HOUSE OF COMMONS
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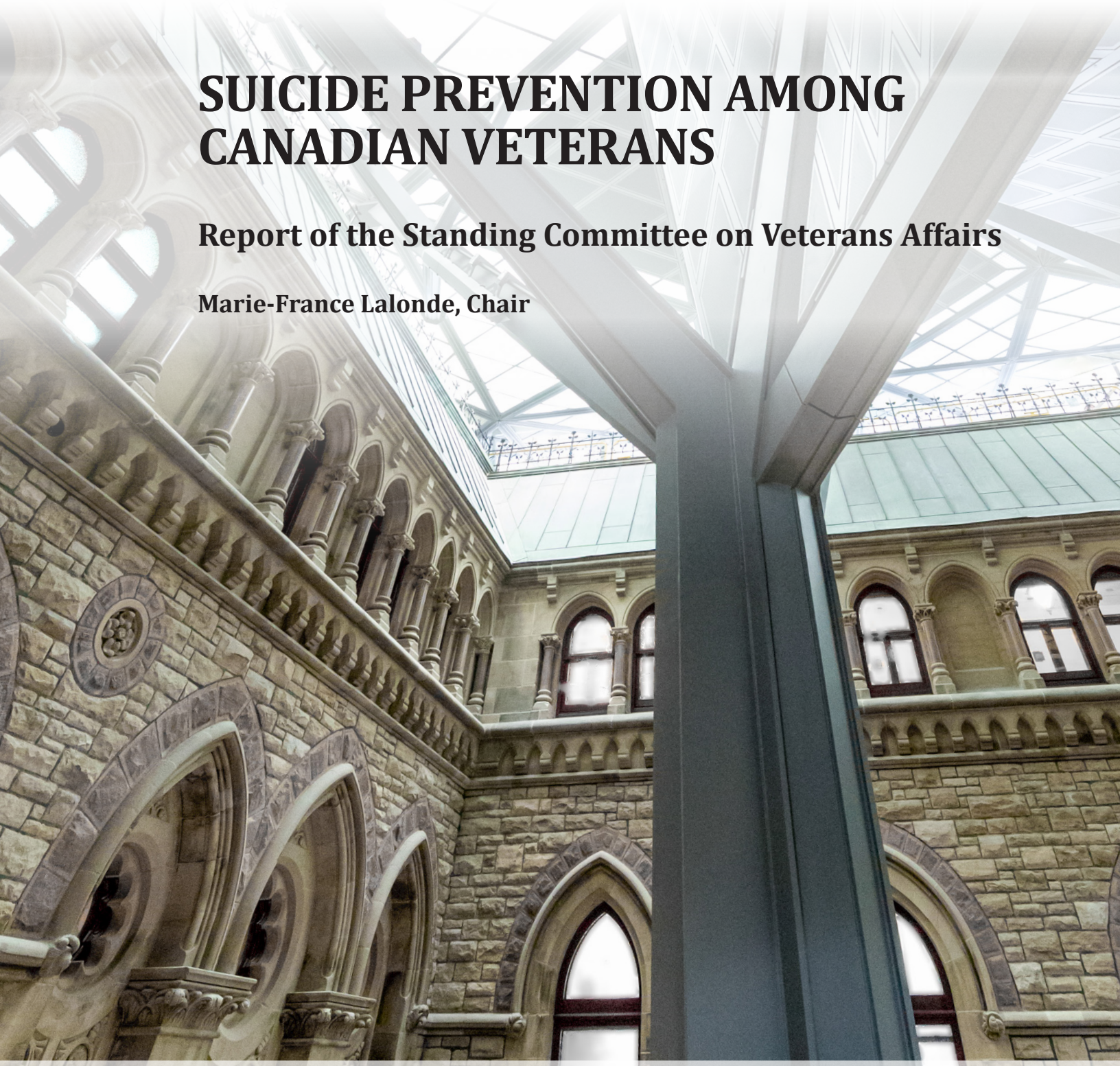
CANADA

SUICIDE PREVENTION AMONG CANADIAN VETERANS

Report of the Standing Committee on Veterans Affairs

Marie-France Lalonde, Chair



APRIL 2026
45th PARLIAMENT, 1st SESSION

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Chair

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NOTICE TO READER

Reports from committees presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

I miss Your laugh, the sound so dear
The way You joked, Your constant cheer!
If I could have just one more day
I'd beg You darling, please, please stay!
I'd wish You back but not in pain
I'd wish the rainbow not the rain.

Whatever forever.[1]

In honourable memory of those whose loved ones participated in this study:

Shawn Hatcher

Jason Renato Simon

Stuart Langridge

Brad Elms

Jordan Anderson

Lee Brent Ruth

George Hohl

Samuel James Hills

Michael Scott Bush

And to all the others who, in leaving us, found their peace and protected ours.

1 ACVA, *Evidence*, 9 October 2025, Margit Simon (Transition Trainer, Canadian Armed Forces Transition Group, As an individual), 0850.

CONTENT WARNING – DISCUSSION OF SUICIDE AND SUICIDALITY

This report discusses suicide and suicidality among Veterans and currently serving members of the Canadian Armed Forces. Some content may be distressing or triggering. If you are affected, consider reaching out to someone you trust or seeking professional support. We aimed to address these topics in a trauma-informed, responsible, and non-stigmatizing way. Because we cite evidence and materials from other sources, some wording may not always reflect current best practices.

If you need immediate help, call **9-1-1** or go to your nearest emergency department.

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has the honour to present its

FOURTH REPORT

Pursuant to its mandate under Standing Order 108(2), the committee has studied suicide prevention among veterans and has agreed to report the following:

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LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

Recommendation 1

That Veterans Affairs Canada:

- **release an annual report on deaths by suicide among Veterans;**

- **review how the findings and approach used in Australia by the Royal Commission into Defence and Veteran can be applied to the Canadian context, and table its conclusions to the Committee within 120 days of the tabling of this report.** **13**

Recommendation 2

That the Department of National Defence, in its annual Report on Suicide Mortality in the Canadian Armed Forces, include deaths by suicide among Reserve Force members. **13**

Recommendation 3

That the Department of National Defence and the Canadian Armed Forces:

- **Develop an early intervention protocol that all military members exposed to tragic circumstances involving children during service are required to undergo.**

- **Document the incidents that military members have been exposed to.**

- **Work with Veterans Affairs Canada to facilitate the sharing of relevant information.** **16**

Recommendation 4

That leading military sexual trauma (MST) research available in both Canada and internationally be used to update policies and practices of the Department of National Defence, the Canadian Armed Forces and Veterans Affairs Canada to recognize MST as one of the leading identifiable risk factors for death by suicide among military members and Veterans. 18

Recommendation 5

That in the absence of compelling evidence to the contrary, Veterans Affairs Canada presume that all deaths by suicide that occur during military service are service-related. 20

Recommendation 6

That the Minister of Veterans Affairs determine the most appropriate mechanism that would provide access to mental health supports to family members of Veterans while respecting provincial and territorial jurisdiction. 36

Recommendation 7

That Veterans Affairs Canada determine the most appropriate path to provide access to the Public Service Health Care Plan for mental health services for the survivors of Veterans should they wish to access it. 36

Recommendation 8

That for all Canadian Armed Forces (CAF) members, the Department of National Defence make regular participation mandatory in resilience support programs which help prevent and mitigate the harmful effects of trauma on the mental health of CAF members and Veterans. 37

Recommendation 9

That the Government of Canada ensure that the 9-8-8 crisis line includes an option dedicated to Veterans. 38

Recommendation 10

That Veterans Affairs Canada avoid re-traumatizing Veterans by eliminating the requirement that they recount the circumstances of traumatizing events leading to the medical condition for which a claim has been filed, when this

information has already been compiled by a recognized professional institution and forwarded with the Veteran's explicit written consent. 40

Recommendation 11

That Veterans Affairs Canada works with the provider of its rehabilitation program to determine how pre-existing care can be incorporated into the Veteran's rehabilitation plan. 41

Recommendation 12

That Veterans Affairs Canada determine, in consultation with the Department of National Defence, the feasibility of an opt-in or opt-out approach to share Veteran status with the Veteran's informed written consent with the provincial and territorial health authorities to have Veterans' identifiers included in their provincial or territorial health files upon transition. 41

Recommendation 13

That the Canadian Armed Forces work with provincial and territorial health authorities to ensure that military members who no longer meet the requirements for universality of service and have been diagnosed with a condition that constitutes a risk factor for mental health are not released until the availability of a family doctor has been confirmed. 44

Recommendation 14

That Veterans Affairs Canada establish a fast-track approval process when department-approved organizations need to provide services quickly to Veterans with urgent mental health needs. 46

Recommendation 15

That Veterans Affairs Canada and the Department of National Defence develop a new joint suicide prevention strategy for military members and Veterans, including Reserve Force members, setting out measurable objectives and based on the strategy resulting from the work of the Australian Royal Commission into Defence and Veteran Suicide. 51

Recommendation 16

That, if the Government of Canada were to develop a comprehensive national suicide prevention strategy, it should include a component for Veterans. 52

SUICIDE PREVENTION AMONG CANADIAN VETERANS

INTRODUCTION

Every nine days, one Regular Force Veteran dies by suicide in Canada. If we knew anything about the suicide rate among Reserve Veterans, the combined rate for all veterans would probably be more than one a week. That is 50 to 60 per year, meaning that 2,500 to 3,000 Veterans have died by suicide over the past 50 years, which is as far back as the Government of Canada can estimate.[1] This is almost 50% higher than the rate of a comparable sample from the general Canadian population, not counting the 20 active-duty military members who die by suicide on average each year.

These figures are alarming, and as far as we know, they do not change from year to year. In other words, nothing done since we became aware of this tragedy has worked. Unlike most OECD countries, Canada does not have a national suicide prevention strategy. With regard to military members and Veterans in particular, the Canadian Armed Forces (CAF) and Veterans Affairs Canada (VAC) developed a joint suicide prevention strategy. However, as we will see later in this report, this is more of a to-do list of actions that could contribute to suicide prevention than an actual strategy.

As highlighted in the brief submitted to the Committee by The Trail, an organization that supports Veterans, “this statistical stagnation should therefore be interpreted not as a sign of reassuring stability, but as a symptom of a structural problem. It is an indication of the lack of current measures to counter a deeply entrenched phenomenon with intersecting social, psychological, identity-related and institutional dimensions.”[2]

When faced with a similar situation, where numerous action plans failed to yield results, Australia decided that the seriousness of the issue demanded a more urgent, vigorous and coordinated response. Several years of study resulted in a comprehensive strategy with measurable objectives. As well, an independent institution was tasked with overseeing implementation and evaluating outcomes. The scale of the initiative, at first limited to military members and Veterans, sparked a broader conversation that led to Australia developing a full-fledged national suicide prevention strategy. In the United

1 ACVA, *Evidence*, 2 October 2025, Amy Hall (Senior Epidemiologist, Department of Veterans Affairs), 0920.

2 The Trail, Brief submitted to the Committee, 5 December 2025, p. 5.

States, a strategy developed a decade ago has begun to yield results. There, the military member and Veteran suicide rate has started to come down in recent years.

Suicide prevention is a complex issue that would require an important mobilisation of persons, resources and time. That is what Australia chose to do. Canada's efforts appear rather timid in comparison. Given the limited tools available to the Committee, all it can do is raise certain issues brought to its attention in this report.

The Committee members would like to thank the 54 individuals who took part in this study as witnesses, as well as the 20 or so other individuals or organisations that submitted written submissions. We especially acknowledge the courage of the spouses and families who wanted to honour the memory of a loved one who took their own life.

STATISTICS CONCERNING MILITARY MEMBERS

The "Standardized Mortality Ratios" (SMR) compare suicide rates in a given population with those of the general Canadian population.

For Regular Force men:

- the SMRs were lower than those of the general population between 1995 and 2007;[3] and
- since 2007, the SMRs have remained higher than those of the general population when calculated over a five-year period.

This shows that over the past fifteen years the situation has gotten worse for male Regular Force members.

For Regular Force women:

- "From 2001–2022, Regular Force women had a 71% higher suicide rate than Canadian women in general."[4]

The statistical data trends comparing suicide mortality rates among the general population show that the situation has deteriorated among Regular Force men, while

3 Department of National Defence, *2024 Report on Suicide Mortality in the Canadian Armed Forces*, figure 2.

4 Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025, p. 1.

the rate has remained stable among servicewomen, albeit at a significantly higher rate than that among women in the general population.

Given these findings, the remarks by Major-General Scott Malcolm, Surgeon General of the CAF, do not seem to convey urgency:

> While in any individual year there may be slight blips in the number of suicides, it's been generally stable. On average, we're looking at about 15 suicides per year. In the last published report, we were looking at 21; there were 17 in the regular force and four in the reserve.[5]

As well, the triggers identified do not appear to have anything to do with military service:

> We noted within that that many suffer from mental health-related issues, be it depression, or substance abuse being the most prominent. Factors that represent triggers for them can be breakups in relationships, financial issues, problems with the law or overall struggles with work performance.[6]

The report does not present comparable statistics for reservists:

> Reserve Force data has some issues associated with completeness, in addition to concerns with possible identity and attribute disclosure. Since many Reserve Force members receive their health care in the provincial health care system, Reserve member reporting and their available records may be incomplete.[7]

However, the report indicates that there were four deaths by suicide among reservists in 2023, while these figures did not appear in previous years' reports. The difficulties of gathering data about reservists are the same as those affecting data on Veterans, but the CAF has an employer-employee relationship with reservists. This should allow the CAF to follow them more closely.

In the United States, the annual report on suicide mortality[8] includes death by suicide for Active, Reserve and National Guard members, as well as suicide mortality among military family members.

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5 ACVA, *Evidence*, 2 October 2025, MGen Scott Malcolm, Surgeon General, Canadian Armed Forces, Department of National Defence, 0940.

6 ACVA, *Evidence*, 2 October 2025, MGen Scott Malcolm, Surgeon General, Canadian Armed Forces, Department of National Defence, 0940.

7 Department of National Defence, *2024 Report on Suicide Mortality in the Canadian Armed Forces*, figure 2.

8 U.S. Department of Defense, *Annual Report on Suicide in the Military, Calendar Year 2023*.

- for Active members, the SMRs are comparable to the civilian population;
- for the Reserves and the National Guard, the SMRs are lower than for the civilian population; and
- for family members, the SMRs are significantly higher than for the general civilian population.

Australia's Royal Commission into Defence and Veteran Suicide also looked at deaths by suicide of reservists. For Regular Force members, the death rate was compared not to the general population, but to the employed population of the same age and gender. This approach was chosen to account for the known risk factor of unemployment. The difference between the rates is therefore smaller than it would have been had it been calculated based on the general population of the same age and gender, as is the case for Canadian statistics. The key findings regarding Australian service members are as follows:

- For all male regular force members, the SMR suicide rate is 30% higher than for the Australian employed population of the same sex and age.[9]
- Men who served in combat and security roles have a death by suicide rate 100% higher than the Australian employed population of the same sex and age.
- Men who served as riflemen in infantry units have a death by suicide rate 253% higher than the Australian employed population of the same sex and age.
- The results for servicewomen were suppressed from the report due to their low numbers,[10] and no deaths by suicide were recorded among female regular force members in combat and security roles from 2011 to 2020.[11]

9 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 66.

10 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 65.

11 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 75.

- Men in the reserve forces who have never served in the regular forces are 62% less likely to die by suicide than other civilian Australian males, regardless of employment status.[12]

STATISTICS CONCERNING VETERANS

Statistics on Veteran deaths by suicide are determined by comparing the rates to those of the general population of the same age and gender. For Canada, data on Veteran suicide comes from the Veterans Affairs Canada (VAC) 2021 Veteran Suicide Mortality Study. The study followed a cohort of 253,645 Regular Force Veterans[13] who left the Canadian Armed Forces (CAF) over a 41-year period between 1975 and 2016.

Men make up 89.3% (226,415) of the cohort. Given the small number of women (27,230 or 10.7%), data on women Veterans yields a much wider confidence interval and, in some cases, does not allow for reliable percentages to be established.

Military records could be statistically linked to death certificates collected by Statistics Canada when provincial and territorial coroners' reports stated suicide as the cause of death. This data was age-adjusted to be comparable with data on the general Canadian population.

The following are the study's key findings:

- During this 41-year period, 1,855 male Veterans died by suicide, roughly one every nine days.
- During the period from 1975 to 2016, 95 female Veterans died by suicide.
- For the entire period, the rate of death by suicide for male Veterans was 47% higher than for men of the same age in the general Canadian population.
- For men 29 years old and under, the rate is 146% higher.
- For Veterans aged 60 and over, the rate of death by suicide is lower than for the general population.

12 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 93.

13 Class C reservists were included in the statistics because they were active in a Regular Force unit. They make up 5% of the male Veteran cohort and 8% of the women Veteran cohort.

- For the entire period, the rate of death by suicide for female Veterans was 115% higher than for women of the same age in the general Canadian population.

- The suicide rate is 157% higher for female Veterans 34 years old and under.

These statistics do not reflect the higher risks associated with certain military occupations during service. For example, according to Karen Breeck, "physicians have significantly elevated suicide mortality: ~40% higher for men and more than double for women. Women physicians remain 24%–70% higher risk than women in the general population."[14] As noted later, Australian data allows for a much more precise distinction between the risks associated with certain occupations.

Canadian data also does not make it possible to identify specific at-risk populations. For example, the Assembly of First Nations said that "First Nations Veterans face compounded risk from multiple, overlapping sources of trauma."[15]

It is difficult to compare countries based on these percentages due to differences in data collection methods and the specific institutional and operational contexts of these countries. However, trends in these statistics can be compared over long periods of time within the same country to note progress and setbacks.

The key findings for Australia are as follows:

- Male Veterans who served in the regular forces are 37% more likely to die by suicide than Australian men of the same age.[16] The rates are highest for those who served:

    - in general combat and security roles in the army (112%).

        - for those who served in commando units, the rate is 364% higher;

        - for those who served in infantry units, the rate is 120% higher;

14 Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025, p. 2. She presents a series of recommendations that the CAF could implement to reduce this risk.

15 Assembly of First Nations, Brief submitted to the Committee, 28 November 2025, p. 4.

16 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 121.

        - for drivers of specialized vehicles, the rate is 95% higher; and
        - for maritime logistics chefs, the rate is 174% higher.
    - in logistics roles (+69%);
    - in combat and security roles and separated during army initial training (+170%);
    - in the regular forces and were separated for medical reasons or for the reason "retention not in service interest," the rates are, respectively, 202% and 187% higher;[17]
    - those who were convicted of non-compliance, unsatisfactory conduct or unauthorized absence offences:
        - for absence without leave (+426%);
        - for failing to comply with an order (+487%); and
        - for prejudicial conduct (+1144%).
    - Male Veterans who served solely in the reserve forces are no more or less likely to die by suicide than Australian men of the same age.
- Women who served in the regular forces are 110% more likely to die by suicide than Australian women.
- Women who served solely in the reserve forces are 89% more likely to die by suicide, while men who served solely in the reserve forces are no more or less likely to die by suicide than Australian men. For women, the rates are also higher for:
    - regular forces Veterans in combat and security roles (+452%) or health roles (+212%); and

17 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 135.

- Veterans who served solely in the reserve forces and enlisted as a minor (+189%).[18]
- Specifically:
  - Veterans who served in the regular forces and who separated for medical reasons or whose "retention was not in service interest" had rates that were, respectively, 388% and 245% higher.

- For both men and women who served in the regular forces, Veterans who suffered a traumatic joint, ligament, muscle or tendon injury during service are 335% (men) and 578% (women) more likely to die by suicide.[19]

The quantity, depth and sophistication of the data collected in Australia contrast sharply with the scarcity and lack of detail available from comparable government analyses in Canada. As several witnesses pointed out,[20] Canadian data on Veteran suicides dates from 2016 and only covers Veterans in the Regular Force. We know nothing about deaths by suicide among reservists, even though they made up more than a third of the troops deployed to Afghanistan.[21] VAC senior epidemiologist Amy Hall announced that a new version of the report will be released in 2026.[22]

It is obviously easier to monitor the situation among active members of the Regular Force, since the CAF is their employer and keeps their medical records. However, this does not justify the lack of attention given to data collection in Canada. The situation described by Jonathan Lane, Chief Psychiatrist with the Australian Department of Veterans' Affairs, is very similar to the challenges Canada faces in terms of medical record confidentiality and care for Veterans.[23] Ben Wadham, Professor at Flinders University, told the Committee that this did not prevent them from gathering crucial information for developing their strategy, since the Australian Royal Commission realized

18 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 114.

19 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 7, p. 116.

20 See for example: ACVA, *Evidence*, 28 October 2025, Kelsie Sheren (Mental Resilience Expert, As an individual), 1550.

21 See for example: ACVA, *Evidence*, 7 October 2025, Philip Ralph (Captain (Retired), Director, Clinical Services, Wounded Warriors Canada), 1720; The Trail, Brief submitted to the Committee, 5 December 2025, p. 12.

22 ACVA, *Evidence*, 2 October 2025, Amy Hall (Senior Epidemiologist, Department of Veterans Affairs), 0950.

23 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0830.

along the way that previous analyses had greatly underestimated the number of deaths by suicide.[24] The recommendations that the Australian government subsequently agreed to implement are designed to ensure that the strategy can be evaluated.

As will be seen later in this report, it is hard to imagine how it would be possible to develop a suicide prevention strategy for military members and Veterans without first having a clear picture of the current situation and then comparing it with the situation a few years after the strategy has been implemented. Such a comparison is currently impossible in Canada.

In her brief, Karen Breeck points out these gaps:

> Australian suicide research tracks variables that Canada does not—including release reason, years since separation, rank, and service type. This enables identification of high-risk patterns: ex-serving women are nearly twice as likely to die by suicide as civilian women; medical releases sharply increase overall risk; younger members are most vulnerable. Canada cannot perform equivalent analysis because its suicide-surveillance systems omit collection of many of these key variables.[25]

Given the gaps in the statistics on deaths by suicide among Canada's Veterans, the Committee recommends:

Recommendation 1

That Veterans Affairs Canada:

- **release an annual report on deaths by suicide among Veterans;**
- **review how the findings and approach used in Australia by the Royal Commission into Defence and Veteran can be applied to the Canadian context, and table its conclusions to the Committee within 120 days of the tabling of this report.**

Recommendation 2

That the Department of National Defence, in its annual Report on Suicide Mortality in the Canadian Armed Forces, include deaths by suicide among Reserve Force members.

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24 ACVA, *Evidence*, 20 November 2025, Ben Wadham (Professor, Flinders University and Director, Open Door Initiative, As an individual), 0855.

25 Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025, p. 2.

RISK FACTORS

When trying to explain death by suicide, all we can rely on are reasonable probabilities. It is not possible to determine causes that would make suicide predictable for any given person. The same is true in the field of health in general, since we know, for example, that smoking increases the risk of developing cancer without being able to predict who in particular will suffer from it. This is not therefore a cause in the strict sense, but a risk factor that can be acted upon once it can be identified.

According to Oliver Thorne, Chief Executive Officer of the Veterans Transition Network:

> Although suicide is extremely difficult to predict at an individual level, research from the Canadian Armed Forces and Veterans Affairs identified several risk factors that are consistently associated with suicide among veterans. Service in the junior ranks, in the army and in combat roles places veterans at elevated risk. It peaks for many within the four years after they leave the service. A difficult transition to civilian life, mental health injuries, a loss of identity and purpose, social isolation, and disconnection are all associated with increased risk of suicide among Canadian veterans. … This series of risk factors often has a domino effect that can lead to suicide.[26]

Trauma

> **“[I]f you don’t deal with trauma, nothing else matters.”[27]**
>
> Captain Philip Ralph (Retired), Director,
> Clinical Services, Wounded Warriors Canada

One of the most significant risk factors for suicide is the experience of a major trauma. Ernie Wouters of Seven Edge Success said that “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.”[28]

Experiencing, either by witnessing or by taking part in, extreme violence during a deployment, or being the victim of sexual assault are two forms of trauma that occur

26 ACVA, *Evidence*, 7 October 2025, Oliver Thorne (Chief Executive Officer, Veterans Transition Network), 1555.

27 ACVA, *Evidence*, 7 October 2025, Philip Ralph (Captain (Retired), Director, Clinical Services, Wounded Warriors Canada), 1605. See also: ACVA, *Evidence*, 18 November 2025, Ernie Wouters (International Trauma Specialist and Consultant, Seven Edge Success Inc.), 1640.

28 ACVA, *Evidence*, 18 November 2025, Ernie Wouters (International Trauma Specialist and Consultant, Seven Edge Success Inc.), 1605.

disproportionately among military members compared with the general population. The first is related to military service itself, while the second is related to military culture.

Operational Trauma

Trauma experienced during military deployments causes what are now called "operational stress injuries." This term, which includes post-traumatic stress disorder, encompasses the mental health issues most commonly experienced following military deployments. In his brief, Christopher Banks describes the circumstances of his deployment to Kandahar.

> We went out everyday, even days we weren't scheduled to go out; usually in the mornings the Quick Reaction Force was overwhelmed with the number of calls and the Battle Group backed them up. We were hunted, hunted by people who knew what they were doing. Snipers and IEDs were an everyday occurrence, there was hardly a day when you couldn't hear explosions, cannon fire, fighter jets, or UAVs. We were shot at near daily, usually as a way of them telling us not to proceed any further, we called them Shoot n Scoots. There were some particularly memorable days: we took casualties on our very first patrol, we were on the receiving end of danger close friendly artillery, we were sent to pick up the remains of 4 Americans and 1 Afghan who were blown up by an IED, I watched an IED explode under the LAV in front of me, our platoon was scheduled for a patrol but was switched to another platoon at the last moment and the vehicle which would have been mine ran over an IED with the driver killed, 4 of us were cut off and caught between the insurgents and the ANA in a firefight, and on our last patrol we took casualties: 2 Canadians and 1 Afghan dead and our company commander wounded.[29]

Such experiences, which are common for military members deployed in conflict situations, are deeper and more intense than what most Canadians will experience in a normal lifetime.

Moral Injury

Moral injury is a specific kind of trauma affecting military members who encounter horrors or atrocities that fall outside what is normally expected in military deployments. As explained by Shelly Whitman, Executive Director of the Dallaire Institute for Children, Peace and Security, these incidents frequently involve children, something military members are not prepared for:

> Moral injury emerges when personnel face events that violate deeply held beliefs about what is right and wrong, identity and duty. Encounters with children create profound

29 Christopher Banks, Brief submitted to the Committee, 1 December 2025.

> moral conflict that persists long after deployment. Moral injury is distinct from PTSD but the two are interconnected. It often presents as guilt, shame, existential distress, loss of trust and social withdrawal. Persistent moral injury without support is strongly associated with increased suicide risk.[30]

Moral injury is clearly described in the brief from a Veteran who prefers to remain anonymous:

> As a retired Warrant Officer of the Princess Patricia's Canadian Light Infantry (PPCLI), I witnessed firsthand the depths of human cruelty in theatres of war. From the former Yugoslavia to Somalia, Rwanda, Iraq, and Afghanistan, the experiences that I had cannot be captured by any camera or described in any report but are long shadows that cast over Veteran's life long after the uniform is hung up. I witnessed what levels of undeterred, unaccountable hatred are capable of through a front-row seat. Ethnic cleansing clips on a TV screen don't do it justice, no matter the skill behind the lens. … I cried last night thinking I needed to write you. I cried hiding in my garage this morning trying to have a smoke, and even now my eyes are full. It is as if each tear is supposed to make things better. The shame you can't grasp is the weakness I carry within. My internal war still letting me know it's still here, not ever going away. There were times I just wanted sleep. I just wanted quiet. I just wanted it to stop. I used to think about how others had found the courage to make it stop. I remember planning how I would make it stop and how alcohol always helped me make the best plans.[31]

As is clearly documented in the brief from the Dallaire Institute, moral injury poses a very high risk for suicidal behaviour.[32] Since the prevention of such injuries seems not to have been given sustained consideration and does not appear in the CAF/VAC Joint Suicide Prevention Strategy, the Committee recommends:

Recommendation 3

That the Department of National Defence and the Canadian Armed Forces:

- **Develop an early intervention protocol that all military members exposed to tragic circumstances involving children during service are required to undergo.**

- **Document the incidents that military members have been exposed to.**

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30 ACVA, *Evidence*, 4 December 2025, Shelly Whitman (Executive Director, Dallaire Institute for Children, Peace and Security), 0835. See also: Anna-Lisa Rovak, Brief submitted to the Committee, 12 December 2025.

31 Anonymous Author, Brief submitted to the Committee, 10 November 2025, pp. 1–2.

32 Dallaire Institute for Children, Peace and Security, Brief submitted to the Committee, 12 December 2025, pp. 1–2.

- **Work with Veterans Affairs Canada to facilitate the sharing of relevant information.**

Sexual Trauma

As analyzed by the Committee in its June 2024 report *Invisible No More*, military sexual trauma is a major risk factor for mental health problems among female military members and Veterans. This was mentioned by several witnesses.[33] The U.S. Department of Veterans Affairs recently compiled data from a large number of studies on the correlation between sexual trauma and the risk of death by suicide, concluding that military sexual trauma is a "significant risk factor for suicidal ideation, suicide plans, suicide attempt, and completed suicide"[34] for both female and male victims.[35] The Australian Royal Commission confirmed these findings based on independent research by Prof. Ben Wadham,[36] which resulted in several recommendations.

During their appearance on 2 October 2025, no CAF or VAC official mentioned sexual trauma. General Malcolm appeared to downplay the issue:

> When it comes to the mortality rate among women, particularly in the case of suicide, it's a little difficult to explain.
>
> Even though one suicide is one too many, we are talking about suicide among women last year. According to the data, there were very few, but it still increased the rate. My colleagues at Veterans Affairs Canada and I continue to monitor the situation and try to find the reason behind this. However, as we have already discussed, the problem is multifactorial. Members of the Canadian Armed Forces or veterans have committed suicide, but that does not mean that all of their problems at that time began in the forces. We know very well that half of our members experienced trauma before enlisting in the Canadian Armed Forces.[37]

That prompted a reaction. According to Christine Wood:

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33 ACVA, *Evidence*, 23 October 2025, Noémie Veilleux (Licensed Sexologist and Policy Consultant, As an individual), 0820. See also: Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025, section 3.0; Jennifer Smith, Brief submitted to the Committee, 19 December 2025, section 5.1.

34 U.S. Department of Veterans Affairs, From Science to Practice: Military Sexual Trauma, A Risk Factor for Suicide, "Overview," May 2025.

35 See: ACVA, *Evidence*, 18 November 2025, Justin McKay (Veteran, As an individual), 1550.

36 Government of Australia, *Royal Commission into Defence and Veteran Suicide Report*, Vol. 1, para. 161.

37 ACVA, *Evidence*, 2 October 2025, MGen Scott Malcolm, Surgeon General, Canadian Armed Forces, Department of National Defence, 0855.

> Public testimony in this ACVA study on suicide prevention has not received enough informed data from the CAF Surgeon General and the VAC Chief Medical Officer. Together in concert, these two individuals appeared ignorant of the connection between military sexual trauma (MST) and suicidal ideation and suicidality.[38]

Someone could search for all the "multifactorial" and complex explanations they like, but the fact remains that, although pre-enlistment risks are the same for recruits as for the general population, suicide mortality rates are significantly higher during and after military service. This means that something happened during military service. There is a well-established correlation between sexual trauma and suicide risk. This makes it less "difficult to explain" and appears to be the most plausible "reason behind this." The Committee therefore recommends:

Recommendation 4

That leading military sexual trauma (MST) research available in both Canada and internationally be used to update policies and practices of the Department of National Defence, the Canadian Armed Forces and Veterans Affairs Canada to recognize MST as one of the leading identifiable risk factors for death by suicide among military members and Veterans.

Mental Health

Trauma causes mental health issues, and as several witnesses explained, the most significant risk factor for death by suicide is a mental health issue. To illustrate this point, Steven Harris had to use analyses of military deaths since this data does not exist in Canada for Veterans: "65% of people who died by suicide had at least one mental health condition, and many had more than one. The most common conditions were addiction or substance use disorders, depressive disorders and trauma and stress-related disorders."[39]

Mr. Harris added that mental health issues are much more prevalent among Veterans than in the general population:

38 Christine Wood, Brief submitted to the Committee, 12 December 2025. See also: Jennifer Smith, Brief submitted to the Committee 19 December 2025. Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025.

39 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0820.

> What are often called operational stress injuries, or OSIs, capture the persistent challenges resulting from service. OSIs can include PTSD, depression, anxiety, trauma and moral injury, and they can disrupt daily functioning, work and social relationships.
>
> PTSD is particularly prevalent among the veterans receiving disability benefits. More than 48,000 veterans currently receive a pension for PTSD. Since the end of Canada's mission in Afghanistan in 2014, we have observed a steady rise in these claims. Approximately 29% of veterans receiving a disability benefit for PTSD served in Afghanistan, underscoring the lasting impact of the mission.[40]

Such figures clearly illustrate that military service itself poses a significant risk to mental health. A mental health issue serious enough to pose a suicide risk is the result of incidents and experiences that military members encounter during their service. A mental health issue is not just another risk factor. It is the consequence of other risk factors. Individuals who do not have mental health issues rarely die by suicide.

Some of General Malcolm's comments regarding sexual trauma also appear to downplay the mental health and suicide risk of military service in general:

> The problem is multifactorial. Members of the Canadian Armed Forces or veterans have committed suicide, but that does not mean that all of their problems at that time began in the forces. We know very well that half of our members experienced trauma before enlisting in the Canadian Armed Forces.
>
> Suicide is truly a societal problem that must be addressed at its source. The country must address this issue to prevent suicide rates not only in the forces, but also among the Canadian population.[41]

In this regard, it is worth going back to the point raised earlier about sexual trauma. If suicide in the CAF were truly a "societal problem," then we would expect the rate of death by suicide to be comparable to that of the Canadian population, if not lower since military members go through an initial physical and psychological evaluation that would exclude a significant segment of the Canadian population. However, the rate is substantially higher. This means that something must have happened during military service.

40 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0820.

41 ACVA, *Evidence*, 2 October 2025, MGen Scott Malcolm, Surgeon General, Canadian Armed Forces, Department of National Defence, 0855.

This is why Ashley Thompson, whose spouse died by suicide while still serving in the CAF, does not understand that "Veterans Affairs Canada continues to classify his death as non-service-related."[42]

We must acknowledge that, until contrary evidence is provided, there is an intrinsic dimension to military service that poses such a significant risk to the mental health of military members and Veterans that it leads to a higher rate of suicide than among non-military members. It is as though the nobility of the vocation contained its own built-in curse.

The Committee therefore recommends:

Recommendation 5

That in the absence of compelling evidence to the contrary, Veterans Affairs Canada presume that all deaths by suicide that occur during military service are service-related.

During his appearance, Marc-André Bernard highlighted the specific risks associated with the self-sacrifice inherent in military service:

> Enlisting in the Canadian Armed Forces is a professional commitment unlike any other. It involves developing a new personal identity that merges with one's professional identity. Ideals such as public service, common good, defending shared values and strong camaraderie are prioritized, and military personnel give up some of their self-determination and individuality to prioritize the collective, in some cases risking their lives to do so. These career choices must involve individual sacrifice, and it is those sacrifices we ask of them that later increase the risk of suicide.[43]

During their service, military members must endure physical hardship and pain. They cannot give in to their negative inner states, which are often seen as a sign of weakness. As explained in the brief submitted by The Trail:

> The CAF's organizational culture has historically focused on strength, resilience, performance and emotional regulation, which is an asset in an operational context but becomes a major barrier to seeking help when symptoms of psychological distress emerge. … many military members are reluctant to seek help for fear of being taken off active duty or medically released, which is often seen as a form of professional exclusion or stigma. This deeply entrenched fear causes many military members to conceal their

42 ACVA, *Evidence*, 9 October 2025, Ashley Thompson (As an individual), 0935. See also: ACVA, *Evidence*, 23 October 2025, Judith Hills (Corporal and Aviation Technician, Canadian Armed Forces, As an individual), 0925-0930. ACVA, *Evidence*, 28 October 2025, Shaun Fynes (Retired Chief Security Officer for the Government of British Columbia, As an individual), 1600-1605.

43 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0815.

> symptoms or downplay their distress until the situation becomes critical. The pattern is even more marked among military personnel who have never deployed: many believe that their suffering is not "valid."[44]

Ashley Thompson, whose spouse died by suicide, described how he suffered in silence:

> The invisible wounds he carried—the trauma, the operational stress and the lasting pain of a sexual assault he endured while serving—changed him. Over time, those wounds deepened, and the weight of them became too heavy to bear. He was scared to speak up about his mental health because he feared losing his job, his identity and the pride that he took in being a soldier. He would cringe every time anyone would mention help. As his mental health declined, so did the sense of purpose and belonging that had once defined him.[45]

The Trail's brief also states that this culture hinders the integration of women:

> While women are less likely to act on their suicidal thoughts, their psychological suffering is frequently underestimated. Recent studies highlight factors specific to the female military experience: feelings of isolation in a still male-dominated environment, exposure to discriminatory behaviours or military sexual trauma, and trouble relating to support models traditionally designed by and for men.[46]

This stoic exterior that both male and female military members must maintain is necessary for military life, but it can be detrimental to harmonious family, social and professional relationships outside the military. "Being wounded on the job and no longer able to perform the same function within the group can trigger distress."[47]

Chronic Pain

The connections between chronic pain, mental health issues and suicide risk are well documented. As Retired Sergeant Cameron Kowalski of the Chronic Pain Centre of Excellence for Canadian Veterans said, "there is a deep connection between suicidality

44 The Trail, Bried submitted to the Committee, 5 December 2025, pp. 13–14.

45 ACVA, *Evidence*, 9 October 2025, Ashley Thompson (As an individual), 0935.

46 The Trail, Brief submitted to the Committee, 5 December 2025, p. 9.

47 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0815.

and chronic pain."[48] One research area the Centre chose to focus on is the connection between suicidality and chronic pain.[49] Veteran Shane Nedohin described how it affects him on a daily basis:

> Anybody who has ever lived with chronic pain knows it affects your mental condition. It affects your mood; it makes you irritable. Do you know somebody who has a toothache? They're cantankerous and irritable. You couple the physical pain with the TBI and what's going on there. I suffer from vertigo and dizziness. Some days I'm good; some days I'm bad. It's something you live with, and it impacts you greatly. You figure a way through it.[50]

Veteran Stephen La Salle experiences the effects that chronic pain has on mental health on a daily basis:

> In 2018, a training injury caused severe ligament damage and complex regional pain syndrome, one of the most painful conditions known. Despite exhaustive treatments, my condition deteriorated and by the summer of 2021 I was bed-bound.
>
> By this point, my mind was in a very dark place. I felt like a burden to everyone, especially my family. I had lost my identity as a Canadian Armed Forces member and my independence as an individual.
>
> …
>
> A below-knee amputation in October 2021 slowed the progression, but inoperable nerve damage has left me unable to use a prosthetic. Today as you see, I rely on a wheelchair to get around.[51]

According to Dr. Ramesh Zacharias, Centre President and CEO, 20% of civilians have chronic pain, while the figure is 40% for male Veterans. As for female Veterans, 50% suffer from chronic pain after leaving the CAF.[52] Dr. Zacharias also said that "treating

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48 ACVA, *Evidence*, 20 November 2025, Cameron Kowalski (Sergeant (retired) Director of Operations, Chronic Pain Centre of Excellence for Canadian Veterans), 0935. See also: The Trail, Bried submitted to the Committee, 5 December 2025, p. 9; and ACVA, *Evidence*, 30 October 2025, Nicholas Held (Interim Scientific Director, Canadian Institute for Military and Veteran Health Research), 0935. ACVA, *Evidence*, 9 October 2025, Hélène Le Scelleur (Captain (Retired), Vice-Chair, Centre of Excellence Advisory Council for Veterans of Chronic Pain Centre of Excellence for Canadian Veterans), 1015.

49 ACVA, *Evidence*, 20 November 2025, Cameron Kowalski (Sergeant (retired) Director of Operations, Chronic Pain Centre of Excellence for Canadian Veterans), 1010.

50 ACVA, *Evidence*, 30 October 2025, Shane Nedohin (Farmer, As an individual), 0935.

51 ACVA, *Evidence*, 27 November 2025, Stephen La Salle (As an Individual), 0825.

52 ACVA, *Evidence*, 20 November 2025, Ramesh Zacharias (President and Chief Executive Officer, Chronic Pain Centre of Excellence for Canadian Veterans), 0945.

chronic pain can and will reduce the suicide risk in Canadian male and female veterans."[53]

As we will see later, it is surprising that this well-established link between chronic pain and suicidality has not been given special attention in the CAF/VAC Joint Suicide Prevention Strategy.

Change of Identity After Transition

> **"When things are going sideways, we're those strange people, as you know, who run towards danger when all of the smart people run away from it."[54]**
>
> Captain Philip Ralph (Retired), Director, Clinical Services, Wounded Warriors Canada

> **"I need stress, I need danger. It's too comfortable in civilian life."[55]**
>
> Michel Marceau, As an individual

For a significant number of military members, mental health risks are mitigated by the military community's support network. As General Malcolm explained:

> It's more than just recognizing if someone is displaying suicidal thoughts; it's recognizing if things aren't quite right. Rarely does it start with someone immediately being suicidal. There are signs that something perhaps is not quite right with them. Your buddies and your chain of command are the ones who see them every day and are best placed, including their families, to note if there's a change going on.[56]

Once members leave the service, this network is no longer there. As described by The Trail in its brief:

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53 ACVA, *Evidence*, 20 November 2025, Ramesh Zacharias (President and Chief Executive Officer, Chronic Pain Centre of Excellence for Canadian Veterans), 0935.

54 ACVA, *Evidence*, 7 October 2025, Philip Ralph (Captain (Retired), Director, Clinical Services, Wounded Warriors Canada), 1605.

55 ACVA, *Evidence*, 25 November 2025, Michel Marceau (As an individual), 1545.

56 ACVA, *Evidence*, 2 October 2025, MGen Scott Malcolm, Surgeon General, Canadian Armed Forces, Department of National Defence, 0845.

> The transition often sparks an identity crisis when Veterans are confronted with a radically different reality, as the military structure that governed every aspect of their lives for years is suddenly replaced with a brutal, sometimes destabilizing autonomy. Many Veterans report feeling a profound sense of emptiness, isolation and rootlessness, worsened by the loss of the camaraderie that was previously an essential source of emotional support. … Many veterans base their self-worth on their military role. Consequently, they may see their departure from the CAF as an existential loss, severing their connection to the meaning, mission and fraternity that instilled them with pride and gave direction to their lives.[57]

Veteran Gordon Hurley eloquently described this feeling of loss of value after the transition:

> 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.[58]

All current data shows that the first years of the transition from military to civilian life are critical. According to Marc-André Bernard, "the moment people leave the armed forces, they enter a period of high risk for depressive episodes. I've seen this in my clinic. Suicidal thoughts may emerge."[59]

A third of VAC clients report having difficulty making the transition. "Of these, 64% attributed this difficulty to health challenges, while 60% felt as though they lost their sense of purpose."[60] These difficulties seem to particularly affect young men during the

57 The Trail, Bried submitted to the Committee, 5 December 2025, p. 6. See also: ACVA, *Evidence*, 20 November 2025, Ben Wadham (Professor, Flinders University and Director, Open Door Initiative, As an individual), 0905.

58 ACVA, *Evidence*, 18 November 2025, Gordon Hurley (Veterans Mental Health Advocate, As an individual), 1700.

59 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0815.

60 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0820.

first years of transition.[61] For female Veterans, the risk appears to develop over a longer period.[62]

As explained by Philip Ralph of Wounded Warriors, at the time of transition, Veterans are faced with a world that they feel they do not understand, and in turn, they feel misunderstood by the very people who should be helping them but who do not seem to speak the same language:

> We come from a culture where we're trained that when something happens, there is an SOP for it. You do this, and then you do that, and then you do this. They want a plan. They want to see that there's something there that makes sense and that there's a goal. When it gets all lofty and fussy they think, "This civvy doesn't understand me." …
>
> The problem with stoic culture is, of course, that when you bring something out of the "doing your job" atmosphere and bring it into your home and wider society, A, people don't understand it, and B, it doesn't really work that well in other situations.[63]

Marc-André Bernard explained that society has unrealistic expectations about new Veterans' ability to handle the same independence as civilians, as they have spent their entire adult lives serving their country in the CAF. This can lead to feelings of inadequacy and ingratitude, causing Veterans to isolate themselves.

Veteran Michel Marceau described this disconnect:

> I called Veterans Affairs 10 or 20 times. Ironically, I'm still the same guy who served in the Canadian Armed Forces. I had security clearance and was 100% trustworthy. When I left the military, I went from hero to absolute zero. Not just me, but my buddies too. It's the same for everyone. When you leave the Armed Forces, it's simple: take your pills, cash in your cheque and shut your yap. No one wants to hear about your experience in Afghanistan anymore.[64]
>
> Then you get to the grocery store and you're eighth in line. That's a problem veterans face. Civilians don't get it. When you're in line, you feel exactly the same way you did in Kandahar, next to what we called "Candy Lane." There was a plastic barrier separating the two lanes. We were sitting in an RG-31, it was 45°C or 47°C—oddly enough, the air

61 Canadian Mental Health Association - Alberta and Centre for Suicide Prevention, Brief submitted to the Committee, 12 November 2025, p. 3.

62 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0835.

63 ACVA, *Evidence*, 7 October 2025, Philip Ralph (Captain (Retired), Director, Clinical Services, Wounded Warriors Canada), 1610.

64 ACVA, *Evidence*, 25 November **2025,** Michel Marceau (As an individual), 1540.

> conditioning wasn't working—and we were gritting our teeth, waiting to get blown up. When you're waiting in line, you feel exactly the same way.[65]

This feeling of social isolation and misunderstanding can quickly turn into a feeling of betrayal if military members and Veterans feel rejected by those who taught them the language of military culture and who are still serving in the CAF. It becomes intolerable if this military language seems to be misunderstood by VAC, whom Veterans, overcoming their resistance, have dared to ask for help.

Sanctuary Trauma and Institutional Betrayal

The terms "sanctuary trauma" and "institutional betrayal" are often used interchangeably. In her brief, Anna-Lisa Rovak draws important distinctions between the two:

> Sanctuary Trauma occurs when an individual who suffered a severe stress or next encounters what was expected to be a supportive and protective environment and discovers only more trauma. Institutional Betrayal: moral injury or burnout where the institution (and those in charge) fails to intervene and prevent or respond supportively to challenges within the institution, where an individual expects some degree of fair treatment or protection. The difference between the two concepts is that institutional betrayal focuses on the failure of the institution, whereas sanctuary trauma focuses on the experience of the individual who expected the institution to be a safe place or sanctuary.[66]

Todd Hisey, founder of Veteran Hunters Canada, summed up his experience of institutional betrayal:

> It was also while awaiting my voluntary release that I contemplated suicide. I continued to feel alone, unappreciated for my 10 years of service and multiple deployments, my skill set under-utilized. I was disconnected, abandoned and betrayed by my fellow officers and the chain of command. I barely received a mention at morning coffee on my last day of service in 2001.[67]

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65 ACVA, *Evidence*, 25 November 2025, Michel Marceau (As an individual), 1610.

66 Anna-Lisa Rovak, Brief submitted to the Committee, 12 December 2025. See also the comments by: ACVA, *Evidence*, 9 October 2025, Hélène Le Scelleur (Captain (Retired), Vice-Chair, Centre of Excellence Advisory Council for Veterans of Chronic Pain Centre of Excellence for Canadian Veterans), 0940.

67 ACVA, *Evidence*, 4 December 2025, Todd Hisey (Chief Executive Officer and Founder, The Veteran Hunters Canada Ltd.), 0825-0830. See also the comments by: Captain (Retired) Edward Kamps, Brief submitted to the Committee, 27 October 2025.

The clearest example of sanctuary trauma is sexual assault. This trauma is clearly illustrated in the many accounts captured in the report *Invisible No More*. Other accounts were added during this study.[68]

Sanctuary trauma can occur in a wide variety of circumstances. Jessica Ruth spoke about the distress experienced by her spouse, Constable Lee Ruth of the Royal Canadian Mounted Police, before his death by suicide in June 2025:

> Often, my spouse would talk about sanctuary trauma, a type of psychological trauma that occurs when a person who has already experienced a stressful event is further harmed by the place or institution they expected to be supportive. After years of serving his country as a trusted member of the RCMP to uphold the law, he felt that his needs were often questioned and felt like he had to prove them to be true. The amount of complex paperwork and justification to get benefits approved, which he was entitled to, was very discouraging. This can impede a veteran from obtaining services.[69]

Steven Harris said that he accepts that "sanctuary trauma is absolutely something that veterans feel and has an effect on whether or not they want to come forward and work with Veterans Affairs to obtain the services that they need."[70] The primary way to prevent this trauma is to adequately train those working within the institution. Mr. Harris reiterated the importance that VAC placed on such suicide prevention training, both for VAC employees and its contractors, particularly those registered with Partners in Canadian Veterans Rehabilitation Services (PCVRS).[71] As Mr. Hosseiny put it:

> When veterans get care, it's a courageous step they're taking. They're finally putting their hand up and saying they need help. But when you get a service provider who doesn't understand your realities or who doesn't understand your world or your culture,

68 For instance: Anna-Lisa Rovak, Brief submitted to the Committee, 12 December 2025. See the overwhelming spiral of frustrations as told by Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025, pp. 6–7. See also the comments by: ACVA, *Evidence*, 23 October 2025, Noémie Veilleux (Licensed Sexologist and Policy Consultant, As an individual), 0820.

69 ACVA, *Evidence*, 23 October 2025, Jessica Ruth (As an individual), 0825. See also: ACVA, *Evidence*, 23 October 2025, Judith Hills (Corporal and Aviation Technician, Canadian Armed Forces, As an individual), 1010. ACVA, *Evidence*, 28 October 2025, Christine Gauthier (Corporal (Retired), As an individual), 1540.

70 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0825.

71 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0925.

> you'll never go back. If that's your first experience, unfortunately it means you're not getting the care you deserve.[72]

Denise M. Brend of Laval University said that this needs to go beyond staff training:

> I would say that for Veterans Affairs to be trauma-informed would be to hold a mirror to itself and look at all of its functioning systematically and ask, "Does what we're doing and how we're doing it adhere to our very important mission, and is it trauma-informed? How will this land for the people who will receive it, and does it further what we want to do?"[73]

Wait times are another frustration that the Committee has heard about for many years. This was clearly acknowledged by Mr. Harris: "In any case, whether it's physical or, in particular, for mental health, we know that if they have to wait longer for it, the individual veteran themself is going to suffer and probably get worse before they get better."[74] He also highlighted the significant efforts made by VAC to promote better mental health among veterans:

- Automatic coverage of mental health treatment costs while a disability claim is being processed;
- A network of 21 mental health clinics and mental health professionals that veterans can access in person or remotely;
- Peer support offered to military personnel, veterans, and their family members through the Operational Stress Injury Social Support Program;
- The addition of psychologists and psychiatrists to the Department's healthcare teams.[75]

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72 ACVA, *Evidence*, 7 October 2025, Fardous Hosseiny (President and Chief Executive Officer, Atlas Institute for Veterans and Families), 1615. See also: ACVA, *Evidence*, 7 October 2025, Gabrielle Dupuis (Director, Research Partnerships and Government Affairs, Atlas Institute for Veterans and Families), 1655.

73 ACVA, *Evidence*, 27 November 2025, Denise M. Brend (Assistant Professor, Université Laval, As an individual**)**, 0935. See also the remarks by Sergeant (Retired) Vicky-Lynn Cox, Brief submitted to the Committee, 10 November 2025.

74 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0850.

75 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0825.

However, there is a persistent impression among Veterans that the department is making the problem worse rather than helping to solve it.[76] The solution put forward by critics of the depersonalization of VAC services has a simple objective but is extremely difficult for a government institution to implement: ensure that processes serve Veterans, not the other way around; adapt programs to people rather than forcing people to fit into programs. Bruno Plourde from The Trail spoke about the importance of in-person listening: "More than processes, humans will always save lives."[77]

Prescription Drugs as a Risk Factor

Prescription drugs are used to mitigate the effects of other risk factors. However, witnesses told the Committee so many times that they are potentially harmful to mental health that the Committee chose to treat them as a risk factor unto themselves.

Discussions focused particularly on selective serotonin reuptake inhibitors (SSRIs). Nicholas Held, Interim Scientific Director of the Canadian Institute for Military and Veteran Health Research, said:

> Suicide [is] a potential side effect, which is really important to consider, and it highlights the key piece to this, which is having that evidence where we know for whom something does work, but also, importantly, whom it could potentially harm. We could talk about many different areas where it does work for some people, but as a standard

76 See for example the remarks by: ACVA, *Evidence*, 18 November 2025, David Bona (As an individual), 1615. ACVA, *Evidence*, 9 October 025, Hélène Le Scelleur (Captain (Retired), Vice-Chair, Centre of Excellence Advisory Council for Veterans of Chronic Pain Centre of Excellence for Canadian Veterans), 0940. ACVA, *Evidence*, 18 November 2025, Darren Simons (As an individual), 1700. ACVA, *Evidence*, 20 November 2025, Mark Meincke (Corporal (Retired) and Host, Operation Tango Romeo, Trauma Recovery Podcast for Military, Veterans, First Responders, and Their Families, As an individual), 0925. ACVA, *Evidence*, 27 November 2025, Stephen La Salle (As an Individual), 0825. ACVA, *Evidence*, 4 December 2025, Todd Hisey (Chief Executive Officer and Founder, The Veteran Hunters Canada Ltd.), 0830. Christopher E. Richardson, Brief submitted to the Committee, 12 December 2025, p. 1. ACVA, *Evidence*, 28 October 2025, Diane Hill Rose (Peer Support Advocate, United Federation of Canadian Veterans), 1710. ACVA, *Evidence*, 28 October 2025, Brendan Hynes (As an individual), 1720. ACVA, *Evidence*, 30 October 2025, Samara Symonds (As an individual), 0825. ACVA, *Evidence*, 27 November 2025, Chloé Deraiche (Executive Director, The Trail - Transition Housing Inc.), 0845. ACVA, *Evidence*, 27 November 2025, Denise M. Brend (Assistant Professor, Université Laval, As an Individual), 0945. ACVA, *Evidence*, 18 November 2025, Darren Simons (As an individual), 1555-1600.

77 ACVA, *Evidence*, 27 November 2025, Bruno Plourde (CD, Founder and Administrator, The Trail - Transition Housing Inc.), 0850.

> practice of health care, we also need to know for whom it may not work and put some time into that as well.[78]

Veteran Michel Marceau described his experience with antidepressants:

> The first time I had a reaction to my antidepressants was at the Valcartier military base. … In my case, it was the antidepressants that made me the way I am. I hit rock bottom, and I had no choice but to take control of my life. Otherwise, I wouldn't be here today. In my case, antidepressants almost killed me. The reason I'm bitter is because it was the third time.
>
> … I'm not against pharmaceuticals, but they're not the only solution. In my case, they brought me to where I am today.[79]

Dr. Lane confirmed that there are similar concerns in Australia, where there were cases of military members and Veterans calling emergency services:

> The polypharmacy rates in veterans were enormous. Something like 80% of veterans were on three different medications, which included psychotropics and sedatives like benzodiazepines and opiates, these kinds of drugs. We're now seeing more along the lines of the same with medicinal cannabis. It makes people impulsive and disinhibited and then more likely to do something quite risky at a specific moment, which massively increases the risk of a negative outcome for them.[80]

PROTECTIVE FACTORS

> **"To get treatment, you need courage. To have courage, you need to realize that you are worth it."[81]**
>
> Marie-Noël Duhaime, veteran

78 ACVA, *Evidence*, 30 October 2025, Nicholas Held (Interim Scientific Director, Canadian Institute for Military and Veteran Health Research), 0950. See also: ACVA, *Evidence*, 18 November 2025, Ernie Wouters (International Trauma Specialist and Consultant, Seven Edge Success Inc.), 1640. ACVA, *Evidence*, 23 October 2025, Jessica Ruth (As an individual), 0825. ACVA, *Evidence*, 23 October 2025, Judith Hills (Corporal and Aviation Technician, Canadian Armed Forces, As an individual), 0925. ACVA, *Evidence*, 28 October 2025, Shaun Fynes (Retired Chief Security Officer for the Government of British Columbia, As an individual), 1600-1605.

79 ACVA, *Evidence*, 25 November 2025, Michel Marceau (As an individual), 1635.

80 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0855.

81 ACVA, *Evidence*, 18 November 2025, Marie-Noël Duhaime (As an individual), 1710.

Close Relationships

The most important protective factors can be grouped under what are called "close relationships": family, friends, peers and community-based services. Basically, these are anything that breaks the cycle of solitude and isolation. As Bruno Plourde from The Trail said, "prevention and local teamwork are the only effective ways to reduce suicidal ideation. It isn't cool, it isn't photogenic, it isn't clickbait, and it isn't good for statistics, because it's impossible to measure the success of prevention, because nothing happened."[82]

Marc-André Bernard said that "families are the primary supports for veterans. It's often at the spouse's suggestion that a veteran seeks help and receives support."[83]

Some pointed out how the change in identity after transition leaves Veterans without the social connections of military life. It is difficult to find such a community of shared sense of purpose in everyday civilian life. This can make it crucial for Veterans to join another type of community. Dr. Lane, from the Australian Department of Veterans' Affairs, gave the example of adaptive sports.[84]

Peer support is another kind of support that helps restore a sense of community. As the Mood Disorders Society of Canada wrote in their brief:

> Peer support leverages the power of shared Lived Experience to foster community, building hope and resilience by connecting individuals to supportive communities and sharing practical coping mechanisms. This approach actively reduces stigma and breaks down barriers, making it easier for individuals to open up and access the support they need for recovery.[85]

Like several other witnesses, Marie Blackburn, who runs a food bank for Veterans, stressed the importance of community organizations. She told the Committee about how, on a hot summer day, she had approached a Veteran who was hesitant to ask for help:

> He came up to me and asked if he could talk to me. I said, "You absolutely can." Back into the hot building we went, and he just broke down, saying that he was losing

82 ACVA, *Evidence*, 27 November 2025, Bruno Plourde (CD, Founder and Administrator, The Trail - Transition Housing Inc.), 0830.

83 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0845. See also: Robert Olivier, Brief submitted to the Committee, 4 December 2025, p. 2.

84 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0910.

85 Mood Disorders Society of Canada, Brief submitted to the Committee, 3 December 2025, p. 4.

> everything he could possibly lose—his wife, his kids, his home—and he was at the very end of his rope.
>
> I asked him what would help the most. We ended up paying all of his bills and getting him a hamper. By the end of the conversation, he was pretty stabilized and doing well. Off to home I went, and he went home. About six months later or thereabouts, [h]e said, "Seriously, if you hadn't done that, it would have been the last day of my life." He said, "I was waiting for you to leave, and if you had left, I would have pulled into your parking stall and blown my brains out. I had a loaded handgun under the seat of my car."[86]

One of the critical roles these organizations play is to refer Veterans to services:

> I think veterans may know what they need, but they may not necessarily know how to get the services.
>
> In my case, the Legion was able to speak out. It is unfortunate to have to use a third party to advocate and to do the paperwork, either because it's so complex to navigate the system or because it's very stressful, as the other witnesses said too.[87]

As The Trail explained in its brief, most of these organizations serve in one way or another as a form of peer support and can play a preventive role in a way that no government institution could:

> Veterans arrive at our doors after exhausting their options with federal institutions or after months of waiting for an answer. Some reported being bounced from one department to another, with no clear direction or ongoing guidance. … This institutional fragmentation reflects an organizational culture that is still siloed, with responsibilities divided between different departments and intervention levels. Suicide prevention and psychosocial support require an integrated approach in which the CAF, VAC and community organizations work in continuity rather than in silos. Frontline organizations such as The Trail, which work closely with veterans and establish a bond of trust with them, play an essential complementary role: they address the system's blind spots and provide human support when institutional mechanisms fail.[88]

However, Marc-André Bernard pointed out that some Veterans will not want to seek help from these organizations:

> Some will feel that they need to be supported by people who can fully understand their situation. They will therefore benefit greatly from peer support, from people to whom

86 ACVA, *Evidence*, 7 October 2025, Marie Blackburn (Executive Director, Veterans Association Food Bank), 1600.

87 ACVA, *Evidence*, 27 November 2025, Stephen La Salle (As an individual), 0900.

88 The Trail, Bried submitted to the Committee, 5 December 2025, p. 12.

> they don't need to explain a lot of things. It's a protective network. However, other veterans, upon leaving the armed forces, feel the need to distance themselves from the military and their comrades in arms. In their case, the support would be very different and would instead involve helping them create a network in the civilian world that would provide them with support.[89]

This makes it important to ensure that individualized support is readily accessible to them.

Mental Health Services for Family Members

The Committee's June 2021 report on caregivers contains the following observations:

> The scope of the programs for which family members are eligible has been raising ambiguities for many years. In 2009, in its evaluation of the New Veterans Charter programs, VAC had noted that "family members are not entitled to direct support from VAC initially as a matter-of-right." As early as 2010, the Committee had raised this issue in its report entitled *A Timely Tune-Up for the Living New Veterans Charter* and recommended: "That family members of veterans be able to access VAC's rehabilitation programs independently."
>
> The Committee reiterated this shortcoming in its May 2012 report entitled *Improving Services to Improve Quality of Life for Veterans and Their Families*, followed by its June 2014 report entitled *The New Veterans Charter: Moving Forward*, and its December 2016 report entitled *Reaching Out: Improving Service Delivery to Canadian Veterans*.
>
> In August 2016, on its blog, the Office of the Veterans Ombudsman recommended that mental health treatment benefits be provided to family members, according to their own needs, and that a caregiver benefit be created.

The Committee's key recommendation then was:

> That the Government of Canada work to ensure that spouses and dependent children of veterans who would be eligible to VAC's rehabilitation program, can access other VAC programs, including financial support and mental health services, in their own right, and with an individual client number.

This issue was addressed by a report by the Office of the Veterans Ombudsman in January 2021. According to the annual update on the implementation of its recommendations, the Office of the Veterans Ombudsman states that the government agreed with this recommendation. However, it has not been implemented. As confirmed by Mr. Harris:

89 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0900.

> Legislative authority does not exist for us to provide those services in their own right to family members. There are a number of other services that are available for families, such as the VAC assistance service, which can be used by any family member who's facing a mental health issue or crisis. That can give them 20 sessions with a mental health provider and can be used at any time. There's the veteran family program through military family resource centres.[90]

According to the Office of the Ombudsman's report, this inability to provide care to family members stems from an arcane distinction in the *Department of Veterans Affairs Act*:

> The Department of Veterans Affairs Act Sub-paragraph 4 (a)(ii) specifies that VAC has the authority to provide care and treatment to Veterans, but only care (not treatment) to dependents and survivors. "Care" and "treatment" are not clearly defined or differentiated in the legislation. Further compounding this is the fact that the Veterans Health Care Regulations omits the provision of treatment to family members.[91]

This distinction is incomprehensible. No definition distinguishes between these two terms in the *Health Care Regulations*, nor is there any distinction in the *Canada Health Act*. The Committee therefore holds the view that the Minister of Veterans Affairs, pursuant to section 4(a)(ii) of the *Department of Veterans Affairs Act*, has the authority to prescribe by regulation who is entitled to which services.

This recommendation from the Committee and the Veterans Ombudsman is even more meaningful in the case of family members of Veterans who have died by suicide. Amanda Hatcher described how abandoned she felt when the services she needed were discontinued following her husband's death:

> I am unable to utilize treatment or therapy through Veterans Affairs as I am not entitled, with my husband being deceased.[92]
>
> I was told that we were supposed to receive four phone calls a year, basically like a check-in. … and then I was told, "Well, he's off on mental health leave, so now you have a lady." I did receive an email from this lady saying, "No, no, I don't have you."
>
> … she's telling me that she doesn't have me and to call the 1-800 number if I need anything… I first used the 1-800 number, the mental health line, when my husband

90 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0900.

91 Office of the Veterans Ombudsman, *Mental Health Treatment Benefits for Family Members, in their Own Right, for Conditions related to Military Service - January 19, 2021*, note 46.

92 ACVA, *Evidence*, 20 November 2025, Amanda Hatcher (As an individual), 0920.

> passed away. It was in the nighttime and I was told, "Unless you're suicidal… We only take suicidal clients at night, and I don't have time to talk to you, only 15 minutes."[93]

As explained by Amanda Anderson, the widow of a Veteran, VAC policies regarding mental health benefits and access to rehabilitation services depend on the active participation of Veterans. Family members will be invited to participate in the rehabilitation program if it is deemed beneficial to the mental health of the Veterans. "What happens when the veteran can't participate in therapy because they're dead?"[94] Survivors then only have access to the VAC Assistance Service, which provides up to 20 hours of mental health counselling, but "you're not guaranteed a registered psychologist, nor an expert in grief or trauma."[95] Or as Sherri Elms, whose husband died by suicide, said, "I'm going to call the 1-888 number, and I'm going to get 10 sessions with this wonderful counsellor, I'm sure, on the other side of the phone, but it's not mine."[96] Jessica Ruth had a similar experience:

> My biggest concern was continued counselling for me and my children. It was at that point that I was advised that we were no longer eligible …
>
> I could not believe what I was hearing, because, at this time of immense grief when I could hardly put a sentence together, I was thinking about what I needed to do to continue this counselling with our counsellor. I was advised that there is the VAC assistance line, but that is very different from long-term, ongoing mental health counselling with someone you've already formed a relationship with.[97]

Herself a Veteran, Samara Symonds was able to access mental health services independently of her Veteran spouse:

> I have the treatment that many other family members need and deserve. Regular sessions with a psychologist experienced with PTSD and policing have gotten me through unbelievable circumstances. I've accessed counsellors through the VAC assistance service who describe my family as in crisis and don't know how to help us when we're just surviving.[98]

93 ACVA, *Evidence*, 20 November 2025, Amanda Hatcher (As an individual), 1005.

94 ACVA, *Evidence*, 25 November 2025, Amanda Anderson (As an Individual), 1535. See also: ACVA, *Evidence*, 23 October 2025, Jessica Ruth (As an individual), 0830.

95 ACVA, *Evidence*, 25 November 2025, Amanda Anderson (As an Individual), 1535. See also: Christopher Banks, Brief submitted to the Committee, 1 December 2025, p. 5.

96 ACVA, *Evidence*, 9 October 2025, Sherri Elms (As an individual), 0920.

97 ACVA, *Evidence*, 23 October 2025, Jessica Ruth (As an individual), 0840.

98 ACVA, *Evidence*, 30 October 2025, Samara Symonds (As an individual), 0825.

The Committee hopes to one day hear from the children of Veterans struggling with mental health issues.[99] Given that family is the most important protective factor against deteriorating mental health issues, the Committee once again recommends:

Recommendation 6

That the Minister of Veterans Affairs determine the most appropriate mechanism that would provide access to mental health supports to family members of Veterans while respecting provincial and territorial jurisdiction.

Recommendation 7

That Veterans Affairs Canada determine the most appropriate path to provide access to the Public Service Health Care Plan for mental health services for the survivors of Veterans should they wish to access it.

Prevention

Philip Ralph served as a CAF chaplain for 26 years and is now Director of Clinical Services at Wounded Warriors Canada. He believes that since untreated trauma is the main cause of suicidality among military members and Veterans, preventive action is needed. Trauma must be prevented by better preparing military members to deal with situations that could cause it.

With that in mind, the organization developed Warrior Health, a training program designed to prepare individuals who may be exposed to traumatic situations: “These things need to be done up front so that people understand what they’re going to encounter. That won’t prevent injury, but it will certainly make people aware. It will make them seek help at an appropriate time. They’ll get the care they need.”[100]

The Atlas Institute for Veterans and Families, an independent organization funded by VAC, has also developed a range of evidence-based tools and resources in collaboration with Canadian Mental Health Association Alberta and the Centre for Suicide

99 On this issue see the remarks by: ACVA, *Evidence*, 4 December 2025, Kathryn Reeves (Dallaire Institute for Children, Peace and Security), 0905.

100 ACVA, *Evidence*, 7 October 2025, Philip Ralph (Captain (Retired), Director, Clinical Services, Wounded Warriors Canada), 1620.

Prevention.[101] Gabrielle Dupuis, the Institute's Director of Research Partnerships, presented a few of these, including the "Veteran tool kit," which helps them recognize warning signs and act quickly, and the "family tool kit," which helps family members support Veterans while also caring for themselves.[102] The Institute has also developed conversation guides to facilitate suicide-related discussions, as well as media guidelines aimed at reducing stigma and the risk of contagion.

Recommendation 8

That for all Canadian Armed Forces (CAF) members, the Department of National Defence make regular participation mandatory in resilience support programs which help prevent and mitigate the harmful effects of trauma on the mental health of CAF members and Veterans.

Another part of this prevention effort pertains to crisis services. Several witnesses, including Aaron Dale of the Toronto Police Service, recommended that the national 9-8-8 crisis line be modified to include a dedicated option for Veterans.[103] This already exists in the U.S., and Dr. Allison Crawford of the 9-8-8 Suicide Crisis Helpline also recognized its benefits:

> The Veterans Crisis Line in the U.S. has had about 3.8 million interactions—calls, texts and chats—from 2021 to 2024. That's about 2,600 interactions each day. That volume has increased each year, with a 30% growth over the last three years. It's the integration with the 9-8-8 service that's responsible for a large proportion of that growth.
>
> … Evaluation of the service has demonstrated an impact on engaging veterans in mental health services, on increasing uptake of mean safety precautions and reducing distress.[104]

On 16 January 2026, the Minister of Veterans Affairs and Associate Minister of National Defence, the Honourable Jill McKnight, issued a news release in support of the crisis line

101 Canadian Mental Health Association - Alberta and Centre for Suicide Prevention, Brief submitted to the Committee, 12 November 2025, p. 2. See also: ACVA, *Evidence*, 4 December 2025, Allison Crawford (Psychiatrist and Chief Medical Officer, 9-8-8 Suicide Crisis Helpline, Centre for Addiction and Mental Health), 0820.

102 ACVA, *Evidence*, 7 October 2025, Gabrielle Dupuis (Director, Research Partnerships and Government Affairs, Atlas Institute for Veterans and Families), 1535.

103 ACVA, *Evidence*, 27 November 2025, Aaron Dale (Program Coordinator, Military Veterans Wellness Program, Toronto Police Service), 0835-0840.

104 ACVA, *Evidence*, 4 December 2025, Allison Crawford (Psychiatrist and Chief Medical Officer, 9-8-8 Suicide Crisis Helpline, Centre for Addiction and Mental Health), 0820.

expansion announced by the Minister of Health, the Honourable Marjorie Michel. However, there was no mention of Veterans. The Committee therefore recommends:

Recommendation 9

That the Government of Canada ensure that the 9-8-8 crisis line includes an option dedicated to Veterans.

Restoring Continuity of Care

In the introduction to its October 2024 report on transition, the Committee wrote: "the key difficulties associated with the transition to civilian life are related to the capacity of the provinces and territories to provide health care services in a timely manner, particularly access to a family doctor." An entire section of the report was devoted to this issue. This same issue was the subject of Recommendation 3 of a 2017 report comparing services available to Veterans in other countries, as well as in a 2016 report on service delivery.

It was therefore not surprising to see this recurring theme reappear: "I would ask that we be given less money and that we be given a doctor instead,"[105] pleaded Bruno Plourde of The Trail:

> Veterans Affairs Canada delivers services to veterans, but the key to accessing the services is in the hands of someone who doesn't even know they have that key in their kit, and that's the doctor. Veterans have to go looking for this key, sometimes putting their health and even their lives at risk.
>
> During that process, that's when veterans are most vulnerable. They have to make decisions or draft documents that will have a significant impact on their lives.[106]

Veteran Michel Marceau went further:

> I left the military 12 years ago. I don't even have a family doctor. All through the winter, the Veterans Affairs agent, who was very polite, kept telling me that I did have one. I called my family doctor 12 times over seven years only to be told each time to call back

105 ACVA, *Evidence*, 27 November 2025, Bruno Plourde (CD, Founder and Administrator, The Trail - Transition Housing Inc.), 0900.

106 ACVA, *Evidence*, 27 November 2025, Bruno Plourde (CD, Founder and Administrator, The Trail - Transition Housing Inc.), 0830.

> in a year. I ended up going to the private sector for $2,000 a year. I don't have a family doctor.[107]
>
> I came back from Afghanistan with 14 diagnosed health issues and couldn't get a doctor. It's ludicrous.
>
> Back in the army, I only went to the doctor if something was broken or torn. I never abused health services, but I need a prescription and a check-up from time to time, just like anyone else. Will I have to become an astronaut to get a doctor? What do I have to do for my country to deserve one? What about my buddies?[108]

Access to a family doctor is just one of the factors that disrupt continuity of care. The repetitive cycle of examinations, assessments and forms can "ratchet up humiliation and shame when they have to face their shortcomings. They may become intensely angry when they find their experience has become run-of-the-mill and bureaucratized."[109]

Veterans who manage to overcome the hurdles to accessing health care must undergo repeated examination and assessment processes depending on the institution they are dealing with. Marc-André Bernard gave the following explanation:

> These veterans were properly assessed while in the service. They are completely reassessed when they leave the forces, as if the forces' assessments didn't count. Many of them have to fight with the officials to get me to do the assessment, because the officials want someone else to do it. Continuity is not a priority. I know that it's extremely humiliating for veterans to have to tell their story over and over again.[110]

This was addressed in the June 2024 report *Invisible No More* and was the subject of Recommendation 30. In its Response, VAC agreed with the recommendation when it involved mental health issues arising from sexual assault:

> VAC will accept that the incident occurred and was service-related based on the Veteran's statement, without the need for a detailed narrative of traumatic events and without the need for corroborating evidence. Decision-makers then rely on information available in medical reports and other documentation such as medical questionnaires, which can be provided directly from healthcare professionals to VAC with consent of the Veteran, to complete their evaluation of eligibility and assessment of the extent of the disability.

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107 ACVA, *Evidence*, 25 November 2025, Michel Marceau (As an individual), 1540.

108 ACVA, *Evidence*, 25 November 2025, Michel Marceau (As an individual), 1555.

109 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0815.

110 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0845. See also: ACVA, *Evidence*, 9 October 2025, Sherri Elms (As an individual), 0910.

The Committee members believe that the recommendation is valid in all cases where a mental health issue has been recognized by VAC as being service-related. The Committee therefore wishes to reiterate it:

Recommendation 10

That Veterans Affairs Canada avoid re-traumatizing Veterans by eliminating the requirement that they recount the circumstances of traumatizing events leading to the medical condition for which a claim has been filed, when this information has already been compiled by a recognized professional institution and forwarded with the Veteran's explicit written consent.

Another continuity of care issue concerns the requirement for Veterans participating in a rehabilitation program to obtain their care from subcontractors assigned to them by PCVRS, even if these same Veterans are already being treated by other health professionals. Shane Nedohin was medically released after 22 years of service. He was harshly critical of this approach:

> PCVRS is a program more akin to parole than a support system, in my opinion. PCVRS holds veterans hostage by threatening to take away pay and benefits if you refuse to comply with their program. It refuses to let veterans use any care provider but a Lifemark facility. … I was forced to do my occupational therapy physio assessment virtually by standing in front of my laptop, raising my arms and moving around while the guy on the other end tried to see my range of motion through a grainy video. This was despite the fact that I am currently seeing a physiotherapist through my Blue Cross benefits, and I had literally done a proper assessment the week prior. They wouldn't take that, because it was unacceptable to have an assessment that was done through a non-Lifemark facility.[111]

Mr. Bernard pointed out that, despite all the good intentions that could be behind these programs, "the standardized rehabilitation services currently available from Partners in Canadian Veterans Rehabilitation Services seem to me to be largely unsuited to veterans and do not allow for adjustments to be made for those who are vulnerable and whose military identity was all they had."[112] The Committee therefore recommends:

111 ACVA, *Evidence*, 30 October 2025, Shane Nedohin (Farmer, As an individual), 0915. See also: ACVA, *Evidence*, 18 November 2025, Darren Simons (As an individual), 1635. ACVA, *Evidence*, 28 October 2025, Christine Gauthier (Corporal (Retired), As an individual), 1640.

112 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0815.

Recommendation 11

That Veterans Affairs Canada works with the provider of its rehabilitation program to determine how pre-existing care can be incorporated into the Veteran's rehabilitation plan.

Since one of the major continuity of care challenges stems from the constitutional division of powers giving provinces the authority to legislate on health care, it is crucial to be able to identify Veterans once they are no longer under the federal jurisdiction of the CAF. This would facilitate care delivery and data collection.

Several witnesses, including Bruno Plourde from The Trail, recommended that everyone leaving the CAF be given a unique identifier recognized by provincial and territorial governments.[113] This would enable VAC to set up a system to periodically follow up on Veterans and allow it to be proactive, reach out and offer them services before problems become serious. As Chloé Daraiche from The Trail put it:

> Problems often arise after military service. At the time of release, things may not be well established. After that, problems emerge in everyday life. However, the link to military service isn't always apparent right away. In that context, it would be really important to have long-lasting follow up.[114]

The Committee therefore recommends:

Recommendation 12

That Veterans Affairs Canada determine, in consultation with the Department of National Defence, the feasibility of an opt-in or opt-out approach to share Veteran status with the Veteran's informed written consent with the provincial and territorial health authorities to have Veterans' identifiers included in their provincial or territorial health files upon transition.

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113 ACVA, *Evidence*, 27 November 2025, Bruno Plourde (CD, Founder and Administrator, The Trail - Transition Housing Inc.), 0830. See also: ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0835. ACVA, *Evidence*, 27 November 2025, Chloé Deraiche (Executive Director, The Trail - Transition Housing Inc.), 0850. Dr. Karen Breeck, Brief submitted to the Committee, 5 December 2025. Christopher Banks, Brief submitted to the Committee, 1 December 2025, p. 4.

114 ACVA, *Evidence*, 27 November 2025, Chloé Deraiche (Executive Director, The Trail - Transition Housing Inc.), 0850.

Preparing the Transition

Since the creation of the rehabilitation program in 2006, continuity of care has remained a key challenge for the CAF and VAC in facilitating a smooth transition for military members to civilian life. When it comes to mental health and suicide prevention, significant efforts and investments have failed to pay off. Suicide rates among Veterans have remained unchanged.

What is known is that military life is a significant protective factor that disappears upon transition. None of the services put in place to facilitate the transition has been able to compensate for this loss. Veterans' testimony and expert analyses converge on three key issues: 1. the need to recreate a fulfilling social environment that replaces the sense of belonging once provided by the military community; 2. the abandonment that results from the break in continuity of care, which challenges the sense of honour Veterans have regarding the social value of their military service; and 3. complex bureaucratic processes that imply that Veterans are not trustworthy and that it is up to them to figure out what they are entitled to and to prove that they deserve what is offered to them.

Veterans must be at least reasonably confident that these three challenges can be overcome when they make the transition to civilian life. This means: 1. having developed a rewarding personal and professional life plan and having taken the necessary action to achieve it; 2. having access to a family doctor within a reasonable time frame, as this is the key that unlocks access to everything else; and 3. having received at least an initial response to financial compensation claims filed with VAC so that they can realistically anticipate the resources that will be available to them.

These discussions bring us back to a recommendation that the Committee has made repeatedly and that the government has always rejected: that military members should not be released until the necessary steps have been taken for a successful transition. As we have seen, military members have not had a chance to develop the independent living skills that civilians take for granted. That is why all-important steps should have been completed prior to release, whereas currently, even with transition centre enhancements, many transition services are only available after release.[115]

Several witnesses, including Marc-André Bernard, spoke about this need to prepare for the transition:

115 On this issue see the remarks by: ACVA, *Evidence*, 9 October 2025, Brad Field (President, Homes for Heroes Foundation), 0910.

> In one of this committee's reports on the release of Canadian Armed Forces personnel, I read that it was recommended that Veterans Affairs Canada be able to process all veterans' claims and that veterans be assigned a civilian family doctor before being allowed to leave. I think this is a very good example of what could really make a difference in the lives of some former military personnel and reduce their feelings of helplessness, humiliation and frustration around the profound identity loss they must grapple with. It remains our responsibility to take care of these people, who have sacrificed some of their health to public service.[116]

It is important to acknowledge the government's efforts to explain its disagreement in its Response to the 2024 report on transition:

> The Government considers impractical the Committee's proposal to precondition military release on a Veteran's access to a family physician, given the absence of jurisdictional levers to guarantee the timely assignment of providers by provincial and territorial authorities. With a nationwide shortage of healthcare providers, and noting the uncertainty underpinning timelines for Veterans to gain access to a regular family physician, implementing the recommended policy risks generating substantial costs and logistical challenges.

In other words, once Veterans are no longer part of the CAF, they become a provincial responsibility, and continuing to provide them with care would hinder the CAF's operational priorities.

> This may include bottlenecks in the military release process, transition delays for other personnel, disruptions to workforce planning, and increased financial burden related to maintaining salaries, benefits, and support for postponed releases. Additionally, expanding healthcare capacity to accommodate Veterans in transition would require significant new investments in Canadian Armed Forces (CAF)-operated health services. While National Defence's planned initiatives focus on addressing immediate critical health service gaps, they do not account for the additional costs associated with supporting postponed releases. The latter would risk diverting funding and focus from other critical missions contributing to national security, as well as recruitment and retention initiatives.

It is understandable that the CAF would want to prioritize its operational needs, but it then becomes difficult to believe that it considers suicide prevention among Veterans to be a priority, since it clearly states that it is washing its hands of one of its key aspects. This also calls into question the CAF's contribution to what should be a responsibility of the Government of Canada as a whole. That is why the Committee once again recommends:

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116 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0815-0820. See also: ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0905. ACVA, *Evidence*, 27 November 2025, Aaron Dale (Program Coordinator, Military Veterans Wellness Program, Toronto Police Service), 0905.

Recommendation 13

That the Canadian Armed Forces work with provincial and territorial health authorities to ensure that military members who no longer meet the requirements for universality of service and have been diagnosed with a condition that constitutes a risk factor for mental health are not released until the availability of a family doctor has been confirmed.

Diversifying Treatment Options

As Mr. Bernard explained, combining talk therapy or another form of psychotherapy with medication is recommended in many mental health treatments.[117] The medication risks were discussed earlier and must continue to be closely monitored. Samara Symonds said that alternative treatments, such as equine or canine therapy, are treatments:

> …that those of us who are skilled in bureaucratic things will seek out, but we have to provide research and a rationale and we have to get a doctor, a psychologist, an occupational therapist and every possible professional imaginable to verify what we're asking for. In contrast, if I come in with prescriptions for numerous medications, those will be covered without hesitation.[118]

In terms of psychotherapy treatments, the "gold-standard treatments," as described by Dr. Hosseiny of the Atlas Institute, are "prolonged exposure and cognitive processing therapy. There are some elements of peer support that have been shown to be quite beneficial."[119]

However, recognizing certain treatments should not result in excluding other approaches. Mr. Bernard said that Veterans' experiences are very diverse and may not align with the approaches used for the civilian population. He mentioned equine therapy, eye movement desensitization and reprocessing (EMDR) and narrative therapy: "One of the main problems with PTSD is the digestion of emotional baggage, which a lot of people have trouble with. Whatever helps the person connect with their emotions and learn to manage their emotions will prevent the PTSD from getting bigger."[120]

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117 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0845.

118 ACVA, *Evidence*, 30 October 2025, Samara Symonds (As an individual), 0905.

119 ACVA, *Evidence*, 7 October 2025, Fardous Hosseiny (President and Chief Executive Officer, Atlas Institute for Veterans and Families), 1715.

120 ACVA, *Evidence*, 30 October 2025, Marc-André Bernard (Psychologist, Institut Alpha, As an individual), 0840.

However, it is not enough to simply make these treatments available. They must also be available at the right time. Early intervention is key to promoting treatment following trauma.

That is why programs such as those offered by the Veterans Transition Network, which use a trauma exposure approach in a group setting, must be available as soon as possible after trauma has occurred, or as soon as a Veteran expresses interest in participating.

> We work with many veterans who are at the highest risk of suicide. Our goal is to provide them with the care, human connection and hope needed to prevent this tragic outcome.
>
> Evaluations of our programs show that more than two thirds of the veterans who participate have experienced suicidal thoughts, most in the past year. Those same evaluations also show a significant and sustained decrease in suicidal ideation among veterans who have participated in our programs and responded to our follow-ups.[121]

As Mr. Ralph said about the Veterans Transition Network and Wounded Warriors Canada programs:

> It's a sad state that these programs that are essential to veterans' recoveries are funded largely off bake sales, bike rides and other community-based fundraising.
>
> These programs, although not cheap, are affordable when you look at the alternatives, such as long-term in-patient facilities, because they deal specifically with trauma. It's no different from a physical injury. The earlier you get care, the better the outcome.[122]

Mr. Thorne expressed concern that the VAC approval process for services such as those provided by the Transition Network has become increasingly slow and cumbersome. This has led to a significant decrease in the approval rate. When there is a risk of suicide, the organization does not wait for approval, but the department will not cover the services if they were used before authorization was obtained. In Thorne's opinion, an automatic approval process for specialized root-based transition programs and trauma programs "can get the veterans who are the most at risk quickly into the care and community they need before the dominoes of suicide begin to fall."[123] The Committee therefore recommends:

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121 ACVA, *Evidence*, 7 October 2025, Oliver Thorne (Chief Executive Officer, Veterans Transition Network), 1555.

122 ACVA, *Evidence*, 7 October 2025, Philip Ralph (Captain (Retired), Director, Clinical Services, Wounded Warriors Canada), 1620. See also: ACVA, *Evidence*, 28 October 2025, Diane Hill Rose (Peer Support Advocate, United Federation of Canadian Veterans), 1715.

123 ACVA, *Evidence*, 7 October 2025, Oliver Thorne (Chief Executive Officer, Veterans Transition Network), 1555-1600.

Recommendation 14

That Veterans Affairs Canada establish a fast-track approval process when department-approved organizations need to provide services quickly to Veterans with urgent mental health needs.

The Latest on Psychedelic-Assisted Therapy

Witnesses called for greater recognition by VAC of the fragmentary yet promising evidence supporting the benefits of psychedelic-assisted therapy. Veteran Kelsie Sheren said that "there's a proven peer-reviewed study and treatment to treat PTSD and depression."[124] Veteran Gordon Hurley cited recent decisions in Australia and the U.S. in proposing a framework that would allow Health Canada to expand access to treatment.[125] However, the promising studies that he referred to are still preliminary, and some significant risks of treatment have been identified. Furthermore, as pointed out by Dr. Lane of the Australian Department of Veterans' Affairs, access remains limited to clinical trials as a treatment of last resort and under strict conditions that make treatment expensive.[126] He said:

> The evidence isn't where the public would like it to be, unfortunately. As clinicians, we are talking about treatments that are publicly funded and that are significantly expensive. The body of evidence isn't necessarily there to say that they work to the standard that people would like them to work. You can see this from the applications through the federal drug administration in the U.S. and the fact that this still hasn't gained traction in the U.S. in that particular way.[127]

This does not mean that this treatment cannot benefit some people. For example, Veterans Shane Nedohin and Paul Farell said that they greatly benefited from it.[128] However, as explained by Nicholas Held of the Canadian Institute for Military and

124 ACVA, *Evidence*, 28 October 2025, Kelsie Sheren (Mental Resilience Expert, As an individual), 1550. See also: ACVA, *Evidence*, 18 November 2025, Gordon Hurley (Veterans Mental Health Advocate, As an individual), 1540.

125 ACVA, *Evidence*, 18 November 2025, Gordon Hurley (Veterans Mental Health Advocate, As an individual), 1540. See also: Project Life Spark, Brief submitted to the Committee, 21 November 2025.

126 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0835.

127 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0835.

128 ACVA, *Evidence*, 30 October 2025, Shane Nedohin (Farmer, As an individual), 0950. Paul Farell, Brief submitted to the Committee, 31 October 2025.

Veteran Health Research, the benefits remain unpredictable, and suicidal ideation has been identified as a possible side effect.[129]

On this issue, the Senate Subcommittee on Veterans Affairs tabled a cautious report in November 2023, concluding that the embryonic state of the research does not support expanding access to these therapies today. The report contained only one recommendation, calling for the launch of a large-scale research program to refute or confirm the existing incomplete data. In its response to the report, the government agreed with these conclusions:

> Additional research is required to determine both short- and long-term safety and efficacy of using [psychedelic-assisted therapies] to treat mental disorders. Health Canada and the Canadian Institutes of Health Research (CIHR) play a role in the Government of Canada's mandate to help the people of Canada maintain and improve their health, Health Canada as the regulator of therapeutic drugs and clinical trials, and CIHR as a research funding agency.

The Committee will remain open to any scientific advances that could warrant revisiting these conclusions.

THE CANADIAN STRATEGY TO PREVENT MILITARY MEMBER AND VETERAN SUICIDE

The Australian Royal Commission into Defence and Veteran Suicide showed what a systematic approach to engaging all relevant individuals and organizations could look like with the specific objective of working to mitigate the harmful consequences of a complex problem. Fardous Hosseiny from the Atlas Institute for Veterans and Families put it this way:

> The Australian Royal Commission into Defence and Veteran Suicide offers a strong model of systemic inquiry. It collected thousands of submissions, including from Atlas, heard directly from veterans and families, and issued more than 100 recommendations. Its findings emphasize accountability and oversight, longitudinal care, the centrality of lived experience and the need for robust data systems.[130]

As discussed earlier, it has been well established and documented that experiencing trauma is the main risk factor for mental health issues among military members and

129 ACVA, *Evidence*, 30 October 2025, Nicholas Held (Interim Scientific Director, Canadian Institute for Military and Veteran Health Research), 0955.

130 ACVA, *Evidence*, 7 October 2025, Fardous Hosseiny (President and Chief Executive Officer, Atlas Institute for Veterans and Families), 1535. See also: ACVA, *Evidence*, 20 November 2025, Ben Wadham (Professor, Flinders University and Director, Open Door Initiative, As an individual), 0815.

Veterans. The Australian Royal Commission into Defence and Veteran Suicide took a trauma-informed approach to all of its work. This includes operational stress injuries, moral injuries resulting from traumatic experiences, sexual trauma, physical trauma that can cause chronic pain, and a range of physical, psychological, institutional and cultural factors that could be risk factors or protective factors. As one might expect, each of these risks was addressed in one or more of the Commission's 122 recommendations.

In the 2022 CAF/VAC Joint Suicide Prevention Strategy, the risk factor related to trauma is captured within "adverse events in personal history" (p. 18), which in turn are only one of the 17 risk factors listed. This choice to prioritize the "multifactorial" dimension of the risk for death by suicide seems to have led to a sense of helplessness when it comes to the ability to intervene effectively on at least those risk factors that are well known. As General Malcolm put it, "I will just remind you that, again, given the multifactorial nature of suicide, it becomes difficult to pinpoint the exact drivers."[131] According to Dr. Courchesne:

> That is the big challenge. We need to identify the trend and the causes. We know that the causes of suicide are multifactorial. There is not just one factor, there are several.
>
> Although we have these figures, we cannot investigate the exact causes, because some of these veterans may not be clients of Veterans Affairs Canada. These people live in their communities, and it is thanks to Statistics Canada that we can do this triangulation.
>
> That said, I can assure you that this rate did not increase between 1975 and 2016, the last year for which we have figures, I believe.[132]

The most striking oversight stemming from this decision to dilute the best-documented causes in a multifactorial complexity is that sexual trauma is completely absent from the Strategy, even though it is one of the best-documented risk factors. Not one mention.

This sense of helplessness resulting from the lack of objectives and a multifactorial approach contrasts sharply with the optimism emerging from the Australian approach. Dr. Ben Wadham had this to say:

> There may be mental health issues, but if we can get employment, education, housing, mobility, identity, purpose and belonging right, then those are major preventative issues for veteran suicidality.

131 ACVA, *Evidence*, 2 October 2025, MGen Scott Malcolm, Surgeon General, Canadian Armed Forces, Department of National Defence, 0925.

132 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0840.

> I would say that, in my research, with over 300 interviews now, social disconnection is, for me, the overwhelming issue. That is an issue that we can prevent really effectively just by wrapping services, knowledge, wisdom, experience and empathy around veterans when they're in service, when they leave service and even years after their service when they're out, well into their civilian lives.[133]

> We have a complete sheet now to go from in order to address things, and things are starting to happen. … I think the future looks bright.[134]

In Canada, the initial strategy was released in October 2017 and updated in 2022. It stems from a commitment set out in the 2015 mandate letters of the Minister of National Defence and the Minister of Veterans Affairs and Associate Minister of National Defence. The strategy includes seven "lines of effort" tied to seven "domains of well-being."[135] It resulted in 160 initiatives presented in the annex to the 2017 plan. Of these, 63 fall under VAC jurisdiction, and the implementation deadline was initially set for 2017 to 2020. In October 2022, the update specified that 52% of these 63 initiatives had been completed. According to Dr. Cyd Courchesne, implementation of the plan did not continue after 2022 since during her appearance on 2 October 2025 she said that "to date, 50% of the initiatives have been permanently implemented."[136]

Steven Harris said that one of the positive outcomes of the Strategy is that it allowed psychologists and psychiatrists to be added to health care teams, allowing for remote consultations.[137] According to Oliver Thorne of the Veterans Transition Network:

> Veterans Affairs and the Canadian Armed Forces have taken steps to reduce suicide risk by improving transition education and access to one-on-one counselling and by investing in peer programming, but we don't yet know if those efforts are working.[138]

The Strategy does not include any measurable objectives as to the effectiveness of these 160 initiatives. This makes it more of a list of tasks than a real strategy. Since death by

133 ACVA, *Evidence*, 20 November 2025, Ben Wadham (Professor, Flinders University and Director, Open Door Initiative, As an individual), 0815.

134 ACVA, *Evidence*, 20 November 2025, Ben Wadham (Professor, Flinders University and Director, Open Door Initiative, As an individual), 0850.

135 ACVA, *Evidence*, 2 October 2025, BGen Serge Ménard (Commander, Canadian Armed Forces Transition Group, Canadian Armed Forces, Department of National Defence), 0905.

136 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0915.

137 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0825.

138 ACVA, *Evidence*, 7 October 2025, Oliver Thorne (Chief Executive Officer, Veterans Transition Network), 1555.

suicide is a “multifactorial” phenomenon, we are firing blindly in all directions, hoping to achieve results that we do not even believe we will be able to verify. It is as though the department has abdicated its ability to act on this phenomenon. As Dr. Courchesne said:

> Often, it is not necessarily mental health issues that lead to these acts. It is therefore difficult to implement measures when we do not know exactly what the causes are. We can make many assumptions and base our programs on these assumptions.[139]
>
> We have the Canadian Armed Forces and Veterans Affairs Canada Joint Suicide Prevention Strategy. However, the difficulty with prevention strategies is that we cannot assess what has not happened. We can only rely on the rates that we continue to monitor.[140]
>
> Even though we can’t get to the root cause or the trigger that pushes someone to follow through, we gather more information. … We’ll gather more information like that until we get to a point where we will crack that nut. We’ll keep learning through continued research in this.[141]
>
> Right now, we’ve measured the rates up until 2016. We’ll have to wait for the first five-year block to see if there was any effect of that. Regardless, we know that all the measures we have put in place were good measures, were improvements on things we had done in the past.[142]

Amy Hall, senior epidemiologist with the department, hopes that surveys will perhaps one day tell us more.

> [The Canadian Veteran Health Survey] was conducted for the first time in 2022. It looks at veterans who identified themselves as such in the 2021 census. That survey captures information on suicidal ideation and suicide attempts, so that might be another source of information we can use to understand what’s going on in veterans.[143]

As pointed out by witnesses, the primary objective of a prevention strategy should simply be to reduce the number of deaths by suicide. In Australia, since the start of the

139 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0840.

140 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0840.

141 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0850.

142 ACVA, *Evidence*, 2 October 2025, Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs), 0955.

143 ACVA, *Evidence*, 2 October 2025, Amy Hall (Senior Epidemiologist, Department of Veterans Affairs), 0950.

Royal Commission's work in April 2021, "the numbers have been trending down, which does suggest that we're doing something good."[144] As Nicholas Held noted:

> It's one thing to set up programs, but it's another thing to understand whether they're having their intended impact. If they're not, how do you change that??
>
> … If we make this investment in longitudinal research over time, we can see at different points in time when something like this has come forward, and we will hopefully see action and reduced suicide over time in our veteran population. If we have only these small, one-year studies without that investment in the larger datasets, we're not really going to know if there's been an impact over time.[145]

In light of the CAF/VAC Joint Suicide Prevention Strategy's shortcomings, the Committee recommends:

Recommendation 15

That Veterans Affairs Canada and the Department of National Defence develop a new joint suicide prevention strategy for military members and Veterans, including Reserve Force members, setting out measurable objectives and based on the strategy resulting from the work of the Australian Royal Commission into Defence and Veteran Suicide.

Canadian Mental Health Association Alberta wrote in its brief that "Canada is one of few industrialized nations without a national strategy."[146] As was done in Australia, several witnesses wanted to see the suicide prevention strategy for Veterans become a distinct component of a comprehensive national suicide prevention strategy.[147]

Dr. Lane of the Australian Department of Veterans' Affairs hopes that the national strategy developed in Australia will help prevent Veteran suicide since "roughly 70% of the people who died from suicide weren't concurrently engaged in or getting services

144 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0820.

145 ACVA, *Evidence*, 30 October 2025, Nicholas Held (Interim Scientific Director, Canadian Institute for Military and Veteran Health Research), 1010. See also: ACVA, *Evidence*, 27 November 2025, Bruno Plourde (CD, Founder and Administrator, The Trail - Transition Housing Inc.), 0940. ACVA, *Evidence*, 27 November 2025, Aaron Dale (Program Coordinator, Military Veterans Wellness Program, Toronto Police Service), 0940.

146 Canadian Mental Health Association - Alberta and Centre for Suicide Prevention, Brief submitted to the Committee, 12 November 2025, p. 4.

147 ACVA, *Evidence*, 23 October 2025, Robert Olson (Research Librarian, Canadian Mental Health Association), 1010. See also: Canadian Mental Health Association - Alberta and Centre for Suicide Prevention, Brief submitted to the Committee, 12 November 2025, p. 3.

from our Veterans' Affairs."[148] It is likely that the situation in Canada is similar, but we have no way of knowing that since data on Veterans is not collected systematically and excludes reservists.

Mr. Harris discussed the screening done during transition interviews with military members about to be medically released.[149] This is certainly necessary, but once again, it only applies to medically released Regular Force members.

The Committee therefore recommends:

Recommendation 16

That, if the Government of Canada were to develop a comprehensive national suicide prevention strategy, it should include a component for Veterans.

CONCLUSION

The data on deaths by suicide among military members and Veterans is concerning. Among military members, the rate of death by suicide among Regular Force men has deteriorated and remains higher than that for the general population, while the rate among servicewomen is stable but significantly higher than that for Canadian women. Data on reservists are incomplete, limiting any in-depth analysis. Compared to Australia and the United States, Canada must improve data collection and recognize the urgency of taking action as the situation continues to deteriorate.

Regarding Veterans, there are critical data collection challenges. The lessons learned from the Australian Royal Commission into Defence and Veteran Suicide show that a detailed and nuanced understanding of the epidemiology of suicide is essential in order to come up with effective prevention strategies.

The Australian data reveals alarming disparities in suicide rates by gender, type of service, reasons for release, and injuries sustained during service. This information helps identify high-risk populations and tailor interventions accordingly. In Canada, the lack of such granular data, particularly regarding reservists who made up more than a third of

148 ACVA, *Evidence*, 20 November 2025, Jonathan Lane (Chief Psychiatrist, Department of Veterans' Affairs, Government of Australia), 0905. On this point, see the testimony of a Veteran who was voluntarily released: ACVA, *Evidence*, 4 December 2025, Todd Hisey (Chief Executive Officer and Founder, The Veteran Hunters Canada Ltd.), 0825.

149 ACVA, *Evidence*, 2 October 2025, Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs), 0935.

the troops deployed to Afghanistan, is a major obstacle to developing an evidence-based national suicide prevention strategy.

It is, of course, impossible to predict specific cases of death by suicide. However, the key risk factors are known, the primary one being trauma. It can take many forms. Operational trauma can result from combat situations, difficult humanitarian operations or other deeply traumatic experiences in the course of military service. Moral injuries, particularly those resulting from tragic events involving children, pose a very high risk of suicidal behaviour. Military sexual trauma is one of the most significant and identifiable risk factors for suicide, particularly among women military members and Veterans. The downplaying of this risk factor by CAF and VAC representatives during their appearance is concerning.

An analysis of the testimony and data presented in this study shows that suicide among military members and Veterans cannot be dismissed as merely a “societal problem.” The significantly higher rate of deaths by suicide in the Canadian Armed Forces compared with the general population demonstrates that there is an intrinsic aspect of military service that constitutes a major risk factor for mental health.

Military service demands tremendous sacrifices: the merging of personal identity with professional identity, the acceptance of physical and emotional deprivation, and a culture of stoicism that, while essential in operational contexts, becomes a major obstacle to seeking help. This organizational culture, centred on strength and resilience, pushes many military members to bottle up their distress until the situation becomes critical.

This makes it imperative to view all deaths by suicide during military service as service-related deaths. Recognizing this fact is not merely an act of justice for the deceased and their families but is also an essential step toward the cultural transformation needed within the Canadian Armed Forces.

Chronic pain is strongly correlated with mental health issues and suicide risk among Veterans. While 20% of civilians suffer from chronic pain, the rate is 40% among male Veterans and 50% among female Veterans. Treating chronic pain can indeed reduce the risk of suicide, but there is no mention of it in the CAF/VAC Joint Suicide Prevention Strategy.

The transition from military to civilian life is a critical time that puts Veterans at higher risk of psychological distress and suicidal behaviours. First, Veterans go through a profound cultural shift. After living in a structured environment where every situation has a clear procedure, they end up in a civilian world that they struggle to understand and that does not understand them either. The military stoicism that was once a

strength becomes a liability in civilian life, and social expectations that Veterans should immediately demonstrate autonomy are unrealistic.

This social shift can lead to isolation that feels like a betrayal. Veterans go from “hero to zero.” Those who served with confidence and dedication feel abandoned by the institution they served and misunderstood by VAC programs and staff who should be supporting them. The first two years following release are particularly critical for young men, while the risks for women Veterans appear to develop over a longer period.

There is no silver bullet: human connection and attentive listening remain irreplaceable. The pitfalls identified throughout this study —red tape, lack of personalized services, frustration with bureaucratic processes — must be addressed if VAC is ever to be regarded as a protective factor.

Prescription drugs, particularly selective serotonin reuptake inhibitors (SSRIs), have also been identified as a risk factor affecting the mental health of military members and Veterans. In Australia, Veterans have been observed to have high rates of polypharmacy.

Protective factors against suicide among Veterans are grouped primarily around the concept of “close connections”: family, friends, peers and community-based services. These social ties break solitude and isolation, which are major risk factors. Family is often the first line of support, and spouses frequently play a crucial role in encouraging Veterans to seek help.

The transition from military to civilian life leaves Veterans without the strong social ties they had in the Forces. This makes it essential that they be able to integrate into new communities. Peer support is especially important. In providing close connections, community organizations play an essential role complementing that of government institutions. They provide personalized support, guide Veterans through the complex system of services, and can intervene preventively in ways that no institution ever could.

Access to mental health services for the family members of Veterans remains limited, which is particularly distressing after the death of a Veteran by suicide. Spouses and children of Veterans who died by suicide are being denied access to the therapists with whom they have built a relationship of trust and are instead directed to VAC’s 1-800 helpline without any guarantee of accessing a grief or trauma specialist. This discontinuity of care comes precisely at a time when these families are experiencing traumatic grief and are most in need of ongoing professional support. This is contrary to the repeated recommendations of the Committee and the Veterans Ombudsman Office and ignores the fact that family is the most important protective factor against worsening mental health issues.

Preventing suicide among military members and Veterans requires a multidimensional approach that addresses trauma before it occurs. Untreated trauma is the primary cause of suicidality among Veterans. This makes it essential to adequately prepare military members for potentially traumatic situations. Several organizations have developed invaluable resources that help reduce stigma and promote early intervention.

Continuity of care for Veterans remains a major issue for fostering a smooth transition from military to civilian life. Fragmenting services among the CAF, VAC and Partners in Canadian Veterans Rehabilitation Services (PCVRS) undermines this continuity. It forces Veterans to repeatedly describe their trauma, which can needlessly retraumatize them and compromise their healing. Creating a unique identifier recognized by provincial and territorial governments would allow VAC to proactively and periodically follow up with Veterans.

Testimony and analyses reveal three major problems related to the transition: the loss of belonging to the military community, the break in continuity of care challenging the Veterans' sense of honour, and the bureaucratic complexity that places the burden of proof on them. To meet these three challenges, Veterans need: a rewarding personal or professional life plan, access to a family doctor, and quick responses to claims submitted to VAC.

The Committee is therefore reiterating the recommendation it has repeatedly made to not release military members until these conditions are met. The government rejected this proposal, blaming jurisdictional constraints and logistical costs. The CAF states that they must prioritize their operational needs. The Government of Canada must force the institutions involved to take a comprehensive approach to this impasse that, left unresolved, will render any other military member and Veteran suicide prevention efforts ineffective.

At this time, Canada does not have a suicide prevention strategy for military members and Veterans. What has been presented as the CAF/VAC joint strategy is at best a checklist with no measurable objectives. VAC and CAF officials described the wide range of initiatives in place. While essential, these initiatives do not constitute an integrated framework able to address the scale and complexity of the issue.

International examples, particularly the Australian experience, show that a coordinated national approach can yield tangible results in suicide prevention. In light of these findings, the Committee recommends that the Government of Canada develop a real military member and Veteran suicide prevention strategy. This could be part of a comprehensive national suicide prevention strategy in Canada. Adopting such a strategy

would represent a significant commitment toward those who have served our country, recognizing their sacrifices and providing them with the support they need.

It is with solemnity and respect that the members of the Committee, on behalf of Parliament, wish to express their deep gratitude to those who, despite the pain reignited by their testimonies, found the strength and generosity to share them with Canadians, thereby helping to inform our understanding and the actions that will result from this report.

APPENDIX A:
LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

Organizations and Individuals	Date	Meeting
Department of National Defence	2025/10/02	4
MGen Scott Malcolm, Surgeon General, Canadian Armed Forces		
BGen Serge Ménard, Commander, Canadian Armed Forces Transition Group, Canadian Armed Forces		
Department of Veterans Affairs	2025/10/02	4
Cyd Courchesne, Director General, Health Professionals and Chief Medical Officer		
Dr. Amy Hall, Senior Epidemiologist		
Steven Harris, Senior Assistant Deputy Minister, Service Delivery		
Atlas Institute for Veterans and Families	2025/10/07	5
Gabrielle Dupuis, Director. Research Partnerships and Government Affairs		
Fardous Hosseiny, President and Chief Executive Officer		
Veterans Association Food Bank	2025/10/07	5
Marie Blackburn, Executive Director		
Veterans Transition Network	2025/10/07	5
Oliver Thorne, Chief Executive Officer		
Wounded Warriors Canada	2025/10/07	5
Philip Ralph, Captain (Retired), Director Clinical Services		

Organizations and Individuals	Date	Meeting
As an individual	2025/10/09	6
Sherri Elms		
Margit Simon, Transition Trainer, Canadian Armed Forces Transition Group		
Ashley Thompson		
Chronic Pain Centre of Excellence for Canadian Veterans	2025/10/09	6
Hélène Le Scelleur, Captain (Retired), Vice-Chair, Centre of Excellence Advisory Council for Veterans		
Homes for Heroes Foundation	2025/10/09	6
Brad Field, President		
As an individual	2025/10/23	8
Judith Hills, Corporal and Aviation Technician, Canadian Armed Forces		
Jessica Ruth		
Noémie Veilleux, Licensed Sexologist and Policy Consultant		
Canadian Mental Health Association - Alberta Division	2025/10/23	8
Robert Olson, Research Librarian		
SM Sansouci, National Government Relations Lead		
As an individual	2025/10/28	9
Kenneth Bennett, Warrant Officer (Retired)		
Shaun Fynes, Retired Chief Security Officer for the Government of British Columbia		
Christine Gauthier, Corporal (Retired)		
Brendan Hynes		
Kelsie Sheren, Mental Resilience Expert		
United Federation of Canadian Veterans	2025/10/28	9
Diane Hill Rose, Peer Support Advocate		
As an individual	2025/10/30	10
Marc-André Bernard, Psychologist, Institut Alpha		
Shane Nedohin, Farmer		
Samara Symonds		

Organizations and Individuals	Date	Meeting
Canadian Institute for Military and Veteran Health Research	2025/10/30	10
Dr. Nicholas Held, Interim Scientific Director		
As an individual	2025/11/18	12
David Bona		
Marie-Noël Duhaime		
Gordon Hurley, Veterans Mental Health Advocate		
Justin McKay, Veteran		
Darren Simons		
Seven Edge Success Inc.	2025/11/18	12
Ernie Wouters, International Trauma Specialist and Consultant		
As an individual	2025/11/20	13
Amanda Hatcher		
Mark Meincke, Corporal (Retired) and Host, Operation Tango Romeo, Trauma Recovery Podcast for Military, Veterans, First Responders, and Their Families		
Ben Wadham, Professor, Flinders University and Director, Open Door Initiative		
Chronic Pain Centre of Excellence for Canadian Veterans	2025/11/20	13
Cameron Kowalski, Sergeant (Retired), Director of Operations		
Dr. Ramesh Zacharias, President and Chief Executive Officer		
Department of Veterans' Affairs, Government of Australia	2025/11/20	13
Jonathan Lane, Chief Psychiatrist		
As an individual	2025/11/25	14
Amanda Anderson		
Michel Marceau		
As an individual	2025/11/27	15
Dr. Denise M Brend, Assistant Professor, Université Laval		
Stephen La Salle		

Organizations and Individuals	Date	Meeting
The Trail – Transition Housing Inc.	2025/11/27	15
Chloé Deraiche, Executive Director		
LCol (Ret'd) Bruno Plourde, CD, Founder and Administrator		
Toronto Police Service	2025/11/27	15
Cst Aaron Dale, Program Coordinator, Military Veterans Wellness Program		
As an individual	2025/12/04	17
James Grant, Emergency Medical Responder		
Centre for Addiction and Mental Health	2025/12/04	17
Dr. Allison Crawford, Psychiatrist and Chief Medical Officer, 9-8-8 Suicide Crisis Helpline		
Dallaire Institute for Children, Peace and Security	2025/12/04	17
Kathryn Reeves		
Dr. Shelly Whitman, Executive Director		
The Veteran Hunters Canada Ltd.	2025/12/04	17
Todd Hisey, Chief Executive Officer and Founder		

APPENDIX B: LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's webpage for this study.

AfterGlo Wellness Society Ltd.

Anderson, Amanda

Anonymous Author

Assembly of First Nations

Banks, Christopher

Bernard, Marc-André

Breeck, Karen

Canadian Mental Health Association - Alberta Division

Cox, Vicky-Lynn

Dallaire Institute for Children, Peace and Security

Mood Disorders Society of Canada

Olivier, Robert

Project Life Spark Inc.

Richardson, Christopher

Rovak, Anna-Lisa

Seven Edge Success Inc.

Smith, Jennifer

The Trail – Transition Housing Inc.

Veilleux, Noémie

Wood, Christine

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 4 to 6, 8 to 10, 12 to 15, 17, 24, 25 and 29) is tabled.

Respectfully submitted,

Marie-France Lalonde
Chair

Supplemental Report: Conservatives Call for Action to Support Veterans and their Families with Regard to Suicide Prevention

During the study on Suicide Prevention in the Standing Committee on Veterans Affairs, there were many reoccurring themes heard from survivors, family members, and experts on how to address the epidemic of suicide that is affecting our veterans. While the committee report touches on several of these areas, Conservatives would have liked to have seen more specific recommendations to the government based on testimony heard during the study.

Additionally, there were many witnesses who reached out to the committee disappointed that they did not have a chance to appear or contribute to the study and many of them had valuable perspectives and experiences to add which we would like to reflect within this supplementary report.

There are few other issues affecting the veterans community that are as grave as suicide and suicide prevention and therefore it is incumbent that the Liberal Government take the recommendations of the committee report and the accompanying supplemental reports seriously and not just agree in principle, but take concreate action to implement the changes that will quite literally save lives.

Sanctuary Trauma

The most common reoccurring theme throughout the study was that of “sanctuary trauma”. While it was referenced in the committee’s report to the House, Conservatives want to really draw attention to this factor affecting suicide rates because it is entirely preventable. This unique form of trauma is caused through perceived or realized institutional betrayal when a veteran or their family seeks help but does not receive it. Most commonly this took the form of Veterans Affairs Canada refusing to approve claims for mental health support or abruptly ending support for veterans and their families, even during their time of need.

There are concrete actions that VAC can take to minimize the possibility of inflicting sanctuary trauma upon veterans and their family members. At a minimum, they can take action to address the growing backlog of claims within the department, which has nearly doubled in size since March 2025. The burdensome process of navigating VAC in search of help or support directly contributes to the sense of hopelessness and betrayal during their most vulnerable times and can sometimes be enough to drive a veteran towards suicidal feelings of hopelessness. Not only is this entirely unacceptable, but it is also completely avoidable.

When someone is dealing with depression and suicidality, they need access to immediate and compassionate care, not long and uncaring bureaucratic processes and questionnaires. Many tragic testimonies were shared of veterans who in their time of need were lost in a sea of paperwork and processes before losing their battle with suicide.

Independent Family Care

Another issue that was mentioned in the committee report was that of independent family support. The report rightfully points out how many times over the years the Standing Committee on Veterans Affairs has recommended more support for veterans families and how each time it has been ignored by the Liberal Government including several committee reports with specific recommendations to take action in this area. It is for this reason that Conservatives draw more attention to this crucial position because the Liberal Government has been ignoring the committee, veterans and their family members requests for too long now.

Tragic testimony was heard of military spouses and family members who were receiving mental health support by virtue of being immediate family to a veteran, being cut off of this support in the aftermath of losing their loved one to suicide.

This cruel practice perfectly highlights the worst of the "administrative state" where bureaucrats coldly address human tragedy with a rigid application of policy. This process prioritizes policy and cost saving over veterans and their families and has dire consequences.

Therefore, as the committee has acknowledged several times before, military family members are vital to the support and well-being of those who served and properly supporting them directly impacts the well-being of a veteran. It is of vital importance then that these sentiments are backed by more than just platitudes, but with action, with policy that allows immediate family members of veterans to access mental health support independent of their veteran spouse/parent/child. Addressing this would prevent anymore situations like the ones brought before the committee of spouses and family members receiving a call from VAC in the aftermath of their devastating loss to be told they are being cut off from help.

More Long-Term Care Support and Faster Approval for Prolonged Care

It would appear through the various witnesses who contributed to the committee study that there have been good strides made in suicide awareness and prevention at an immediate level. We have come a long way over the past few decades to educate the public about suicide and what can be done when someone is struggling with suicidal ideation. From this many programs, help lines, and organizations have been established meaning that someone who makes a plea for help concerning suicide can often be reached and secured quickly.

The problem is that past this initial point of contact, very little exists to carry on the healing process. Many stories were heard of veterans who several times reached out for help and were immediately met and taken to the hospital but then released – sometimes without even seeing a doctor – and told to follow up on their own with a mental health professional. This happened sometimes up to a dozen times until the veteran was lost to suicide.

These instances highlight a gap beyond initial care/reaction where most people are able to take the first step to help, but then afterwards the veteran and their family are often right back where they started within the same week. While the initial reaction has improved over the years, it is not enough to stabilize someone and help them address their needs.

Veterans who require prolonged psychiatric care are often waiting for several months of paperwork, assessments and approvals before they can be considered for it. That is far too long for someone who is actively suicidal to wait and tragically many don't have months of time left waiting for paperwork and questionnaires to be processes.

VAC needs to implement better processes to enable veterans seeking prolonged care for mental health reasons to get into the care that they desperately need when they are at their most vulnerable.

MAID

Perhaps most egregiously, was during the course of the study on preventing suicide, many veterans raised concerns and stories about Veterans Affairs Canada still offering Medical Assistance in Dying to veterans, including those who were seeking help and not death.

With the many witnesses mentioning the issue of MAID still being offered to veterans, we believe it should have been reflected in the report that this issue does not seem to be put to rest, and that the Liberal Government's internal review/investigation of the situation has not convinced veterans, especially since there have been new revelations of payouts/lawsuits that have happened since the scandal. Additionally, the one staff member who was supposedly the only member of the Department offering MAID was a female, while many witnesses said they were offered MAID by Male case managers/VAC staff.

These reports from veterans deserve to be taken seriously and must be thoroughly examined as the Parliamentary Secretary for Veterans Affairs mentioned:

""I expect that you're aware that Medical Assistance in Dying and counselling medical assistance in dying is not, has never been, and never will be a practice or a policy of the government of Canada. You have indicated that you know of 6 people who have been offered medical assistance in dying. The Government of Canada wants to investigate that and make sure that to the extent that these instances are substantiated that they are dealt with because they are completely contrary to government policy. If there is anything you can do, sir, to urge the sources of this information to come forward to anyone on this committee, to the Minister's office, to the Ombud's office, please do. We want to know, we want to investigate it, we want to get to the bottom of it. If it is an indicator of a more systemic problem than what we know about then we want to deal with it."

Conservatives agree with this sentiment that the issue of veterans being offered MAID – especially in light of all the damage caused by sanctuary trauma – should be chased down and

investigated relentlessly to ensure no veterans are being harmed by the Government of Canada. In fact, there are even legislative efforts currently underway such as Bills C-219 and C-260 which seek to address the grave concerns surrounding MAID in Canadian society as this is still an issue of concern for all veterans and Canadians alike.

Helping Veterans in Crisis

There were many witnesses who mentioned that the topic of suicide must be viewed holistically – where other comorbidities must be considered. For example, it is difficult to treat someone in mental health crisis when they also suffer from substance abuse issues or homelessness. It goes much further to stabilize the foundational aspects of their lives as far as food and shelter goes before, they can be properly treated. We believe it should be reflected in the report that other issues in Canadian society are adding to the crisis of veterans' suicide – issues such as homelessness/housing crisis, food insecurity, drug addiction, etc.

This was reflected in quotes such as from expert witness Ben Wadham who said:

"…we may have mental health issues, but if we can get employment, education, housing, mobility, identity, purpose and belonging right then that is a major preventative issue for veteran's suicidality."

It is common sense that any program aimed at suicide prevention will not be effective if the veterans it seeks to help are living on the streets, addicted to drugs, or living on the razor's edge unable to afford adequate food or shelter. Treatment requires stability and the issue examined in this committee study made it exceptionally clear – suicide prevention must be viewed holistically.

Another angle in this regard comes from witness testimony that revealed cases where a veteran in crisis and struggling was prescribed a wide array of medications including SSRIs that often-caused worse side effects as they were mixed. This comes partially from the lack of continuity of care where policies at VAC force veterans to change service providers in some cases and also from an over reliance on "quick remedies" such as making a quick prescription for veterans suffering from PTSD, depression, or suicidality, with no thorough follow-up or investigation into their medical history.

Witness Judith Hills recounted an example of this when she said:

"The medications Sam had been prescribed were not even discussed in the BOI. Wellbutrin has long been known as a drug that can cause both nightmares and hallucinations. Rather than weaning him off the drug, he was instead prescribed Latuda, the antipsychotic, as an addition to the two antidepressant drugs he was already taking. The psychiatrist who saw Sam just days before he died did not prescribe the drug. Somebody at the MIR did, and did not consider the contraindications of mixing these three drugs together.

After he died, I spoke with a pharmacist and asked if it was safe to prescribe all three at once. He said, no, not unless the patient is in hospital and is under observation. Sam was not even on sick leave, let alone under any kind of observation."

Therefore Conservatives feel like there should have been more done to convey the issues around a system that has a lack of due diligence to ensure veterans in crisis are actually receiving proper care and not just quick patches which may prove more dangerous in the end when improperly administered.

Recommendations

In light of these under addressed issues of sanctuary trauma, independent family supports and more long-term care, and MAID Conservative members of the Standing Committee on Veterans Affairs are proposing the following recommendations:

- That the Government acknowledge the fact that their practices and burdensome procedures result in sanctuary trauma in the veterans who they are supposed to serve and that they need to do more to ensure veterans receive the help they need.
- That the Department of Veterans Affairs issue an official apology to the veteran's community in Canada for causing undo stress and harm through sanctuary trauma and commit to doing more for veterans.
- That this committee call upon the government to adopt the Military Veterans Wellness Program nationally to ensure veterans in crisis can be met where they are by individuals trained to work with them during a crisis.
- That the Department of Veterans Affairs Canada establish case managers specifically to serve family members of veterans.
- That the Department of Veterans Affairs Canada commit to providing veterans' family members with mental health benefits and support that are not contingent on the veteran themselves.
- That the Department of Veterans Affairs and the Department of National Defence work to establish continuity of care so that veterans and their family members do not need to change their health care providers when transitioning out of the military.
- That the Government do more to ensure an immediate approval process for medium to long term mental health care for veterans who are experiencing mental health crisis.
- Recommend that all members of the Primary Reserve Force, including part-time members, can access full mental health supports.
- That this committee express to the House the importance of supporting Bill C-260 which seeks to legislate safeguards against public servants continuing to offer MAID to veterans and Canadians seeking care.

- That the Government work with opposition parties to establish an extra-governmental investigation into the Department of Veterans Affairs to assess whether or not Veterans are still being offered MAID by government bureaucrats.
- That the Government communicate clear and strict consequences to any bureaucrat offering MAID to veterans who are seeking help from the Department of Veterans Affairs.
- That the Government do more to address homelessness in the veteran's community and commit to identifying homeless veterans to ensure they can receive the benefits and services they are entitled to.
- That this committee call on the Government end its pro-drug policies which are harming veterans and costing Canadian lives by providing opioids and drug paraphernalia rather than mental health support for veterans living with addiction.
- That this government commit to ensuring veterans have more access to housing and peer support programs rather than just prescribing them medications with no follow up or plan for addressing their mental health.
- That this committee denounce the change in indexing of veterans' pensions which will make them more susceptible to the cost-of-living crisis.
- That this committee denounce the cuts being made to the Bureau of Pensions Advocates which will set back veterans' cases by several years and directly contribute to sanctuary trauma.
- That the Government of Canada direct Health Canada to review the safety and oversight of psychotropic medication (SSRIs) prescribing for Canadian Armed Forces members and veterans, including the prevalence of multi-drug regimens, potential links to suicide risk, and the adequacy of monitoring and investigation following adverse outcomes.
- That this committee condemn the hypocritical actions by the Liberal Government which is using legislation to retroactively define legal definitions to avoid paying back veterans in long term care homes the money they were over charging them while they simultaneously send out hundreds of repayment letters to veterans.

Conclusion

Conservative members of the Standing Committee on Veterans Affairs would like to thank all of those brave individuals who had the courage to come forward and share their painful experiences. It is these brave acts that arm us with the knowledge to address the gaps that changed your lives forever. We acknowledge the difficulty of reliving those harrowing days of loss and heart break, but with these stories and knowledge we aim to implement change so that future veterans and their families may get the help they need in time. Your appearance and contributions were not in vain, and we sincerely thank you for making the effort to help others.

It is for this reason that we strongly believe that the study on suicide prevention needed to be stronger on the aforementioned topics and that the voices and experiences of those who did not receive a chance to appear for the study should also be reflected and shared.

It is the aim of this supplemental report to address the shortcomings of the committee report and give a voice to all those who contributed or offered their experience and solutions because every single one of them contained valuable information that may one day save a life and a family.

There is a lot to be done on this issue, but to start the Department of Veterans Affairs and the Government of Canada need to do serious work to restore the broken trust between them and veterans. After cutting billions in funding to veterans, retroactively changing legislation to avoid compensating disabled veterans they have been over charging, or reducing disability pensions, the Liberal Government has a poor track record when it comes to building trust with our national heroes.

To begin to repair this situation, VAC needs to address its outdated and inefficient systems that are causing stress and trauma to the vulnerable veterans who are left on their own to navigate the bureaucratic mess. VAC needs to immediately investigate and chase down any claims of their staff offering MAID to veterans and the Government of Canada needs to reign in its inflationary policies which are seeing more veterans than ever before standing in lines at food banks and living in their cars.

These changes address some of the basic destabilizing concerns that affect all veterans, but may be the difference for a veteran pushed to their limits and suffering with suicidal ideation. Policy has real impacts on real people and right now they are suffering. It is also the family members of veterans who suffer from these poor policies and struggles and therefore the Liberal Government MUST take immediate action to ensure immediate family members to veterans can receive mental health support independently of their veteran family member so that no more cruel experiences need to happen where a grieving family is called just days after losing their loved one to be told they are being cut off. We are Canadians and we are better than that cold, rigid, bureaucratic tyranny.

Lastly, while significant gains have been made when it comes the immediate reaction and actions for someone who is suicidal, more needs to be done to ensure that prolonged psychiatric care is available for someone suffering from suicidality or who has attempted to take their life. It is inexcusable to hear stories of veterans who check themselves into hospitals a dozen times only to be held for 48hrs then released with no support. It is unacceptable that these folks who are pleading for help are subjected to administrative processes which take months to approve from VAC for prolonged care. We know these veterans needed help, they told us – its time to start believing them.