



HOUSE OF COMMONS  
CHAMBRE DES COMMUNES  
CANADA

# **Standing Committee on Public Safety and National Security**

---

SECU • NUMBER 007 • 1st SESSION • 42nd PARLIAMENT

---

**EVIDENCE**

**Thursday, March 10, 2016**

—  
**Chair**

**Mr. Robert Oliphant**



## Standing Committee on Public Safety and National Security

Thursday, March 10, 2016

• (1110)

[English]

**The Chair (Mr. Robert Oliphant (Don Valley West, Lib.)):** I call the meeting to order.

Thank you to our witnesses for waiting.

This is our first meeting on our study looking at PTSD and OSI. We are going to be studying the issue over the next several weeks, starting with some foundational witnesses.

Just so you know, you are foundational witnesses. From your testimony today and the questioning, we'll be developing our study over the next several weeks and moving ultimately with a report to Parliament with recommendations for government actions. That's the context of what we're doing.

We welcome Jitender Sareen, professor of psychiatry, from the University of Manitoba, as well as Dr. Shlik, the clinical director at the Royal Ottawa. I'm going to suggest that we begin with Jitender Sareen.

You have 10 minutes to present. Then we'll have a second presentation of 10 minutes. Then the committee will ask questions, and they can direct them to either of you as we go.

The floor is yours. We'll let you know at just around 10 minutes, so if you're running out of time, you might...

**Dr. Jitender Sareen (Professor of Psychiatry, University of Manitoba, As an Individual):** Thank you very much for inviting me. It's a pleasure to be here. I really appreciate the opportunity to speak to this important issue for us.

To give the committee a context of who I am, I'm a psychiatrist at the University of Manitoba, and I've worked here for 16 years. I've worked at the Winnipeg operational stress injuries clinic for about seven years, and I've also done work with our team in post-traumatic stress epidemiology research as well as military mental health research and suicide prevention work. Currently I chair the research committee and I'm a board member for the Canadian Psychiatric Association.

Today I'll summarize what we know about operational stress injuries and my suggestions for future work in helping public safety officers in Canada.

An operational stress injury, as defined by Veterans Affairs Canada, "is any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian Armed Forces or as a member of the Royal Canadian Mounted Police." It is

used to describe a broad range of problems which include diagnosed psychiatric conditions, like post-traumatic stress disorder but also other conditions.

Operational stress injuries are associated with substantial morbidity, mortality, health care utilization, and financial cost to our society. They not only affect the member but also the member's family, and it's important that we address these issues carefully.

Here I'd like to underscore that most people exposed to traumatic events are actually resilient. Almost all of us have struggled with trauma and have faced traumatic events, but the vast majority of people do recover. Post-traumatic stress is the signature condition, but other difficulties like anxiety, depression, alcohol problems, and physical health conditions can also result from traumatic events.

It is also important to note that there is a dose-response relationship between the number and severity of traumatic events, for example, seeing dead bodies and being physically assaulted. If there's an increased number of events at work there is a dose-response relationship with mental health difficulties. However, it is really important to understand that mental health problems are a combination of biological risk and protective factors, psychological risk and protective factors, and socio-cultural factors.

Biological factors that are known to increase the risk of operational stress injuries include being female, having a family history of mental health problems, which increases the genetic risk, as well as physical health problems, very commonly, traumatic brain injury.

Psychological factors that are known to be associated with mental health difficulties include an impulsive, aggressive personality style and a highly perfectionist and self-critical cognitive style.

Socio-cultural factors are also very important, including the experience of adverse childhood events, poor social supports, family violence, racism, and poverty and financial stress.

From the international literature, there are six main approaches that are important in the prevention and treatment of work-related mental health problems and post-traumatic stress.

First, prevention strategies include selecting people who are resilient and have little history of severe mental health difficulties.

Second, workplaces that provide systematic training, an organized work environment, and supportive colleagues and managers reduce the risk of mental health difficulties.

Third, the military has developed resilience training programs for personnel and families to help them learn skills in managing stress before they're deployed as well as after they're deployed. At this time we're not aware of evidence-based national resilience training programs that are being implemented among public safety personnel. We're working on developing a mindfulness-based cognitive behaviour therapy course to help people learn coping skills when they enter a stressful job.

● (1115)

Fourth, there is strong evidence that cognitive behaviour therapy and prolonged exposure therapy—another psychological treatment—are useful in treating people who have acute stress disorder and post-traumatic stress disorder. These treatments are delivered by trained mental health providers. Due to the limited number of providers and large number of people who could benefit from this type of intervention, the latest research is testing innovative strategies for providing cognitive behaviour therapy through Internet-based platforms, telephone-based strategies, as well as large classroom platforms.

It is also important to note that medications are important in treating people who are suffering with post-traumatic stress and other mental health conditions. Antidepressants, like paroxetine and sertraline, have been approved for the treatment of anxiety and depression.

Medications that specifically target insomnia, which is often a major concern of people who come to us for care, are very important. Prazosin is a high blood pressure medication that has been shown to be quite effective in helping people with nightmares, sleep difficulties, and PTSD symptoms. Trazodone, another antidepressant, and zopiclone, which is a hypnotic, can also be used.

Benzodiazepines are generally not recommended for post-traumatic stress disorder. However, they can be used carefully among people with severe anxiety. Atypical antipsychotics have also been shown to be effective in people with severe anxiety and depression.

Here it is important for me to clarify that none of the practice guidelines support the use of medical marijuana for PTSD. Although this is a common question from clients, the evidence weighs in the favour that marijuana use can actually worsen PTSD symptoms. I think it is important for us to carefully study the impact of marijuana and medical marijuana in PTSD, not just in short-term outcomes but long-term outcomes, especially around functioning.

Here are some specific recommendations for policy.

Although there is increased awareness of operational stress injuries in public safety officers, we do not have good Canadian information on the prevalence, prevention, and treatment of these conditions in our unique Canadian environment. Much of what we know comes from the U.S. and other countries.

However, we can learn from our Canadian military and veteran partners that have systematically addressed mental health problems

and suicide over the last 15 years. Although a lot of work can be done in this area, the military has placed significant strategic initiatives that have been very successful in improving the lives of military and veterans.

The military has invested in getting accurate estimates of mental health problems among their populations by conducting state-of-the-art epidemiologic surveys that are nationally representative. They have also implemented post-deployment screening tools to identify and treat people quickly.

Veteran Affairs Canada has funded a national network of operational stress injury clinics that include interdisciplinary teams to help people recover from operational stress injuries. They've also worked with Queen's University to develop the Canadian Institute for Military and Veteran Health Research, which encourages unbiased, arm's-length research with university partners. Over 35 institutes across Canada are involved with this Canadian institute.

Similar to the approach taken by the military, I suggest that we need to do three things. First, we need to invest in a national mental health survey of public safety personnel. Second, we need to create an arm's-length institute that engages academics, policy-makers, and key stakeholders to advance the knowledge in this area. Third, we need to develop clinics that are funded in partnership with federal, provincial, and workers' compensation boards to help people have quick access to appropriate treatments.

To give a bit more detail around this, there is a need for a national mental health survey, because the rates of mental health problems in this group range from between 10% to 40%. Some argue that because of the selection, people who are public safety officers might have lower rates of mental health difficulties, where others argue that because of the high-stress environment, there are actually higher rates than in the general population. We actually don't know.

● (1120)

A national institute—

**The Chair:** I'm just going to ask you to wind up a little bit if you can.

Thank you. I'll give you another minute or so.

**Dr. Jitender Sareen:** I have two last comments.

The national institute would guide a national action plan for research; create a national online resource for clients, families, and providers who have evidence-based information; and have standards of minimal intervention.

Thank you so much for the attention. I look forward to your questions.

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

Mr. Shlik.

**Dr. Jakov Shlik (Clinical Director, Operational Stress Injury Clinic, Royal Ottawa Health Care Group):** Mr. Chair, esteemed members of the committee, Professor Sareen, I'm speaking to you from the Royal and just using the opportunity to acknowledge that we are very privileged to contribute to work on this important topic here at the Royal. The Royal, as you may know, is an academic health science centre and it has been contributing to the leading edge of research on a variety of topics, amongst them depression and suicide.

The Royal has some experience in work with first responder services. For example, we have provided extensive mental health training to nurses within the correctional services. I work at the operational stress injury clinic here at the Royal, and at some other clinical programs at the Royal. I am a psychiatrist and clinical director of the OSI clinic. I have a few notes about the OSI clinics, which Professor Sareen also mentioned in his introduction, which, by the way, was an excellent overview.

The Royal has operated the OSI clinic since 2008, so this is part of the network funded by Veterans Affairs. We provide specialist care and support to the members, and mostly veterans, of the Canadian Armed Forces and also to the current and past members of the Royal Canadian Mounted Police who are experiencing mental health problems, as well as their respective families. I will speak to my experience as a clinician providing services to this particular population. To the issues of public safety officers and first responders we can easily apply some of our experience to that population as well, although, as it was mentioned before, particular aspects of their mental health issues, operational work stress problems, definitely need a further, more detailed survey and study.

We have some experience with paramedic services. Our department of psychiatry has been engaging in a round table around the issues that paramedic services, first responders, are struggling with, and they, in their grassroots-level initiative, have been collecting some data on the impact, on the consequences, on the services required, and this type of work needs to be done in a more coordinated and integrated way.

As was mentioned before, operational stress injuries in public safety officers and first responder types of workers, may be in some ways similar to those experienced by federal police and armed forces personnel and veterans, but there are certain specifics and certain cultures and subcultures that need specific attention. For example, the issues that corrections workers deal with in their day-to-day life and those of paramedics overlap somewhat, but also have many specific differences. This may lead to a certain fragmentation of the system of care and approach. We, on the site, have been witnessing certain developments that may lead to a variety of approaches, a lack of coordination, and the resources, as a result, are not used properly and not accessed in a way that leads to impact.

One obvious aspect, especially from our work with the federal police, which is really important to emphasize, is the importance of promoting a positive culture and perception around the work-related stress and operational stress injuries. To give some examples, Professor Sareen mentioned work done by the Department of National Defence. We found that for one of the programs, which is named road to mental readiness, R2MR, this approach has been adopted now as far as we know by the RCMP as well. The process of

training and implementation has been done in various units and this program takes into account the continuum of mental health difficulties in operational work and also provides certain ways to access help and also how to help themselves.

• (1125)

This type of program may be easily adopted by the first responder services, and as was mentioned before, the models of care and expertise of the existing hubs of research and care should perhaps be taken into account, and correspondingly, a data-driven integrated strategy would be very helpful to have with all the input of stakeholders on national and provincial levels.

Perhaps I will stop now.

I will be happy to answer any questions and comments. Thank you very much for your attention. It's definitely a privilege to contribute to this important work.

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

We turn to the questions, and we have seven-minute rounds with four questioners.

Ms. Damoff, you'll begin, please; thank you.

**Ms. Pam Damoff (Oakville North—Burlington, Lib.):** Thank you very much and since I am the first one to ask questions, I would like to comment on the fact that a parliamentary committee is studying this issue. I think it's a huge step forward and I can't say how thrilled I am that we're doing this and we're going to get it out there.

One of the things that you mentioned, Dr. Sareen, was the definition of operational stress injuries. You mentioned it was defined by Veterans Affairs Canada. I know from reading some information it's not recognized by the American Psychiatric Association. Is it recognized in Canada?

Before you answer that, one of the issues I've come across is different terminology. There are operational stress injuries, there's operational—my mind's gone blank—occupational.... What is the difference and what is the recognized terminology within your organization?

**Dr. Jitender Sareen:** That's an excellent question.

Operational stress injuries is the term that has been defined by the Canadian Forces and Veterans Affairs. I think the important piece is that it shows that post-traumatic stress is not the only disorder that can happen related to combat stress or trauma. It is a signature condition but generalized anxiety disorder, panic disorder, and other conditions can also be linked.

The other thing that's important for you to know is that there's a move in psychiatry away from dichotomous "does the person meet the full criteria for a condition or not?" Lots of people who come with some threshold PTSD symptoms are resilient. They have lots of supports but they're struggling with nightmares or having difficulty with irritability, and it's linked to their service. The Canadian Psychiatric Association agrees with this terminology.

The other question is occupational stress versus operational stress, I think that is a bit of semantics because there's a whole literature on occupational health, and I think the aim is to try to link the mental health difficulties to the occupation. I'll try to make some comments around this at another opportunity. The most emotional difficulties are an interplay between the stressor and pre- and post-vulnerability. When I'm sitting with a person it's hard to try to figure out if it's exactly related to their work or not, and we've done work showing that it's a combination. Adverse health experiences—family stress, financial stress—impact on and worsen symptoms as well as a person's recovery.

•(1130)

**Ms. Pam Damoff:** One of the other things you talked about were clinics where partnerships between federal, provincial, and the WSIB, for example, provide quick access. There's a stigma attached to this. Even providing the quick access, people may not want to go to it because they're afraid other people they work with in corrections or in policing or firefighting will look at them differently. How can we go about removing the stigma? I like what you were saying about not putting terminology on it, but do you have any comments on that?

**Dr. Jitender Sareen:** That's an excellent question.

What we're trying to move toward is giving people lots of different options as far as care is concerned. There's a lot of work now being done on Internet-based cognitive behavioural therapy, so people can have access to evidence-based psychological treatment on their own. That might help people with mild to moderate conditions.

There's some very nice literature showing that Internet-based CBT actually has similar effectiveness to face to face. That's one piece. We need to think about a range of different options.

Yes, there is stigma in the clinics. You could argue that people who develop cancer, and are going to the cancer care building, are going to have to deal with some of that stigma. What we find is that people often suffer alone and feel they are the only ones dealing with this. As you know, suicide is an outcome of people feeling alone and not feeling there's anybody there for them. We have used a lot of classroom and group-based work. People learn from each other and often recover faster because they challenge some of those concerns.

I think this is where there has to be some support within the leadership for destigmatizing mental health issues. You can get burned and have a physical injury that everyone can see. PTSD is a silent injury, but it's probably just as severe.

**Ms. Pam Damoff:** I only have a few seconds left. I've asked this of a few other people before.

Do you know of any research being done on the cost of these mental health issues, the cost to the RCMP or corrections? Do you know of any work that's been done on that?

**Dr. Jitender Sareen:** We don't have good estimates in Canada about the costs to the system, but what we know from other countries is that they cost the system a lot, huge amounts of disability payments.

If you look at disability claims, the most common reason for disability claims is depression. This is where the fractionation and

the fragmentation of the system is. People often suffer, they are off on disability, they don't have timely access to psychological treatment and medical treatment, they fear going back to work because they might have difficulties performing, and then they are on disability and can't get back to work.

•(1135)

**The Chair:** Thank you, Dr. Sareen.

Go ahead, Mr. O'Toole.

**Hon. Erin O'Toole (Durham, CPC):** Thank you, Mr. Chair.

Thanks to both of you gentlemen. I found it very illuminating, dealing with some of the issues I've been working on as a passionate advocate before I became a parliamentarian. Your work is appreciated. I've also had the opportunity to go to the Royal on a few occasions, so thank you for your work.

I think most of my questions are going to be for Dr. Sareen, based on your testimony here today.

Your comments on medical marijuana struck me because, as you may know, I was veterans affairs minister, and I tried to have a clear discussion on the use of medical marijuana, which as you know, veterans affairs approves when prescribed by a physician.

There's a real divide between use for some symptom relief—which is known for chronic pain or a variety of other things—and some suggestion by advocates and some commercial companies that it is a cure or recognized treatment for PTSD.

That concerned me, so I went out clearly on that because people who are striving for assistance should not be preyed upon by the growing commercial practice. I still get notes from some of the online folks suggesting there's clinical support, and then I look at the article and it's not clinical support at all. Can you talk about that for a moment?

**Dr. Jitender Sareen:** Absolutely. There was a systematic review done last year on the use of medical marijuana in medical conditions in *The Journal of the American Medical Association*. What it showed was that in certain non-psychiatric conditions there might be some benefit, but in psychiatric conditions the data is not strong enough to say that medical marijuana is a long-term useful treatment.

I think that, as you were saying, there is a divide between what the public perception is and industry. I made that comment specifically because I think it is important for this committee to appreciate that there is a lot of wish.... Every single week I get questions about prescribing medical marijuana. I don't do it. The reason is that we know and have known for a number of years that marijuana use is associated with worse outcomes in PTSD. Especially in young adults, in whom there's a developing brain, there is a risk of psychosis that has been shown repeatedly.

I think there is a major divide between the medical knowledge... and I think it calls for important research that is unbiased and that looks not only at short-term but also at long-term outcomes. If you think about alcohol, it helps with anxiety, but we also know that alcohol problems can happen, long term. I don't disagree that it may have short-term benefit, but we're trying to help people, long term, return to their best level of functioning and get back to helping their family.

**Hon. Erin O'Toole:** Thank you.

I appreciate your raising it, because I think it's important, particularly for the cohort you talk about, the young person who is trying to transition to a new career and who is looking for symptom relief, that we not hold this out as some solution when it can be more a detriment. I appreciate that.

I also appreciate, because we are starting to look at this, and my colleague Todd Doherty is here, who has been long advocating for a national strategy on operational stress.... Your three recommendations were very helpful. I'm going to explore number two for a moment, on the national institute.

In many ways, the previous government, working with universities, Veterans Affairs, DND, CIMHVR, and Dr. Aiken at Queen's, and their network of I think as many as 25 or 26 universities now.... Is that institute, in some ways, or do you think it could be....? Does it need a broader mandate? Can it be that national institute you're talking about?

• (1140)

**Dr. Jitender Sareen:** I think it probably requires a separate institute or a partnership.

I want to highlight the importance of the institute. First, everybody has a bias, including me, drug companies, and police. One piece is to try to bring people together to really look at the science and try to understand the truth—does this work or does it not?

The other important reason there's a need for an institute is that we know from research that usually a research discovery sits on a bookshelf for 30 years before it comes into clinical practice. These kinds of institutes really drive the relationship among policy-makers, stakeholders, and academics. We academics like to sit in an office and write papers. This gets us out to understand what the questions are: what are the firefighters and the national firefighters association dealing with at this time, and can we work together on addressing these questions in a timely manner?

**Hon. Erin O'Toole:** Can I jump in? I want to get one more question in, and I'm conscious of my time.

You talked a little bit, under the national institute section of your recommendation, about the online resources. One thing we developed while I was minister—and I was very happy to see the new minister roll it out—was online tools for caregivers particularly, or for people working with somebody struggling with OSIs in the home. Have you had the chance to look at or contribute to what Veterans Affairs produced, and what are your thoughts on these tools going forward?

**The Chair:** Be very quick, please.

**Dr. Jitender Sareen:** I think it's the future. I think that trying to get people to have access—and we use large classrooms where we give people self-help tools they can utilize at home—is the future of care.

**Hon. Erin O'Toole:** Thank you.

**The Chair:** Monsieur Dubé.

[Translation]

**Mr. Matthew Dubé (Beloeil—Chambly, NDP):** Thank you, Mr. Chair.

Thank you, gentlemen, for being here today.

In the context of this study and related issues, the situation facing corrections officers is being somewhat overlooked. An officer once told me that the people who perform those duties sometimes feel like forgotten police officers, in the sense that most people have no idea that officers on the front lines have to deal with extremely difficult situations.

We have learned that, in recent years, the number of accidents in that work environment has been on the rise, especially in 2014. These are often called accidents, as though these incidents were happening in a factory, but in fact, these accidents are often associated with violence and very troubling situations.

I would like you to comment on the resources that may or may not be available. I actually think this is a major problem. Of course, I mean no disrespect to the RCMP, the Canadian Forces, police forces, and firefighters, but I note that we are talking about them a lot, even though there is often a tendency to forget these officers.

Based on your expertise, can you tell us how it might be possible to learn more about the problems these people face, and therefore provide them with the resources they need?

[English]

**Dr. Jitender Sareen:** I'll give the opportunity to respond first to Dr. Shlik.

**Dr. Jakov Shlik:** Thank you.

I appreciate very much, Mr. Chair, the fact that this question was raised. We have had some experience with people who we've worked with in the corrections system through our clinic for veterans, because some of the veterans went on to work in the corrections system. This experience is very cursory. It doesn't give us a big picture, but it does give us some reflection.

For us, it was striking how difficult this work can be, and how little support and how little ability to cope people might sometimes experience. It's not that the support systems do not exist, but perhaps they are just not accessed, not developed, or not supported.

We've heard—again, as was mentioned before, it's hard to find really reliable data—that the rate of diagnosis of post-traumatic stress disorder specifically in correction services is striking, and possibly startlingly high, and it calls for action. Some work can be done on more training, at least in practical experience with mental health nurses.

In correction services, that was provided by the Royal and it seemed to be well received. That is suggested as probably one of the stepping stones in the system. I think the workers in correction services should be empowered by the same tools and systems, including peer support and access to care, with a variety of technologies and options, as any other operational employee would be.

● (1145)

**Mr. Matthew Dubé:** Before you answer, Mr. Sareen, I just want to elaborate on that. You've mentioned a lack of data. Is the lack of data representative of a lack of tools? Does the fact that we don't have the answers to those questions demonstrate that there is more work to be done to better understand that specific work environment and what tools we can put in place?

**Dr. Jitender Sareen:** Yes, I think it's both that and the fact that there hasn't been a survey done. Mental health surveys, if they are done well, are expensive. But we have worked with Stats Canada, and the military and Veterans Affairs have invested in getting accurate information, because you can't guide policy if you don't have an accurate number. If we have  $x$  percentage of cancer, then you know how much to spend on cancer.

We don't have information about this. What are the accurate estimates? Are we dealing with 10% PTSD, or 30%, or are we dealing with 50%, whether that's in nurses or in security officers? I completely agree with you. I've treated and seen in my practice people who have struggled with PTSD, because it is a very high-risk environment. You're holding people down and you're being assaulted, and that physical assault has been shown to be a specific risk factor for post-traumatic stress disorder.

**Mr. Matthew Dubé:** I appreciate that.

The work that happens when we're talking about data, and when you look at the purview of Veterans Affairs, I don't believe it covers necessarily correctional officers. I might be wrong about that, but do we have more work to do to get data that's more in tune with their specific workplace and the issues there?

**Dr. Jitender Sareen:** Absolutely.

That is exactly what I'm recommending. We need evidence-based policy, and you can't start with programming without a good estimate of.... You know if you look at cancer registries, first you need to get accurate information about how common it is and what's happening before you can invest in it. At the same time you still have to invest in getting people treatment. I think we're about 15 years behind the military and veterans around public safety officers and what we do in Canada.

[Translation]

**Mr. Matthew Dubé:** Okay.

Fifteen years is quite a significant gap. I appreciate your comments on this issue.

Regarding my first question, I mentioned situations that are described as workplace accidents.

For police officers and soldiers, there is a degree of physicality associated with the work they do. When we hear about accidents related to their work, we have a pretty clear idea of what that entails.

I think I read in a recent report that two-thirds of those kinds of accidents involved violence.

In your opinion, should we be using more appropriate language when talking about these issues?

● (1150)

[English]

**Dr. Jitender Sareen:** Yes, I'm just trying to understand the question.

Is the question, should we change the terms of workplace safety?

**Mr. Matthew Dubé:** When we say workplace accidents, and two-thirds of those involve violence, are we doing a disservice in making it sound like it's something that might...giving a different perception of the public that impedes our job to get the proper treatment for PTSD and such.

**Dr. Jitender Sareen:** Yes.

I agree with you. I think it is important to note though that the majority of people who are hurt are resilient. Saying that if somebody gets injured that means they have PTSD, I just don't want that to be the outcome.

You're absolutely right that the more times a person is injured there's a higher risk of getting post-traumatic stress, but I wouldn't equate it.

[Translation]

**The Chair:** Thank you.

Mr. Mendicino, go ahead.

[English]

**Mr. Marco Mendicino (Eglinton—Lawrence, Lib.):** I'd like to thank both of the witnesses for appearing today, and I have been listening attentively also.

I also want to thank Mr. O'Toole for his work on the file in the previous administration. I'll echo Ms. Damoff's comments. I think this is an important topic worth taking up at this committee at this time.

I have a number of questions for Dr. Shlik.

I'd like to take you to your written submission. Do you have that before, sir? If you could go to point 4, key learnings based on our clinical experience....

**Dr. Jakov Shlik:** Yes.

**Mr. Marco Mendicino:** What I see in this section are what appear to be the elements of a strategy or a way forward. Some of the elements or the key ingredients of this strategy include a move toward developing policies.

The first point talks about policies to develop a positive culture and perception in the workplace. Is that a fair characterization?

**Dr. Jakov Shlik:** Yes, it's a fair characterization. It's an assortment of impressions and suggestions as you mentioned, indeed.

**Mr. Marco Mendicino:** A little further down you address resources, and you talk about access to care. There is a bullet point that says, “Access to care: specialized assessments and effective evidence-based and research-informed therapies”.

We need resources to ensure those who suffer from OSI or PTSD have the requisite access. Am I right about that?

**Dr. Jakov Shlik:** That's correct.

**Mr. Marco Mendicino:** Further down you have a component that deals with education and training on traumatic stress. Yes?

**Dr. Jakov Shlik:** Yes.

**Mr. Marco Mendicino:** Then there's technology. This is about leveraging innovation and the developments we have in technology to ensure that those who suffer from OSI and PTSD are able to get the best treatment possible. Yes?

**Dr. Jakov Shlik:** Yes, indeed, technologies can be critical to the empowerment of individuals. They can help people become more capable of dealing with their situations and be open to seeking help when they realize that this is the time. We need to help people to make that differentiation.

**Mr. Marco Mendicino:** Obviously, ideally we would be detecting these symptoms at the very earliest of stages so that we could prevent the onset and development of OSI to its latter or worst stages. Is that a fair statement as well?

**Dr. Jakov Shlik:** Yes. We as clinicians know that when an individual comes to seek help, in our minds we often think to ourselves that unfortunately it's a bit late. People do not seek help for a variety of reasons.

**Mr. Marco Mendicino:** Very succinctly, could you help us stitch together these elements in a coherent strategy? How do you see these pieces fitting together?

To go back to my original analogy, I see the ingredients here. They are bullet-pointed out, and we can take them out and look at them in isolation. But do you have a vision that pulls all of these elements together for a strategy that works for your institution and that could be applied potentially as a model across the board for first responders?

**Dr. Jakov Shlik:** I really appreciate how you put this question, because it's critical to have a big picture but not to miss important components.

I might not be able to provide a very quick strategical review here at this time, but I see it as a continuum. It's a continuum that starts with the culture in the workplace: supports, openness, and the presence of certain tools and settings. Peer support, for example, is extremely helpful and in great need of empowerment. Peer support has been supportive, always useful, but sometimes it's destructing; that's maybe a separate topic.

From there it is access to care, using the opportunities provided by self-help, by self-education, by group education, and by manager education. Then there's the proximity of services in the community, a network of community providers. Not far from that is the specialized mental health services clinic.

In that continuum, specialized clinics, somewhat analogue to the OSI clinics perhaps, all—

•(1155)

**Mr. Marco Mendicino:** Sorry, can I pause you right there?

**Dr. Jakov Shlik:** Yes, of course.

**Mr. Marco Mendicino:** I'll tell you the reason I asked the question. For those of us who are learning about this subject for the first time in a serious way, I think you can imagine that it can be a rather overwhelming subject to tackle. Just by sheer volume, and disparate views on how to address this important health issue, I have found in the early stages that is there not a lot of uniformity. What I am going to try to extrapolate, as we move our way through this study and through our witnesses, are some of the common themes, which I hope we'll weave into a committee report.

Perhaps not today—it doesn't seem we'll have the time, given what's left—but if both of you could turn your minds to this question when you leave here, I think we'll be able to build on it as we make our way through the course of this study.

**Dr. Jitender Sareen:** I think that's a great idea.

One thing I want the committee to be aware of is the model of stepped care that's talked about.

If somebody is struggling with emotional difficulties, they get their care and support in the primary care clinic. If they're still struggling, they move to specialized care.

I really want to underscore what you were describing. That early intervention in the first year of the onset of these conditions is really an important timely piece. We have shown in Manitoba that, with people who have their first diagnosis of a mental health problem, the first year is the time of highest risk for suicide. So I really support what you're saying, that we really need a systematic approach and screening and development of services. I think the challenge is that you have provincial, national, and workplace issues. It's really important to try to interact with those three.

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

We have time for one more questioner.

Mr. Doherty, you have five minutes.

**Mr. Todd Doherty (Cariboo—Prince George, CPC):** Thank you, Mr. Chair.

I want to thank our guests, as well as my colleagues across the floor.

As my colleague Mr. O'Toole has mentioned, I'm deeply passionate about this. This is something I'm very familiar with and I have spent a long time working with those who have been inflicted with PTSD. I have had a lot of colleagues, over the years, who have been dealing with this.

I'm going to direct a few questions, but I'm going to do a shameless self-promotion, if I can, because my passion and my belief in this area and why it's so critical—and I applaud this government for taking this on—is that this discussion is long overdue. That is why I tabled Bill C-211 calling for a national strategy and the development of a national framework dealing with PTSD in first responders and veterans.

Specifically for the areas of concern that we've been talking about here and some of the intricacies in dealing with what our guests are talking about, there has to be a national strategy that deals with and then can build on the standards and consistencies among all of the levels of first responders or the classification. This means the terminology, the best practices, ultimately the care and education, looking at pre- and post-vulnerability, dealing with the very real stigma attached to PTSD, so that our first responders or veterans have the ability to come forward and have a voice, and that we've armed their colleagues and families with the tools to be able to deal with and recognize the concerns and the challenges as we move forward, and the warning signs, so that we don't lose another person.

I do have a question for Dr. Sareen.

In your testimony before the Senate Subcommittee on Veterans Affairs, you referred to a concept called "the rule of thirds" and you indicated that a third of OSI patients can be expected to have a full recovery, a third will have a moderate recovery that leaves some remaining symptoms but it enables a patient to function well, and another third will continue to struggle over a long period of time

I have to challenge you on this. I'm not quite sure we can erase the traumatic incident from people, which they've experienced. I agree on recovery. I think we can provide resources and the ability to cope and to lead a productive life, but I'm not quite sure that we can fully recover, as with any other mental health issue.

Dr. Sareen, can you provide a little bit more insight as to how you came to that recommendation that there can be full recovery on that? I'm interested in your comments.

• (1200)

**Dr. Jitender Sareen:** It's a very good point.

I'll tell you where I learned that first. I learned from my first supervisor when I was a resident about the prognosis of emotional difficulties. In the DSM, the Canadian Psychiatric Association and the American Psychiatric Association, the idea that someone who... I agree with you that you never erase the traumatic event, but people can recover and have amelioration of their symptoms and get back to the highest level of functioning. They still have a—

**Mr. Todd Doherty:** Let me interject for one second.

In my opinion, it is comments like those, unfortunately, from academics and our medical profession— again, we are all learning as we move forward with this to fully understand the scope of it—that then lead to those who are suffering.... They may go back to work, because as somebody has said there is a full expectation that they can recover, but then another traumatic event comes up, or a flash, and they are again having to go off.... It puts the burden of proof back onto the person who is suffering to demonstrate that he or she is not fully recovered.

Would you agree with that?

**Dr. Jitender Sareen:** It's a controversial issue. On the one side, you could say that a person who's ever had some PTSD will never be able to go back to work, and that's also a challenge.

I completely agree with you that we don't want to put people at risk of trying to show that they are ill or anything like that, but I guess it is a challenging issue. I can understand your perspective.

• (1205)

**Mr. Todd Doherty:** I have just one final comment. This is to Dr....

Do I have time?

**The Chair:** Well, yes; you have 20 seconds.

**Mr. Todd Doherty:** The comment is about not having a national resilience program or a program that is national. I think we have a great tool at our hands, the road to mental readiness program that the military and the Royal have been implementing. I think it deals at the earliest point of induction into either the military or RCMP or first responders. I think it is a great model that we can move forward with.

The one other thing I would probably recommend is that we also include 911 or emergency call dispatchers in this area.

**The Chair:** Thank you, Mr. Doherty. You'll have more chance, for sure.

**Mr. Todd Doherty:** I know. I know.

**The Chair:** I want to thank our witnesses for your truly expert testimony today.

We're just going to take a few minutes as we change the regime and get our next panel ready. Thank you very much.

• (1205)

\_\_\_\_\_ (Pause) \_\_\_\_\_

• (1205)

**The Chair:** Let's reconvene.

I want to thank our witnesses. We have, via video conference, Tom Stamatakis, the president of the Canadian Police Association.

It's nice to see you again—twice in one week.

From the Mental Health Commission of Canada we have Louise Bradley and from Mood Disorders Society, Phil Upshall.

I'm going to suggest that we begin with the Canadian Police Association for a 10-minute presentation and then go to our guests here, only because it always gives us a chance, if the video conference somehow fails us, to get you back in if we need you. If we begin with you, it gives us a little extra chance.

Thank you for your attendance today.

•(1210)

**Mr. Tom Stamatakis (President, Canadian Police Association):** Good morning, Mr. Chair and members of the committee. Thank you for the kind invitation to appear before you today as you begin a very important study into the effects of operational stress injuries and post-traumatic stress disorder upon public safety officers and first responders.

With so many new faces around the committee table, I want to begin my remarks today with a brief introduction of the Canadian Police Association, though I am very happy to say that I had the opportunity to meet with many of you during our annual legislative conference in Ottawa. I'd like to thank you for taking the time to meet with our delegates last week.

The CPA represents more than 60,000 civilian and sworn front-line police personnel across Canada. Membership includes police personnel serving in 160 police services across Canada, from those in Canada's smallest towns and villages to those working in our largest municipal and provincial police services and members of the RCMP, railway police, and first nations police personnel.

I should also note that I'm a police officer in the city of Vancouver. I'm seconded from the Vancouver Police Department to the Vancouver Police Union as its president. I'm also the president of the British Columbia Police Association, which is an association of all the municipal police unions in the province of British Columbia, and I am the president of the Canadian Police Association.

I am seconded to these positions while I'm elected in the capacity as president. If I were no longer in that capacity, I would return to my policing career in Vancouver.

Introductions aside, though, the CPA is quite encouraged that your committee has made this important issue one of the first topics you have chosen to study in this new Parliament. As I mentioned, our organization recently concluded our annual legislative conference, at which almost 200 delegates from policing agencies across Canada came to Ottawa to meet with members of Parliament on the need to push the new government to fulfill its platform commitment to establish a national strategy with respect to first responders who are suffering from post-traumatic stress disorder. We're very encouraged by the responses we received from MPs representing all political parties. It can sometimes be an overused cliché, but in this case, protecting those who protect others is truly a non-partisan issue.

Part of the difficulty in this discussion, though, is that there is no single cause for operational stress injuries or PTSD in the first responder community. For some it's a question of a single traumatic event, which is often followed by intense analysis by supervisors, media, and the general public, all with the benefit of hindsight and time, while for others it is built up over years of exposure to some of the worst circumstances. It's almost impossible to predict and extremely difficult to prevent. We also must not forget the role that organizational policy and practices play in this issue.

There's absolutely no question about the urgent need for action. Since April 2014, 77 first responders have taken their own lives. Obviously, not all of these suicides are a direct result of PTSD, but apart from the elevated risk of suicide, almost every officer I know has direct experience and knows a friend, a colleague, a partner who

has suffered from what we now recognize as PTSD or operational stress injury.

To illustrate, the Vancouver Police Union recently completed a survey of my own home service in which we reached out to members through their private email addresses to get a better idea of how widespread PTSD might be. In tallying the responses, it became evident that more than 30% of our members meet the criteria to be clinically diagnosed with PTSD.

Surveys conducted in other major police services across Canada by the Canadian Police Association have shown similar results. These results offer a glimpse into the scope of how serious this problem is.

While suicide is obviously the most severe of the consequences that can be suffered, it's far from the only one. Our recent conference heard testimonials from service police personnel regarding their own personal experiences dealing with provincial workplace insurance boards when filing claims for benefits for those suffering from a disease whose symptoms aren't always easily visible. This is why our members have been actively advocating for presumptive legislation to reverse the burden of proof for those who have been diagnosed.

I am pleased to say that a number of provinces have already taken very positive steps in this regard, including Ontario, which is the latest to move in this direction.

Of course, not all the solutions come directly from government, and I will certainly acknowledge that we have work to do ourselves as police leaders, both on the front lines and particularly at the executive level. "End the stigma" is a familiar refrain that recognizes that we all need to work harder to understand the difficulties faced by those who are suffering. It will come as no surprise that in a world like policing, there has been for a long time a culture that encourages our members to tough it out and work through problems while still pulling your weight as part of your policing team, whether on patrol or as part of a specialized unit within the service.

Everyone from partners to supervisors must work harder within the policing structure to understand the signs and to reach out with a helping hand and the necessary assistance when one of our colleagues needs it the most.

I should also note that police associations across Canada have made tremendous progress in recent years in addressing the issue. Employee assistance programs, peer counselling, and psychological health and safety standards are all innovations that have been pushed by front-line representatives.

•(1215)

Despite all of that, there is still a tremendous lack of research into the issue itself, particularly with respect to first responders, and I believe that is one major area where the federal government can play a significant role. While a number of organizations have taken steps to begin to better understand PTSD, there is a lack of focus in this area that could be addressed with federal leadership. As president of the CPA, I'm approached regularly by researchers and groups that want to be more involved. However, without proper coordination, there is a serious concern that any new resources might not be used in the most effective or efficient way possible.

Underlying all of this is one very important point. While any action plan needs to engage professionals across a number of disciplines, from academic researchers to psychiatrists, this must be a process for and by first responders. I firmly believe that for any new project to have the necessary credibility among those who need it the most, it must be driven by those with a serious understanding of the particular culture and environment that is unique to the first responder community, and I hope the committee can help us reinforce this important point. I know the time here today is limited, so while I could continue for some time, I've always found the greatest benefit in appearing before a committee is the opportunity to answer your questions.

I'll conclude here and I'll reiterate my thanks for the invitation here today and for the work you're all doing taking on this study. I know I speak on behalf of my front-line colleagues when I say that we appreciate your efforts and I look forward to seeing some action on this front.

Thank you.

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

Now we're going to turn to our other witnesses. You have 10 minutes together. I don't know how you're going to split that time.

Thank you.

**Ms. Louise Bradley (President and Chief Executive Officer, Mental Health Commission of Canada):** Thank you very much. I'm absolutely delighted to be here today to talk about operational stress injury and post-traumatic stress disorder.

I'm Louise Bradley of the Mental Health Commission of Canada, and I'm joined by Phil Upshall from the Mood Disorders Society of Canada. Together, our organizations are poised to act quickly in a critical area, thanks to internal knowledge, and strong and existing stakeholder partnerships in Canada and worldwide.

Canadian first responders and public safety officers bear the weight of tremendously responsible jobs. These unsung heroes are quick to act in times of crisis, courageously putting their personal safety at risk in an effort to help others. In a relatively short time, the true toll exacted by this work has become the focus of an impassioned national dialogue. The safety risk faced by first responders goes well beyond their physical well-being. That's why it's heartening to see the federal government showing leadership and taking an active role in confronting the reality of occupational stress injuries like post-traumatic stress disorder.

It's important to note that the mental health concerns of public safety officers are not limited to PTSD. They include a range of problems, from depression and somatic and psychosomatic complaints to chronic fatigue and difficulties with alcohol and other substances. We know the suicide rate is approximately 30% higher than comparison groups, while marital problems are twice as prevalent.

Thankfully, the collaborative work spearheaded by organizations like the commission is lending a voice to this quiet crisis. Our efforts are centred on empowering first responders by exchanging knowledge, sharing best practices, and leading cutting-edge research.

Among our seminal work is the adaption of the road to mental readiness program, referred to as R2MR, which is a program that was originally developed by the Department of National Defence and designed to foster stigma reduction and mental health promotion in the Canadian Forces. The Mental Health Commission has taken this excellent blueprint and modified it to reflect the needs of police officers, firefighters, paramedics, and other first responders. Participants are familiarized with a mental health continuum model and provided with a simple, colour-coded self-assessment tool with clear indicators of good, declining, and poor mental health. R2MR also focuses on teaching a set of cognitive behavioural techniques that help manage stress and build resiliency.

Currently, more than 500 police, firefighter, and paramedic organizations across the country are partnering with the Mental Health Commission to deliver this training. Within the federal government, our partners include the RCMP, which has agreed to deliver training to its 30,000 employees. The recognized need for R2MR is overwhelming. Meeting the demand is among our significant challenges.

It's certainly an area where the allocation of more resources would have a significant impact. To date, the Mental Health Commission has also conducted two train-the-trainer courses with Correctional Services Canada—one in English, one in French. They are rolling out R2MR to corrections personnel as we speak. We're also doing work at the provincial level, both in corrections and with other first responder groups.

I'd like to touch just briefly on our efforts to support the training of Ontario's 30,000 regular and volunteer firefighters, which began in February of this year. We are particularly honoured that the R2MR has received the endorsement of the Canadian Association of Fire Chiefs.

Our work with first responders also extends to the provision of mental health first aid. Offered in over 20 countries around the world, mental health first aid consistently offers key results for those who participate in the course, namely an increased awareness of the science and symptoms of mental health problems and decreasing stigmatizing attitudes. The importance of this training also extends to the promotion of good mental health and prevention of mental illness among first responders themselves. In 2013, more than 40 fire departments, 30 paramedic organizations, and 80 police organizations, as well as the Department of National Defence, delivered mental health first aid training.

We're also working to adapt mental health first aid for use by veterans and their families.

• (1220)

As president and CEO of the Mental Health Commission of Canada, I feel very fortunate to be at the helm of this organization at a time when so many positive initiatives are being undertaken. However, I'm even more hopeful about the positive outcomes that may result as mental health becomes an integral part of workplace safety training, for which the commission has given a great deal of time, effort, and research.

Now, more than ever, we're in a position to equip our first responders with life-saving tools and training. As far as I can see, it is a societal obligation. Ultimately, to neglect the mental health of our first responders is to put the welfare of our communities at risk, and that's a risk we cannot take.

I'd now like to turn the rest of the remarks over to Phil Upshall, who's going to tell you about a proposal that will help ensure first responders seek help, and that it's met with informed and supported care.

Thank you.

**Mr. Phil Upshall (National Executive Director, Mood Disorders Society of Canada):** Thank you, Louise.

Thank you for the opportunity, Mr. Chair and members, to be with you today.

My name is Phil Upshall. I'm the national executive director of the Mood Disorders Society of Canada.

Before I start into my quick remarks, I'd like to point out the fact that Syd Gravel is sitting here with us today. Syd is the co-chair of the Mood Disorders Society of Canada's peer and trauma support team. Syd has lived and continues to live with PTSD and its impact, as a former police officer in Ottawa. He's well informed on both the national stage and the provincial stage, particularly in Ontario as it looks at its WSIB issues. Syd and his co-chair lead our peer support and trauma team, which is the largest peer support team in Canada, and probably in North America, directed specifically at first responders and people who have significant issues with PTSD. If you want to talk to him later on, you're more than welcome to. He's really a great guy.

The Mood Disorders Society of Canada is a national consumer-led, patient-led, and caregiver-led organization. All of our team, including me, have lived with mental illness, at one stage or another. My associate national executive director, Dave Gallson, lives with

PTSD, having lost his legs in a terrible accident. It took him a year to recover physically from losing his legs, and it's taken him many years to recover from the PTSD associated with it.

My senior research person and project manager, a fellow by the name of Richard Chenier, is a former RCMP officer whose colleague was shot to death while he was writing up a report. He lived with that trauma for 29 years before he got the proper help.

Now I'm going to have to really go quickly.

As we outlined to the finance committee a few weeks ago, 85% of first responders and veterans dealing with mental illnesses, including PTSD, go to their primary health care provider. Regardless of all the other opportunities out there for help, if someone is going to go for help with PTSD, most go to their family physicians. Sadly, many of them, over half in many instances, leave without adequate care.

I'm not going to remind you of PTSD's significance today. Because of the expert advice you've been given, I won't get into what PTSD is. But from our perspective, PTSD is an issue that does not need to come to fruition, if you like, if early diagnosis is available and if help in the community in which that person lives is available.

Mood Disorders Canada learned about this problem when people phoned us and asked, "Where can we get help? There's no help for us." We would refer them to the armed forces, Veterans Affairs, or their own police department, and they would always come back saying there was no help.

The first thing we did was ask, "How come?" We held a meeting. It was called Out of Sight, Not Out of Mind. At that meeting, it became very clear that we needed to attack the problem in a very significant way. As an organization with limited financial resources, we chose to focus on one thing, and that was family physicians and health care providers. They are the door. They're the gatekeepers. They're the first ones who see people living with mental illnesses. They are not taught appropriately in their medical training with regard to mental illnesses generally, and certainly not with regard to PTSD.

We have a very good working relationship with the College of Family Physicians of Canada and the shared care community, including all primary care providers. We've talked to them about working to engage them in the business of learning about PTSD, and they're all on board.

• (1225)

**The Chair:** I'm afraid I'm going to have to cut you off, please wind up.

**Mr. Phil Upshall:** Thanks very much for the opportunity. I'm happy to respond to any questions.

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

Mr. Spengemann for a seven-minute round.

**Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.):** Thank you, Mr. Chairman.

Ms. Bradley, Mr. Stamatakis, Mr. Upshall, thank you so much for joining us today. I think I speak for all members of the committee when I say we're extremely grateful to have this opportunity to conduct this study, and we are grateful for the opportunity to hear your insights this afternoon.

For the benefit of Canadians who may be listening or reading the transcript later, and for the benefit of the committee, I wonder if we could start by taking a closer look at the human costs of what we call OSI, PTSD, the mental stressors we're talking about. What exactly is it? How do the individuals react who are exposed to these circumstances? How do their families react? How destructive a force is it? With examples, if you can, could you illuminate this issue for us and paint a picture of what we're talking about?

**Mr. Phil Upshall:** How about the fact I got a call yesterday that a first responder had killed himself? That's a pretty big impact.

How about a family that's broken apart with six kids? The person involved with PTSD is totally unable to cope with life, after asking for three or four years for help. The family breaks apart. There's no income, no disability payments. Those are just two of hundreds of thousands of issues in terms of the cost. I leave it to the others to comment as well, but it's very significant and it's a totally avoidable cost.

**Ms. Louise Bradley:** I can provide a personal example as well.

My niece is a police officer, 24 years of age. She called me after her first call-out in the middle of the night to an abandoned car and she said to me that the woman had died by suicide. She told me the woman's face looked like a Halloween mask and she had to stay with that person for about an hour before help arrived. She went on a few weeks later to have other similar situations. She's 24 years old and I think it's safe to say that's pretty traumatic. The expectation was that she go back to work the next day. Had she broken her leg in the line of duty, it would have been different.

Fortunately, I am head of the Mental Health Commission. Not everybody has such an aunt. I pushed her to get help and she's doing well, but it's an ongoing process because these situations are very real on a daily basis, and I'm sure our police officers have many examples.

•(1230)

**Mr. Sven Spengemann:** Thank you for that.

Mr. Stamatakis, would you have anything to add to that?

**Mr. Tom Stamatakis:** Sure. I have a colleague who killed himself on New Year's Eve, December 31, 2014. He was working a project targeting a number of high-level criminals. He was away from home working an excessive amount of overtime for an extended period of time, away from his two young children and his spouse over the Christmas vacation when they were expecting him to be home. There's a lot more to this story but ultimately it appears to have culminated in this police officer becoming so overwhelmed by his circumstances—he also suffered a head injury during that time that was misdiagnosed—that he went to his hotel room on New Year's Eve 2014 and killed himself with his own service pistol.

I'm still supporting his spouse who's now left with no husband and no father to her two children. She has received no benefits. She's now lost the primary provider in the home, and is still now, over a

year later, waiting for a response from the local workers' compensation board. I don't want to come across as being critical of the board because they are, of course, investigating and doing all those things, but there's a clear example of something that has resulted in the loss of a life. It's left two children without a father, a wife without a husband, and a lot of questions and uncertainty around their future.

That's just one example. We had four suicides in the police community early this year. I can give you many more examples, and that's just on the personal side. There's an impact organizationally when you have people suffering from operational stress injury or PTSD. The absences from work, the suffering, the issues with their performance that manifest themselves in disciplinary processes, and how that consumes an individual and the individual's family and an organization, and how inefficient that is, it's just a travesty.

That's why this is so important and why we have to get so ahead of it so that we understand it, so that we can diagnose it early, so that we can prevent it, and treat it, and provide people with support so they can stay productive, not just in their personal lives but also professionally.

**Mr. Sven Spengemann:** Thank you for that.

These are only four stories. Suffice it to say that there's a tremendous economic cost. I won't ask about that.

What I wanted to seek your help on is some clarification of concepts—again for the benefit of the Canadian public—and separation of what we're talking about here and what else might be going on in the workplace. You've already alluded to it, but one of the terms that floats around a lot is “burnout”. It's a common Canadian term. You can have burnout in investment banking, but you won't get PTSD. Could you talk about the stressors that exist in the workplace outside of the actual events that would trigger OSI or PTSD, and how they might serve as an accelerant and how we need to focus on those as well as the actual symptoms that we're looking at here?

**Ms. Louise Bradley:** I have—

Oh, sorry, go ahead.

**Mr. Sven Spengemann:** Mr. Stamatakis, go ahead.

**Mr. Tom Stamatakis:** There was work done by Professor Linda Duxbury a few years ago. She's at Carleton University. She found—and this is a huge contributor I think, particularly in the police community—that most police officers were working an excessive number of hours on a weekly basis. Let's say roughly that we work about a 40-hour work week, as everybody else does. But she found through her research, which is a national research project, that police officers were regularly putting in between 10 and 20 additional hours on top of the 40 that they normally work. So when you talk about burnout, there's not a police agency or a police officer across this country who won't tell you that on a weekly basis they're having to put in additional time.

Sometimes that's because they're appearing in court to help prosecute the cases in which they've arrested people, so victims can be supported and the accused can be convicted of the serious crimes they were committing. There are special events. There are always additional demands on police officers, in addition to the regular hours of work they typically do.

That's just one example that leads to this burnout, this constant demand.

• (1235)

**The Chair:** Thank you.

Go ahead, Mr. O'Toole.

**Hon. Erin O'Toole:** Thank you, Mr. Chair.

I'm going to be dividing my time with my colleague Mr. Doherty.

I want to welcome and thank all the witnesses for your frank testimony, personal in some cases, and your advocacy. I've had the pleasure of working directly with many of you in the last few years. Particularly, I think one of the real achievements of the Conservative government was the Mental Health Commission of Canada, and I applaud this new government if it's going to build upon that. I hope to see some of you at the Sam Sharpe mental health breakfast on May 5, which Roméo Dallaire and I host on the Hill each year.

Thank you for your work and the training program that, Mr. Upshall, your organization's been critical in creating for family physicians, because as you said, that's a first point of contact for veterans and first responders, and we need to empower them with knowledge.

My question will really be for Mr. Stamatakis. I had the honour of addressing your group. I talked about PTSD and OSIs and the need for the federal government to share, and the road to mental readiness program is being shared and built upon. Dr. Sareen, who was just before you, talked about the dosage issue and that a single event, as you said, or prolonged exposure can lead to OSIs. How do you track that sort of prolonged exposure at the police level? Is it being monitored now, so that there can be a health check for your members?

**Mr. Tom Stamatakis:** No. That's the short answer. We've done a terrible job of tracking, and I think that's tied a little bit into this notion of stigma and an unwillingness in our culture, in particular, to acknowledge the scope of the problem and the fact that it is an issue that must be tracked. We're just starting now to try to track that as best we can. I think programs like the road to mental readiness are a step in the right direction.

We in policing also have done a terrible job, in my view, of building the capacity that you need to build in order to allow programs like R2MR to be successful, so that, when police officers and first responders are educated and able to self-identify that they're in one of these stressful situations for whatever reason, there's the capacity then to manage that without adding to the whole stigma issue. If I declare that I'm suffering and I need some time away, I need to be in a position where my colleagues aren't going to be left short-handed and upset because they've just lost someone and now they have to work twice as hard because there's a vacancy in that work unit.

We've done a terrible job, and that's where I think this committee can play a significant role by creating some broad framework around what we need to do nationally to make sure we track these issues more carefully and understand the scope of the problem.

**Mr. Todd Doherty:** Mr. Stamatakis, I just want to say thank you to our guests as well.

In developing my bill, Bill C-211, I am deeply familiar with some of the concerns that are being experienced, but one of the things that I failed to do adequately, and the question has been raised.... How would you define the term "first responder"?

**Mr. Tom Stamatakis:** Typically what people look to are the front-line police officers who are wearing the uniform and responding to calls for service and ambulance paramedics wearing uniforms and who are responding. It's the same for firefighters.

We have a number of people who work in policing, in particular, because that's my area of familiarity. We have 911 operators, so communications operators who take the calls from the public, and these are sometimes pretty traumatic calls. We have analysts that work side by side with our police investigators, who are looking often at some pretty horrendous evidence and dealing with horrendous images and scenes.

• (1240)

There's all manner of other police personnel or personnel in the other partners in the first responder community who also need to be included in this discussion.

**Mr. Todd Doherty:** Really quickly, I'm glad you brought it up in terms of the compensation act, and having survivors, the friends and family members who are left behind.... We really need to build a real-world solution by engaging those who are putting their boots on the ground, those who are putting their lives in danger every day, and those who are tasked to take charge and look after those who are putting their lives in danger.

How do you see that moving forward in terms of developing that national framework so that we can develop a framework that is most effective, so that it's not just for now but for the long term?

**Mr. Tom Stamatakis:** One of the things I see is that we need to first of all come up with some common understanding of what we're talking about.

Let's define terms like "occupational stress injury" or "PTSD" clearly. Let's all talk the same talk. You can talk to different groups or advocates in this area that have different definitions around common terms.

Then let's get to some common discussion about what we think those appropriate tools are or what we think those appropriate treatments or supports are for people who are suffering, so there's some consistency around that across the country. I think again that's where this body can play a significant role.

There's been lots of talk about presumptive legislation provincially, which I know doesn't fall within the jurisdiction of the federal government, but the most important piece from my perspective is what happens after. Just getting the diagnosis and the acceptance of the claim is one part of the problem, but it's what happens after.

In the example I gave you about the spouse whose husband killed himself, she herself was diagnosed with PTSD because of the circumstances around the death of her husband, and she's still paying out of pocket to get the counselling service that is helping her manage her own diagnosis. This is over a year later, and there's no mechanism for providing people with access to that counselling. In her case she's getting lots of support, but the common theme is where people don't have the financial capacity to manage that on their own. They go without.

**The Chair:** Thank you.

Mr. Dubé.

[*Translation*]

**Mr. Matthew Dubé:** Thank you, Mr. Chair.

I want to thank the witnesses for being here with us today.

Ms. Bradley, you mentioned the support program, the pilot project.

**Ms. Louise Bradley:** I'm sorry, but I don't speak French.

[*English*]

**Mr. Matthew Dubé:** While the clerk shows you where the translation earpiece is, I'll continue in English.

You talked about the pilot projects that are being organized with Corrections Canada in the Pacific region and in Quebec. That's under way now, I believe. Can you perhaps give an update on how that's going and where things are at?

**Ms. Louise Bradley:** We're seeing a large uptake right across the country, so we're very pleased about that in terms of R2MR and mental health first aid.

Another component relates to several of the other questions that were asked along with yours, which is that the commission has the "National Standard of Canada for Psychological Health and Safety in the Workplace". We are seeing some areas in health care and first responders looking at this, because regardless of whether the workplace is in an office or out on the streets or wherever it may be, it applies equally. This can look at and address the stigma that is associated with the thought that it's a career-limiting move to admit that you're experiencing difficulties. It also allows people to take steps to make sure that things like this are prevented. It could involve everything from peer support groups to accommodating people. We know how to accommodate somebody in a physical setting if they have a physical injury, but psychological ones, not so much.

It's costing Canada over \$51 billion a year in lost productivity, so we are promoting the psychological safety standard in the workplace. We are seeing more of them take this up, so that allows for a much broader and in-depth approach to prevention and being able to respond quickly to a situation than just the two tools—which are extremely effective, by the way—R2MR and mental health first aid.

• (1245)

**Mr. Matthew Dubé:** I know that you guys are only partners, but do you know where that specific pilot project is right now? I appreciate the overarching theme, but is that going well? Is it going to be adopted at large?

**Ms. Louise Bradley:** Do you mean R2MR specifically?

**Mr. Matthew Dubé:** Yes, but the pilot project with Corrections Canada that was kicked off in August....

**Ms. Louise Bradley:** It's still at the very beginning. Some correctional centres are doing some training for train-the-trainers, but I couldn't say that it's widespread.

**Mr. Matthew Dubé:** It's still early, fair enough.

[*Translation*]

I will continue in French.

In your road map—it was in 2012, if I'm not mistaken—you talked about the importance of better collaboration with the provinces on mental health services. Although the issues we are focusing on here today have more to do with what the federal government can do, would you still say that services need to be better integrated in order to really be able to provide as many services as possible to those who need them?

[*English*]

**Ms. Louise Bradley:** Yes, I do think that more work can and should be done in that regard. After all, the provinces are largely responsible for providing health care.

I think the good news is that with a mental health strategy for Canada where all these items are identified, several of the provinces have now developed individual provincial mental health strategies that overlap with the national one. That's a good thing, but I think that is dependent. Not all provinces are dealing with it and doing as well as others, so there isn't all that much consistency.

I think that working with the provinces and territories is absolutely critical. The issues that are occurring, for example, in the Northwest Territories are going to be quite different from those in Toronto. Yes, the outcomes are very frequently the same, but the issues are different and therefore have to be dealt with differently, which is why we've done adaptations specific to mental health first aid for northern peoples, first nations, and seniors.

[*Translation*]

**Mr. Matthew Dubé:** That's an interesting point.

When we think about the federal government's role in terms of public safety for indigenous people, one has to wonder how an approach that is more tailor-made for first nations could be developed. This could include mental health services and various actions by the RCMP, for instance, as well as other similar situations.

[English]

**Ms. Louise Bradley:** I will answer this question to the best of my ability with a great deal of caution because I'm not an indigenous person. Therefore, I think that the solutions that you would need in an indigenous setting are going to be quite different. We need to be culturally aware and sensitive, and certainly the approaches need to take that into perspective. I don't think there is just one approach that would work there. In fact, I would suggest that there are probably quite different approaches from what I've heard from my indigenous colleagues. That's something that they caution us about on a regular basis.

**The Chair:** *Merci.*

Mr. Di Iorio.

[Translation]

**Mr. Nicola Di Iorio (Saint-Léonard—Saint-Michel, Lib.):** Thank you, Mr. Chair.

Good afternoon and welcome, ladies and gentlemen.

I want to echo my colleagues' expressions of thanks and welcoming, although I won't repeat everything, considering our time constraints.

Ms. Bradley, the doctors who appeared before you indicated that some people were at higher risk, were more vulnerable, and more likely to have reactions that are harmful to their health.

Could you comment on the work, research, considerations, and steps your organizations has taken to identify those individuals?

• (1250)

[English]

**Ms. Louise Bradley:** There are definitely people that are at higher risk because of the work that they are doing and the situations that they find themselves in. Some are definitely more vulnerable. Youth

[Translation]

**Mr. Nicola Di Iorio:** Let me interrupt you, since we are running out of time.

Can you tell us about any work or research that has been done in that regard? We can share personal opinions, but more importantly, I want to know if your organization has taken a science-based approach to this.

[English]

**Ms. Louise Bradley:** The commission has not done any specific research on PTSD other than with the road to mental readiness training. We've certainly done a great deal of research in the area of stigma. Of anything that we talk about in this regard, that has a major impact. It's huge in that people simply will not go to get care. We are conducting research right now into how well various areas are adopting the psychological safety standard. These are all very important areas, but we have not done any specific research in those two.

[Translation]

**Mr. Nicola Di Iorio:** Thank you, Ms. Bradley.

Mr. Stamatakis, as you know, this committee is a federal parliamentary committee, but the situation we are talking about also exists within organizations that fall under provincial jurisdiction. It also exists in the U.S., in Latin American countries, in European countries, and elsewhere around the world.

Has your organization taken any steps to identify best practices, especially when it comes to prevention and treatment, in jurisdictions outside of Canada and in the provinces?

[English]

**Mr. Tom Stamatakis:** There's nothing specific. We are just starting to survey our own organizations in Canada. We have a network of affiliations internationally where this is now something that we've added to the agenda to start having a discussion about, to discuss best practices and similarities.

I think you touched on the key point, and where I think there is a role for the federal government to play. It is around research identifying what's happening in the different provinces and creating some kind of a broad overarching framework that everybody can look at to find consistent information, particularly when it comes to research about how to build resiliency.

What should we be looking at when we're recruiting brand new police officers, for example, to ensure that they have the tools or the capacity to manage the situations that we put them in? How do we recruit more diversity into our organizations? We want to have more women in policing. We want to have our police organizations reflect the diversity in our communities. How do we build the capacity to manage different values and religious beliefs? How do we manage women who come into policing but then want to have families, so that we remove the stigma that Ms. Bradley was talking about?

These are the things that we have to have a conversation about and create some consensus around, so that we can consistently respond across the country in each of the provinces.

[Translation]

**Mr. Nicola Di Iorio:** In response to a question from my colleague, Mr. Spengeman, you used the expression "totally avoidable cost". What you are telling the committee, then, is that concrete action could be taken and that certain projects could become a reality.

I would like you to elaborate on this. You mentioned it, but did not have the opportunity to discuss it in further detail.

• (1255)

[English]

**Mr. Tom Stamatakis:** In my opinion, and I think you've heard a lot about this from Ms. Bradley as well—and I agree with her—we have programs like the road to mental readiness that are being adopted. She referred to the psychological standards in the workplace, which organizations are very slow to adopt. If we build, adopt, and create policies and practices that recognize these features in our workplace and then build the capacity to manage them better, then I think the costs can be avoided. We can avoid the long absences. We can avoid the dysfunction in the workplace and the dysfunction in the home.

For example, on the road to mental readiness program, we're now for the first time educating our members around why they're feeling the way they're feeling and giving them some options around what they can do about it.

What's missing so far, though, is that if I identify that I'm in crisis and I need some assistance, we haven't yet built the capacity organizationally for me to be able to get quick access to that support so that I can stay at work and so that I can stay productive, and not think I have to take advantage of sick benefits, and not start to rely on medications or alcohol or other substances to manage my feelings or the stress that I'm going through. That's what I was alluding to.

[*Translation*]

**Mr. Nicola Di Iorio:** Thank you.

[*English*]

**The Chair:** I think we have to end there. It goes by quickly.

Monsieur Rayes.

[*Translation*]

**Mr. Alain Rayes (Richmond—Arthabaska, CPC):** Thank you, Mr. Chair.

I would like to thank the witnesses for being with us today and helping us in our work.

Before I was a member of Parliament and a mayor, I was a school principal and teacher. On a number of occasions, I saw people who were suffering from depression, burnout, or anxiety. I saw how they felt ashamed and weak. They were afraid of being judged by their peers, and they didn't understand what was happening to them.

We are talking about training, awareness, and research tools, but there is a need for cultural change within organizations, in the institutional environment. Some tools have been put in place, and it has been a difficult process. From what I understand, the Canadian Police Association is just getting started. You haven't started talking about this at the international level to find out what other countries are doing.

We see police officers, firefighters, and members of the military as strong people who are immune to weakness. I imagine that there must be work to do, even when it comes to the corporate culture.

Have you taken your research further and involved the managers of these sectors and the police stations to see what could be done?

My question is for all three witnesses.

[*English*]

**Ms. Louise Bradley:** Thank you.

Yes, the points you raise are excellent points and they're extremely accurate. Again, I harken back to the research that we've done on stigma and the workplace.

We're finding that getting past the stigma is really the biggest challenge. It really is. We have discovered at the commission through our research that contact-based education is what makes a difference, so I as a nurse can tell you the signs and symptoms of post-traumatic stress disorder or depression, but to actually be able to

talk about it, my own experience has a much more significant impact.

We're seeing in a couple of police conferences that we have co-hosted that when police officers and other first responders are able to talk about their own experiences it really makes a big difference in terms of others feeling free to be able to talk about it. That's one of the biggest things.

Until we have work environments and cultural settings that will allow us to talk about depression in the same way as I would talk about having the flu, we're simply not going to get past it.

All of these pieces that we're talking about here today are working together. They can't be looked at in separate little pieces. Things are coming together quite nicely, but there's a great deal left to be done structurally.

• (1300)

**Mr. Phil Upshall:** There's no doubt that corporate cultures have to change from the ground up, but when you start changing corporate cultures and you start asking people to be prepared to talk about their stories and discuss these issues, a lot of it boils down to the fact that maybe we need to get them some help.

Try going to get help. There is none. In many instances you can talk all you like about research and everything else that's going on at our levels but on the ground across Canada, people can't get help. There are no waiting lists for people with mental illnesses, whether they're first responders or not. Why aren't there? Because there's no help. People go to see their doctors.

We have an instance going on today where a person's gone six months trying to get in to see a psychiatrist. They can't get in. They're willing to talk about it. They're out there and self-help groups are doing all that neat stuff. They're listening to people who say they should get help but when you knock on your doctor's door, you find out that the help is not there. Our solution is to get the doctors and health care providers involved. They're the gatekeepers to help change the corporate culture.

[*Translation*]

**Mr. Alain Rayes:** Thank you, Mr. Upshall.

I would like to hear from the president of the Canadian Police Association, Mr. Stamatakis.

Of course, I hear the stories about doctors, but within the organization, if the culture prevents these people from speaking out, they may not even get to the point where they are seen by a professional.

I imagine that in police forces, the fact that this is being studied must be a very sensitive subject.

[*English*]

**The Chair:** Be very quick, please. We're over time.

**Mr. Tom Stamatakis:** Specific to your question, I alluded earlier to some surveying we're doing directly with our members. We're identifying some pretty startling outcomes particularly around PTSD, where we're including some diagnostic skills on the survey tools we're using. On average about 30% of our members in major police departments are suffering from PTSD or diagnostic for PTSD. There are similar rates of people suffering from depression, anxiety. We have very few people in the normal range for depression and anxiety. That's our first step. We're trying to create a baseline in terms of what's happening in our organizations across the country.

To your point around the cultural or the organizational piece, we're trying to introduce a different approach to some of the organizational structures that contribute to operational stress or PTSD, which I eluded to as well. Another finding we're getting from our surveys is that a lot of the stress also comes from organizational practices.

We're introducing new methodologies around how we promote people, how we deal with issues around tenure where people are going into assignments and are becoming embedded in their communities, because they engage with their community quite extensively. Then they're being told they have to go to a different assignment, so they lose these relationships and that has a huge impact on them.

We're starting to make some proposals around looking differently at how we promote people. Let's look differently at how we deal with people, how we assign them, so we can take away some of the pressures and stigmas that go along with it. That's just one example.

**The Chair:** I'm afraid I have to stop you.

Thank you very much.

I want to thank all our witnesses. We've come to the end of our meeting.

Committee, I want to mention two things before we break. First, in the middle of that meeting I asked our analysts if they could

prepare a short note on some terminology on the object of our attention—first responders and public safety officers—what is included, and how we can find a short form without having to list everybody every time. They're going to give us some advice on that, based on some work we've done. We'll get that for our next meeting.

Second, I wanted to get a quick poll about the meeting on March 22, which is budget day. There has been some conversation lately that some members want to be in lock-ups that day and others would like us to continue with our study. I wanted to get a nodding or a shaking about whether people would like to cancel that meeting and be available for budget issues or whether they would like to continue with this study that day.

Mr. O'Toole.

**Hon. Erin O'Toole:** Mr. Chair, the position of the Conservative Party with respect to budget day, or as we're describing it "Black Tuesday", is that we would still want the committee to work that day.

● (1305)

**The Chair:** That's all right.

Monsieur Dubé.

[*Translation*]

**Mr. Matthew Dubé:** I agree with Mr. O'Toole.

I think there are enough resources so that members can do their work on budget day and the meeting can still take place.

[*English*]

**The Chair:** I am going to suggest that we meet that day. If one of the members wants to be away from committee, they can get a substitute so they can engage, but we will meet on the 22nd.

The meeting is adjourned. Thank you.





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

---

### SPEAKER'S PERMISSION

---

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

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

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

---

Also available on the Parliament of Canada Web Site at the following address: <http://www.parl.gc.ca>

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

---

### PERMISSION DU PRÉSIDENT

---

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

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

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

---

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : <http://www.parl.gc.ca>