like. I sat in back bunkers with the muzzle of a rifle in my mouth, clicking the safety off and taking up the slack on the trigger too many times to recall. I have attempted suicide three times. Each time I had someone step in to stop me. I'm very lucky to be here right now.

If you have any questions on mefloquine, I have all the answers. I went to all the conferences. I talked to the experts. I immersed myself in it.

Thank you very much for your time.

• (1605)

The Chair: Mr. Bona, thank you very much.

Mr. Wouters, you have five minutes, please.

Ernie Wouters (International Trauma Specialist and Consultant, Seven Edge Success Inc.): Good afternoon, Madam Chair, members of the committee and fellow Canadians.

Before I make a few comments—I have provided speaking notes—I want to make a number of defining comments for you. Before I do that, I want to make it clear that I honour and respect all of my peers and fellow mental health servants in this field. Their value and contributions are not the issue I'm discussing. What I am discussing is.... I'm a professional engineer. I have a master's in psychology and a number of other credentials. My evaluation is based on the critique of the process. That's what's most important here, so I want to just underscore that.

Twenty-five years ago, I had a defining moment at an international police conference as the police chaplain in our city, when the keynote speaker got up and asked if we realized that every year in North America, a police officer will take his or her life. At that moment I did not know that, but as an engineer, I couldn't help but grapple with the question of why.

Since that conference and for the four or five years previous—almost 30 years now—I've sought to discover the enigma of suicide, for which I have an answer for you today.

Part of this, I've devoted to the statistics, which I'm sure you've all heard. Almost every hour, just in North America, a military personnel will take his or her life. That's every hour. That's terrible and it's shocking, but every 43 seconds, globally, someone's taking their life. We often talk about there being no silver bullet and I'd like to argue that I believe suicide is a silver bullet.

I'm going to describe how it gets there. When I think about these statistics, they're not just statistics; they're souls. I am specifically talking about the soul because that is the breaking point that a person gets to when they decide to take their life. When you think about this, the soul is the one part in the human design that's absolutely missing from psychology and psychiatry. It's ironic that five letters of both of those terms in the Greek mean “study of the soul”, yet neither of them address the soul when it comes to trauma.

I'm here to declare that the soul is actually the missing link in resolving trauma. When you think of science.... From all of creation to present day, there is a triad formula. I'll make it simple with the fire triangle. Most people are familiar.... You need oxygen, combustibles and an ignition source. I can stand here for quite a bit discussing the science of how that triad exists absolutely everywhere.

As an engineer, when I'm trying to solve a fatal failure of some design, the first thing I consider is the materials, the structure and what's available for the design. From studying suicide, what do we have available to overcome? We have a soul, a brain and a body, which is the triad I'm talking about.

If I was to get each of you to take a pen and draw three or four triangles on your paper, I would say, at the peak, I want you to put the soul. On the bottom left-hand corner, I want you to put the brain and at the bottom right-hand corner, put the body. This is our design. It's perfect, by the way.

Say you go to a medical doctor and are asked the question that they're asking, they would ask where it hurts. Of the three components of design, which of those three is the medical doctor addressing? It's the body.

Let's go to psychology now. Psychology talks about behaviour. I have a master's in psychology. These are my peers. I care about them desperately, but it's not a science and neither is psychiatry. The fact that they don't meet these three criteria on the triangle.... They are addressing the brain. The soul's left out. The body's mostly left out. For both psychology and psychiatry, they're dealing with one-third of the solution.

If I go into the theology component, they would deal with the soul, but now they're leaving out the brain and the body.

My point is that none of these approaches, even if I had all four practitioners in the room, could actually resolve trauma. The only way to solve trauma is.... Unresolved trauma is ultimately the number one issue that leads to suicide.

Where is the trauma occurring? It's occurring at the soul level. Trauma is an offence and that offence goes to the soul. The target of trauma is to degrade and dehumanize a person's self-value and self-worth. The system that is created has actually driven suicide by the nature of the way we treat or do not treat.

• (1610)

One day, I was driving my vehicle, and I phoned Dave Bona—because I worked with Dave. I said, “Dave, I just thought of something. I had an epiphany moment.” The epiphany moment was that, in wartime, strategy is torture. There are four components for a successful torture: mental anguish, physical anguish, emotional anguish and spiritual anguish. When you achieve those four, you will end up with death, and suicide is the answer.

That's the answer that people get to. Every day, our military—every second, every minute, every hour, 24/7—is under those four. Unresolved trauma leads to the majority of illnesses and diseases, and as a result of that, it includes mental illness. This is the missing link for resolving trauma: the soul. Neuroscience, near-death experiences.... All of these point at the fact that not only does the soul exist but also it exists beyond death, which means that in order for consciousness to be beyond death, you must have the constituents of a soul, which are your mind, emotions and free will.

The Chair: Wrap up, Mr. Wouters, and then we'll start the questions.

You have 10 seconds, please.

Ernie Wouters: When I think about the primary drivers behind suicide, I see that the perfect storm absolutely is that unresolved trauma, number one. Number two is mind-altering drugs of all sorts. Number three is non-scientific models that cannot resolve trauma. Then there are the global trauma illiteracy and incompetence, and the continual retraumatization of family in systems.

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

Ernie Wouters: You're welcome.

The Chair: On behalf of the committee, I want to thank you for your courage in being here.

To those who have served, thank you for serving your country. I really appreciate your taking the time out of your very busy schedules to be with us today.

On this note, I will go to Mr. Richards for six minutes.

Blake Richards (Airdrie—Cochrane, CPC): Thank you. Let me just echo your thanks to all of the veterans who are with us today for their service.

As I see it, the government, through Veterans Affairs, has two basic obligations to veterans through which everything it does should be filtered. The first one is to provide the services and supports that veterans need to live their lives. The second one is com-

memoration. That latter one is how we honour their service. The former is how we meet the obligations that we have to veterans for what they've given to this country.

I think what I heard about in the opening statements from a number of you are some failures in both those areas. I'd like to explore them both a little further if time allows.

I guess I'd like to start with this: We had a witness—I think it was a couple of weeks ago—who brought to us that she was aware of 20 veterans who had come to the government looking for help to live their lives and had instead been offered medical assistance in dying. I just want to put it out there whether any of you have experienced that, or any of you are aware of a fellow veteran who has experienced that.

I see, Mr. Bona, that you have your hand up. If others want to....

I see Mr. McKay.

Let's start with you, Mr. Bona, and we'll work our way across for anyone else who may have experienced that.

• (1615)

David Bona: I deal with the veterans who are the reason that there's bulletproof glass in your Veterans Affairs office. I deal with the veterans who have extreme anger management issues because that's part of the injury from mefloquine. It causes uncontrolled rages and seizures. These individuals are the ones actually living down by the river in that tent because they can't access veteran benefits. I have gotten a veteran off the streets a bunch of times.

It's dealing with Veterans Affairs with individuals who are not set up to do this. It's the bureaucrats. Everything is set up so that it's easy for the bureaucrats to do their jobs, but the injured veteran has to jump through hoop after hoop after hoop. You even heard from Darren.... He's saying that he's trying to do a simple travel claim, and it's denied. No one will follow up and ask you if you need assistance with anything anymore.

When I first came onto veterans benefits in 2000, I had a case manager. There are no more case managers. I requested, four months ago, assistance from Veterans Affairs. I got a call about a month and a half later from a random 1-800 number, and it was this woman who barely even spoke English. I'm as deaf as a post, so when you have someone with a strong accent, I can't understand them. That was Veterans Affairs' response to me.

It's gotten to the point where I don't do my travel anymore, because I can't fight with them. I don't even bother. Oh, my God.

Blake Richards: Yes.

So—

David Bona: Oh, and then there's medically assisted suicide. These veterans, these are the guys who can't get treatment because they're not functioning enough in society to walk into a Veterans Affairs office to say that they need help. They can't get help.

Blake Richards: I'm sorry. I'm going to let the other guys jump in. We're cut off after a couple of minutes. I have to make sure the other guys get a chance, too.

David Bona: These are the guys who are ending up getting offered medically assisted suicide because they can't get care.

Blake Richards: Right, that's the challenge exactly.

David Bona: You have a veteran, and he can't get care, so let's just offer him suicide.

Blake Richards: Unfortunately, that's exactly what the problem is.

Mr. McKay and Mr. Hurley, I guess you'll have to be as quick as you can.

The Chair: You have one minute.

Justin McKay: Briefly, while holding an event about a year and a half ago at our local Legion, I was pulled aside by a veteran's wife. She divulged to me that her husband was offered medical assistance in dying. This man's a double Afghan veteran.

We're not lame, broken farm animals that are to be put down. We're broken soldiers.

Blake Richards: I'm sorry. Did that happen a year and a half ago? It would be after the period of time that the government claimed it's no longer happening.

Justin McKay: Right. It was during one of your first studies. It was after one of the first studies that was going on.

Blake Richards: Go ahead, Mr. Hurley.

Gordon Hurley: Yes, I had a close friend who was offered MAID. He was one of the first guys who went public. He was just reaching for regular services. To hear the story from his mouth, it completely caught him off guard that MAID was going to even be an option when he was just looking for normal services. This guy's not suicidal like what Dave was talking about. He's just a normal guy. Sure, maybe he pushed through his limits with Veterans Affairs, but to be offered MAID is not on. It's full stop. We cannot be offering MAID to people.

Blake Richards: I couldn't agree more. This kind of gets us to the next topic, sanctuary trauma, which I'll have to explore in a future round. I'd like to explore that one with all of you after, if I get another opportunity.

Thank you for being here today.

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

Mr. Clark, you have six minutes.

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

Thank you to all of our witnesses for being here today, for your testimony and for your service. I really want to say that off the top.

Mr. Hurley, I want to touch on some things you mentioned in your opening statement around psychedelics and the work that you're doing and also hoping to do. I think, over the course of this study, we've heard this issue come up more than once, without question. Just last week on Remembrance Day, I was at a Legion in my riding, and a veteran came up to me and was talking to me

about the value of ketamine in his life and his recovery. There's no question that it's an issue that is out there and that people see value in it.

I'm just curious. I hope I wrote this down correctly when you mentioned it: veteran accelerated access research program. I know you talked about it a bit in your opening statement, but could you elaborate for us what your vision is for that? How you think it would help? What do you think VAC and the government could do to make that happen?

• (1620)

Gordon Hurley: Yes, absolutely. When we talk about the veteran accelerated access research program, we're talking about a partnership.

Veterans Affairs has a wait-and-see approach when it comes to anything medical, which makes sense, because Health Canada is in charge of it. We're petitioning Veterans Affairs to change medical stuff that they can't even change anyways.

Let's lead with Health Canada, and we'll fund it through Veterans Affairs, implemented provincially through Alberta, who already has psychedelic-assisted psychotherapy baked into their health care system. We're going to run the pilot program through Alberta, test and adjust, and then re-roll. That is the essential framework for it.

Braedon Clark: Thank you.

I think you said that, in your mind, there would be 10 to 15 patients in the beginning. You mentioned MDMA in your opening statement. Are there other psychedelics that, in your mind, would be beneficial to explore as well?

Gordon Hurley: Absolutely.

It's important to bring up something called the special access program. That's the legal framework of the legal way to get psychedelic-assisted therapy in Canada. Psilocybin and MDMA are legal. Ketamine is completely legal.

The special access program was made for extreme circumstances. Little Timmy at CHEO has a rare form of blood cancer. He needs an experimental drug that hasn't been approved by Health Canada. You apply through a bureaucratic process called the special access program, and it allows little Timmy to get his medicine and go on.

Canada is forcing people to go through the special access program, which is meant for extreme cases of health care. Psychedelic-assisted psychotherapy is not an extreme form of health care. It's actually defined in a ruling from the Supreme Court of Canada in a landmark case won this summer. Under the Charter of Rights and Freedoms, you have rights as a Canadian under section 7 to "reasonable" health care, and "reasonable health care" are the key words. We went from extreme use to now reasonable health care.

The law asks, what is reasonable? Who determines what's reasonable? A doctor determines what's reasonable, not a bureaucratic system. You're forcing people to go through a special access program, which is a bureaucratic pathway to get an extreme version of an exotic drug, whereas in actuality you would need to create a new health regulatory system specifically for it.

None of this has to do with ethics. That's the big point we're missing here. This is all administrative. You can access this stuff. You're just telling people to jump through 50,000 hoops, which at the end of the day goes to the Supreme Court of Canada. That then gets overturned in favour of the plaintiff, because our Charter of Rights deems that we're allowed to have that care.

Australia, two weeks ago, on October 31, started funding psychedelic-assisted psychotherapy: psilocybin and MDMA. America last week just expanded their psychedelic research program to over nine veterans hospitals. We're one of the most progressive countries in the world and we're up here doing what exactly?

Braedon Clark: You touched on a couple of other things that I wanted to get your take on, too, with the Australia example. Is there a certain type of veteran in your experience or a certain type of person in your mind that this type of treatment would be the most effective for? Are there commonalities you see, or is it difficult to generalize?

Gordon Hurley: Yes, it's hard to generalize. I gave you my little example when I led in. I could talk for hours. I am on the leading edge of this.

I just released a documentary two weeks ago called *Advance Force Operations*, which is a mission set in the special operations world, where you go and you set the conditions for the regular force to come and follow on. I did the same thing. I'm doing that for the psychedelic landscape for our veterans. I did a documentary on ketamine-assisted psychotherapy because there's a lack of education.

Is there a specific veteran? I've seen it take a veteran off being suicidal, just like that, with no problem. The flip side of it is that if there is no support when putting this person back into his home in Petawawa, he all of a sudden goes bonkers because he doesn't have the health care system around him. Then, all of a sudden, people say, "Oh, that's the scary thing about psychedelics." Yes, it's a very powerful substance that you're taking, and without the proper people taking care of you.... Hence, you need a regulated program to actually help people through this.

You're not just getting guys like Gordo sending people to Mexico and Peru or getting treatment in their house from someone they don't know. That's unacceptable. It's actually a massive fault of the Government of Canada that we're not taking care of this properly.

• (1625)

Braedon Clark: Thank you, Mr. Hurley. I appreciate that. I thank you for coming to the committee with a solution and a structure in mind, based on your experience and the work you're doing.

I only have about 10 seconds left, but I want to thank you for that. I appreciate your time.

Thank you.

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

[*Translation*]

Ms. Gaudreau, the floor is yours for six minutes.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

In fact, I would like to give the floor to Ms. Duhaime, if she would like. I have the feeling that she has "set the table" and she has wanted a platform for 30 years. We have time to listen to her. I have the feeling she has suffered tremendous trauma and I do not want to retraumatize her. She has chosen to be here and I think talking about all of it is important, not just for us, but also for her.

Ms. Duhaime, is there something you would like to explain to us about what you have experienced?

Marie-Noël Duhaime: Sandra Perron took phase 2 of her training in Gagetown in 1990. I did the same thing in 1995. If you want to know how the army treated us, go see the film. I told Chloé I needed help. It took her less than 30 seconds to buy my ticket and she said she would come see the film with me. Chloé Deraiche is the general manager of *Le Sentier*. Do you know what *Le Sentier* is?

Sandra Perron saved my life in 1996, in Kingston. She almost allowed me to commit suicide several times that year, not because she wanted to, but because her hands were tied. It's about money. It's about laws. It's about rules. It's an aberration of capitalism. Be careful, because it is a traumatizing film. People who watch the film need to make sure they have help.

I am lucky to have met with psychologists. I'm not talking about the first psychologist I had in Kingston. I had asked for help, and I was sent to see a psychologist, but she told the member of the military everything. That member of the military then told me that I should keep quiet instead of talking about suicide and rape. Even the commander of the 12th Regiment told me I was one of three or four people who have... I don't recall now; I have had electroshock treatments and my memory is not so good.

The electroshock therapy was a lifeline for me. They kept my lifeline safe, down below. It was not safe for the others. Yes, but it was my lifeline.

Do you know what this is? It's a corkscrew; it's for drinking my wine. I'm sorry, I just have to get another can out. I don't know whether it's leaking. It's still alcohol.

Do you have other questions to ask me? I have lost the thread, I'm sorry. I'm lost.

• (1630)

Marie-Hélène Gaudreau: I don't want you to go into the details. You talked earlier about 30 years. What would be good for you right now, for you and the other brothers in arms? You can talk about your experience, or not, but we need to hear—

Marie-Noël Duhaime: Let's look forward. Let's find a common mission to save our souls.

The magic number is three. Ask my daughters. Amélia and Charlotte, I am trying to do better, for you. It's their father's birthday today. Thank you, Jean-François.

[English]

The impact of post-traumatic stress disorder, the ultimate violence that we were all willing to give to all humans—mind, body and soul.... You paid millions to train me, and then you discarded me.

[Translation]

The social value of a garbage can is billions of dollars that we prefer to invest in war.

This is what happened about two weeks ago.

[English]

A good friend of mine found a lady intoxicated who had passed out in a pool of blood. The lady knew she was pregnant, but she was afraid to go to the hospital. She wasn't safe there—they would steal her kid. She gave birth on a freezing evening. She didn't have a red coat to keep her warm. She had multiple layers of dirty clothes.

[Translation]

Two superwomen dressed me today, with their honesty.

[English]

It's a trigger. I've been strangled before—many times—but I wanted to wear this trigger to show you about all of the money you invest in soldiers.

[Translation]

We invest millions of dollars. The prostitute's pay they send me every month... It's a luxury credit card for \$30,000.

[English]

I've been asking for help, and people say, "What's in it for me?"

What time do we have? Is it done? I'm sorry.

Next person, please....

[Translation]

The Chair: Thank you.

We will now go to the next round of questions. Each member will have five minutes.

[English]

Next is Mr. Tolmie for five minutes, please.

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

Thank you to our witnesses for coming here today. Your testimonies have been extremely powerful.

Sometimes we have to face some of the things that have been ignored. I apologize for what you've experienced. When we keep hearing the term "dehumanizing the soul", it's troubling.

I have a few questions I'd like to ask, and Mr. Simons, I'd like to start with you. In your opening statement, you mentioned that you were a base brat, which means your father served in the military, or your mother...?

• (1635)

Darren Simons: My father served for over 30 years. He did five years in Germany, two tours of Cyprus and he served across the country.

Fraser Tolmie: Okay, I'm going to ask you a question here. Did he ever deal with Veterans Affairs?

Darren Simons: I think he was a client shortly before I was. I don't know if he was a client until he was almost close to retirement.

Fraser Tolmie: Okay. I just want to know what kind of service he may have received compared with the service you have received as a client of Veterans Affairs.

Darren Simons: When he passed away, I dealt with his estate. I believe one of the issues he claimed benefits for was hearing. That was about it, that I can recall.

Fraser Tolmie: Okay. Did he get that claim for hearing?

Darren Simons: Yes.

Fraser Tolmie: Okay. All right.

Would you say that the service he received was better than the service you received?

Darren Simons: No. I would say that he was probably not informed as much as to what he could claim for, because I believe he was entitled to much more.

Fraser Tolmie: Right.

Darren Simons: As an army brat, moving around, you lose your social networks and you gain social networks. I saw the effect it had on my mother, and a divorce was the result. I think he probably needed some help psychologically but never applied for it. I don't know why.

Fraser Tolmie: Okay. You mentioned in your testimony as well that you met Mr. Wouters. It wasn't just that you went through his program; it was your wife too. Was there anybody else in your family who went through it?

Darren Simons: I was asked to bring my wife. My wife asked, "Why am I coming?" and I said, "I've been asked to bring you." We're both glad that we went together.

Fraser Tolmie: Can you share a little bit about what you experienced?

Darren Simons: It was a different approach, and that's the big thing. He talked to me and talked to my wife and got us to open up. For me, there was an aha moment in it, which helped me, but the big thing is that my wife's been through a lot. When you walk through a muddy puddle and get yourself muddy, when you come home, you're still going to have mud on you, and she's going to see that. She saw a lot of what I went through. I talked to a veteran recently, and he didn't realize how much his wife knows about what he went through or how it affected her.

Fraser Tolmie: Can I ask you a quick question? Was that covered by Veterans Affairs?

Darren Simons: That was covered by the Royal Canadian Legion in Saskatchewan.

Fraser Tolmie: It wasn't covered by Veterans Affairs.

Darren Simons: No, it had nothing to do with Veterans Affairs.

Fraser Tolmie: Should it be covered by Veterans Affairs?

Darren Simons: I think Veterans Affairs has to expand and try different things. What works for one person may not work for another. Did that work because I believed it worked? Maybe. Did it work for my wife because it was more spiritual? Maybe. The fact is that we both were willing to try something to help us. We want to get better. We're willing to try things.

Fraser Tolmie: As service becomes more complicated, care should become more specialized, in my opinion. Would you agree with that?

Darren Simons: Yeah, and another challenge is if you're a rural client. My mom has a friend who's a veteran, and he goes to a one-stop shop in Edmonton. I've asked for assistance in advance for a trip to Regina. I have to go 12 weeks to see my psychologist for sessions. I asked in advance if I could get my wife pre-authorized to drive me or maybe get an overnight stay. I've been driving three hours there and back. I have to get a doctor's note and say exactly which day I think I'm going to need. After a three-hour drive, I'm going to have an hour-and-a-half-long session. I know I'm going to be drained, but I don't know which day, so it's challenging.

Fraser Tolmie: Thank you.

Mr. Hurley, I'm sorry I have very little time here, but you mentioned how the care narrows when you start dealing with Veterans Affairs.

Would you be in agreement that we need to expand the services we provide for veterans?

I see Mr. McKay shaking his head, and Mr. Bona is also agreeing.

Gordon Hurley: Just recently, I was informed that the wife of one of our friends who was in the military and killed himself is no longer able to get treatment for herself for any type of psychological issues. Maybe someone can explain that a little bit more clearly.

Fraser Tolmie: That is shocking.

The Chair: Thank you very much.

We have Mr. Casey for five minutes, please.

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

Thank you to all of our witnesses for being here and for sharing some very powerful stories, and thank you for your service.

• (1640)

Mr. Wouters, I'd like to start where you left off in your opening statement when you talked about the perfect storm. I was trying to jot it all down. You talked about drugs, unresolved trauma and global misapprehension.

Can you first walk us through the elements of the perfect storm?

Ernie Wouters: Yes, sure.

Sean Casey: Then I'm going to ask you for some specific recommendations for where we can make a difference in this phenomenon of veteran suicide and what the key recommendation you'd like to see come forward would be.

Ernie Wouters: Thank you, Madam Chair and committee members.

The perfect storm is first and foremost unresolved trauma. Everybody has unresolved trauma. Have you heard of the ACE study, adverse childhood experiences study? That study was done in 1997 and they basically interviewed almost 20,000 people in North America. It had to do with the top 10 reasons that people have childhood trauma and there were 10 categories. Every form of abuse, so physical, mental, emotional, spiritual, are in the categories. There's incarceration, living with somebody with mental illness, and the list goes on. The number is 10.

The average person in the military has an ACE score of six before they don a uniform, which means they have PTSD before they start—before they start—so we should be helping them before they start. Unresolved trauma is the number one issue.

Psychiatry and psychology in their own documents state they have no strategy or plan to resolve trauma. That's not what they're after. They're there to maintain and manage. Their entire approach is a symptoms approach, which isn't a root-cause approach. What I'm delivering is, let's find the root cause and let's resolve the trauma, which we can do. I can help people in three hours who were diagnosed with PTSD to no longer meet the criteria for PTSD using this approach.

It's the entire science of the soul, brain and body being used.

Number one is unresolved trauma. If you solve the trauma, all of the symptoms go away. My clients have symptom reductions of 60% to 80% on average. There are 82 symptoms in the Federal Emergency Management Agency's categories. The average person here will have 15 to 45 symptoms per trauma. The average person has on average 15 to 45 unresolved traumas at any one time. If you just do the math on that, let's say 10 traumas with 20 symptoms, you have 200 symptoms walking around at any one time. This is not just 15 to 30 people. This is 1,500 life stories I have completed at 20 hours per person in four categories over their life of physical, personal relationships, spiritual education and vocation. This is all categories.

The second issue is the mind-altering drugs. There have been studies done in the past that showed that this issue started in the early 1950s when the Sackler brothers in the U.S. bought a marketing agency and a pharmacy and started releasing slow-release opium and heroin in pills, which led to the opioid crisis. It's also responsible for the current overmedication, which is also the history of psychiatry, in that it's also not a science. In fact, the people who started the process have admitted that there are no biological markers, so there's nothing scientific about psychiatry. However, it is also causing a rapid point towards death by suicide.

The average military personnel diagnosed with PTSD have three or four major drugs, all with black box warnings on them, and this means they're six times more likely to commit suicide. This is a constant, regular diagnosis for those in the military.

The other thing about ACE, which I talked about earlier, is that if you have an ACE score of six or more, you're 15 times more likely to commit suicide. Then just with those two right there, you're 21 times more likely. We're actually moving our vets with the current system towards death at a rapid rate, and that's what's happening within our ACE score.

Sean Casey: What is the term you just used?

Ernie Wouters: The ACE score, adverse childhood experiences. Our military, the average person, goes in with a six. If you have a six or more.... Last month I had a military personnel whom I did an evaluation on right up front. I sent him the ACE score and he had 10 out of 10. On average, most of my military guys have a 10 out of 10 ACE score, which means they're not only 15 times more likely to commit suicide, but it's even higher.

Combine that with the meds and now we have a perfect storm for suicide.

• (1645)

The Chair: Thank you very much.

I apologize, Mr. Wouters.

Ernie Wouters: Okay.

The Chair: I apologize, Mr. Casey.

[Translation]

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Ms. Duhaime, I see there are a lot of little notes in front of you. If you want to add something, you have two minutes to do it.

Marie-Noël Duhaime: It's going to be too violent, and we don't need that. What I want to say is that, personally, right now, I have a \$3 million debt. I am ready to invest in my project. Into the future together, feed the earth and care for souls.

December 10 is International Human Rights Day. I don't want to say "*droits de l'homme*" because there are women. There are also children and babies dying in bus shelters. Three million dollars of a prostitute's pay. It is your money, ladies and gentlemen. The government doesn't have money, but the taxpayers provide that money. All I need from you is a little handkerchief. I ask for help, but everybody asks me:

[English]

“What's in it for me? What's your mission?”

[Translation]

My mission is to combat the capitalist aberrations. People would rather have "Sephora kids," or babies, I don't know, Amélie isn't here to correct me. Down with capitalist aberrations.

[English]

I believe in you.

[Translation]

Thank you for being 100% you. Into the future together, with a signature. Another capitalist aberration is that you can't join the movement, a solidarity cooperative, if you don't pay \$10. Do you think the little baby who died had \$10? No.

Three million dollars of my money that I won after being repeatedly raped in the Canadian Forces.

The Chair: Thank you.

[English]

Mrs. Wagantall, go ahead for five minutes, please.

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

I do appreciate all of you being here. We need about 10 more hours.

That being said, Mr. Wouters, you talked about brain, body and soul, a healing of the whole triangle, and began to speak about the core findings. Just so that everyone at the committee knows, SEP-TR is “seven edge program for trauma recovery”. That is Ernie's program. He has trained many people. It's very effective, so it's an opportunity, I would say, after this.... You've submitted all of these notes, have you?

Ernie Wouters: Yes.

Cathay Wagantall: Okay. Great.

I would like to carry on from where Mr. Casey was. You went through unresolved trauma and mind-altering drugs. We don't have a lot of time, so...just a very quick overview of three, four and five, and then how that works into this system we're using right now, which treats only the fragments because we aren't dealing with the whole. Can you do that?

Ernie Wouters: That's correct. The non-scientific models go back to psychology and psychiatry, and this is the one thing that the committee must look at: Psychology and psychiatry are self-governing. There's no external regulatory body that expects or demands them to actually prove that it's scientific. The National Institute of Mental Health in the U.S., the past director for 15 years said that, even in 2011, they wrote a paper—and they were getting 500 signatures a day—requesting the APA to have an independent third party scientific evaluation of the DSM-5. This was 2011. It's now 2025, and it has not been addressed, so they're refusing to allow an independent study on psychiatry.

The other major issue is that psychologists use the DSM-5 for their diagnosis, which means that now there are two dysfunctional bodies that Veterans Affairs is using as criteria for approving programming. My program has amazing results, with a 60% to 80% reduction in symptoms, but also PTSD, in three hours and less—multiple hundreds of people have been through it. As a result of this approach as well, people no longer meet the criteria for lupus, fibromyalgia, multiple sclerosis issues and autoimmune disorders, because once the trauma is resolved, the autonomic nervous system shuts off and the body will heal on its own. I have hundreds of clients who can testify to this.

This is a scientific model. With my engineering degree, it meets all the six criteria of a science. Psychology meets none. Psychiatry meets none. We have to look at who's allowing the process to be approved when they don't have independent credentials to actually fulfill it—and they're not claiming this. Psychology and psychiatry are not claiming that they have a solution. Why are they directing...?

• (1650)

Cathay Wagantall: Can I comment on that?

Dave, when we did the study on mefloquine here in 2016-17, I asked the psychologist who was in Somalia whether, when people faced traumatic scenarios, he saw a difference in those who had faith, or soul development, as being more able to cope. He didn't even hesitate. He said he absolutely did.

That shows a bit of that, but you have one more here. You talked earlier about professionals without trauma education. Can you talk about repeated betrayal within the system?

Ernie Wouters: Yes. This was a national story. It was from a number of years ago. One of our Canadian military went to the Ukraine. It was suicide by war. The reason he went there was actually not because of PTSD from war but PTSD from home. If I could have gotten to him before he left, I probably could have saved his life.

The tragedy was that he abandoned his partner and his adopted daughter. On June 11, he left. He left behind a suicide note that said he was not coming back. They waited for six months for him to finally perish. On November 6, he perished.

For the next year and a half, the mom and the daughter, both suicidal, both tried multiple times to take their lives. The second time the daughter tried, she took 19 pills. She was air evacuated from Swift Current to Saskatoon. That's when Chad Wagner from the Royal Canadian Legion, who's been funding my work for the last two years.... I've probably served about 25 to 30 vets.

Those two came to my clinic—Dave, you drove them, so thank you—in Medicine Hat. In four sessions, I was able to help them release the trauma. They are no longer on any meds. The young girl was 14 years old and she was on five meds. Three of the five meds had black box warnings. I consulted with the psychiatrist and the doctor as I put this program through and said that now that we've solved the trauma, we can actually back off the meds. They're doing amazing.

It's an amazing story. Dave's seen that.

The Chair: Thank you again, Mr. Wouters.

Ernie Wouters: You're welcome.

The Chair: I appreciate it.

Ms. Hirtle, you have five minutes, please.

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

As has been said, thank you to all for being here today and for sharing your information and your stories.

Mr. McKay, I understand you're involved in the Amherst Legion. I want to thank you for your continued service to veterans within the community. This committee has interviewed veterans from across the country, although not that many from Atlantic Canada. I'm wondering if you could share your thoughts on whether there are challenges that veterans face in Nova Scotia or Atlantic Canada that may be different from other regions of the country.

Justin McKay: One of the biggest obstacles we face is access to proper care and, as Darren was saying, the one-stop shop. When I had to go to Halifax, it was a six-hour day for me. I had two hours of driving, two hours of counselling and two hours of driving home. In Cumberland County, because we're a small border county, we don't have that kind of access to medical care. It was either drive three hours to Fredericton or drive to Halifax—pick your poison on that one.

I know that we have a need for a one-stop shop in as many rural settings as we can get them in, but in Nova Scotia definitely. Saskatchewan would be another one that would struggle with that kind of problem—and Manitoba too. Sorry, Gordo.

• (1655)

Alana Hirtle: Thanks.

This summer I heard from Legions in Amherst, Oxford and Spring Hill. I think the members had created programs to check in on one another, buddy checks and coffee chats.

Can you describe in more detail those programs and how they help support veterans?

Justin McKay: I was the one who got the Amherst buddy-check coffee going, and then one of the guys who worked with me on the Afghanistan memorial became the president of Oxford. He got the Oxford program going in conjunction with another veteran who'd already had a previous program. They mended the two together.

We've seen our veteran coffee groups go up to 10 people. I know it's a small Legion, but we've had up to 10 or 12 guys in there. With the recent closing of the Ralston armoury in Amherst, we've absorbed their coffee group as well. That has upped our numbers.

Alana Hirtle: How has that helped to support those veterans?

Justin McKay: It's still giving them that weekly opportunity to go out, have coffee and talk to their peers. It's just to get out of the house and not think about the daily grind.

Alana Hirtle: That makes sense.

In your experience and in considerations of things like institutional trauma and sanctuary trauma, how do organizations like the Legion best serve veterans or their families when they're facing a crisis?

Justin McKay: It's really hard now for the Legion to serve in certain ways, because of paperwork. With Veterans Affairs paperwork being protected B, if you don't have a security clearance, if you're not a case manager or the provincial service officer, you can't complete that paperwork by the letter of the law now for a veteran. In that sense, it's made it a little hard in our area.

We've had multiple homeless veterans in our area. I actually just had an email today from one for housing, before I came to committee. In the last year or year and a half, that's the third or the fourth email that I've gotten or known about, just in that time, but there's probably more than that.

Alana Hirtle: Thank you.

I'm sure you're familiar with the organization VETS Canada, through the work that you're doing. They're being considered, of course, by the Town of Amherst to work out of the Ralston armoury and provide services for veterans in the community.

How can the VAC and DND ministers work with VETS Canada to enhance access to mental health resources for veterans?

Justin McKay: Whatever way they can help to attract the medical professionals we need to that area, through any kinds of sponsorship programs that Veterans Affairs or the government can do, and to have that one-stop shop would make life easier for a lot of people, rather than having to worry about trying to get a hotel room approved to have a caregiver go with them.

At the end of the day, it would definitely make life a lot easier for people.

Alana Hirtle: I'm working on that. Let's have a chat.

Thanks so much.

The Chair: Thank you very much.

For five minutes, we have Mr. Richards.

Blake Richards: I promised if I had another opportunity, I'd ask you about the next topic of sanctuary trauma.

Maybe I'll start with you, Mr. Wouters, because, obviously, you work with lots of veterans. Then I'd like to give each of our veterans an opportunity to speak to it if they would like.

We heard the other side asking questions about all the other great organizations out there that provide the programs that only have to exist because our government isn't doing the job. When a veteran is constantly betrayed, ignored, delayed and denied by the very organization that's set up to serve them, what does that do to that veteran in terms of that sanctuary trauma? Does that lead to or further the thoughts or ideas around being suicidal?

Ernie Wouters: Yes, 100%—it's a great question.

I mentioned earlier the ACE score of six or more, so they're already traumatized from their home. Many of them go to the military to find family—that's why they go. Then what happens is that they get into the family, they find out that they may not be functioning at the level they may want, and pretty soon they get turned on. Then if they do have issues, all of a sudden it now becomes trauma from the military.

This becomes a real issue not only with the member, but also, when they try to access services, it just continues to retraumatize them. The issue in every single instance is that when you have childhood trauma...and everybody has it. There's a developmental trauma that most therapists and most systems will not...because they don't spend the time with the members. Basically the message that they get from early on, right from attachment through to 17, is that they're not good enough. That's the message they get. It's subconscious, but it's regularly there. It's one of the things I treat in the process.

Then in that moment every time they get triggered by the sanctuary or by the facility or the military, it's sending them a message that they're not good enough, which they already had in ample amplitude throughout their lives. This further attacks the issue of self-worth and self-value, which is the lowest level of consciousness that leads to suicide.

Earlier when I was mentioning those two women, I counted 22 traumas within a year and a half from counsellors, doctors, police officers and teachers. For the daughter, on her second attempt, it wasn't because of her dad. It was because she felt like she was a victim. She felt she was, essentially, a criminal. That's why she attempted her life the second time.

• (1700)

Blake Richards: I'd like to open it up to any of our veterans who'd like to weigh in on this in terms of what that sanctuary trauma that exists does. Some of you spoke to it earlier, about the issues you have in dealing with Veterans Affairs, with the excuses and the paperwork that force you not to get the help that you need.

What does that do, for someone who might be suicidal?

Mr. Simons, go ahead

Darren Simons: For me, and it's just me personally, I send a message to VAC and when I get a notice that VAC sent me a message back, it sets me back because I have no idea what it's going to be. It's probably not going to be the answer to the question I'm asking. Recently, I asked a question and they answered, but they did not answer the question. I had to resend the message. They did apologize for not answering the question.

It's just knowing that you're going to have to fight again. Like I said, at the beginning it was good and positive for me. After that, it seems like it's a fight all the time. For a lot of people, they're giving up. They're tired of fighting.

Blake Richards: Mr. Hurley, I see you nodding your head. I assume you want to weigh in.

Gordon Hurley: War trauma or what Ernie was saying about what you bring to the party mental health-wise before you join the military... There's war trauma, moral injury and then sanctuary trauma. The big one is the last two right now and they get mixed, but it's very different. With moral trauma, maybe you drop a bomb and, sure, it lands on the bad guy, but it also kills a civilian. Now you have to live with that for the rest of your life.

Sanctuary trauma.... Opposite of what Ernie says, you go to special forces and you're told you're the best. Then all of a sudden, you're on medical release and, boom, no one cares. You're off. You're left having to deal with knowing it's more important for these guys to focus on the mission, so it's not worth it for you to engage and be a part of it, but that really destroys you as a person. That's just putting a medical release in. All of a sudden, you get put out, you get a medical release and your first two years are owned by an insurance company—by Manulife. At the end of that, they make you do an employment accessibility scale. They released me. Why is the veteran having to re-prove all their injuries over again?

You want to talk about sanctuary trauma? I have a partially detached retina. I'm 50% blind in my right eye. It took three years to come to a decision. The first decision came up and they said they were going to give me 2%. I fought it through the bureau of pensions advocates. I waited another year and went to BPA. It's an awesome organization. I didn't even have to say anything; they believed me. I didn't even have to state my case because they believed me.

The issue, though, is that there's no Performa on this that says that I'm half blind. It only says that when I see around this big floating mass in my eye, I can see clearly, so I have 20/20 vision, and yes, I'm good at 9% for grievous irritability.

Blake Richards: You just talked about that “we believe you” thing. Wouldn't it better if Veterans Affairs just said, “We believe you”?

The Chair: Mr. Richards, I'm very sorry.

Thank you very much, Mr. Hurley. I'm so sorry I had to interrupt.

I was very generous.

[*Translation*]

Ms. Auguste, the floor is yours for five minutes.

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

Mr. Wouters, in the document you sent the committee, the fourth point relates to professionals who have not been trained to treat trauma. At the beginning of the meeting, we talked about the importance of providing training for Veterans Affairs Canada staff, including training on trauma-informed approaches.

In your professional opinion, how can Veterans Affairs Canada better equip its staff so they really have practices that would help veterans without re-traumatizing them?

• (1705)

[*English*]

Ernie Wouters: That's an excellent question. Thank you for asking that.

First and foremost, I think it should probably shock almost everybody in the room that medical doctors, psychiatrists and psychologists have not a single class in trauma during their core degree granting. It's zero.

To become a trauma expert you have to put in the hard work. We've heard of Bessel van der Kolk, Gabor Maté and myself. I've put in—and I'm being conservative—50,000 hours on this topic. It's probably more like 60,000 to 70,000. The information's out there, but you have to go dig it up and then actually be on the front lines of being a practitioner.

The answer to the question is that I can provide that kind of training for the people here because that's what's required. It's that they must understand that trauma.... You can actually train people. We're designed as humans to actually overcome trauma. The key component is to address all three aspects of our design—body, brain and soul. I do three hours of psycho-education before I work with a client on how the brain is affected by trauma and what it's designed to do, how the body's designed and what its limitations are, and how the soul is the key to the story. The soul leads, the brain releases and the body heals. This is a science.

Training and equipping them with this would be the way to do it. Trauma-informed care is information. Trauma-empowered care is transformation. It means the person can actually resolve the trauma. In 12 hours of training, I can train a person to resolve all future trauma.

[Translation]

Tatiana Auguste: What you are telling us is very interesting.

You talked about the ACE score a bit earlier. You said that you would often meet with veterans who had a score of ten out of ten, and you said they were 15 times more likely to die by suicide, sadly. Could you tell us a bit more about that?

[English]

Ernie Wouters: I missed the last part of that.

[Translation]

Tatiana Auguste: Can you tell us a bit more about the ACE score?

[English]

Ernie Wouters: Just elaborate on that...? Okay. That ACE score is the number of individual traumas that person has. They would be checking. Are you living with someone who is suicidal? Yes. Have you been fondled sexually? Yes. Have you been living with someone who's physically abusive to you? Yes. Have you gone with dirty clothes and not enough food? Yes. There are 10 of those.

My recent client had 10 out of 10. He's suicidal.

Almost without exception, the measurement, when I'm doing my initial assessment, is that they're in severe psychological distress across seven mental health areas, which I can explain later. The issue becomes that it's a soul wound. Even on the moral injury that you were talking about earlier, the soul is the first missing component. The second missing component is the ability to actually release the trauma, which is actually forgiveness.

Globally, through all the major independent faith groups in 94% of the world's religions, no one really knows how to operationalize forgiveness. "Forgiveness" in Greek means to release, to let go, to no longer hold onto the events, which trauma is, which makes it 100% about the offended and 0% about the offender.

When I help these military people, I help them to release the offence with that definition, which means that it releases their soul from being captive. Then it actually shuts off your autonomic nervous system and the body heals. I can actually see this take place right before my eyes. They're no longer suicidal within two treatments like that.

• (1710)

[Translation]

Tatiana Auguste: Thank you.

[English]

Ernie Wouters: It directs the therapy, the ACE score.

Thank you.

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

[Translation]

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

My time is short, but at the same time, we really have an opportunity to talk about some solutions and different ways of helping.

Ms. Duhaime, would you like to talk about the kind of treatment that helped you, or that didn't? How have you managed to get access to certain treatments?

Marie-Noël Duhaime: To get treatment, you need courage. To have courage, you need to realize that you are worth it.

When you get told,

[English]

truth, duty, valour, but don't get caught.

The Royal Military Colleges of Canada Alumni Association invests in "mission-critical Academic, Athletic, Bilingual and Leadership development opportunities." You spend millions—billions—in training soldiers, but then you throw them out just like garbage.

The solution is simple. Just like for women who are terrified for their lives, we have an emergency shelter.

Let's call that the psychiatric ward, just for fun, and then we have a second-level shelter.

[Translation]

Thank you, Chloé, and thank you, Marion.

[English]

There, we teach these soldiers, who we have trained to kill, to not snap and kill others, just like I almost killed my neighbour after she threatened my life. I almost snapped.

Then I moved out. Everybody says, "You're crazy, you're crazy." I am crazy. I am trained to kill and I'm about to snap. Do you really want me to complete this act?

You've trained. You spent millions. I was trained to kill, so let's train these soldiers to lead

[Translation]

solidarity cooperatives.

[English]

It's an easy solution. Two hours, is that what you said? Two hours...?

Ernie Wouters: Three hours.

Marie-Noël Duhaime: I have \$3 million in debt that I have invested in this project. It's \$3 million of my own money. Well, actually, it's everybody's money. It's my whore paycheque.

[Translation]

The Chair: Thank you.

Marie-Hélène Gaudreau: Thank you.

[English]

The Chair: We'll go to Mr. Richards for five minutes.

Blake Richards: I'm going to split my time with my colleague.

The last thing I mentioned in my first round of questions was commemoration. I just want to ask one question about that, Mr. McKay, because you were behind the Afghan monument that's in Amherst, Nova Scotia.

Can you tell us a little bit about that process and whether you got any help from Veterans Affairs in that?

Justin McKay: First off, I started it in 2022 as soon as I became the sergeant-at-arms at the Amherst Legion.

I had a meeting with the Town of Amherst CAO. Within half an hour he was on board with the project. He asked me when I wanted to unveil it. I said September 11, but then I said how about the end of Legion week, September 23, and that's when it was unveiled.

Veterans Affairs did not contribute to the project. I had multiple engagements with the commemorative partnership grant unit, the last being by Skype the day that the PSAC strike started two years ago. The answer I was given was that they were not funding new monuments, but if I were putting up a memorial for marginalized veterans, they had money for me that day. I said to the commemorative partnership manager, "You know, Ainsworth Dyer, one of the first four Canadians who died in Afghanistan, was African Canadian." She didn't know what to say to me.

Our Legion raised \$42,000 and paid for the whole thing, minus donations from the Town of Amherst and in-kind contributions from the Province of Nova Scotia.

• (1715)

Blake Richards: Thank you for picking up the slack where Veterans Affairs failed.

Let me just ask one more question, because veterans have been waiting 11 years for a national monument for the mission in Afghanistan.

What does that do to a veteran when, first of all, they can't get the help they need, and then second they can't even get a basic monument to thank them for their service. What does that do to a veteran?

A voice: What's the point?

Justin McKay: It's demoralizing.

It's like, "Why did these guys go and die? Why do I have 12 friends who didn't come home?"

Marie-Noël Duhaime: It's garbage.

Justin McKay: When I started this project, I said to our CAO in the Town of Amherst that I didn't want my generation of veterans being like my grandfather's, who was a Kapyong vet, fighting for years and years to get acknowledgement for Korea.

Blake Richards: You had something to say there. Just be very brief, though, because I want to give my colleague a chance to ask a question as well.

Gordon Hurley: I don't know what the government wants from us anymore. I don't understand what the point is of a military in Canada. I don't think we have adult conversations about what a military does and what they're supposed to do. I don't think we have adult conversations around the spending. I sure as heck don't think we have adult conversations around the care that we're supposed to be giving people who say, "Hey, I'm going to put it on the line for everybody in this room".

Blake Richards: Thank you for that.

It's understandable, but I really hate the fact that you feel that way. I understand why, though.

Mrs. Wagantall, I'll turn the rest to you.

Cathay Wagantall: How much time do I have?

The Chair: You have a minute and 30 seconds.

Cathay Wagantall: Both Dave and Darren, you have relationships—and you have opportunities within your service, Dave.

Do you know of any way that we might be able to track suicide amongst veterans? We're always told it can't be done unless they're members of VAC.

David Bona: What are you asking me?

Cathay Wagantall: Let's put it this way. You served in Somalia.

David Bona: Yes.

Cathay Wagantall: The Canadian Airborne was dispersed—

David Bona: It was disbanded, yes.

Cathay Wagantall: You were there and then you went looking for a lot of them when you had this realization about mefloquine.

David Bona: Yes.

Cathay Wagantall: How did you find out?

David Bona: When I started reaching out, I would start noticing clusters because of part of my verification process. For example, one rotation in Afghanistan had the record number of suicides that I've come across, which was 14 in one rifle company.

Cathay Wagantall: Is there a record of that?

David Bona: No, that's the record I found through my interactions with people. I've seen companies with eight and 10, but 14 was the record, though.

Cathay Wagantall: Thank you.

Darren, do you have anything to add? It's important that we figure out how to identify when someone passes away from suicide.

Darren Simons: When someone passes away from suicide, and they're serving, they know and we know.

Cathay Wagantall: Right.

Darren Simons: For me, as veteran and as a former police officer, every sudden death that takes place outside of a medical facility is investigated by a police officer, at least everywhere I worked. We have boxes to check on a form. We used to call it a preliminary report of death. Why don't we put a box or a chapter there asking if the person was a veteran?

The answer could be yes, no or unknown. Take the effort to find out if they're a veteran, and then we can start tracking this.

Justin McKay: I have one quick point. A veteran buddy of mine served in the Medak Pocket in 1993 with 2 PPCLI in Croatia. It was a group of three of them from the N Sask R that all went with 2 PPCLI to Croatia that year. Now there's one alive. That's two in three, if you want to average it out. Two in three veterans die.

Cathay Wagantall: Were they serving?

Justin McKay: I think both were retired or out when they—

• (1720)

Cathay Wagantall: This is a suicide—

The Chair: Mrs. Wagantall, I—

Cathay Wagantall: Thank you.

The Chair: I'm sorry about that.

Cathay Wagantall: Can I suggest that if people have more they would like to submit, they can do it in writing.

The Chair: I definitely invite all members to do so.

Mr. Clark, you have five minutes.

Braedon Clark: Thank you very much, Madam Chair.

Mr. Hurley, I know you talked in your opening statement and during the first round as well about the example in Australia and how you see that as a positive one that we could be learning from.

Later this week, at our next meeting on Thursday morning, we'll have a chance to hear from Jonathan Lane, the chief psychiatrist for the Australian equivalent of VAC, the Department of Veterans' Affairs in Australia.

If you were us and you could ask questions, what would you recommend that we ask Mr. Lane, and what do you think we can learn from him?

Gordon Hurley: I would ask for a holistic picture: "What made you guys comfortable with this?" That's what it really comes down to, an education piece, because we've had such ingrained cultural stereotypes for 50 or 60 years about psychedelics. I would really ask, "How did you move this forward and win people over?"

As soon you say the word "psychedelic" it has a connotation to it, so it's a big conversation. Maybe it should be called a "neurotherapeutic" instead of a "psychedelic" just because it's, "Oh my god, it's so scary." I would lead with "How does this work?" because Australia is way more conservative than Canada when it comes to psychedelic-assisted psychotherapy, which caught the world stage off guard, the fact that the Department of Veterans' Affairs started funding it. Lead with why, how and what made people understand.

The data is there. There's so much data and research behind this stuff. Texas just passed \$150 million into legislation for the study

of ibogaine for opioid use disorder and post-traumatic stress disorder with veterans, but they led with opioid use disorder. Canada is asleep at the wheel right now when it comes to emerging therapeutics for everybody, not just for veterans.

Braedon Clark: Thank you. I appreciate that. That's very helpful for Thursday, as I said.

I'll ask each of you to just give us, in probably 30 seconds or so, your number one takeaway for us as committee members as we get close to starting to work on a report for this study. What would you say, if you could distill things down to the one thing, that we should take away from your testimony today and your experience in this field?

Mr. Wouters, I'll start with you, and then go down the line.

Ernie Wouters: Number one is unresolved trauma. It's the absolute route to all illness and disease, including suicide. The other thing would be that psychiatry and psychology are leading this show, and neither of them are a science. Where's the credibility for those two professions to guide the trauma approach when they have no expertise in trauma, and they don't claim to have it? That's another major problem. They're leading it, and there's no reason for it because they don't have the expertise to do it.

I treat psychiatrists and psychologists. They confess to me that they're a fraud, that they're not solving the problem. I say, "Well, it's not really that you're totally responsible because the institutions are not teaching this." They're not teaching it.

Braedon Clark: Thank you.

David Bona: I have a few points.

The first point is that if you guys want to stop the suicides within the veterans community, start screening for mefloquine use. Mefloquine has been given to Canadian Forces members since 1992. It is actually what is driving our suicide epidemic, because it's creating situations like mine.

Veterans Affairs spent a quarter of a million dollars in 14 years on one-on-one counselling sessions for me. It did nothing. It wasn't until my doctor finally got frustrated and snuck me into a brain injury treatment program she was using for young Afghan vets that, within three months, I was starting to deal with my deployment to Rwanda.

Finally, Ernie finished it off and actually took me up to a veteran retreat by Prince Albert, where, for two three-hour sessions after that first one, he started to get going. After that second one—oh, my God—I have no problems with long-term trauma issues. When I get into a situation that triggers me, I don't get swamped with visual imagery anymore, so it does work.

Screen for mefloquine use.

Ernie—

• (1725)

Braedon Clark: Thank you.

The Chair: I was going to say that we're going to have to move on. I apologize.

I want everybody to speak, but thank you.

Darren Simons: You need to treat us as individuals. We all join the military or the RCMP as a team, but we're individuals and it affects us differently. You have to let us try things that we think are going to make a difference, because if we think it's going to make a difference, it may make the difference.

Braedon Clark: Thank you.

Mr. McKay...?

Justin McKay: As Darren said, the biggest thing right now that we all need to do is work together to get this solved.

We have a Facebook page right now for the 2 PPCLI guys. Not many of them have reached 65, or even 60, whether they died of natural causes or unnatural causes.

We need to all work together to get this solved.

Gordon Hurley: Yes, psychedelics are good. More importantly, there is a thing called “operator syndrome”. As Mr. Wouters was saying, we are just looking at things through the lens of post-traumatic stress disorder. There is subconcussive blast wave: Any time you fire a rifle that's larger than a regular assault rifle, you're going to have a subconcussive blast wave, which damages the brain. It's very different from CTE and from impact.

When you have brain injuries, it presents like post-traumatic stress disorder. If you have low testosterone, it presents as post-traumatic stress disorder. If you have substance use disorder, it presents as post-traumatic stress disorder.

We are broad-brush painting post-traumatic stress disorder from a position where we're not even looking at the whole body. We're not even looking at what's happening. We really need to open our eyes and start looking at understanding how the body keeps the score.

[Translation]

The Chair: Ms. Duhaime, the floor is yours.

Marie-Noël Duhaime: I was the victim of a war crime, but it is not considered to be a war crime, because it was committed by my brothers in arms, people who were supposed to help me and protect me.

[English]

Women are there to entertain us—nothing more, nothing less.

[Translation]

I am the victim of a war crime that will never be recognized, because it happened on military bases in Canada. In Gagetown, in Farnham, in Moose Jaw, at the Royal Military College of Canada, in Valcartier and in Petawawa; those are just a few of the military bases I went to.

I dream of changing the world, one hour at a time and one soul at a time. I dream of feeding the land to care for our souls.

Protégeons nos foyers et nos droits.

[English]

I stand on guard for thee. Let's stand on guard for thee together.

[Translation]

Think about investing in the souls of your brothers and sisters. There are babies dying in bus shelters because it's too cold and because the mother has been forgotten by the system. Stop blaming her and get her help. You won't be giving a handout. Nothing is free. Invest in human health and the human soul.

I have removed all the bureaucratic red tape. You are being offered a handkerchief to help you.

[English]

Imagine all the people.

[Translation]

With your signature. Let's create a viral movement.

The Chair: Thank you, Ms. Duhaime.

[English]

Mr. Hurley, Mr. McKay, Mr. Simons, Mr. Bona and Mr. Wouters, thank you for your courage. Thank you for coming today.

Thank you for your service, all of you, to our great country. This will stop this portion.

I do have a few administrative items—a minute of your time, members—that I have to go through for a budget. I apologize to all of you. I do need to just get some consensus from my colleagues.

[Translation]

Two budget proposals were recently distributed by the clerk. One is for the study of barriers to entrepreneurship among veterans and one is for the meeting on October 21, 2025, that the Minister of Veterans Affairs attended.

Is it the pleasure of the committee to adopt these proposed budgets?

Some hon. members: Agreed.

• (1730)

The Chair: Perfect.

The next meeting will take place on Thursday, November 20, 2025. We will be resuming our study on suicide prevention among veterans.

Some hon. members: Agreed.

Does the Committee wish to adjourn the meeting?

The Chair: The meeting is adjourned.

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