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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I'll call the meeting to order. Welcome to meeting 144 of the Standing Committee on Health. We're going to start a new study today.

Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Mr. Chair, I don't wish to delay the meeting. I want to bring something to the committee's attention. I will be very brief. I know we're getting near the end of the parliamentary session, but I think it's worth it to have at least one meeting in regard to medical marijuana facilities for a person. The issue is around bending the rules.

There are two what I'll call illegal medical marijuana grow-ops in my riding. One has 2,000 plants in it, if you can imagine, and another has an entire greenhouse full. These are for individuals with prescriptions, who are growing it for themselves. This is an issue coast to coast. I'm sure most constituents have this issue. It's a twisting of the rules, a loophole. I'm not saying I'm against medical marijuana. All I'm saying is that I think the committee should bring attention to this and maybe have officials and police in, because I think it is a very important issue of public health. The odour in the communities I represent is quite bad in these developments, and they do not adhere to the same rules as a licensed facility.

I don't want to delay any longer. I want to bring it to the attention of the committee. I'm sure some of my colleagues have the same issue. It is a public health problem, as well as definitely twisting the rules or a loopholes in the rules.

Thank you.

The Chair: I appreciate your bringing it to our attention.

We have committee business at the end of today. We can bring it up and talk about it a little more there.

Did you have a comment?

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Yes, I have a quick comment on that. I wanted to let you know that in multiple instances across the country people are not complying with the odour regulation of both medical cannabis and regular cannabis or the security or the number of plants.

I have forwarded numerous complaints to Health Canada from Langley—Aldergrove, from Dave Tilson's riding, Jamie Schmale's riding, my riding, Leamington, a whole bunch of them. The problem is Health Canada is telling us to call the police. The police are saying they can't enforce Health Canada's regulations and Health Canada is not enforcing the regulations. So there is definitely something to talk about.

The Chair: All right. We'll talk about this in committee business. You certainly brought up an issue that I think is prevalent.

Back to violence faced by health care workers. This is going to be another interesting study for us. We welcome our guests today.

On behalf of the Canadian Association of Emergency Physicians, we have Dr. Alan Drummond, co-chair, public affairs committee.

On behalf of the Canadian Federation of Nurses, we have Linda Silas, president.

On behalf of the Canadian Support Workers Association, we have Miranda Ferrier by video conference from Guelph.

On behalf of the Paramedic Chiefs of Canada, we have Randy Mellow, president. Now we're going to find out if you're really mellow.

Everyone has a 10-minute opening statement. We'll start with the Canadian Association of Emergency Physicians, Dr. Drummond.

Dr. Alan Drummond (Co-Chair, Public Affairs Committee, Canadian Association of Emergency Physicians): That's more than I anticipated, so thank you very much.

The Canadian Association of Emergency Physicians is the national specialty society for emergency medicine in Canada, with over 2,500 members.

With the birth of our specialty approximately 40 years ago, our primary focus was on education and training to identify and treat life- and limb-threatening emergencies. Over the ensuing decades, our role has changed. Emergency physicians now bear daily witness to failed social policies that result in increasing visits to our departments by patients with substance abuse—including alcoholism—poverty, marginalization and violence. The latter, in particular, is of grave and increasing concern to both our members and our nursing colleagues.

Health care providers have a fourfold higher rate of workplace violence, and 50% of all attacks on health care workers occur in the emergency-department setting. Our nursing colleagues in particular bear the brunt of much of this violence. Most of the assaults on emergency department personnel were by patients or visitors, and the degree of physical violence has been increasing.

It is both under-reported and underappreciated. Studies have shown that only about 30% of violent incidents in the emergency department are reported to higher authorities.

The root causes and contributing factors to violence have been well described. There's a very extensive literature base. As with many problems that beset the emergency department, many contributors lie outside the department itself, and are societal and cultural in nature.

Chronic oppression, with racism, poverty, inequity and social exclusion, lead to substance abuse, mental illness and violent behaviour.

All are important, but substance abuse, and in particular the increasing incidence of crystal meth use in the western provinces, has many of our western colleagues particularly concerned.

As the population ages, complex presentations of the elderly in the emergency department, coupled with prolonged waits for care, as a result of crowded hospitals, lead to an increased risk of delirium and violent acts by the elderly.

While violence in the community is certainly a driver for violence in the ER, it is not the sole driver. There are factors intrinsic to our departments and to our hospitals, including overcrowding and increased wait times, that lead to immeasurable stress for our patients and their families, as they wait eight, 12 or 24 hours to be seen. We have insufficient—in our view—nursing staffing ratios, leading to poor communication and poor basic care of the patient who's been deemed to require admission. They wait in the hallways, and it's totally unacceptable.

We also have poor environmental design, all of which lead to an increased risk of violence in the emergency department.

With respect to the effects, multiple studies and reports have shown that exposure to violence in the ER has a deleterious and demoralizing effect on staff, most notably nursing staff. Occupational strain, impaired job performance, fear of patients and future assaults, decreased feelings of safety and reduced job satisfaction have all been commonly identified.

It also leads to absenteeism, lost-time injuries and prematurely shortened careers. Workplace violence in the health care sector also has a large and well-quantitated economic effect.

This is a national problem that requires a national solution. I know that many of you believe that health care is a provincial responsibility, and it largely is, although you're paying part of the health care tax dollar. However, you could be very helpful, I think, in helping develop a template of best practices to be shared with your provincial colleagues.

Violence in the emergency department, as I stated, is a symptom of a much bigger problem—broadly societal—with racism, poverty, substance abuse, gang and personal violence and inadequate upstream mental health resources for the mentally ill and, of course, those with substance abuse. This is a societal issue, and is beyond the immediate control of emergency physicians.

Within the hospital and the emergency department per se, however, we can consider the following. While individual staff members can contribute to safety through their practice and behaviours, ultimately, the legal and moral responsibility to provide a safe workplace falls to the employer, and thus to a hospital's administration, from board to departmental leadership.

● (1535)

These are a few of the major considerations and the literature is quite extensive, so I will keep this relatively short.

There should be an increased focus on appropriate facility design, with a limited number of controlled entry points to the emergency department with the capability to rapidly lock down the department.

Monitoring is often an afterthought, but there must be a visible security presence 24-7 with adequate backup available in response to an actual or potential incident. It's always the last thing to happen, usually after the incident has already happened.

Regarding skills and attitudes, all emergency department personnel should receive training in non-violent de-escalation to defuse the situation.

There should be clear policies and procedures in place with regular staff training to cover how staff should respond to a high-risk situation, including and regrettably, the active shooter protocol, which is now a part of many urban hospitals.

There should be care plans. Security as well as the clinical staff should have a system for tracking the high-risk individuals and identifying them on return, as well as ideally suggesting a safe approach individualized to a person's behaviours and known clinical issues.

There should be an incident reporting system, as well as a process for incident review. There needs to be a clear line of accountability for all aspects of emergency department safety for our nursing colleagues, patients and ourselves.

We hear the phrase zero tolerance. We believe that—and this is really quite important to stress—violence in the emergency department is first and foremost a medical symptom which requires an assessment to diagnose the etiology. Intoxication, psychosis and mania, dementia and delirium, brain trauma and tumours are all potential causes of violent behaviour.

Violence can also be reflective of a much bigger socio-economic problem, as previously discussed. We support zero tolerance of violence in the emergency department and every incident requires an institutional response, but the phrase “zero tolerance” cannot be used as an excuse to evict or ban patients who have not been properly assessed. This only makes us complicit in a culture of stigmatization and inequity. We believe violent patients deserve the very best possible assessment and care from their ED providers. Their individual social circumstances must be considered in their ultimate care plan. The zero tolerance lies with zero tolerance of an administration that turns a blind eye to the issue of safety in a department.

Thank you very much.

● (1540)

The Chair: Thank you very much.

We will now go to the Canadian Federation of Nurses Unions, Ms. Silas.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Good afternoon, everyone.

Thank you for inviting me on behalf of CFNU. We represent over 200,000 nurses across the country. My name is Linda Silas. I am a proud nurse and a proud New Brunswicker. Thank you to the committee for doing this study. I remember testifying here on other issues. When violence in the workplace was mentioned, it was a surprise to everyone, so we are very pleased to see this.

Workplace violence is a growing epidemic among health care workers as staffing levels heavily decline, patient acuity increases and weak security protocols fail to offer adequate protection. From a Canada-wide survey, 61% of nurses reported abuse, harassment and assault on the job during the last year. A recent survey here in Ontario said that 68% of nurses and personal support workers experienced violence on the job. We know that these numbers are unacceptable.

CFNU members across the country recently shared with me different examples. I literally sent an email to my board telling them I was appearing at the committee on May 14 and asking for any examples that came to mind. Last June a nurse in Newfoundland and Labrador was stabbed multiple times with a pen. Last fall a nurse supervisor in P.E.I., working in a long-term care facility, was punched over and over in the throat and tripped and pinched by a resident. This March, in my own hospital in New Brunswick, a nurse was attacked and strangled for 11 minutes by a patient's spouse before security showed up. Of course, she is still off. In Nova Scotia, violence in some facilities has reached a point where the nurses have begun pursuing charges against patients and family members who strike them. Earlier this month in Manitoba, on three consecutive days a nurse was punched in the stomach by a patient.

Studies in Manitoba also talk about ER, as Dr. Drummond mentioned, where 30% of ER nurses have been physically assaulted once a week in the last year. Last year, a nurse in Saskatchewan was brutally assaulted by a patient to the point where one more blow to his nose would have been fatal. That was March 2018 and he is still not working. He will probably never work again. In March of this year, a patient's visitor brought a gun into a hospital in Alberta. The last time Dr. Drummond and I testified together in front of you, it was about gun control.

We deeply appreciate the support provided by MP Doug Eyolfson for supporting the e-petition that the CFNU recently submitted on violence against health care workers. I cannot emphasize enough how important it is for Canada to tackle this crisis, not only for the health care workers from coast to coast to coast who signed the e-petititon but for all Canadians. As we frequently say in nursing, when nurses and health care workers aren't safe, patients aren't safe either. Nurses are even more susceptible to violence in the workplace than any other type of workers who work directly with the public. There were more than 4,000 incidents of serious workplace violence against nurses—serious enough to prevent them from going to work—reported in the last five years. That number—4,000—is higher than for police and firefighters combined. In order to tackle this mounting crisis, we need to go to the heart of the problem. For this we need to have an occupational health and safety lens in both staffing and training.

On January 17 of this year, a nurse and a security guard were assaulted at the Southlake community health centre in Newmarket, Ontario. The nurse, a 33-year-old mother with young children, was struck in the face and suffered skull fractures and a brain bleed. Between April 2018 and December 2018, an eight-month period, we saw 170 violent incidents reported by staff in the same hospital. Nurses describe the hospital as bursting at the seams.

● (1545)

We're calling on the federal government to undertake a comprehensive study in health care human resource planning to determine the current and future shortage and to equip governments across the country with tools to address this shortage. The federal government can, once again, lead by example. lt can implement the highest recognized, comprehensive violence-prevention programs and infrastructure, including hands-on de-escalation training, appropriately trained in-house security, communications devices for staff, wellness programs focused on the physical and mental health of health care workers, and the flagging of patients with a history of violence.

We are calling on this committee to recommend that the federal government legislate national minimum standards of security training for health care environments. To ensure that positive training programs are put in place in a harmonized fashion, minimum standards must exist for health care environments across the country through appropriate legislative changes.

Further, security must be part of the circle of care and viewed as an integral part of the care team. The CFNU is advocating for a revision to the Criminal Code through Bill C-434 as a tool to deter violence against health care workers. The bill amends the Criminal Code to require courts to consider assaults on health care workers as aggravating circumstances for the purposes of sentencing. A similar provision already exists for police officers and transit workers. We commend MP Don Davies for introducing this bill and urge this committee to recommend that Parliament adopt Bill C-434. The CFNU is calling on the federal government to enforce the Westray law, which holds employers criminally responsible for negligence causing physical injury to workers.

Currently, standardized national statistics on workplace violence do not exist. The Canadian lnstitute for Health Information, CIHI, which collects and reports facility-level data, needs to publicly report data on facility-level violence in the workplace.

ln closing, Canada's nurses are appealing to members of this committee to amplify your voice in the committee's report to the federal government. We are calling for a comprehensive federal study on health human resources planning; targeted federal funding to enhance protections for health care workers through violence-prevention infrastructure and programs, with community police included as an essential partner within joint health and safety committees; the adoption by the federal government of best practices around violence prevention in federally regulated health care settings; the legislating of minimum national standards for security training in health care environments; support from this committee for Bill C-434 and the promotion and use of the Westray law by Crown prosecutors in cases involving health care workers; and federal funding toward CIHl's collecting and reporting of data on facility-level violence in the workplace.

Thank you.

The Chair: Thank you.

Now we'll go to the Canadian Support Workers Association, with Miranda Ferrier by video conference.

Ms. Miranda Ferrier (President, Canadian Support Workers Association): Thank you very much.

My name is Miranda Ferrier. I am a personal support worker. I have worked in long-term care and home care settings in Ontario for many years as a front-line personal support worker. I'm also the founder and president of the Canadian Support Workers Association and the Ontario Personal Support Workers Association.

Unfortunately, violence faced by health care workers is nothing new. Over the last 20 years, the incidence of violence against support workers has increased to the point where this profession, and consequently health care in Canada, is now firmly past crisis. In Canada, support workers occupy a very unique role in health care in that they are responsible daily for providing Canadians with the most personal and intimate care. They become a constant for these Canadians and, many times, a part of their family.

Support workers face violence on the job daily. This has become so prevalent that it is now viewed as the norm. Is this right? Absolutely not. However, we believe that it will take a small change in our health care system to help rectify this issue for the support workers.

Right now support workers are responsible for caring for up to 15 residents per shift in long-term care homes, or more, in some cases. They also care for up to 16 clients a day in home care across our province.

One of the situations that comes to my mind occurred in August of last year, near Toronto, Ontario. One of our member personal support workers was stabbed on the job, while working in home care, by a grandson of a client. She survived, but that just shows how we are at such a critical and crisis level.

No matter where they work, the system is constantly plagued by short-staffing due to two reasons. There is no professional acknowledgement, as personal support workers and support workers across our wonderful nation are not regulated, and there is no accountability. As a result, the support workers in Canada are professionally isolated, lack the tools to advocate for their own safety and must contend with a profession that is 600% more dangerous than being a police officer or firefighter. On the flip side, they can be fired for abuse, walk down the street and get hired as a support worker again without any recourse. Add in the levels of burnout across our nation and we have our current situation.

In order to properly address the issue of violence faced by support workers, the provinces and federal government must allow the support worker to have the same professional respect offered to all other members practising health care in Canada. This professional recognition is not only long overdue, but it would end the pervasive culture of fear so prevalent in health care. Our Ontario association has long been lobbying and advocating for self-regulation of the support workers, even receiving an endorsement from the Canadian Nurses Association.

The presence of this culture of acceptance has resulted in a situation where the support workers are simply unable to report incidents of abuse for fear their employment will be terminated and their professional reputations ruined.

In order to effectively address the issue of violence faced by support workers, the Canadian Support Workers Association and the Ontario Personal Support Workers Association are formally calling on this committee to endorse and formally recommend to provincial health ministries that the Canadian Support Workers Association and its provincial chapters form the self-regulatory body for the support workers across Canada. This action would promote a recognition of the value that these workers provide to health care in Canada through effective and confidential whistle-blower protection. It would end the professional regulatory gap that allows for the continued tolerance of abusive behaviours towards the support workers and those in their care. It would provide assurance that there will be a sustainable and stable workforce to care for Canada's most vulnerable for decades to come. We are currently losing support workers at a rate of 33% quarterly.

Self-regulation will create a respected profession, which will provide the safety net and accountability so desperately needed for our most vulnerable in all of our communities across Canada.

● (1550)

This model of self-regulation has proven successful partially in Ontario, with our association there representing over 32,000 personal support workers. We have had no abuse claims to date.

Thank you very much for giving me the time.

The Chair: Thank you.

Could you define “support worker”?

Ms. Miranda Ferrier: They are called something different in every province across Canada. A support worker is also called a health care aide, personal support worker, personal care attendant, personal care aide. The list goes on. We're called something different everywhere. We work in the front line in long-term care homes, home care, community care, sometimes in hospitals and acute care settings. We're unregulated.

● (1555)

The Chair: Thanks very much.

Now we'll go to the Paramedic Chiefs of Canada, with Randy Mellow.

Mr. Randy Mellow (President, Paramedic Chiefs of Canada): Good afternoon, Mr. Chair, and members of the committee.

I would like to start off by thanking you for the invitation to appear here today and for the opportunity to contribute to a crucially important discussion on violence faced by health care workers, and specific to my community, violence faced by paramedics.

It's my distinct honour to be here today as the president of the Paramedic Chiefs of Canada. That's an association that represents paramedic chiefs and service chiefs across all of our provinces and territories.

I was to present today with the Paramedic Association of Canada as well, which represents our practitioners. Unfortunately, they were not able to be here. But we share this message that we're bringing to you today.

We're pleased to participate in this national dialogue on this important issue that's crucial to the safety of paramedics in Canada on the front line, in our communications centres and in our hospitals, and by extension, the safety of Canadians.

We can't address this issue without also including the paramedic service organizations, their leadership that works with paramedics each and every day, as well as the families that need to be included in this dialogue, as they are such important social supports to paramedics.

In Canada, there are over 40,000 paramedics who stand ready to respond to people in need and to save lives. Unfortunately, each day, as they perform these tasks with compassion and dedication, these same individuals are at very high risk of being victims of violence and abuse. Regrettably, paramedics are often the target of physical and verbal violence, bullying, threats, sexual assault and sexual harassment. Physical violence includes, but is not limited to, pushing, punching, scratching, kicking, biting, slapping and the use of weapons. Acts of violence and abuse may come from patients, the families of the patients and even bystanders at emergency scenes. Sadly, all too often paramedics are victims of violence by the very patients they're trying to care for.

Internationally, studies have found that between 55% and 83% of paramedics have experienced threats or violence during the performance of their duties annually. In a 2014 study of Canadian paramedics, 75% reported experiencing violence of some sort, 74% reporting multiple forms of violence annually. Of the 1,676 paramedics who participated in this study, 67% reported verbal abuse, 41% reported intimidation, 26% reported physical assault, 4% reported sexual harassment and 3% reported sexual assault. Sadly, these paramedics reported that they felt violence was part of the job.

Violence experienced by paramedic personnel has many consequences. It has been linked to psychological injury in the form of stress, anxiety, post-traumatic stress and burnout. Violence has been linked to physical injuries, resulting in time lost from work in between 17% and 32% of the cases. It has also been linked to the intent to leave the profession early. Violence against paramedics jeopardizes the quality of patient care that paramedics strive to deliver. It also leads to immense financial loss in the health sector, not to mention the indirect and direct costs to the paramedics themselves and their families.

Violence and abuse against paramedics in unacceptable. The Paramedic Chiefs of Canada supports a zero tolerance position on all forms of violence and abuse in all areas of the Canadian paramedic community. There's an immediate need to intervene on this crucial issue.

Our association recommends that interventions to prevent violence need to occur at multiple levels.

First, we feel we need to sponsor and support research. Research is necessary to obtain a better understanding of the scope of the problem, to evaluate the impact of violence on personnel and to assess means of mitigation, as we heard earlier today. Currently, there is only one peer-reviewed article that examines the issue in Canadian paramedics. This is insufficient.

Second, evidence-informed strategies must be developed and training provided for the management of violent patients and situations for front-line personnel.

Third, we must increase public awareness of the human and financial impacts of this issue among health care workers and paramedics.

Fourth, consideration must be given to changes in policy and legislation—as we also heard earlier—to protect paramedics and health care workers through increased punitive measures where appropriate.

We certainly welcome the opportunity to work with the federal government and partners to assist in coordination, research and communication to ensure the safety of all paramedics and health care workers is addressed.

Thank you.

● (1600)

The Chair: Thanks very much.

Ms. Marilyn Gladu: Is that a vote call?

The Chair: Okay, it seems we just had a vote called. We'll need unanimous consent to continue. Will we go on for a few more minutes?

Oh, it's a quorum call. It will shut down. They'll find some members.

It's amazing to me that we have to have this study, but hopefully we'll be able to help.

We're going to start our first round of questioning with Dr. Eyolfson, for seven minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you all for coming. I've met some of you before, and it's good to see you all again.

I brought up the motion to have this study. This was important for me. I've had a number of colleagues assaulted in their careers. I was assaulted twice in the emergency department, and on both occasions, not only was I expected to finish my shift, but I was actually expected to come in for my next shift. They couldn't find coverage, and they said it's too bad, but you have to come in.

Dr. Drummond, you mentioned that the employer is legally responsible for the well-being of their employees. Do you think it's acceptable for any employee who has just been assaulted to be told you have no choice, that you have to keep working and you have to show up the next day?

Dr. Alan Drummond: Of course not.

You know, I work in a small town; the good doctor worked in an urban environment in Winnipeg. In my view of the world, I tend to look at what happens in my little department in Perth, Ontario as a manifestation of what happens in the bigger picture. I can tell you that in our small town, which sees about 30,000 patient visits per year, we often have about three nurses on staff at any one point in time. We're chronically understaffed; it's chronically difficult.... There's no acceptance of illness, because it puts the onus on somebody to fill in that shift. Many of them feel incredibly stressed by their sense of community and commitment to work through illness, through family stress, through psychological difficulties.

In our department, where we have a fantastic, supportive team—intercollegial—many of our nurses are getting fed up with the degree of—I'll be polite, because I'm in mixed company—nonsense that happens on a day-to-day basis. It's true that we don't tend to see a lot of the significant violence, such as you might have seen in Winnipeg, but every day there is verbal abuse, grabbing, kicking, scratching—not always by patients, sometimes by their families—and the nurses are traumatized.

Some of our best nurses, who've been with me for nigh on 10 or 20 years, are thinking that they've had enough now and they're going to leave, because there just isn't enough accountability from the hospital to address the problem. They do feel, as my colleague from the personal support workers mentioned, that if they raise the issue, there will be retribution or their problems will not be taken seriously; therefore, they remain silent. It has become that staff feel it's a normal part of the job, but it is not.

In answer to your question, the obvious answer is no, it's not acceptable.

Mr. Doug Eyolfson: All right, thank you.

I kind of thought that was going to be your answer. But as you say, it seems that in the medical and nursing professions there's an attitude that is, for lack of a better word, macho. You know, if you can't take the heat, get out of the kitchen. You're right, there is that mindset that if you're sick or injured, so what; you're supposed to rise above it. I think we have to evolve beyond that.

Ms. Silas, you talked about staffing issues. As you probably know, in Manitoba it's made the news a lot, and I witnessed this first-hand when I took a family member to the emergency department last weekend. We have severe staffing issues. I was there during a night shift when literally all of the nurses had been coming off a day shift and were mandated to work an additional eight hours overnight. Of course, this leads to short tempers, to fatigue, to errors. It leads to upset patients.

Do you see an increase in violence toward staff that seems to be correlating with the shortages of staff in departments?

● (1605)

Ms. Linda Silas: Yes. That's the short answer. But it has gotten worse. We saw in the 1990s a restructuring of our health care system. Now we have a very acute health care system. If they're not there, as per your witness on personal care workers, they're in the home with any help they can get. It's like a boiling pot. The fuse gets very short for everyone in the system. This is a health and safety issue. That's what we need to look it. It's about training, training, training; staffing, staffing; and safety—police officers or corrections. You have to put that into it.

I'm starting to show my age here, but the first campaign we had for no violence in the workplace was in 1991. We had big hearts in the workplace and, you know, “no violence here” or “zero tolerance”. Like, sorry, but that's BS. Right now I can take a taxi in New York City that has a big sign in it saying that if you attack the taxi driver, there will be a criminal charge. That's what I want posted in the hospitals and in home care. No more little hearts. If you touch a health care worker, you're going to jail. It's as simple as that. We will staff our health care system appropriately to make sure. Prevention is number one, but if we can't prevent, we will throw them in jail.

Mr. Doug Eyolfson: Okay. Thank you.

Mr. Mellow, I have some experience with EMS. I was the medical director of Manitoba's land ambulance program for six years. I also flew for our provincial air ambulance system, which involved some ground transport. I've spent a lot of time in the back of ambulances and known a lot of paramedics. Would you agree that the public does not appreciate how dangerous being a paramedic can be?

Mr. Randy Mellow: Absolutely I would agree with that. I don't think the public has a good understanding of the dangers of our jobs. As I quoted at the start, the number of injuries we're seeing is phenomenal.

I operate a small ambulance service here in Ontario. It's not very big. It's in Peterborough. It's just a couple of hours away from here, a small rural area in cottage country. In the past two years, two paramedics were sexually assaulted and one paramedic had a knife reportedly drawn on them, all resulting in cases that are in the courts right now. People don't understand how dangerous the job can be, just as it can be in other health care professions.

One issue we have is that we are two people who are quite often out by ourselves, with no security and no one else to respond. Especially in rural Ontario, where it can be many minutes before we have police who can arrive at the scene, it's very difficult. Our legislation mandates that we must actually see a dangerous scene and confirm it to be a dangerous scene before we can legally stage and not go into that scene. It places paramedics in danger intentionally to confirm that the danger exists. These things need to change. We need to review not just the public's opinion but our governments' view of this as well.

The Chair: Thank you.

Now we go to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

Thank you to our witnesses.

I want to start off by talking about the prevention aspect. CIHI collects some data, but do we know who is perpetrating the violence? Do we know the breakdown of people? How many are patients and how many are family? Is there a breakdown for drug addicts and for people with mental health issues? Do we have any kind of data on that?

Dr. Alan Drummond: I'm not aware of any.

Ms. Marilyn Gladu: So that's something we definitely will need.

The paramedics go in pairs, but my daughter was a nurse in home care, and in home care you're alone. I consider this to be very dangerous. One protection would be to pair up in home care and make sure that there are multiple people who are trained in security-type interventions. Would you agree?

● (1610)

Ms. Linda Silas: It's not only about intervention. It's also about having a security device on you. I'm sure Miranda could answer this too, but it's about having a security device on you. If you press a button and nobody comes...like the nurse in the regional hospital where it took 11 minutes before somebody other than her co-worker showed up. I feel for your daughter. It is scary what can happen there. They can't even negotiate to have a cellphone with them, never mind an emergency device.

The Chair: Ms. Ferrier, do you have an answer?

Ms. Miranda Ferrier: I was just going to say that in home care for PSWs currently, in different provinces they're not allowed to carry their cellphone with them on their person into the home. They say that if there's an issue, the support worker has to then use the client's phone in order to call in for help. Well, if you're in a dangerous situation and you can't get to that phone, which we hear from our membership all the time.... They get cornered; they have to talk their way out of it.

Let's keep in mind too that support workers have different training across our nation. Some have a lot of training, some have no training, but almost none of them have crisis prevention and intervention training. They have no idea how to talk down a drug addict, an alcoholic.

We're putting really vulnerable people with vulnerable people, doing a job where they're in danger all the time.

Ms. Marilyn Gladu: I totally agree with what you're saying.

I liked your point about how essentially the working conditions for PSWs are so unacceptable. You have 15 clients you're trying to manage.

I think Alberta has a standard of seven clients maximum per PSW. I wonder if there is a definition that we should adopt, as the federal government, to set a standard across the country.

Ms. Miranda Ferrier: Absolutely.

We just started a campaign through the association in Ontario for a resident-to-personal support worker ratio. What we're seeing across the board is one for 15, one for 20, one for 35 to 40 in the overnights. It's a scary situation.

We've heard a lot of talk through the provincial government here about one for eight. However, if the federal government could intercede to say it is mandatory across the board, this needs to happen. Otherwise, we're not going to have the support workers to care for our loved ones.

Ms. Marilyn Gladu: True enough.

With regard to the working conditions for support workers, I heard what they're doing—I see this quite often in Ontario—is making them work multiple part-time jobs instead of making it a full-time position with benefits. For that reason, a lot of people are also leaving the profession. If you consider the working conditions and the violence and the lack of benefits, that's an issue that needs to be addressed as well.

Would you agree?

Ms. Miranda Ferrier: In the province of Ontario, what we hear from members—and also in our New Brunswick chapter and out in Alberta and British Columbia—is that the full-time work is what they really desire. They always start the sentence with "I get no respect. I have no recognition. Nobody listens to what I have to say." Then they go on to talk about wages, full-time versus part-time, benefits on the job.

That's why we are really stressing that self-regulation model for personal support workers, so that they can have something to call their own.

Ms. Marilyn Gladu: You had some great recommendations in talking about limited access and a security presence.

Can you talk a bit more about the security presence part of it?

I think that Ms. Silas has already talked about how if it takes them 11 minutes to get there, it's no good. If you had one security guard for the whole hospital, that's not really what you need.

What would be the best practice there?

Dr. Alan Drummond: I think it depends on the facility to a certain extent, and the realization that the health care budget is not endless and hospitals are struggling to provide basic care sometimes. Such things as security of health care workers sometimes assumes a low priority when you can't balance your budget for operative procedures. So it's always an afterthought.

There are about 850 emergency departments in this country, divvied up into about five levels of classification from tertiary trauma centres to small rural hospitals such as my own.

Clearly the urban hospitals, with the issues of gangs and substance abuse, often have a very clear and present security presence. Rural communities often don't, and rely on local police detachments for some kind of immediate response, should it be required.

There is often not a direct line to the local police detachment; you have to call 911 to get a policeman to come. The delays can be quite extensive.

My colleague mentioned administrative response to violence in our hospital. Two years ago the nurse in our sister hospital in Smiths Falls was stabbed by a violent patient. Our hospital, then and only then, installed lockdown access to the emergency department. You had to be buzzed in after hours to be allowed in. Only then did they hire a security company to sit after hours, because that's usually when a lot of this stuff happens. The security personnel are octogenarians wearing a jacket, and are probably not of much use, but it looks good in the hospital. Our nurses still feel unsafe.

Why is it an afterthought? I believe administrations embrace the concept that it's part of the job. We have to get beyond that once and for all. As you've heard, a broad consensus of health care workers.... The extent of violence in the emergency department or in the emergency sector or in the hospital sector or in the community sector is such that our most talented and experienced people are saying they'll forget about it. They're leaving their job.

● (1615)

The Chair: Thanks very much.

Ms. Ferrier, why can't you take your cellphone into your work?

Ms. Miranda Ferrier: I think that in a lot of cases there were complaints from clients that personal support workers or support workers were on their cellphones while they were doing their jobs. I guess employers were trying to do their due diligence by saying they couldn't have their cellphones on them so they would focus more on their duties. I'm sure that happens in home care, but it really puts these people at massive risk.

The Chair: Thank you very much.

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Thank you to all the witnesses for being here.

I realize that when we talk about the health care system, we're talking about diverse settings that require specific responses. I want to focus for a bit on the major urban hospital.

How frequently would an episode of violence occur in a typical major hospital in a major urban centre: daily, weekly?

Dr. Alan Drummond: Daily.

I mentioned crystal meth because that's an increasing concern for our members out west. They've seen increased use of crystal meth in Alberta, Saskatchewan and certainly Winnipeg. You're now starting to see increased use of crystal meth in Hamilton. It leads to psychosis, intensely aggressive people and violent behaviour.

Violence in the emergency department has been bad for the last 10 years, engendered by all these other issues such as nursing staffing ratios and crowding. But now you dial in this other little monster to the picture, and our members are quite concerned.

Mr. Don Davies: Ms. Silas, would you agree that violence would occur on a daily basis in a major urban hospital?

Ms. Linda Silas: Yes. If you look at Dr. Doug's region, we've seen a 1,200% increase in violence in the last five years due to crystal meth in the Winnipeg area: 1,200%.

Mr. Don Davies: Okay, I'm going to get to the rate in a minute.

One of the first suggestions that comes to my mind: I know that in Vancouver we have police officers permanently located in schools, so there's a police presence in a school. It occurs to me that for a major urban hospital, where we can predict a crime, an assault, being committed every day in that location, would it not make sense to establish a permanent police presence in the emergency ward of a hospital, not security guards, octogenarians or people with radios, but a police officer as a prevention?

Dr. Alan Drummond: You used the word “crime”. I have concerns about that, because for the octogenarian who is delirious from his pneumonia and who tries to strangle you with his Foley catheter, is that really a crime? How is that a crime? It's beyond his control. For the patient with substance abuse issues such as crystal meth and who is psychotic and violent, is that really a crime? Or is that really a reflection of the toxic syndrome he is having?

I'm a Tory-blue Conservative, believe me, so I'm a big fan of punishing crime, but in the context of the emergency department, I have grave concerns with characterizing it as criminal activity and not as aberrant behaviour on the basis of organic disease or toxic syndromes. That's my first thing—

● (1620)

Mr. Don Davies: Sir, if I could just stop it there, I'll delve into that in a minute.

In my point of view, an assault on someone is a crime, but what potential consequence flows from that is a matter for the courts. That could come later on.

If we're going to have zero tolerance and if health care workers are going to go to work with the expectation that they are free from being choked, spat on, assaulted, pinched or strangled, then, to me, we need to have some form of security presence there that is effective in dealing with that. We'll leave the judicial determination to others.

I want to turn now to the Westray principle, which is a very interesting point that you brought up, Ms. Silas. Has any facilities administrator in the country ever been charged under the Westray principle?

Ms. Linda Silas: We only had one hospital in Ontario where it was brought in front, and it was thrown out immediately.

Mr. Don Davies: Let's say I'm a hospital administrator and I know that in my facility every day my workers are going to be subjected to a workplace danger. The consequences you've described are already there and are causing people to have PTSD and leave their workplace and suffer all manner of things. Is that any different from a manager at a factory who sees unsafe oil on the floor or some other unsafe sharp, jagged pieces sticking out...? If that happens in that kind of environment, we would expect the managers to take all reasonable steps to make sure their workers are not injured.

Yet it seems that we all can see this and we all know this is as predictable as rain in Vancouver in January. It's going to happen, yet are we placing the right responsibility on health care administrators, as you said, Dr. Drummond, to change it from an afterthought and to move this up to not only a priority but an obligation under the law?

Ms. Linda Silas: You bring up an interesting point, especially in comparing it to the private sector. The private sector puts security as number one. We don't put that security in the public sector, and far from it in health care. If you look at just Ontario, you'll see that in the recent study on benefits to Ontario health care workers due to violence, close to $5 million was paid out in the last year, so it is associated with dollars.

On your comments in regard to a police officer, that's a symbol. We've seen two positive cases in Ontario at the Michael Garron Hospital and right here in the Ottawa region at the Ottawa Hospital after major violent incidents happened. It's all about training in-house security. It's about having more than one. You don't need a gun, but you need a baton.

I asked my security expert what I needed to recognize the right security guard: is it the lines on their uniform? No. If they have a baton, that means they have a higher level of security training and they're good. You have to work with them. It's about making sure that there are well-trained, supportive security staff everywhere. The Michael Garron Hospital, for example, increased this when they started putting security as number one. Throughout the hospital, they had had 29 cameras. They increased that to 350 cameras. You can see every corner of that hospital. In Nova Scotia, in Bill Casey's area, there was a severe incident in the premier's riding, and I guarantee you that violence became a number one issue.

We can have that in all your ridings. We have to talk about health and safety through training proper security and working with the care team, and the care team is everyone—from physicians to personal care.

● (1625)

Mr. Don Davies: Thank you.

Mr. Mellow, you wanted to say something.

Mr. Randy Mellow: I'd just like to say I absolutely support what you've said around holding the employers accountable for safety in the workplace, but I think before we do that, we collectively—and hopefully, those in the room here will agree—have an obligation to support them in doing so.

If I use our work with PTSD as an example, we've come together, and we've invested money in research to better understand the problem and to better understand mitigation strategies. We've developed a national action plan and will soon have a national framework on this, and I think the same focus needs to happen for violence in the workplace.

In the PTSD world, we have worked with CSA to develop a standard for workplace health and psychological health and safety. That type of standard could be applied in the violence piece if we better understood the problem. I think we have an obligation to support employers before we hold them accountable.

The Chair: Thanks very much.

Now we go to Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Thank you all for being here.

Dr. Drummond, you started to talk about this with Mr. Davies. I want to talk about violence as a medical symptom. In those cases, as you said, the assault wouldn't necessarily be criminal because there would be no criminal responsibility.

I think that all of the witnesses here speak to environments with different places on the continuum. In a hospital, you may have the opportunity to assess people and their medical symptoms in the ER and perhaps in the admission process, but in a case of circumstances where violence is a medical symptom, you still have the danger.

What can one do to protect the workers, the health care workers, from that danger when it's really a medical consequence?

Dr. Alan Drummond: That's a great question, and I think it all goes back to education and training, but somebody has to pay for that education and training. When we talk about verbal de-escalation techniques to lessen the degree of hostility, anger or aggression, somebody has to pay for that, and every nurse, every physician and every clerk in an emergency department setting should be offered that access.

If verbal de-escalation fails, there are other methods to reduce the degree of aggression in a patient, depending on what the circumstances are, be it a toxic syndrome, dementia or delirium. There are medications that can be used and chemical restraints. I think it would be good if we were able to promote—we're talking about best practices here—a best practices solution to the types of toxidromes that we see in the emergency department and what kinds of medications can be used in both rural and urban settings.

This is not something that we like to talk about, but it's a reality, and that's physical restraint. When do you escalate up the degree of intervention you use to lessen the risk of harm to a patient?

We have verbal de-escalation, chemical restraints and physical restraints. Somebody has to pay for all those levels of education, and it can't be a one-off. It has to be an ongoing process of re-education to keep staff, so there has to be an administrative commitment to prioritize safety in the emergency department as one of the core values of that institution, not just for the patient and not just for the staff.

What is lost in the argument is the effect on patients in that emergency department. Someone's sitting there with a child with a sore ear, and in the next room there's some guy dropping f-bombs and throwing his urine all around. That's pretty traumatizing to young families and to family members of the elderly, who are often now forced to stay 24 hours in our emergency department waiting for a bed. There are lots of studies of the impact on nurses and physicians. There are virtually none on the impact of this kind of violence in the emergency department on the patients we serve.

Mr. Ron McKinnon: Thank you.

Would anyone else like to respond to this?

Ms. Linda Silas: I totally agree, and it's a question of staffing too. You have to have enough people to take care of the sick. Especially if violence is related as a medical symptom, you need trained people there.

Mr. Ron McKinnon: You have all mentioned that some of the violence comes not from the patient, but it's due to bystanders or family. What is the nature of that violence? What triggers it? Are there emotional issues, or are there other medical circumstances that they themselves have?

● (1630)

Dr. Alan Drummond: The emergency department is and has become even more so, an extremely stressful environment. I've spent my time in emergency departments not only as somebody who works there but with family members.

The number one issue for emergency personnel, emergency physicians in this country and probably emergency nurses, as well, and to a certain extent paramedics, is crowding. Every hospital in this country is crowded which means that every emergency department has people lying on stretchers for eight, 12, 16, 28 hours waiting for a bed to become available for their loved one to be properly treated. That leads to inadequate care in the emergency department itself because our emergency nurses are trained to deal with emergency situations. It's not really their job to provide toileting care to an 85-year-old lying on a stretcher in a hallway.

The elderly get poor care, not by malfeasance, just because of the nature of the beast. Patients are always coming and always have to be assessed. If I was sitting with my elderly father in an emergency department in Montreal and I was watching him for 24 hours in a brightly lit hallway with no privacy whatsoever, his toileting and basic human needs not being met, I think I would be angry. I think if I was bringing a child with a facial laceration from a dog bite and was forced to sit in the Children's Hospital of Eastern Ontario for 12 hours waiting for somebody to assess my child's laceration, I think I would be angry.

That impact is felt every day. The basic problem is hospital crowding leading to emergency department congestion leading to ridiculous lengths of care which are totally unacceptable in our health care system, coupled with the fact that we have inadequate nursing staff and we have paramedics unable to offload their patients, who then have to sort of sit in hallways waiting for a stretcher in emerg.

If there was one institutional issue that is at the core of all of this, I believe that it's crowding.

Mr. Ron McKinnon: Thank you.

I have time for one quick question. I would like to ask Ms. Silas. You spoke having a baton as something that security personnel need. I was wondering if there's any wisdom in also suggesting tasers?

Ms. Linda Silas: Sorry, could you repeat? I didn't hear.

Mr. Ron McKinnon: You suggested that what's important for security personnel to have would be a baton. I was wondering about things like tasers, whether that would be useful or appropriate or contraindicated in any way.

Ms. Linda Silas: With all due respect, I'm far from a security expert so it is whatever the security team decides. One thing they've been asking us is flagging. We need to flag patients who have violent history, patients who have family members who have a violent history. It's a very taboo thing in health care, I think you'd agree, because am I going to pull a purple dot. We put flagging for allergies, if I'm a vegan or a vegetarian, but we won't put flagging if I'm violent or I have a violent history. We have to get over those.

Security needs to deal with what they have and as an employer, they have to give them the tools they need.

The Chair: Okay, we're done.

Now we're going to start our five-minute round with Mr. Lobb.

Mr. Ben Lobb: Thanks very much, Mr. Chair.

There is a lot to discuss and I think the panel here today has brought up some great points. Dr. Drummond, you did bring up a good point about crowding and we think about the population, I don't know if you want to call it explosion, but the population growth in our urban areas. You mentioned Ottawa and you think about how much Ottawa has grown in the last 10 years and really, have the facilities been able to keep up? I don't think they have, so—

Dr. Alan Drummond: What's changed has been the percentage of the elderly and it's currently around 13% or 15%, those of us over 65, *c'est moi*, and increasing so that by 2030, around 30% of the population will be elderly. We have not prepared for that.

In fact, with the health care restructuring in the mid-1990s we had an across-the-board, across-the-nation reduction of acute care bed capacity in this country of about 30%. Of the remaining beds that still are available, we have about a 15% ALC rate, which is alternate level of care patient, which is the patient who requires to be somewhere other than a hospital but can't go home. From the mid-1990s to the 2019, we've actually had about a 45% reduction in acute care bed capacity.

People keep on coming, but there's nowhere for them to go. The promise has always been we're going to provide better preventative health services and home care. I can tell you that it's a joke. People can't got home so they end up in the hospital waiting months to find a nursing home bed, which doesn't exist. That is a problem which causes crowding. It's not population growth, it's the relative age of the population and inadequate social resources for the elderly.

● (1635)

Mr. Ben Lobb: I was thinking about Mr. Davies' comments about if you get punched or kicked should you be charged with assault, etc. I understand where Mr. Davies is coming from, but I'm thinking in one of my communities I represent in Goderich they have a mental health floor and probably on a daily basis there would be two, three or four charges filed just on staff getting kicked, punched, spit at, shoved, etc. It is a tough balance, and I think our health care workers do take a lot and our doctors take a lot; there's no doubt about it. If you read the news you'll see that liquor store clerks are being assaulted by people trying to break through with booze they're stealing. Convenience store people and people who work at Shoppers Drug Mart just let people walk by with stolen goods because they're afraid of being stabbed or punched in the face.

I know we've always had these problems, but it does seem more prevalent today. Is this because there's just a general lack of respect for human beings, or is this drugs? We just finished a study on crystal meth addiction. Is this because people are so addicted now that they're desperate and doing desperate actions? What is it? I know we did talk about crowding, but it's not the guy my dad's age doing this. Is it the addict who's the problem now, or where are we at?

Dr. Alan Drummond: I think it's broader than that. I think there's a lot of inequity in health care; there's a lot of poverty; there's racism that leads to violence in our community at large. A lot of the conversation here is focused on what you can do in the hospital setting. I'm not a Liberal, but the liberal part of my soul would ask these questions. What are we doing upstream to deal with access for the untreated schizophrenic who can't access mental health services in a rural community? What are we doing for the people who have substance abuse issues, who can't access appropriate programs to manage their substance abuse? What are we doing to deal with the disenfranchised somebody in the inner city core? Those things need to be addressed or violence will not go away.

Mr. Ben Lobb: There's no doubt about that. We don't have to go too far from the steps of Parliament to see the issues with homelessness and addiction here in Ottawa.

I have one last question because my time is running short. This is to Miranda. How many support workers, or PSWs, are we short in Ontario, or in Canada? It must be tens of thousands, I would think. Do you guys have a number?

Ms. Miranda Ferrier: Do you know what? We're the only association in all of Canada for support workers. We have guesstimates; that's the best we can do. In Ontario alone, we've guesstimated there are approximately 135,000 personal support workers with only 52,000 working now. If you look at the mass amount we have in Ontario versus New Brunswick, let's say, that number is a lot lower for support workers and PSWs because the province is smaller. What we're seeing is a huge decrease in PSWs, period. We're seeing schools closing across Canada that actually trained them to become support workers. We are past crisis. We are in the red when it comes to the front line of health care in Canada.

Mr. Ben Lobb: Thank you.

The Chair: Ms. Sidhu, you have five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, I'm sharing my time with Doug.

Thank you to all the panellists.

Dr. Drummond, you spoke about the crowd. I'm from Brampton South and we have 900,000 residents and it's the ninth largest city, and we have just one hospital. There are more provincial health care cuts. It's not acceptable; everyone deserves good care. My question is where do you see more incidents. Is it in the hospitals, the long-term care facilities or the home care facility?

● (1640)

Dr. Alan Drummond: Speaking for the emergency department, it's clear. It's a daily issue of concern both rural and urban. The degrees of violence differ. There may be a quantum leap from shooting somebody in Cobourg to swearing at a nurse, but we're all entitled to a respectful, safe work environment. This is not to minimize verbal abuse. I get more than my share. For a lot of people, it wears them down. They put on their nurse's uniform, they go to work, they're community oriented, they want to do a good job for their community, they're here to serve, they're here to help but they're not here to be somebody's whipping boy or target for unacceptable behaviour. It happens in every community.

Ms. Sonia Sidhu: I think, as my colleague said, we need to do research to put in national data. Do you agree with that?

Dr. Alan Drummond: Canada is a country of research and papers and studies that all end up gathering dust in some filing cabinet somewhere. The take-home message here must be that, regardless of what the studies show, at every part of the continuum in health care there needs to be institutional accountability for the safety of our workers and the safety of our patients. That doesn't need research.

Ms. Sonia Sidhu: Thank you.

Doug.

Mr. Doug Eyolfson: Thank you so much, Sonia.

I want to expand a little on the questions between my friend Mr. Davies and Dr. Drummond.

I'm a bleeding heart Liberal and if anything my liberal....

Dr. Alan Drummond: I didn't say “bleeding heart”.

Mr. Doug Eyolfson: I'm actually more liberal than Mr. Davies on this point.

I'm generally not predisposed to laying criminal charges. In the one assault I refer to where my head left a dent in the wall, the patient was very clearly in the presence of a severe psychosis. The police were called because the incident was ongoing, but I told the police in my statement that I was not predisposed for charges. This man needs a hospital, he is in a hospital and he is getting treated—enough said.

In regard to the police presence, would there be a use—and Ms. Silas, you could also weigh in on this—for the presence of them just for protection, as people who are highly trained and can help to deal with a dangerous situation more than your standard security guard? Would there be a role for that, more from the prevention aspect?

Dr. Alan Drummond: I don't work in urban communities—I have—but there is a subset of the population for whom a police uniform is a red flag. That may not be the best choice of a security service for the hospital setting.

Mr. Doug Eyolfson: Thank you.

I have a comment for Mr. Mellow. It was interesting that you said you're not allowed to hold back and wait for the police unless you're sure of a danger.

Is this a province-wide protocol, or is this unique to your area?

Mr. Randy Mellow: This is an issue in Ontario. We have made some headway, as my colleague was discussing, in actually being able to flag residents—

Mr. Doug Eyolfson: Are you using MPDS protocols?

Mr. Randy Mellow: No.

Mr. Doug Eyolfson: Okay, that's the problem.

This is a medical priority dispatch system. One of my jobs, as well as an EMS director, was as the medical director of Manitoba's ambulance dispatch centre for six years. MPDS is an internationally recognized standard for ambulance dispatch.

You might want to talk to your superiors about this because it actually has a default which is the opposite of what you say. If there is even the slightest bit of doubt, the crews are obligated to stage and wait until law enforcement comes to ensure it's safe.

So if you have the opposite of that, I would suggest that you have something in your system that is actually predisposing your paramedics to injury.

Mr. Randy Mellow: Ontario is moving at the speed of a glacier in that direction.

Mr. Doug Eyolfson: All right. Thank you.

The Chair: Maybe we could help.

Thanks very much.

Now we will go to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

I'm going to start on the topic of the infrastructure changes that could help with this problem. I'm from an urban and rural split type of community and I see in rural communities across the country that the hospital infrastructure has not been well maintained because there is so little money in the system. In addition to the actual electrical and mechanical failures that may ensue, the money to convert an emergency room to try to have lockdown, have a single point of entry and all of those things is probably difficult.

Do we have an idea what a typical cost to convert to a best practice would be?

● (1645)

Dr. Alan Drummond: No.

Ms. Marilyn Gladu: I'm not surprised.

Let's talk a little about the long-term care facilities, because we need more and they're building more, but the issue with people and the aging demographic is, increasingly, they are living long enough to then have dementia. Now you have a situation where you have a bunch of long-term care facilities and you have multiple residents in there who may have dementia and may, multiple times, not know where they are or be reacting violently to the situation that they're in.

What are the recommendations about how that should be staffed in order to protect the safety of both the patients and the workers?

Miranda, maybe we'll start with you. Do you have any ideas on what we should do there?

Ms. Miranda Ferrier: I have lots of ideas.

I actually worked in a lockdown unit in a long-term care facility—I'm specialized in mental health and dementia—and I had my nose broken by an 80-pound old lady, who threw me across the room. I was alone on an overnight shift, and I was one worker with 32 residents. The public, in general, believe that at night, people go to sleep. Unfortunately, there's something called sundowning. That happens when people have dementia. On an overnight shift, in a lockdown unit in long-term care, at least half of the residents will be awake, wandering the halls and having behaviours at that time.

What really needs to be looked at is increasing staffing ratios on the overnight shift. Currently across Ontario—I can speak for New Brunswick as well, and a bunch of other provinces—it's one personal support worker or health care aide—whatever we want to call them right now—with up to 50 residents in a lockdown unit. You have a nurse. You're lucky if she or he is in the lockdown unit with you the whole time, because they have a huge job. It's a disaster, not waiting to happen, because it's happened in many different situations.

Ms. Marilyn Gladu: Does anybody else want to weigh in on that one?

Ms. Linda Silas: I totally agree.

Ms. Marilyn Gladu: Good.

I liked your idea, Linda, about signage to try to disincentivize people, and let them know that if they do attack a health care worker, there are consequences. People forget where they are. They forget that there are consequences, and that it's an actual attack.

Ms. Linda Silas: We have to take it out of the hands of health care workers. If a health care worker or a nurse gets injured due to violence, and the patient or family member, whoever attacks—the accused—breaks hospital equipment, the hospital will put a charge against them to recoup the hospital equipment, but will not help the health care worker bring a charge.

I alway say, “I'm not a lawyer. I'm not a criminal expert. Why is it for me to decide if a criminal charge should be placed?” It should be automatic, unless the court decides. It's not about the diagnostic. The diagnostic is all about safe staffing and appropriate training. That's how we take care of the sick. If it doesn't work, then it's a criminal issue.

Ms. Marilyn Gladu: Do you have a quick question, Len?

Mr. Len Webber (Calgary Confederation, CPC): Yes, I can ask a quick question here.

Mr. Mellow, is it common that paramedics are doubled up around the country?

Mr. Randy Mellow: Yes, they're most frequently in pairs.

Mr. Len Webber: Miranda, with these personal care workers, it's just one person in a home, most of the time. I lost your volume there, but I can see you nodding yes. I know that you're short of personal care workers, but I think doubling up in these homes should be considered. Do you have any thoughts on that?

Ms. Miranda Ferrier: Absolutely. I think it would actually attract more people to the field.

The Chair: Thank you.

Now we go to Mr. Ouellette.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much for your testimony.

According to the World Health Organization, gender plays a significant role in health care, as a risk factor for experiencing workplace violence. A large portion of employees in the health care sector are women. In addition, women tend to be concentrated in some of the lower-paying and lower-status jobs in the sector. Because they lack power and authority in their positions, this might place them at greater risk for being a target of violence, including sexual offences. Could you describe the role that gender might play in the risk of violence against health care workers?

● (1650)

Ms. Linda Silas: Thank you for bringing up the World Health Organization, but also, this June, the ILO, the International Labour Organization is looking at a convention on violence in the workplace, and health care workers, and a gender analysis is being used. We have the federal, provincial and territorial governments, unions and employers who are going to be there debating that. It is an issue. It is also an issue in health care, because still today, 90% of health care workers are female, and there is that caring—that extra guilt—put on you.

As Miranda said, regardless of whether it's a home, long-term care or the acute care sector, if you're working alone, and you're female, you're in a more dangerous situation. Hopefully, we will have a convention in June with the ILO and Canadian government and—

Mr. Robert-Falcon Ouellette: How much does race and being a woman—for instance, a Filipino, small, nurse...? Are they subject to more violence than a large male?

Ms. Linda Silas: Yes. Like anywhere else in society, when you're racialized, it is even more dangerous. That's the discrimination that exists, sadly, everywhere. In home care, that's where we see a lot of nurses of all categories go because they haven't found a job in the acute care sector. They go and work alone in home care, and it's disastrous there, from what we hear.

Miranda could tell you even more horror stories.

Mr. Robert-Falcon Ouellette: I'm sharing my time with Pam.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thank you, Robert.

Chief Mellow, you mentioned the work we've done around post-traumatic stress injuries, and that's something I've actually been involved with since the beginning. It struck me that a lot of the stuff we've talked about is actually provincial and comes through provincial funding.

In terms of looking at violence against health care workers—Dr. Drummond, you talked about training—is there standard training that could be provided to health care workers? Is there a role that we could play, first in raising awareness but also in being able to provide the best training for health care workers? I know that in Halton there's a program called COAST, where mental health workers go out with police. They're specially trained to deal with mental health issues or mental illnesses, and that partnership has dramatically reduced the injuries to the police officers.

I'd ask that to all of you, actually, to see if we could play a role in creating that framework and best practices.

Mr. Randy Mellow: I could briefly start off. My colleagues may disagree, but I'm sometimes accused of being sort of paralyzed by the need for evidence. There are some fantastic hypotheses brought forward, and we've answered them anecdotally. We need to stop doing that. We need actual research on what does actually.... Where's the prevalence? What are the right mitigating strategies? Who are the different target groups? Who's more susceptible? We need a little more evidence around that.

I don't think we should be stopping our interventions, just like we aren't in mental health. We need to move forward with some of those programs that we do understand around recognition of violence, de-escalation, tactical disengagement where appropriate, things like protecting both the patient and the workers through some form of support, as we discussed earlier—chemical restraints and things like that. We need to put some of that in place now, but we can't do that without proper evidence going forward. We need to do more research, and I think that's the role that this group could support.

Ms. Pam Damoff: Are there any thoughts?

Ms. Linda Silas: Yes. We need data, and it's one of our recommendations, but we can't wait for it. I saw a 1,200% increase in violent incidents in the city of Winnipeg. Sorry, we can't wait. What the federal government can do is push forward the best practices. They do exist, as I mentioned, at the Michael Garron Hospital. Those are being transferred here to the Ottawa Hospital because of a champion, who is Dr. Kitts, the CEO. He saw what was happening, went there, and said that it's all about training, staffing and security. They need to work together, and they're changing the way they're doing it in Ottawa. We have other examples.

The federal government can transport those best practices and, yes, do the data analysis and the evidence.

● (1655)

The Chair: Thanks very much. The time's up.

Now we go Mr. Davies.

Mr. Don Davies: Well, I've been 11 years in Parliament as a New Democrat, and I've never been the most conservative person in the room before—

Voices: Oh, oh!

Mr. Don Davies: —so I'm trying to absorb this, but I clearly have misspoken.

I do want to clarify this. Certainly, I don't mean to suggest that a senior who is clearly living with dementia and hits out should be criminally charged. Of course I don't mean that. What I meant to say is that, with a police officer present in a place, their ability to intervene right away is what I think could be stepped up. I trust health care professionals to differentiate between those situations where there's accountability.

That leads to a question, and I wonder if you could help me. If you could venture a guess, what percentage of the violence that you see in the health care workplace is committed by those who are not legitimately responsible versus those you think may be?

Dr. Alan Drummond: I'm not a big fan of guessing, so I won't.

Mr. Don Davies: Is there data you're familiar with?

Dr. Alan Drummond: Actually I'm not. What I would say is this: I think there is a subset of the population that commits or perpetrates violence, or is involved with violence that probably falls into their world view.

Gang violence is regrettably an issue in Canada, and when gang violence ends up in the emergency department, you're a totally legitimate target for judicial undertakings. When you are the loved one of somebody in attendance in the emergency department and you strike out at that staff, you don't have the excuse of somebody who's delirious.

There is, of course, a subset of the population that would benefit from that approach.

Mr. Don Davies: Ms. Silas, do you have anything to help us understand that?

Ms. Linda Silas: No. It would really be guessing. There are horror stories on both sides, from patients and from family and friends—and co-workers too. We just need more data.

Mr. Don Davies: I was just going to say that. It would strike me that we really need that data, because violence committed by people who are not accountable is very difficult to prevent. It's going to happen. I think we'll need different strategies for how to mitigate that versus someone such as a family member who is allowing their frustration to get the better of them and they are striking or shoving a nurse or threatening someone out on the street.

In a hospital, is there any difference? Is the preponderance of violence happening in the emergency room or in wards? If so, are there particular wards in which it happens more? Is it more in extended care homes, or on the street? Do we have a general idea of where this violence is occurring?

Dr. Alan Drummond: Yes. There is a good body of literature that looks at violence. The three major parts in the hospital sector are the emergency department, the geriatric unit and the psych unit. It's those three.

Ms. Linda Silas: Yes, and the new and upcoming one is home care.

Mr. Don Davies: Mr. Mellow, I will give the last word to you. I have only three minutes.

Your members are out on the street, so it's a very different workplace environment. What concrete suggestions would you like to see implemented to make sure those paramedics can enjoy a safer, healthier workplace?

Mr. Randy Mellow: Again, we are out on the street, but not unlike the other workers who are in the homes. It's very similar.

Again, we need supports in that whole continuum of the issue to understand how to recognize, how to de-escalate and how to protect when necessary. We need the public to understand. We need to get that message out.

As I said in my opening statement, we need to support the employers to be able to provide the safety measures that are necessary, but we also need to reduce stigma and empower our workers to stand up for themselves and be able to report these incidents. We need a firm commitment from employers, and we need a firm commitment from the community to actually pursue the charges when it's appropriate.

We understand that probably the majority of incidents aren't egregious behaviour. The majority may be of some other medical issue. When we look at verbal abuse and intimidation, most of those are egregious and we need to get the message out that it's not acceptable, and support our workers and support our employers as well to stop it.

● (1700)

The Chair: The time is up.

I want to say on behalf of the committee, I can't imagine four people who could have defined this challenge better than you four have. You've done a great job of articulating the problem. This is the first meeting we're having on this issue, but I know, from my point of view, it's more pervasive and serious than I thought it was.

Thank you all for what you've done.

Ms. Ferrier, I know it's difficult to do what you have done, to sit there on the video conference, but you have done really well. Thanks very much for that.

Ms. Miranda Ferrier: Thank you.

The Chair: Chief Mellow, we had paramedics here when we did a post-traumatic stress examination, and the stories they shared with us were memorable for sure.

Anyway, thanks very much to all of you for helping us with this. This is meeting one and we have three more to go. We'll learn a lot by the time we're done, but you've given us a good start.

We're going to suspend for a few minutes.

[*Proceedings continue in camera*]