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Chair

Mr. Ben Lobb

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen. We're following up on our study and have two panels today. We're going to get right into it.

Go ahead, Mr. Young.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

I'd like to ask the committee for unanimous consent to move a motion with regard to a follow-up report that the Canadians for Safe Technology attempted to get in on time to be included in the analysis of our evidence, but missed the date. The motion would be that the analyst be allowed to include that in preparing her report for the committee.

The Chair: Is everybody clear on what Mr. Young is asking?

Do we have unanimous consent for that?

Go ahead, Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I just have one question for the analyst. I just wanted to make sure this is not going to impede her ability to do the analysis and still get her report done on time. I just wanted to check that one piece with her.

Ms. Marlisa Tiedemann (Committee Researcher): I haven't seen the document. I don't know how long it is, but my goal is still to meet the deadline.

The Chair: Making sure of our procedure, now that it is on paper, how do you want to vote on this? Do you want a show of hands or do you want to go member by member? What do you want to do?

An hon. member: A show of hands—

The Chair: Is everybody in favour of a show of hands?

Some hon. members: Agreed.

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: The motion is carried and the analysts are clear on what they have to do.

That's about the shortest business we've had in probably two and a half years, or maybe four years. It was most efficient, for sure.

We have three guests here now.

Mr. Phelps, you can go first.

Mr. Fred Phelps (Chair, Public Affairs Committee, Canadian Alliance on Mental Illness and Mental Health): Thank you, Mr. Chairman.

Thank you for the opportunity to present to this committee. My name is Fred Phelps. I'm the executive director of the Canadian Association of Social Workers. The CASW is a proud organization in the Canadian Alliance on Mental Illness and Mental Health, better known as CAMIMH. It is on CAMIMH's behalf that I present to you today.

CAMIMH is a non-profit organization comprising 16 national health care providers as well as organizations that represent individuals with lived experience of mental illness. It would be remiss of me not to acknowledge today that both the CPA and the Mood Disorders of Canada organization are also members of the Canadian Alliance on Mental Illness and Mental Health.

Established in 1998, the alliance provides collaborative national leadership to assure that individuals living with mental illness receive the services and supports they require for recovery. CAMIMH also advocates for government policies aimed at reducing the impact of mental illness on the Canadian population and economy, a negative impact estimated at more than $50 billion annually or almost 3% of GDP.

Our coalition's members span the entire spectrum of mental illness and care in Canada, representing patient groups and professional service provider organizations such as my own. As such, we have a unique and strong voice for the one in five Canadians living with mental illness and, more often than not, without adequate access to services to address those illnesses.

CAMIMH was exceptionally pleased with the recent announcement in Budget 2015 that the mandate and funding of Canada's Mental Health Commission would be extended for a further 10 years to 2028. The Mental Health Commission of Canada played the leading role in developing Canada’s first national mental health strategy. CAMIMH advocated for the establishment of the Mental Health Commission of Canada and has long pushed for its mandate to be extended beyond the originally funded 2017-18 timeline.

CAMIMH and its members look forward to engaging with the government, the Minister of Health and, indeed, this committee on establishing the terms and objectives for the second decade of the Mental Health Commission of Canada's mandate. Though we all agree that there has been much talk about mental health and mental illness in recent years, which is undeniably a good thing, what is needed now is to shift from talking into action. Moving from awareness to action means investments in policy development and, yes, financial resources dedicated to ensuring these vital objectives are met.

Today I am here to present four recommendations on behalf of CAMIMH.

First, as per recommendation 3.1.1 of the national mental health strategy, we would like to see a mental health innovation fund established at the federal level in the amount of $50 million to help foster and disseminate best practices currently taking place across the country.

While we know there are many pockets of excellence when it comes to providing Canadians with access to leading-edge innovative mental health services and programs, the reality is that there's a lack of national coordination and resourcing to ensure that they spread across the health system effectively and equitably. Though the delivery of health care services is largely a provincial and territorial responsibility, CAMIMH knows there is a catalytic role for the federal government to play when accelerating and adopting those proven innovations in mental health.

Secondly, to provide the leadership on workplace mental health, we recommend that the federal government implement the Mental Health Commission of Canada's national standard for psychological health and safety in the workplace—the standard—in a major federal department. In our view, the standard can play an important role in improving overall workplace health and increasing productivity.

While the standard is currently piloted by a number of public and private organizations under the auspices of the Mental Health Commission of Canada, our hope is that it will be widely adopted by public- and private-sector employers across the country. As the country's biggest employer, the federal government should lead the way. While the standard does not expressly address the needs of those working with mental illness, it does support a workplace environment in which all people can work to the best of their abilities.

Our third recommendation concerns the measurement and evaluation of mental health systems in Canada as a basis for improving quality. In the area of mental health, we need a set of system performance indicators to effectively assess and improve the performance of Canada's mental services and systems.

At present, there are no agreed-upon mental health indicators that provide a clear picture of how mental health systems are performing, particularly in terms of measures of access to and the appropriateness and outcomes of services. Additionally, where data is available, it focuses on acute care hospitals, and not community programs and services. This is unfair to people who need and receive services in communities, in the venues where many of Canadian mental health problems are most effectively treated and where, unfortunately, services are insufficiently covered by public and private health insurance plans.

● (1535)

While we are pleased to see that important work has been initiated in the area of mental health indicators and expenditures by the Mental Health Commission, the Public Health Agency of Canada, and the Canadian Institute for Health Information, work on mental health performance indicators needs to be advanced as a national priority to ensure accountability and results. CAMIMH is of the view that the federal government, working in close partnership with the provinces and territories, can play a groundbreaking role in terms of developing the national mental health performance reporting and quality improvement initiatives.

Finally, though health care delivery is constitutionally a responsibility of the provincial and territorial governments in this country, there are several large and under-serviced groups for which Ottawa is directly responsible—veterans, first nations, and RCMP members, to name a few.

Our final recommendation is to establish and implement a mental health strategy to better provide services to the populations for which the federal government has direct responsibility. Recognizing that the populations for which the federal government is responsible face unique mental health challenges and that the services currently provided are inadequate, the government has an opportunity to lead by example by providing a more robust set of mental health services to these groups, and can help demonstrate that in the long run, enhanced investment in mental health pays fiscal and economic, as well as social and human, dividends.

Our needs are great, but so are our resources. Canada is one of the most prosperous and fortunate nations on earth, yet too many of our citizens lack the mental health services they need. Increasing the availability of these services is a social and economic imperative we can no longer afford to ignore.

Thank you for your time. I look forward to any questions you may have.

The Chair: Thank you very much.

Next up is the Canadian Psychiatric Association.

Mr. Carr or Mr. Brimacombe, go ahead.

Dr. Padraic Carr (President, Canadian Psychiatric Association): Good afternoon, Mr. Chairman, and thank you for the opportunity to present to this committee.

My name is Padraic Carr and I am the president of the Canadian Psychiatric Association. I'm joined by Mr. Glenn Brimacombe, the CEO of the CPA.

The CPA is the national voluntary professional association for Canada's 4,700 psychiatrists and 900 residents, and is the leading authority on psychiatric matters in Canada. As the national voice of Canada's psychiatrists, the CPA is dedicated to promoting the highest quality care and treatment for persons with mental illness, and advocates for the professional needs of its members by promoting excellence in education, research, and clinical practice.

The CPA is pleased to see that the standing committee has identified mental health as an issue that requires study from the perspective of the federal government's roles and responsibilities.

While the organization, delivery, management, and funding of health care is largely, but not exclusively, a provincial and territorial responsibility, the CPA shares the view that there are a number of important ways in which the federal government can play a strong leadership role in advancing the mental health of Canadians.

First, let me begin by applauding the federal government for its commitment in Budget 2015 to renew the mandate of the Mental Health Commission of Canada, beginning in 2017. While more discussion is needed to clarify the strategic objectives and outcomes of its mental health action plan, the CPA looks forward to building on the commission's impressive track record of achievement.

We know there is a significant amount of time, energy, and resources invested in developing the commission's mental health strategy, “Changing Directions, Changing Lives”. It should be viewed as an important document that provides a road map in addressing the mental health needs of Canadians.

Over the course of the commission's current mandate, it has developed a series of projects that look to reduce the stigma of mental health—for example, the opening minds project and the mental health first aid initiative— to improve workplace mental health through the National Standard of Canada for Psychological Health and Safety in the Workplace, and to develop a set of pan-Canadian metrics to better view and understand the mental health of Canadians, to name a few of the projects.

Combined, these and other initiatives are essential in moving forward when it comes to improving our collective mental health. While these efforts are necessary, they are not in and of themselves sufficient. More can and must be done to deepen the impact of the commission's strategy and to strengthen the role of the federal government.

There are four elements that can impact the work of the federal government and the MHCC. We need to adopt evidence-based innovations; we need better integration of services; we need to evaluate how the system is performing; and we need adequate funding to make that work.

While one may be tempted to think that the answer to those four elements lies with the provinces and territories, the reality is that there is a substantial leadership role for the federal government to be an active partner, facilitator, and collaborator.

One area where the federal government, through the commission, has played a clear leadership role is with the At Home/ Chez Soi program, which proved to be a sound investment for those who are homeless and suffering from mental illness. Given the savings that were generated for those with high and moderate needs, there is an opportunity for federal leadership to move beyond a pilot project and to expand the project across the country on a sustained basis.

To make this happen, those four elements of innovation, integration, evaluation, and funding must be addressed.

When it comes to mental health and stigma, we know the adverse effects of stigma on those with mental illness have been well documented. They include delays in seeking treatment, early treatment discontinuation, difficulty in obtaining housing and employment, and adverse economic effects. Stigma has been described, actually, as the primary barrier to treatment and recovery. Stigma is a well-documented obstacle to receiving adequate medical care and is only one factor in diminished life expectancy.

While the Mental Health Commission of Canada has made some important inroads through its opening minds project, more needs to be done.

Finally, I would like to turn to the role of research dissemination and best practices for mental health care and suicide prevention. As an evidence-based profession, psychiatry relies on access to the latest research and best practices as they apply to our clinical decision-making process. ln that regard, the Canadian Psychiatric Association plays a very important role in having a number of vehicles to ensure that our members have real-time access to clinical information through our peer-reviewed journal, continuing professional development courses, and at our annual conference.

● (1540)

As we think about how we can improve the sharing of timely clinical information with providers, the CPA is well positioned to assist the government in its study.

At the same time, though, there are other important collaborative opportunities to consider. The CPA is a founding member on the Canadian Alliance on Mental Illness and Mental Health, CAMIMH, and there are various unique opportunities to reach a broad range of mental health providers and those with lived experience.

From a provincial and territorial perspective, there are opportunities to better leverage the work of the Council of the Federation's health care innovation working group. Similarly, we work in closer strategic partnership with those national health agencies whose mission is focused on the provision of quality health care. For example, here I include the Canadian Institutes of Health Research, the Canadian Institute for Health Information, Statistics Canada, the Canadian Agency for Drugs and Technologies in Health, the Canadian Foundation for Health Innovation, and the Canadian Patient Safety Institute.

There are opportunities for these agencies to collaborate more effectively when it comes to focusing on the different dimensions of quality, which include access, appropriateness, cost-effectiveness, and patient and provider satisfaction.

Another way to spread leading practices would be to create a time-limited, issue-specific, and strategically targeted mental health innovation fund. Such a fund would look to invest in proven innovations that have had success in improving access, quality, and health outcomes.

ln closing, Mr. Chairman, some very important, positive steps have been taken by the federal government. However, there are other opportunities that should be considered to improve the mental health of Canadians.

lt's time to see greater parity between resources devoted to physical and mental health. The federal government can play a critical role. As the national voice of psychiatry, we look forward to working with you and others in findings innovative and sustainable solutions that put Canadians first.

Thank you.

● (1545)

The Chair: Thank you very much.

Next up, Mr. Gallson

Go ahead, sir.

Mr. Dave Gallson (Associate National Executive Director, Mood Disorders Society of Canada): Thank you very much. Thank you for the invitation for the Mood Disorder Society of Canada to present at this very important committee.

My name is Dave Gallson. I am the associate national executive director for the Mood Disorders Society of Canada. I have to give my regrets for my colleague, Phil Upshall, who is unable to attend with me here today.

I know that many of you are already familiar with what our organization does and the role we play in mental health care, but I'll just begin by providing a bit of background.

We're a national, not-for-profit, consumer-driven, voluntary health charity. We are committed to ensuring that the voices of persons with lived experience, family members, and caregivers are heard on issues related to mental health and mental illness, particularly when it comes to depression, bipolar illness, and other associated mood disorders, as well as PTSD and suicide.

MDSC was formally launched and incorporated in 2001 with the overall objective to provide people with mood disorders a strong, cohesive voice at the national level to improve access to treatment, inform research, and shape program development and government policies to improve the quality of life for people who are affected by mood disorders. Over the past 15 years, MDSC has been a dedicated and effective leader in efforts to revamp and improve health care on a national basis.

We partnered with the Public Health Agency of Canada to produce the first report on mental illness in 2002, as well as a second report in 2006, “The Human Face of Mental Health and Mental Illness in Canada”. We aIso played an important support role as a key resource to the Standing Senate Committee on Social Affairs, Science and Technology, which was chaired by Michael Kirby and the Honourable Marjory LeBreton. The committee's report, “Out of the Shadows at Last”, resulted in the current government's creation of the Mental Health Commission of Canada.

As a proven and trusted partner to the Government of Canada when it comes to helping Canadians who are affected by mental illness, MDSC is ideally positioned to share our experience and knowledge with the Standing Committee on Health as it undertakes this national study on mental health in Canada. There are a couple of areas outlined in the study's framework where I believe our input could be particularly useful for the committee. I'm referring to section D, how to coordinate the efforts of stakeholders at the national level to improve care and best practices for mental health care and suicide prevention.

MDSC prides itself on our record of collaboration. We have developed programs and resources, and educational programs such as continual medical education programs with such organizations as the Canadian Medical Association, the Canadian Psychiatric Association, Bell, the Mental Health Commission of Canada, Corrections Canada, the Canadian Bar Association, the Canadian Nurses Association, regional health centres, and the list goes on and on. We are truly a strong collaborator in Canada.

We have just signed a new collaborative agreement for our national peer support program with the Public Service Health and Safety Association, which has 1.6 million members. Our national peer support program consists of 17 serving and ex-members of the military, RCMP, and regional police forces. They go across Canada and they teach police forces and organizations how to implement and set up a peer support program to support their members.

ln a major national initiative aimed at ensuring that the Canadian mental health and addictions systems respond collaboratively and appropriately to the unique needs of first nations, Inuit, Métis, and other persons with lived experience and their caregivers, MDSC and the Native Mental Health Association of Canada, with support from the federal government, launched “Building Bridges: A Pathway to Cultural Safety” in April 2009.

As part of this groundbreaking initiative, both national organizations and allied stakeholders across the country collectively developed a comprehensive planning framework on cultural safety that would allow programs and services to deal more effectively with major systemic issues and barriers such as labelling, discrimination, colonization—

The Chair: Excuse me, Mr. Gallson. I'm sorry to ask this, but could you slow down a little bit? They're having a tough time translating it as fast as you're saying it.

● (1550)

Mr. Dave Gallson: I'm sorry. I'd rather slow down, to tell you the truth. It's the seven-minute thing.

The Chair: Okay. We'll give you eight and a half now.

Mr. Dave Gallson: Perfect. Thank you very much. I appreciate that.

As I was saying, they collectively developed a framework that would allow programs and services to deal more effectively with major systemic issues and barriers such as labelling, discrimination, colonialism, racism, stigma, and discrimination in a planned and progressive manner in the years ahead.

ln terms of supporting other mental health organizations, we developed the only national multi-organizational mental health fundraising and anti-stigma and awareness campaign in Canada, called Defeat Depression. It is now taking place in over 55 locations across Canada and supporting local mental health organizations. As you will see by our extensive collaborations, we know that working collectively is the only way to move forward to address mental health and stigma in Canada.

Regarding the coordination of stakeholder efforts, MDSC strongly recommends that this committee consider selecting the Mental Health Commission of Canada as the principal national coordinator. Since the commission was created, it has brought a greater focus on the work of all mental health NGOs, professional health care associations, health care providers, and government departments. While each of the stakeholders has its own legitimate mandate and vision, the MHCC has demonstrated that it has the capacity and the community respect required to bring stakeholders together for a common cause.

The development of the mental health strategy for Canada has helped persuade all levels of government and Canadian society generally to pay greater attention to the huge economic and social burden of mental illness and to the benefits that positive mental health can have for Canadian society.

ln terms of research and the dissemination of findings, MDSC has helped pave the way nationally in the development of a national mental health research agenda, including the availability of statistics. For instance, MDSC was an active contributor to the discussion concerning the legislation that ultimately resulted in the then Government of Canada's creation of the Canadian Institutes of Health Research. MDSC's national executive director was an original member of the institute's advisory board, and MDSC was rewarded a CIHR partnership award in research for its various research activities associated with the institute.

ln Budget 2012 this government entered into a contribution agreement with the Mood Disorders Society of Canada to develop, in partnership with the Mental Health Commission of Canada and the Ottawa Royal's Institute of Mental Health Research, the Canadian Depression Research and Intervention Network, CDRIN. This is to develop a world-leading, patient-focused, engaged national research collaborative network, and we've now reached out to seven hubs across Canada with over 50 research institutions and community organizations involved in the network.

When it comes to the issues surrounding mental health care and suicide, this complex and devastating issue will require a multi-pronged approach involving all members of providers of care within all communities. We know that we are losing a person every two hours to suicide. We can't delay. By the time this meeting is completed today, another fellow Canadian will have taken their life.

As the members of this committee know, we have the experience, we have the will, and we have the reason to move ahead. Now we need to coordinate our approach, join our forces, and properly resource our efforts.

While we have come a long way in improving mental health care, there is still more that needs to be done, particularly in the areas of suicide prevention, the diagnosis and treatment of depression, and the diagnosis and treatment of PTSD. The benefits to the health care system and our economy are clear. As the government continues to position Canada for long-term success, it must aIso recognize and work with its partners to help alleviate social issues that impede our economic prosperity. Mental health issues, PTSD, depression, and suicide in particular, are three areas that must continue to receive attention and support as public policy is developed.

Once again, MDSC is grateful to this committee and wishes to work with you closely as we move forward.

Thank you.

The Chair: That's great. Thank you very much.

The first round of questions is going to be from Ms. Moore.

You're going to get those questions in French, so if you need to put your earpiece in and do a test run just to make sure that you're hearing what you want to hear, we can do that first.

Ms. Moore, do you want to test that out?

[*Translation*]

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you, Mr. Chair.

Is everyone who needs simultaneous interpretation able to hear me in English?

An hon. member: It's perfect.

● (1555)

[*English*]

The Chair: *Parfait*? Okay.

Carry on, Ms. Moore.

[*Translation*]

Ms. Christine Moore: I'm a nurse. Until recently, I worked in emergency and intensive care. I regularly saw patients with chronic or serious mental health problems requiring hospitalization. They were given appropriate care. Afterward, there was follow-up, and they consulted a psychiatrist during their time in hospital.

However, the situation is different for people with acute mental health problems who do not necessarily need hospitalization. Acute mental health problems can stem from adjustment disorder, a difficult event in one's life or other somewhat less serious situations. Being from a small region, I know that these people are often looked after by a family doctor or GP who provides emergency care.

Time is an important factor. Consultation and medication selection happen very quickly. I get the sense that, in many cases, that choice does not necessarily take side effects into account. Over the past 30 years, many new medications have come on the market. In 95% of cases, they're the same two molecules. In my region, citalopram and venlafaxine are the ones we see all the time. However, as everyone knows, compliance is one of the key factors here.

How can we take better care of patients whose cases are slightly less serious and ensure that they are prescribed medications with the least harmful side effects? How can we ensure that we are not neglecting people whose clinical situation is a little less serious than that of others?

[*English*]

Dr. Padraic Carr: You bring up three interesting areas in your question. One is about the training of professionals and who is most qualified to look after what type of patient. There's also the issue of patient access to resources, and the issue of patient compliance. I think all three are laudable objects of any study and, potentially, this study.

To answer your questions a little bit more in depth, in terms of the training of professionals, all medical doctors are trained in psychiatry. They all have training in the various medications and various other types of therapy, whether it's from a biological, psychological, or social model. All doctors should be able to do that. Sometimes the best follow-up for a patient is with their family doctor. Sometimes they have a relationship with their family doctor. If their doctor feels comfortable in those types of treatments, then that may be the best working relationship. Certainly psychiatrists are specifically trained to deal with mental illness and all of the different medications out there. Most family doctors are required to keep their continuing medical education up to date, so they should be aware of what medications are out there and the various options available.

I'm sorry that your experience is that sometimes there seems to be a lack of choice in terms of medications. I can't speak to that, but in general, family doctors are very well-trained professionals, as are psychiatrists.

In terms of access, that's an issue across the country. It's probably a bigger problem in rural areas than urban. That's been talked about by many groups. It's not a problem unique to Canada, either. The U. S. has exactly the same difficulties. Take my own hospital as an example. I work in a major hospital in a major city, and I will discharge patients from hospital. Even though I have a community practice, it's very difficult for me to see all the patients I admit. There is a problem with access in terms of who will follow up with the patient once they leave the hospital.

Access isn't limited just to psychiatrists. Psychiatrists more and more are working in multidisciplinary teams, and very often it's difficult for them to access the teams. Part of that is coordination. Part of that is a lack of funding, just not having the resources out there. In our city we have a really good mental health support team, but the waiting list to get into that team is still two months after you're discharged from hospital. That makes it very difficult.

Your last comment was on the issue of compliance. That's a separate issue. Many factors are related to compliance. It may include a patient's pre-existing ideas toward medication. It may include their family's ideas about medication. It may include what they've heard from other people. It may include the relationship with their treating professional in terms of whether or not the medication or treatment has been adequately explained. That's something that needs to be addressed as well. Compliance is a complicated issue. Again, that may be something that this study wishes to look at.

● (1600)

[*Translation*]

Ms. Christine Moore: I'd like to add something to that.

Sometimes I get the impression that when people have a chronic illness, such as schizophrenia, they get excellent care from a team, and all of the resources are deployed because those people have severe health problems.

However, if someone is having trouble coping after a separation and is not seen as needing hospitalization or is not a suicide risk, their case is treated cursorily and they're sent back home quickly. They're prescribed antidepressants after an assessment that lasts about 10 minutes. Their situation is not considered an emergency, and they're not considered to be in need of psychological follow-up.

There are still lots of people without a family doctor. Usually, people who don't have a family doctor are in good health and are not considered priority clients. A man in good health who goes through a separation at the age of 40 might not have a family doctor. I get the impression that it can be harder to provide care for less severe mental health issues because so many resources are allocated to severe cases and people who have many more problems.

Do you see that in your day-to-day practice?

[*English*]

Dr. Padraic Carr: First of all, I think resources are allocated differently in different jurisdictions. In my city, for example, for the type of patient you describe, the patient who is not severely mentally unwell and doesn't require hospitalization but really does need some kind of follow-up, there is actually that resource in my centre. The difficulty with it is the amount of resources that have been allocated to it. That's where we have the two-month waiting list, and it's for that type of patient you're describing, the one who needs some kind of follow-up care but not really the super intense care.

It's different. Different regions emphasize different points. So it really depends on which province you're in and where in that province your are the kind of follow-up care that is available to you. In some jurisdictions the type of care you're talking about does exist and is very good. In some jurisdictions it exists but there are long waits, and in some it doesn't exist at all.

The Chair: Thank you very much.

Next up for seven minutes, Mr. Albrecht. Go ahead.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you, Mr. Chair.

Thank you to all of our witnesses for being here today. I've had the privilege of working with all of your organizations over the last seven or eight years in different capacities in my work on suicide prevention, palliative care, and many of these initiatives that have been forwarded, and you've been very cooperative. All of your groups have been extremely helpful.

The one thing that I did notice in all of your comments was your commendation of the government for having extended its funding and support for the Mental Health Commission over the next 10-year period. I appreciate that because I do think, as Mr. Gallson pointed out, that it is the one single national coordinator and has the capacity and respect to bring stakeholders together.

Mr. Phelps, you mentioned in your opening comment, as you acknowledged the extension of funding for the Mental Health Commission, that now is the time for a call to action in addition to simply research. I would just like your opinion on two of the calls to action that I think the Mental Health Commission has done and is embarking upon. The first was the #308conversations that were engaged in by many parliamentarians and community people over the last year in many communities across Canada. I'd like your opinion on the effectiveness of their goal in reducing the stigma around mental health issues and suicide prevention.

Then, secondly, at the last meeting we had Louise Bradley from the Mental Health Commission here, who pointed out the second phase of an initiative developing a community-based model for suicide prevention. The model aims to adapt and implement an existing and effective suicide program to the Canadian context. It's now developed by Dr. Ulrich Hegerl, in a multi-level, community-based suicide prevention initiative that has been shown to be effective in reducing suicide by 24%. I think as committee members, as parliamentarians, this is our goal. We want to see action. We want to see measurable improvements in mental health and reductions in numbers of suicides and attempted suicides.

Could you comment, Mr. Phelps, and then I'll see if we have time for some of the other panel members to respond on those two questions.

● (1605)

Mr. Fred Phelps: Thank you very much for the questions.

Speaking on behalf of the Canadian Alliance on Mental Illness and Mental Health, CAMIMH has been very supportive of the #308conversations. I think that any movement in the sense of educating people about mental illness and mental health is useful, because we all need to be educated a little bit about that. Raising the level of understanding across the country and raising the level of understanding for our elected officials and bringing that to the community level, I think, is making a huge impact.

As well, I don't know and can't speak specifically to the community-based suicide prevention. But I know that, with regard to the Mental Health Commission of Canada's rolling out of national programs and national standards and looking to put those into an action plan, we're very supportive of that moving forward.

What we're discovering on the local level that as mental health has become something that we can talk about openly and can disclose in the workplace, there aren't the repercussions that there were 20 or even 10 years ago. However, sometimes there are barriers to accessing services on a local level when somebody discloses or feels he or she is in an environment, such as one with something like a #308conversation, where they can open up.

So, from a Canadian Alliance on Mental Illness and Mental Health perspective, it's about moving that to action, taking a national plan, and taking that national plan and applying funds, so that across the country we can apply those performance indicators for the best practices, lift the best practices from communities, and ensure that there is access across Canada. I think that's really the next stage for the Mental Health Commission of Canada.

Mr. Harold Albrecht: That might lead to another question. In your comments you also called, I believe, for a $50 million investment. Was that over a 10-year period?

Mr. Fred Phelps: It's five years.

Mr. Harold Albrecht: It's over a five-year period.

I guess my question on that would be this. With the amount of money that's been invested in mental health initiatives through many of the organizations we've listed, would that appear to be duplicated by other organizations? In other words, we're responsible for effective use of taxpayer dollars, for investing dollars in the Mental Health Commission of Canada. Then there's this other fund, $50 million. How far can we go in what appears to be, at least at first glance, duplication of efforts?

Mr. Fred Phelps: Yes. That's a very good point.

As the national government has provided national leadership in developing a national plan for mental health, each of the provinces and territories has really looked internally at how they're going to address that. At this point with the federal government, we're looking at a $50 million mental health innovation fund, a one-time five-year funding. In looking at those innovations, it's very similar to what At Home/Chez Soi has done in looking at leveraging those evidence-based best practices, so that the provinces and territories potentially could end up taking them on their own. However, the Mental Health Commission of Canada has a next step to be able to lift those best practices that are happening in the provinces and territories and ensure that they're spread out across Canada.

Mr. Harold Albrecht: Do I have a little more time?

The Chair: Yes, you have a minute-and-a-half.

Mr. Harold Albrecht: Dr. Carr, I want to follow up a bit the question by Ms. Moore about the person who may not necessarily have what we would call a classic mental illness but faces a sudden life reversal, whether that's a separation, the death of a spouse, their loss of a job, or myriad issues that will cause a temporary despair or loss of hope.

I've always felt that a large number of those who die by suicide probably have had continuing, ongoing, and perhaps prolonged mental health issues. But there are a number of times where it appears to me, as a non-professional in the mental health field, that people are just faced with insurmountable temporary issues and just lose hope in that context.

Do you have statistics to let us know what percentage of people would be in the category? Apparently they are totally healthy, and yet suddenly we hear that they snapped—to use that term—and something happens?

Dr. Padraic Carr: There are different rates of suicide, depending on psychiatric diagnoses. So, if we look at the totality of people who have committed suicide, it's estimated that about 90% of those will have suffered from a mental illness.

Mr. Harold Albrecht: A longer, ongoing....

Dr. Padraic Carr: Right, some type of mental illness....

So, it's really only 10% who do not.

As well, you'd think that people who commit suicide must be depressed, and it's only 80% of people who commit suicide who actually suffer from depression, as well.

● (1610)

Mr. Harold Albrecht: It's only 80%.

Dr. Padraic Carr: Yes, it's about 80%.

There are many illnesses that are associated with suicide. For example, it's estimated that about 50% of people with schizophrenia will attempt suicide at some point in their life, and 10% will actually succeed and eventually die by suicide. So the numbers are very high, and it's not necessarily just people who have depression.

Now, what you're talking about, I think, is the person who has faced an overwhelming stress and has been totally healthy his or her entire life prior to that. Very often those people can be suffering from what we call an "adjustment disorder". So, someone has a catastrophic reaction to a bad event and can be suicidal based on that.

There are resources in the community that do help with that. For example, local mental health care clinics are designed to address those types of scenario. So, there are resources available, too, for those people who don't necessarily have a chronic illness.

Mr. Harold Albrecht: I would like to point out that it's important that we don't lose sight of the fact that suicide prevention is not just a mental health issue but a public health issue and that it takes in the entire community.

Dr. Padraic Carr: You're absolutely right.

The Chair: We are way over time. We're going to have to take time away from Mr. Vaughan, we're so over time. No, I'm kidding.

Mr. Vaughan, seven minutes. Welcome to the committee.

Mr. Adam Vaughan (Trinity—Spadina, Lib.): Thank you very much.

Mr. Phelps, with the innovation fund you speak of, where would you see that best expanded and what programs do you think need investment?

Mr. Fred Phelps: I think, with the $50 million, we would be looking for that to flow through the Mental Health Commission of Canada, and CAMI would be looking at the expertise of the national plan and the action plan to move that forward.

Mr. Adam Vaughan: You cited housing first as one of the programs you helped form. I'm wondering if the housing component is one of the areas you focused that support on.

Mr. Fred Phelps: I think in this recommendation CAMI members were looking more at the mental health piece. At home/Chez Soi is looking more at concurrent disorders and then looking at social determinants of health. That's a larger upstream issue that I think needs addressing as well, but for this $50 million we'd be looking at lifting up best practices when it comes to addressing access to mental health services.

Mr. Adam Vaughan: In many centres, particularly in large cities, it's morphed more into a rent supplement program than it is a mental health or addiction service program. I'm curious as to what you think about the way in which the program has hit the ground and whether or not it is providing medical support for the afflictions that it's aimed at as opposed to simply providing shelter support for them. In other words, have the wraparound services arrived at the same time as the rent supplements?

Mr. Fred Phelps: I can't speak as an expert on each At Home program across Canada. I think in different programs the mental health piece may be stronger, but the backbone and the driver behind At Home/Chez Soi was the recognition that much of what was exasperating a person's mental health or mental illness issue was systemic, from poverty and not having the basic resources to be able to address mental health needs. By addressing the fundamental needs, the shelter and the food, they were able to have insight and manage their mental health illness.

Mr. Adam Vaughan: As a program, have you been able to figure out where the best practices are emerging, given that the program is present in many communities but is radically different from community to community? Is there a best practices assessment to see where patient outcomes were stronger as well as savings for other levels of government?

Mr. Fred Phelps: I have to look at my panel because I'm not aware of any in-depth research.

Dave.

Mr. Dave Gallson: I can talk a little about that.

There is a variety of best practices out there that are extremely well developed. What happens is that when programs are developed mental health and wellness have to be looked at as part and parcel of each other. Mental wellness is not just going to a psychiatrist or a doctor and getting a diagnosis that you're better again. It's a whole life spectrum. You have to have your employment. You have to have your volunteer. You have to have your family life. You have to be part of the community. All of that is meant to become wellness, and if you're missing parts of that, then you're missing part of your wellness.

I've worked with thousands of people with mental illness. I developed a program years ago that put back to work over 1,200 people who had been out of work for longer than three years. What I found was that if you give them some hope and give them some training and you get them a job, then they walk, they talk, and they live differently. They have a reason to go to sleep at night, they have a reason to get up in the morning, and it gives them something to look forward to.

I think when you take a look at the components of what wellness is, this innovation fund should be supporting those kinds of programs that are already created in communities across Canada and should be replicated because they have good health outcomes. That's my opinion anyway.

● (1615)

Mr. Adam Vaughan: I have one final question. You also talk about populations that the federal government has a direct responsibility for, and you didn't list immigrants. I know there has been a fairly important study out of CAMIMH in Toronto that looks at the fact that for the first time in our country's history immigrants are doing worse after five years in Canada than when they first landed. Even though we have the pick of the crop in terms of having a very aggressive immigration policy seeking out individuals with high skills and high levels of health, when they land in Canada, they do progressively worse because of lack of supports. I'm curious as to whether that federal population is being tracked, whether there are direct recommendations on how to attend to that issue, and what your assessment is of the study that discovered that.

Mr. Fred Phelps: Thank you for enlightening me about that study. I'm in the role of CAMI, so I'm not speaking on behalf of my own organization. In that sense, we wouldn't have a position or understanding, but our overall understanding would be that the federal government, whether it be with new immigrants, first nations, aboriginals, or the RCMP, use best practices to lead by example.

Our recommendation would be, if that is the case, the federal government should provide the services that could be the standard for which the provinces and territories have—

Mr. Adam Vaughan: So you have no problem with our reading into that "and immigrant populations and refugees coming to Canada".

Mr. Fred Phelps: If there's a direct responsibility of the federal government to provide services, then no, I don't think we'd be in opposition to that.

Mr. Adam Vaughan: Thanks.

The Chair: You have a minute and a half, if you'd like.

Mr. Young.

Mr. Terence Young: Thank you, Mr. Chair.

I thank everyone for coming today.

Dr. Carr, thank you very much for coming today. I wanted to talk to you about the relationship between medicines and suicides. We don't hear a lot about it.

Dr. David Healy, in his book *Let Them Eat Prozac*, believes that 25,000 suicides happened from patients being on Prozac, suicides that otherwise would not have happened over the period Prozac has been on the market. All antidepressants have very similar adverse effects. There's a list of about 200, including serotonin syndrome, which can be life threatening; nightmares; sexual dysfunction; psychosis; and about 190 others, including akathisia, which is described as when you feel so horrible that you want to crawl out of your own skin.

My concern is with suicides, particularly of young people, which rarely hit the media, because the media doesn't write about them for good reason—because they're afraid of creating a copycat. I hear about them, because I worked on drug safety for years. In my own town of Oakville, there was a 15-year-old girl who lay down on the GO tracks with her puppy. Her mother is quite sure that she changed a lot and believes that the antidepressants her daughter was on caused that.

Sara Carlin, who took Paxil for three months, quit everything she did. She was captain of her hockey team. She had a job. She was at Western University. She went downhill, including substance abuse. Then she came home and hanged herself at three o'clock in the morning after taking her makeup off—a very violent and relatively rare form of suicide, especially for a woman.

Brennan McCartney was 24 years old. He was depressed because he had split up with his girlfriend. The doctor gave him a free sample of Cipralex, so he didn't even get a chance to talk to a pharmacist. He went out four days later and with a rope around his neck jumped out of a tree in a public park.

I hear a lot about these, but I never hear the media talk about them. I think that's because on U.S. television, where you might hear a lot about it, the number one advertiser is the pharma companies. The news companies depend on them for their business success.

When you see young people committing very violent suicides and you see a warning on the label—not a clear warning—that warns against suicidal ideation, this is really a vague way of saying "This drug may make you want to kill yourself." This is really what I think they should be warned about. Every label for every antidepressant says that patients should be monitored closely. But I have never seen that. I have never heard of it.

What doctor has time to monitor a patient closely? How can that occur? How can your members monitor patients closely? How do they? How can family doctors, who are so extremely busy and have a huge volume of patients, possibly monitor their patients closely so they know that if they start to think about killing themselves, they say "Hey, my doctor warned me. I better call my doctor right away." They know that when they change their dose it's the most dangerous time. When they start it and when they stop it are other very dangerous times. How can we monitor patients closely and make sure they understand and get a clear warning of the risk of suicide?

● (1620)

Dr. Padraic Carr: That is a long discussion, but I'll try to summarize it as best I can.

First of all, all medications have side effects. If you read in the CPS, or the *Compendium of Pharmaceuticals*, about the side effects for Aspirin, you'd probably be amazed at some of the side effects that are listed there.

Mr. Terence Young: I wrote a book about it, so I understand about having an effect—

Dr. Padraic Carr: Fair enough.

All medications are going to have side effects.

It's long been known that for people with depression, as they start to get better, very often one of the last things to improve is their subjective mood.

There's another dangerous time you didn't mention, and that's as patients start to improve and when they're discharged from hospital. Very often as their mood is improving, their energy is improving, and their concentration is improving, sometimes when they've had suicidal ideation from being depressed, what can happen is that now they have the energy to carry out those plans they originally had.

Mr. Terence Young: They feel empowered.

Dr. Padraic Carr: So you're right, it's imperative that there is close monitoring of patients. The way that's done is by asking patients how they're feeling and what is going on, and monitoring their symptoms. Some will use rating scales to help monitor those risks. But it really does require regular follow-up to do that.

In terms of the antidepressants themselves, some people feel an increase in impulsivity. That can include self-harm acts and other things. Again, you have to adequately warn patients about that ahead of time. Let them know what the side effects are to the medication they're taking. I would hope every doctor who prescribes medication does that with their patients.

Mr. Terence Young: They don't. The family docs don't. They're so busy. They have a room full of patients and, frankly, they often don't understand the risks themselves. Why would someone give somebody a free sample of Cipralex and then just say “go ahead and let me know how you feel”? This stuff is going on all the time.

What should we do to try to reduce suicides that are actually caused by drugs that are supposed to be helping patients?

Dr. Padraic Carr: In general, I would have to disagree with you. I would say that most family doctors are very good in speaking to their patients, discussing side effects of medications, and explaining risks and what we really should be monitoring for.

There are certainly tragic anecdotal cases where things have perhaps not been done properly or where there perhaps was a tragic outcome despite everyone's best intentions. When those cases come to the fore, I think what's best is maybe something like this study looking at how we can prevent suicides, including whether there are better ways of managing or better protocols that we can do. However, that's really going to need to be done with medical associations, and with colleges as well, in terms of what those standards should be.

Mr. Terence Young: Do I have more time, Chair?

The Chair: You have a minute.

Mr. Terence Young: Thank you.

Dr. Carr, if you had a wish that was going to come true and you wanted to improve mental health in Canada, what would it be?

Dr. Padraic Carr: I guess it would be providing the right treatment for the right patient at the right time.

Mr. Terence Young: How do we make that happen?

Dr. Padraic Carr: Start by looking at the problems. Are we providing adequate services? Also, I think looking at new innovations is extremely important, as is monitoring systems to make sure those innovations are working, as well as providing adequate funding to make sure we can do those jobs right.

Mr. Terence Young: So you're talking about funding for psychology and psychiatry?

Dr. Padraic Carr: For psychology, psychiatry, and mental health teams, the whole gamut. It's all important and we all work together.

Mr. Terence Young: Because I've seen many times that they make patients wait six months to talk to somebody when they really need talk therapy.

Dr. Padraic Carr: We need more timely access to health care, no question.

Mr. Terence Young: Yes.

Thank you, Chair.

The Chair: Thank you, Mr. Young.

Next up is Mr. Bevington.

Go ahead, sir.

Mr. Dennis Bevington (Northwest Territories, NDP): Thanks, Mr. Chair.

I have a couple of topics I want to talk about and I have five minutes, so it's going to be pretty quick.

PTSD is in the news today because many soldiers are self-medicating with marijuana. The minister has said that she doesn't believe that this is good or that it works. What are your opinions on this? Also, how should we come to a conclusive understanding of the nature of this particular drug for mental health issues?

Dr. Padraic Carr: At present, medical marijuana is not indicated for any specific psychiatric illness. For PTSD, the standard treatment is usually specific serotonin reuptake inhibitors and psychological and social therapies.

All I can say is that it's not indicated at the present time.

Mr. Dennis Bevington: Right now, 6,500 soldiers are using it under medical licensing.

Dr. Padraic Carr: All I can say is that there's no medical indication for that.

Mr. Dennis Bevington: Do you think there should be a process to understand it?

Dr. Padraic Carr: You know, I think it bears study. There are difficulties with doing those studies in terms of making sure that the product is uniform throughout the study and that the methods of implementation of it are uniform, but it would have to be done under very controlled circumstances and by professionals.

● (1625)

Mr. Dave Gallson: I was diagnosed with PTSD in 1990 after I was hit by a car. It took me eight years to acknowledge that I had a mental illness. It took me a lot more years after that to go for treatment.

My treatment of choice was not marijuana. At that time, it was alcohol. It wasn't because I wanted to get high or anything like that. It was just because I wanted to bury the thoughts and just pretend I didn't exist. That, from my experience in working with many, many people with PTSD, is often the root cause of being on marijuana or anything else. It's that they want to hide their feelings just for a little while and just escape for the time being. There are a lot of things at play, I believe. That's the way I felt about it.

Mr. Dennis Bevington: Well, after the Second World War, the Legions, with their alcohol on a Friday night, worked very well to give relief to many veterans with PTSD, which we didn't recognize. You can be sure of that.

Mr. Dave Gallson: Yes.

Mr. Dennis Bevington: That was one of the key treaters of our veterans from that conflict.

Now, when it comes to suicide in the north, there's an epidemic of suicide up there. There's one statistic that I note from the north. When you look at the per capita expenditures on health throughout the north, especially in Nunavut, per capita expenditures on drugs are less than half the national average. The national average is between $1,000 and $1,200. In Nunavut, it's between $400 and $600.

Has any work been done on the correlation for remote and isolated communities where they simply have no access to the kinds of drugs you're talking about? They have no access, no follow-up, and no kind of treatment at all. Could we recognize that as a potential problem in this epidemic of suicide, where the rates in Nunavut are 10 times the national average?

Dr. Padraic Carr: I'll start. I don't know of any specific study looking at the north and lack of access to drugs. Certainly there are a lack of resources in the north. That doesn't include medications only, but also lack of psychological services. It includes lack of health care teams in the community. That's understandable. They are isolated communities and there aren't the same resources as there are in the city. When people have fewer resources, they certainly tend to do less well.

I also used to work in Yellowknife on a part-time basis, as a consultant psychiatrist. The federal government paid a lot of money to sometimes transport people to Yellowknife to be assessed by me and to be seen, but really that access isn't there for everybody. It's very difficult for people to get a lot of the services they need.

I can't speak specifically to a lack of access to drugs. I'm really not aware of the entire scenario there, but I know their services are less and they can experience more difficulties as a result.

Mr. Dave Gallson: We get emails from people almost daily, and they don't have to be all the way up there. I received one the other day from Gillam, Manitoba, complaining that they have absolutely no service, no access to care, and so on.

I think we also have to look at care as being more than just going to see your doctor, or more than just seeing a psychiatrist or psychologist; it's also peer support, it's also access to people who have been through it themselves and are there to listen.

A lot of times a person will really benefit from hearing somebody, being allowed to share their experiences with another human being who has been through the same thing. So I think we have to expand our concept of what care is.

The Chair: Ms. McLeod, we have about a minute and a half or two minutes. Would you like to add a question?

Mrs. Cathy McLeod: Absolutely.

The Chair: Okay. Great.

Mrs. Cathy McLeod: Thanks.

First I want to make a note. I think there was a comment made about research. Many of my colleagues had a chance this morning to attend a special breakfast by CIHR, which was honouring four people from McGill who had done absolutely amazing work. It was quite eye-opening in terms of the optimism that we can feel as we look toward ultimately to finding some real cures, opportunities.

Another trip I have made recently was to UBC's Centre for Brain Health, where I again saw the work that's being done. We're really on the cutting edge, I hope, in terms of some really positive things into the future.

I only have about a minute so I'll make it a quick question. Mr. Phelps, you talked about how we should implement the workplace standards, and I don't disagree because I was really significantly involved with the psychological health and safety in the workplace.

Sometimes, should we not wait until these...? We have 40 organizations who are doing a study. Are you saying that people should be doing lots of uptake now, or should we really be asking, how is this standard working for those 40 that have embraced it, and to wait for the actual results of the study?

I guess that's my quick question.

● (1630)

Mr. Fred Phelps: It's a very good point. I think the Mental Health Commission of Canada has done a lot of work to get the workplace mental health standards into place. I think there was research in developing them, and I think because they are there, implementing them as best practices would be what we would like to see....

I could see some research coming from those organizations that are doing it, but I would think the uptake and the recommendation from CAMIMH would be that the uptake be taken now, yes.

Glenn.

Mr. Glenn Brimacombe (Chief Executive Officer, Canadian Psychiatric Association): The other piece is that the Public Health Agency of Canada is already looking at how they can take those standards on a pilot basis. You can't boil the ocean in the sense of having those standards driven across the government en masse, but you can start somewhere, and a good place to start, it seems, is the Public Health Agency.

The Chair: Thank you very much.

This will conclude our first round, our first panel. We'll suspend for a couple of minutes to allow you folks to leave. You can stay if you want. We'll bring in our next panel, and we'll be back in a couple of minutes.

● (Pause)

●

● (1635)

The Chair: Welcome back. We have another panel to go.

First up, we'll have Mr. Marks from the International Association of Fire Fighters.

Go ahead, sir.

Mr. Scott Marks (Assistant to the General President, Canadian Operations, International Association of Fire Fighters): On behalf of our 23,000 members across Canada, I'm honoured to share our views on this very important subject with the committee.

Canada's professional firefighters are on duty 24 hours a day, seven days a week in cities large and small across this great country. We're usually the first on the scene of any emergency. Whether it's a structural fire, a highway accident, a serious medical call, a hazardous materials incident, or any other emergency, we're Canada's first line of defence.

Everyone knows that firefighting is a dangerous and physically demanding occupation, and that firefighters suffer high rates of workplace injury and illness while protecting the lives and properties of the public. For this reason, eight provincial and two territorial governments have enacted legislation since 2002 that includes hard injury and a growing list of cancers to the occupational hazards of firefighters who have a certain number of years on the job. While we welcome these advances, less known are the mental demands of being a firefighter, including the effects of being exposed on a regular basis to graphic scenes and images that anyone would find disturbing and difficult to see.

Like other first responders, firefighters are required to attend the scenes of accidents, crimes, suicides, and other incidents where people, whether adults or children, have died or been seriously injured. Only those who work as first responders know what grim sights we see in the course of our duties. We see things the general public doesn't.

Do these things take a toll on a first responder's mental health? Even for a burley firefighter, a seasoned paramedic, or police officer, of course they do. We are human after all.

For too long, post-traumatic stress disorder has been a hidden secret among firefighters and other first responders. It has existed in the shadows of our profession. Haunted by the effects of our job but feeling the stigma of appearing weak and unwell in front of our shift mates and families, in the face of society's expectations too few firefighters struggling with the mental health implications of our profession have reached out for help. Too often, firefighters have turned to alcohol or other drugs to deal with their difficulties, with marriages and other relationships crumbling under the strain. In many cases, fear of the financial implication of stepping away from a career becomes another reason to stay silent.

Tragically, PTSD has claimed the lives of numerous firefighters across Canada who succumbed to dark thoughts they could not shake and committed suicide. Our friends at Tema Conter Memorial Trust tell us that 18 first responders have died by suicide in Canada so far, in 2015. It's a sad and shocking number. Earlier this year, our affiliate in Surrey, British Columbia, IAFF Local 1271 experienced the shock and pain of two members' suicides in a seven-week period. These are difficult numbers to report, but we agree that, finally, these numbers need to be put out in the open. If we're going to address mental health and PTSD in the first responder community, we had better know the exact scope of the problem and what we're up against.

Recently, there has been a growing awareness of PTSD in firefighting, and a growing willingness among firefighters to acknowledge that they're potentially affected by PTSD and need to ask for help. At the same time, there is growing acceptance that PTSD is a direct result of certain professions, including firefighting. In 2012, British Columbia and Alberta became the first Canadian provinces to formally recognize the mental health aspects of emergency services with legislation deeming PTSD to be presumed the result of a firefighter's occupation for the purpose of workers' compensation. In November 2014, Manitoba announced it would also be adding this important protection for its first responders.

These groundbreaking legislative advances were giant strides in helping to break down barriers that have existed for too long. They assist greatly with any financial concerns firefighters or their families might have about leaving the work place to seek help and treatment for PTSD, and they help bring the disease out of the shadows even more.

The IAFF commends British Columbia, Alberta and Manitoba for leading the way provincially on this issue. We hope to see this protection spread across Canada, the same way presumptive cancer legislation did. We thank everyone who has contributed to the growing awareness about PTSD and first responders in the past year. Slowly but surely the stigma is decreasing. Any initiative that makes it easier for fire fighters to seek assistance is an initiative that will save lives.

While the issue of work place compensation is important, we believe much more needs to be done. We also believe that information and resources should be available to all of Canada's first responders, regardless of which province or city they work in. That's why we're calling on the federal government to establish a national action plan for post-traumatic stress disorder. We believe there's a role for the federal government to play, and it's an important one.

● (1640)

We envision a national action plan that can apply to such first responders as firefighters, police officers, and paramedics, and also to military personnel and veterans. We envision a plan that considers five elements—best practices, research, education, awareness, and treatment—and that becomes a framework for an effective and all-encompassing PTSD tool kit that can be used as a resource by any first responder agency or individual who needs it.

We encourage the committee to recommend the development of a coordinated national strategy through multi-departmental collaboration as well as input from stakeholders, including the IAFF, to assist in identifying the nuances of first responder health and ensure that best practices for mental health care and suicide prevention can be effectively addressed.

We recently lobbied the federal government on the need for a national action plan for PTSD. We were encouraged by the interest expressed by numerous MPs and senators. I hope that members of this committee will share that interest and will agree that when it comes to our first responders and what they do for us on a daily basis, we owe it to them.

In closing, I would like to say to anyone listening that if you're a leader in the fire service, please make sure you foster a culture in your department or organization in which there can be an open conversation about this particular danger; in which those who may need help know what resources are available; and in which they can access those resources promptly and confidentially. If you're a first responder or anyone else struggling with PTSD, there's no shame in reaching out and getting the help you deserve.

Thank you. I'd very happy to answer any questions from the committee.

● (1645)

The Chair: Thank you very much.

Next up is the Tema Conter Memorial Trust.

Mr. Savoia, go ahead, sir.

Mr. Vince Savoia (Executive Director, Tema Conter Memorial Trust): Thank you, Mr. Chair.

My name is Vince Savoia. I am the founder and executive director of the Tema Conter Memorial Trust.

January 27, 1988 was a day that changed my life forever. Working as a paramedic in Toronto, I attended to the homicide of Tema Conter. What made that call so unique for me was that, as I stood over the bed and I looked at Tema, I was sure it was my fiancée who had been raped and murdered. The physical resemblance was so uncanny that my colleague, my partner, vocally asked me if this was, in fact, my fiancée.

After a couple of terrifying seconds and coming to the realization that it wasn't my fiancée, we had to make a decision, and that decision was whether or not we were going to resuscitate her. The decision we made was that we would not. That one decision of not at least attempting to resuscitate Tema caused me to go down the road of PTSD, and it took about 12 years before I even had a proper diagnosis.

Back in the late eighties PTSD wasn't even on the radar. Everybody assumed that PTSD was strictly a by-product of going to war. I don't think anyone really realized how the work of a first responder can truly affect one's psyche.

In 2001, with the blessing of the Conter family, the Tema Conter Memorial Trust was registered as a charitable organization. We originally started off with the mandate of providing a scholarship program to paramedic students at Humber College. What started off as a $1,000 scholarship is today a $30,000 per year scholarship program in which we encourage students in any public safety program, be that EMS, fire, police, correctional services, 911 communications, or even the military, to research psychological stressors of acute stress, cumulative stress, vicarious trauma, compassion fatigue, and post-traumatic stress.

We offer $2,500 per province. We offer two scholarships in Ontario, and the best paper in the country receives an additional scholarship of $2,500.

Since then we have expanded our portfolio. We have partnered with numerous hospitals and universities in the Toronto area to conduct research. We recently partnered with the University of Ottawa and Nipissing University to conduct an OSI study involving police officers across the province. As a result of that research, we now offer peer support training, and what I'm truly proud of is that we host a peer and family support assistance line for any first responder or family member to call. It's a toll-free number, and the mandate of that particular phone line is to ensure that, when they do call us, they are safe and they are not suicidal. More importantly, we act as a referral agent. We really attempt to try to get them to see a mental health professional who can truly support them.

Although peer support is gaining prominence in this country as a methodology for us to assist our colleagues—and I truly do believe in peer support—what I must say is that it is very important that we truly get our first responders, or basically any Canadian suffering from any sort of mental illness or disorder, to seek proper mental health care.

My call to action that I'd like to table here today is the inclusion of psychological care within our provincial health care plans and even the federal health care plan. You've heard from our colleagues today that we need more funding, but where is that funding going to go? I think we've done enough research. I think what we really need to do is have better access to psychologists in this country.

In addition to that I'd like to partner with my colleague, Scott Marks, in calling for a national strategy for PTSD. We really need to look at our first responder community. Our first responder community today is in crisis. Since April 29, 2014, we have sustained 45 suicides, and my suspicion is that the number is higher and that the 45 is just the number of suicides that we have been able to confirm, but anecdotally I suggest that number is higher in Canada. My concern is that there is a lack of response by both our provincial and federal governments to this crisis.

● (1650)

There needs to be a program in place where we really look at raising the awareness of mental health in this country, and especially within the first responder community. There is a John Wayne-ish attitude within our first responder community. Our colleagues are afraid to come forward. They are truly afraid, and they're afraid because there are organizations in this country that ridicule, ostracize, and even terminate first responders who come forward and ask for help—and that has to stop.

As you can tell, I'm very passionate about this subject matter. I consider Tema to be the true leader in the first responder community. We do not receive any provincial or federal funding. We are run strictly by donations from the general population, and we run our organization usually on a budget of about $300,000 a year. If I could ask for anything, I would ask you to please consider funding our organization. We'd really like to expand our peer and family support line, and more importantly, we would really like to get our best practices model of peer support for emergency responders out across this country.

Thank you.

The Chair: Thank you very much.

Next up is Mr. Merali. Go ahead, sir.

Dr. Zul Merali (President and Chief Executive Officer, Royal's Institute of Mental Health Research and The Canadian Depression Research and Intervention Network , As an Individual): Thank you very much. I would like to thank the committee for this invitation to speak to you about the government's investment in the Canadian Depression Research and Intervention Network and about my perspectives on mental health research in Canada.

The global cost of mental illness, according to the World Health Organization, is that it is a leading cause of disability in terms of adjusted life years lost worldwide. Within the mental illness category, depression is responsible for the largest burden of illness. Indeed, 500,000 Canadians did not go to work today because of depression, and the issue is increasing in magnitude. At the recent World Economic Forum held in Switzerland, mental health was a noted concern for the first time, and mental disorders emerged as the single largest cost, with global projections increasing to $6 trillion—an unimaginable amount—annually by 2030. This is more than diabetes, cancer, and pulmonary disease combined.

Why is mental illness such an issue? It is because it usually starts early in life, and it increases the risk of other concomitant disorders in terms of non-communicable diseases associated with depression.

CDRIN, which is the Canadian Depression Research and Intervention Network, is a pan-Canadian network that is focused on depression and related conditions, including post-traumatic stress disorder and suicide. We are very grateful to the Government of Canada for its $5.2-million contribution in its federal budget to support the establishment of this network.

Through the stewardship of three founding organizations, the Royal's Institute of Mental Health Research, which is affiliated with the University of Ottawa, the Mental Health Commission of Canada, and the Mood Disorders Society of Canada, I am proud to say that the network is up and running full steam ahead.

The strength and power of this network are to promote discovery and to translate results into practice through its nationally distributed research hubs. These hubs of discovery bring together the best researchers, clinicians, people with lived experience, and young trainees. CDRIN has seven hubs spanning across Canada right now, from British Columbia to the Maritimes, including an indigenous hub in Saskatchewan, which is the newest one.

We have hosted two very successful conferences for the purpose of knowledge exchange and knowledge translation opportunities. Through the network research hubs, the best minds in research are joining forces to understand the causes of depression and to discover more effective ways to diagnose and treat depression. Each hub is akin to a large tent that brings together academic organizations, clinicians, and people with lived experience, creating a true transdisciplinary experience. The discoveries will be shared across various hubs, and the promising practice-changing approaches will be applied locally and then nationally.

Crosscutting opportunities for young researchers will ensure sustainability and progression of this effort. International links have also been forged with like-minded organizations, in particular the NNDC, which is the National Network of Depression Centers in the United States, as well as the European Alliance Against Depression.

CDRIN is taking a leadership role in partnering with people with lived experience through every phase of the research process. We are training people with lived experience how to become active members around a research table, and training researchers to embrace and incorporate the issues and ideas that emanate from people with lived experience. This partnership will ensure that the research being conducted is relevant to those suffering from mental illness, and it will help transform the mental health landscape in Canada.

In terms of military health, at the Royal we are fortunate to house an operational stress injuries clinic, and the Royal is home to NATO's first research chair in military mental health. This chair is held by Colonel Rakesh Jetly, a senior psychiatrist with the Canadian Armed Forces and a mental health adviser to the Surgeon General. It will focus on care and treatment of those suffering from post-traumatic stress disorder and other combat-related injuries. It will also focus on depression, as this illness has a prevalence rate of 8% in the armed forces, higher than PTSD, which stands at about 5.5% in the uniformed services. The work to be done on research will translate into new treatments for those with PTSD. Canada will work with NATO partners and share research and collaborate.

● (1655)

As for suicide, it is, as you know, a major societal concern. Youths, adults in mid-life, and indigenous communities are at particular risk. Whereas mortality due to cancer and to heart disease has plummeted over the last 10 years, if you look at the graph for suicide, it has not budged. We have not moved the needle on that at all. Suicides are, in most instances, associated with mental illness, depression in particular. It is important to always link depression with suicides.

CDRIN has a formal memorandum of understanding with the European Alliance Against Depression. Dr. Ulrich Hegerl, the head of the European Alliance Against Depression, has been a speaker at our CDRIN conferences. As well, we've hosted workshops with parties for collaboration, including the Mental Health Commission of Canada, Health Canada, and PHAC. We have had two such meetings. The European Alliance Against Depression is willing and keen to be working with us here in Canada.

We are interested in testing the Nuremberg model here in Canada as a model that has been shown repeatedly to reduce suicide by up to 20% within a year or two of its implementation in many of the European communities. We need to test this model here in the Canadian context.

I'm happy to say that we have recently created a chair in suicide prevention in partnership with the Do It For Daron foundation and Mach-Gaensslen Foundation. This person is going to be coming on board any day now.

In Canada we spend less less than 5 per cent of our research dollars to support mental health research despite the fact that mental illness is the leading burden of illness nationwide. For every hundred dollars we spend in health care, Canada has invested less than four cents towards mental health research. We spend more than ten times that amount for cancer research. We have the capacity but we do not have adequate resources to fuel these activities that need to bring us to the next realm. We need to invest more in mental health research.

With that, I'd say thank you for your attention. I'll take any questions.

The Chair: Very good.

That concludes our presentations for this panel. First up for seven minutes is Ms. Leslie.

Go ahead.

Ms. Megan Leslie (Halifax, NDP): Thanks, Mr. Chair.

Thank you all for being here.

I really want to start by commending both of your organizations for taking on the issue of PTSD, especially when you noted that there is a lot of stigma and that people are afraid to talk about it and come forward. It's really wonderful to see both of your organizations really tackle this head on.

I want to ask a few questions about PTSD because I think it's really easy to say a lot this health stuff falls under provincial jurisdiction and that there's no real role for the federal government. I disagree with that for two reasons. The first is that if you look at who first responders are, many of them do fall under federal jurisdiction; veterans and RCMP officers are examples. Also, beyond that, I think that mental health is a public health issue. This is about public health. We have the Public Health Agency of Canada. There is a role here federally.

Looking at PTSD, if the federal government were to recognize the prevalence and seriousness of PTSD, I would imagine that we would need to allocate resources towards early detection, proper awareness, proper treatment, reducing stigma. Those are some areas I think we should tackle. I would see that in something like a coordinated task force that would definitely need to have first responders involved, veterans involved, medical personnel and other relevant groups really taking from the community.

That's part of a response that I could see from the federal government.

I wonder if you have any comments on that, if you'd like to add to it, if I'm off base, if there are things you think that we should be doing.

● (1700)

Mr. Scott Marks: No, I think that's exactly it from our perspective at the International Association of Fire Fighters. There are federal firefighters as well, so certainly there's an impact from a federal basis, but I agree with you entirely.

What we've got to do is to set up a structure here so that employers, and municipalities as well, particularly smaller municipalities, have a framework to work from. Vince can probably speak more to this, but there is so much unknown about it. You know, I joined the Toronto Fire Services in 1981. At that point in time, there was little done to train firefighters even on occupational illnesses that we now know. Now, through the Workplace Safety and Insurance Board in Ontario, there's a whole program recruited firefighters go through so that they can better address their own health and safety when fighting fires to make sure that all their gear's on properly and that they're taught a lot more about the long-term impact of what they are exposed to.

There's still virtually nothing in regard to what they face from a mental health point of view. We're just behind on it, because it is a relatively new disease as far as our understanding goes. That is a role I believe the federal government can facilitate to make sure that all of these communities of interest have some information on the types of programs they should be getting involved with and setting up.

Go ahead, Vince.

Mr. Vince Savoia: I would agree.

One of the factors that concerns me is that when I received my paramedic training back in 1981, at no time did I receive any sort of training in suicide or crisis intervention. That is still the same today. Our first responders, even though they attend to suicide calls, are not trained in suicide intervention nor trained in crisis intervention.

What I'd like to see is a program where we really review the curriculum of our first responders and introduce this training at the college and university level. In addition to that, we really need to focus on educating them about the psychological stressors they will face—not if, but when—both on and off the job, and how to deal with them appropriately.

Ms. Megan Leslie: I'm going to pick up on what you both just said here because my next question is about predicting and/or preventing PTSD. I don't know enough about post-traumatic stress disorder to know if there is a way to predict or prevent it. Is it what you're talking about: at least if you know the signs, then you know when to come forward?

Mr. Vince Savoia: My colleague Dr. Jeff Morley, who's a psychologist, says it best, that there is no test available to predict who will be susceptible to post-traumatic stress. Unless you want to hire somebody who will be a psychopath or a sociopath, no such test exists. When we look at the causation of PTSD, it's exposure to a traumatic event or a series of traumatic events, and we really can't identify which event might be that trigger.

● (1705)

Ms. Megan Leslie: I imagine that prevention's one thing, but another is knowing in advance what the symptoms are and when to get help. I think back to this fall, when we had a shooting incident here on the Hill. Just the fact that I knew that dry mouth is one of the symptoms meant that I knew that the adrenaline was still in my body and maybe I was going to have problems afterwards. So even just something like recognizing some of those symptoms to know to get help; it's not really prevention, but it can help shorten or support you in that treatment period.

Mr. Vince Savoia: The Mental Health Commission of Canada has introduced its new road to mental readiness program that speaks to that exactly. It has been adopted by various police organizations across the country, and that entire program is geared to recognizing those signs and symptoms early.

Ms. Megan Leslie: That fits in well with my next question, because I was wondering if feedback from your members who have had experience with different programs that are out there—

The Chair: Ms. Leslie—

Ms. Megan Leslie: Oh, that's it?

The Chair: We're up to seven minutes here. I'm sorry. Maybe next round....

Mr. Lizon, go ahead, sir.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much.

Thank you to all the witnesses for coming here this afternoon.

Dr. Merali, you spoke a lot about mental disease and mental health. What is going on in research on the prevention side? We do focus on treatment. There are still lots of unknowns. What's happening in prevention? For every illness, we look at ways to prevent it, because if we can prevent it, we don't have to treat it.

To give you an example, if a firefighter wakes up in the morning, his pulse is 170, and his blood pressure is high, what is he going to do? He's going to call a doctor or go to the doctor. He isn't going to go to work. But there's no way to establish his or her state of mind.

Can you maybe elaborate on this a little bit? You're doing research. Where are we on research?

Dr. Zul Merali: You are raising a very good and very important issue right now in terms of prevention. The issue with mental illness, as you know, is that all our diagnoses to date are symptom-based. How do you feel? You express your symptoms. You may or you may not express all your symptoms to the clinician, and/or the clinician may have subjective bias in terms of interpreting the symptoms you're describing.

What we need to do is just as you explained in the case of your blood pressure and your pulse being indicators. We need to have some biomarkers that are pulsing the status of your mental health. We do not have those as yet. The reason we have those for other illnesses is that we've spent a lot of time and effort focusing on those. Once you have those, once you can measure your cholesterol level, you know what to do about it. You go into a gym, or you might try statins or whatever to reduce your cholesterol level, to take care of your health.

In mental health we don't have that. We need tools, biological tools, to be able to measure your mental status and not rely strictly on the symptoms. For example, if you look at PTSD, right now there is a lot of evidence suggesting that if you use certain markers and do brain scans, the brain actually lights up very differently, almost like a Christmas tree, in terms of certain ligands.

So we have the beginnings of understanding. Can we develop those markers as full-fledged markers that will really predict what's going on? Once you know that, you can get going to the prevention strategies much better, because you will know what you want to prevent and how you want to mitigate that risk. This is something we need to spend much more time on than we are right now.

Mr. Wladyslaw Lizon: On that point, Doctor, what direction do you think science will take for the future? Will these markers that you mentioned be based on brain imaging, on blood tests, or on other tests? What do you think?

● (1710)

Dr. Zul Merali: We're looking at all those fronts. We're looking at EEG, just as we look at the EKG for the heart. We're looking at the electrical brain activity using relatively cheap devices to measure the electrical activity and getting signature patterns. We're looking at brain imaging. We're looking at genetics. We're looking at other biochemical changes and markers in addition to the clinical symptoms that are also being taken into account.

Where will we find the solutions? We don't know, as yet. I think we need to do it. We need to find it. It's very important that we do.

Mr. Wladyslaw Lizon: With PTSD or any other mental condition, there is the time from when a person gets that mental condition to the time when it's diagnosed. In that time period, in most cases the person has no idea what's wrong with him or her.

How can we, or how can the medical world, help those people and identify the signs, whether they have PTSD or some other medical condition? There is a time during which people have no idea what's wrong with them. Last week we were at a breakfast with veterans. Two of them who had PTSD gave testimonies. One said very clearly that for a while he had no idea what was wrong with him. He tried to commit suicide. On the second attempt he stopped, and realized there was something wrong with him. That was when he started looking for help.

Dr. Zul Merali: I think that's a very good point that you raised.

One of the things that we have done in partnership with the Mood Disorder Society of Canada and CDRIN is to develop curriculum—maybe I'll have Dave talk about the specifics—that actually helps clinicians identify PTSD much more rapidly in the primary care setting. That's one way. The other way is, you're absolutely right in the sense that people need to know what those early signs and symptoms are so that they or their families can begin to identify an issue before it reaches a critical stage.

There are devices being developed right now, for example, mobile cell technology. On your cell phone you can access programs that can help you answer a few easy questions, and they will indicate to you whether you might be at risk for PTSD or not, whether you might be suffering from it or not. Then you need to go to your physician or clinician for the next steps.

But the lack of awareness and the lack of knowledge about the signs and symptoms is a critical issue for PTSD and for depression as well.

We had a recent symposium where we had brought in managers from the workplace. We asked how many of them would recognize depression if it walked into the room. Three hands went up out of a hundred. People just don't know how to recognize these things. I think that the work that's being done by the Mental Health Commission of Canada in developing some of the working tools and early intervention strategies are very important.

The Chair: Okay. Perfect timing.

Dr. Zul Merali: Really?

The Chair: Yes, sir.

Mr. Vaughan, go ahead.

Mr. Adam Vaughan: Thank you.

You talked about the fact that anybody is susceptible to post traumatic stress disorder. I'm wondering if there are existing preconditions that make someone more susceptible. For example, I know from my time on a police service board dealing with disciplinary action that quite often the event that puts officers in a disciplinary hearing was an extreme response to a very normal situation on the job, but it was the previous stress that they had encountered away from the police force, such as a divorce or a death in the family, that made them susceptible or set a pattern that seemed to be occurring.

Has work been done to take a look at people in the first responder community who may be in a position where they would become more susceptible more quickly to post-traumatic stress disorder?

Mr. Vince Savoia: That is a really difficult question because I know individuals, for example, who were physically or sexually abused as children. They're working as first responders and they're coping with attending to these types of calls very, very well because they have been able to deal with those issues themselves.

Mr. Adam Vaughan: So they actually may be inoculated against it because of trauma they received in early life.

Mr. Vince Savoia: Exactly, they've experienced it.

Again, when it comes to trauma, in my opinion the reason that it's so difficult to understand is that one's response to trauma is a result of previous life experiences, morals, values, and the perception of the event. It's a combination of things and it's very complex. I wish there were a tool that would allow us to identify those individuals, but....

● (1715)

Mr. Adam Vaughan: There are many pathways.

Mr. Vince Savoia: Too many.

Mr. Adam Vaughan: And similar pathways may have a completely different response to exactly the same set of experiences.

Mr. Vince Savoia: I look at my own Tema Conter call. I reacted one way. My partner was totally fine with the incident. We attended to the same call, but for some reason, I perceived that call completely differently.

Mr. Adam Vaughan: Looking at the issue that's starting to emerge in high-risk neighbourhoods, in areas that have experienced persistent and very violent street crime, we're now seeing young children expressing exactly the same conditions that first responders are, and it's actually amplifying some of the violence. Has there been any look at that impact, the impact of persistent or consistent exposure to high levels of violence with young people and whether that may be impeding their ability to respond in society in a way that is more positive than troublesome?

Dr. Zul Merali: Yes. I think that is exactly the case in the sense that early or repeated exposure to stressors predisposes you to PTSD, for sure. Then who develops PTSD and who doesn't? We still don't understand that really well, but we know some of the issues and incidents that trigger the response.

When you talk about kids being exposed to traumatic events, it is really the same across the world, whether they come from a war zone or.... There was an earlier discussion about the immigrant populations versus refugees being vulnerable to mental heath conditions, which has to do with the level of stress exposure they've had, especially in the early years of life, because it seems to be an accumulative toll at times, such that eventually a straw will break a camel's back. That's the result of an accumulation of stressful experiences.

Mr. Adam Vaughan: In acting out, it often puts them in contact with the law, which puts them in institutional care, which has its own series of stresses.

Dr. Zul Merali: Precisely.

Mr. Adam Vaughan: In terms of the research that has been done, peer-to-peer therapy appears to be one of the most positive forms of therapy. You need to know what it is to be able to treat it, and you will be able to talk to someone who understands what you've been through. But it's also because of the social context in which a lot of first responders work. They work in very tight groups where peer-on-peer dependency is almost trained into them. If that's the case, is there not a role, then, for first responders and youth in troubled neighbourhoods to perhaps help each other, as opposed to sometimes being seen on the opposite side of this conversation? Is there a possibility here that you could actually redeploy first responders into a social setting, both as therapy, but also as social programming?

Mr. Vince Savoia: I think that's an excellent idea. I'd be cautious, though, about peer supports. Historically in Canada, most peer support organizations within the first responder community have used a model called critical incident stress management, or CISM. The model works if it's utilized appropriately, but what we're finding most often is that a first responder will take three or four days of training and all of a sudden feel empowered to conduct a psychological debrief. The analogy I have for that is that if you're having a heart attack, do you want to be treated by someone with a two-day first aid certificate or a cardiologist? There is a role for peer support, but in my opinion it's more a role of a referral agent, and making sure that our peers get the appropriate care that they require.

Mr. Adam Vaughan: Finally, to Scott Marks, as we look at public service contracts, one of the areas that governments are targeting is long-term and short-term disability. It's also trying to push productivity by ramping up the penalties for taking sick days. In this context, if first responders are going to get the treatment they need, do the labour contracts have to reflect the fact that time off may be one of the ways that which you mitigate the long-term impacts of post-traumatic stress disorder?

Mr. Scott Marks: I think that with post-traumatic stress disorder and the increased sense of awareness of it, we've overcome some of the basic hurdles in getting it recognized through workers' compensation. In that sense, the more knowledge there is and the more it's accepted as a workplace illness, then some of the issues around contractual agreements go away.

I think the bigger issue with it, and what we've experienced in some of the provinces that have recognized it, is recurrence. It's a disease that just simply doesn't disappear. If a person's being treated for cancer and they're five years in remission and they're symptom-free, you can declare that they've beaten that cancer. I don't think the same applies here, and this is where I know that in some of the provinces that have recognized PTSD, we're having a real problem. A person enters the program and is deemed to have post-traumatic stress disorder; it's covered off under workers' compensation; they get a series of treatments; they're given a clean bill of health and they then sent back to work; but with any recurrence they have to start going through the same set of rules to determine again whether or not they have PTSD. So it just creates another stress around the person.

Contractually, I think it's like anything. As we get more knowledge of this, I think we do have to recognize it within the terms of the contract. One of the key issues, as Vince and everyone talked about is the awareness issue of it. If first responders can get some early psychological treatment covered through some enhanced health benefits, even before it's diagnosed to be directly related to PTSD, they can get some help for mental health issues. The vast majority of first responder contracts, when it comes to psychological counselling, are extremely poor. You would eat up what's in your contract with about one or two visits.

● (1720)

The Chair: Thank you very much.

Mr. Wilks, go ahead.

Mr. David Wilks (Kootenay—Columbia, CPC): Thanks, Mr. Chair.

If I have time left, I'll share it with the parliamentary secretary.

This is a very interesting conversation. I'm retired from the RCMP and have seen my share of crap over the years. We all deal with it differently.

But I was very intrigued, Mr. Savoia, with what you said. I've gone through a couple of critical incidents—stress times in my life—with regard to a team coming in. The jury's out on those. It may have worked for a couple of the people who were in them. I don't know if it worked for me or not. But *c'est la vie*.

I do agree with you, and you mentioned it quite clearly with regard to the incident that bothered you but didn't bother your partner. Why not? I don't know.

I counted them up once, and I think I've gone to about 112 fatals, sudden deaths, in my 20 years. Why not me? I don't know. Am I one of the lucky ones? I have no clue.

But I do know there are far-reaching other problems that come with that. One of those for me, as well as for a lot of my colleagues—and I can't speak for everyone—is that we end up imbibing a little more than we should, shall we say; and it becomes a bit of a habit. For me, I ended up going to treatment for it, and fortunately I'm here today. Again, I'm one of the lucky ones.

But this is where I'd like to hear from Mr. Marks and Mr. Savoia. When it comes to those who serve, whether it's firemen, policemen, or the military—and I heard you say it earlier, and we'll agree to disagree a little bit on this—I truly believe that where we missed the mark is in dealing peer to peer; because, as you said earlier, there's this John Wayne attitude. We're afraid to come forward, because we're afraid of what the public will think of us. But that's not necessarily the case when it's peer to peer, as long as it's kept that way.

So, I'd like both of you to talk a little bit with regard to how we can move forward as a nation dealing with peer to peer consultation—if you want to call it that—or talking this thing out. That's been the best for me during my career, to talk to someone who could relate to what I had gone through; because talking to someone who can't relate to me is like talking to that wall.

Go ahead, please.

● (1725)

Mr. Scott Marks: I'll start. I think there's a role for peer to peer support. I think that's what Vince said. I think is so important to be training first responders on crisis intervention and giving them that knowledge base, not only so they can apply it when they're out in public, but also so they can start to apply it amongst themselves. I think that's the important role. He may feel differently, but I think that's the important role for peer to peer support. When you work in a fire station or a police station, as Mr. Vaughan said, you have that sense of camaraderie, you have that culture, you're relying on each other, and you're in a position to pick up on things.

I think back now on my career and the relationship I had with some of the people I worked with. I realize now the things that I saw that were signals from people who needed help and were in crisis, but at the time you're not aware of them. You're absolutely right that you see the symptoms borne out as drug and alcohol-related dependencies. I look back at how this started. I remember back in 1993 a senior member of the fire department who was going to the chief at the time and who wanted to set up an EAP. He was a person who had suffered from alcoholism. In retrospect, I think it's clear that he suffered from post-traumatic stress disorder. He was ahead of his time. EAPs now are all over the place. We are at the point now where it needs to move to the next stage. I think there's a role for peer to peer support, and that role may be to assist in the recognition of the condition, to assist the person to get further help, or at least to get the wheels turning to get that person help. I agree with what Vince says, that there comes the point where you need that professional help, and you have to turn elsewhere.

Briefly, I think the other thing that comes out is getting a network of therapists who are out there. As you say, it's hard to connect with someone. You connect better with peer to peer support. What we found as well is that there are some therapists who connect really well with people. A lot of our PTSD people may go through two or three professional therapists before they find someone they connect with.

Mrs. Cathy McLeod: Thank you.

It's interesting two months ago when I was with the Resident Doctors of Canada who had implemented resiliency training in their curriculum. They had developed the program in partnership not only with the Mental Health Commission of Canada, but also with our military.

I was quite intrigued, Mr. Marks, by your comments. As the Mental Health Commission of Canada moves forward with its mandate, I look at what they've done for psychological health and safety in the workplace, where they've created a standard, they've created tools, and they've been all-encompassing. To me, when you talk about having some structure, the Mental Health Commission of Canada might be a good place to create that framework. Have you given that any thought?

Mr. Scott Marks: Two or three years ago we were approached by the Canadian Association of Fire Chiefs. A program had been set up for mental health first aid. It was a train the trainer program. We were able to put some people through it on a trial basis. They were hoping to raise funding to wheel this out amongst the first responder community so that the fire chiefs could send people there to be trained in mental health first aid and then bring that back to their departments. We were very supportive of that, but unfortunately the commission couldn't find the necessary funding to get it up and running. The program exists.

● (1730)

The Chair: Ms. Moore, a very quick question and a very quick response.

Ms. Christine Moore: Maybe I will ask my question of Mr. Merali because he's a researcher. Do you think there's a higher risk for first responders working in rural areas? I ask because in those regions everyone knows each other and there's the risk of being confronted with someone you know or have a relationship with. I have witnessed many times in the hospital cases where first responders have to intervene on behalf of family or friends. Do you think the risk is higher for those first responders working in rural areas?

Dr. Zul Merali: It's a good question. It's hard to tell if that really puts you at greater risk. What you're describing is a situation where there is repeated exposure to high trauma. That in itself is a risk factor.

But I think at the end of the day it's an interaction between your personal biology and the environment you get exposed to. As for what it is inside of you that makes you resilient or vulnerable, we still don't understand. What we do know is that repeated trauma is a factor that results in PTSD, so that's the issue.

What you're describing is true in a way because in a smaller community you are more likely to be the first there and to be responding to many more traumatic events than you would if you were in a situation where the pool might be larger, where the population might be larger and you might not have as much exposure to trauma per person.

Ms. Christine Moore: Thank you.

The Chair: Thank you very much.

It was a very good meeting today.

That'll do it. The meeting is adjourned.