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Chair

Mr. Robert Oliphant

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● (1215)

[*English*]

The Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): I will call our meeting to order and begin with apologies to our witnesses who are here to help us with our study on occupational stress injuries and PTSD in public safety officers.

We welcome Lori MacDonald and Michael DeJong, who have come from the Department of Public Safety, as well as Ruth Lanius, who is here from Western University.

I'm going to start with Dr. Lanius by video conference, followed by Ms. MacDonald and Mr. DeJong.

Dr. Lanius, please go ahead for 10 minutes.

Dr. Ruth Lanius (Professor of Psychiatry, University of Western Ontario, As an Individual): Good morning, everyone. It's an honour to be able to join your meeting.

I just want to give a very brief overview of post-traumatic stress disorder, and of course today the focus is on occupational stress injury. As we know, post-traumatic stress disorder can occur from a number of causes, but our first responders are very much affected by post-traumatic stress disorder. They're often exposed to horrific events, so we often have a lot of trauma-related disorders in this population. We also often hear about our war veterans who are, of course, very much affected by traumatic stress as well. As well, something we often don't like to talk about and we're afraid to talk about is childhood abuse. That can be very common and can also be an important risk factor for the later development of post-traumatic stress disorder if the child is exposed to further traumatic events in adulthood.

Just to give you an overview of PTSD symptoms—I'm sure you're familiar with them already—I think the core of post-traumatic stress really is that the traumatic memory is not remembered, but rather it's relived. So when people relive the traumatic memory, they actually feel as if they're back at the scene of the trauma. They may have visual flashes; or they may have hearing flashes of what happened at the time of the trauma, for example screeching tires or people screaming; or they may actually feel what happened at the time of the trauma. They're reliving these sensory flashes that are really relived and not remembered. They actually feel as if they're right back at the scene of the trauma.

People with PTSD also often avoid things that remind them of the trauma. For example, if they've been involved in a bad car accident, they may avoid certain roads, or avoid driving altogether. Often their emotions become so intense that they numb out, because they can't handle the intensity of the emotions anymore.

People often also have a lot of other negative emotions: a lot of anger, a lot of guilt, a lot of shame. For example, I saw an advanced care paramedic the other day who was treating a teenager who was about to die, and the teenager begged him to call his mother, but he wasn't able to, and so he was just guilt-ridden after this traumatic event.

People can also have intense hyperarousal symptoms. They feel on edge; they feel on guard all the time; and they're often very hypervigilant.

That's post-traumatic stress in a nutshell. We've read a lot about it in the media lately, and although we've done a lot about educating the public, there are still some people who think it's all in your head. Actually, as we're learning now, it's a lot in your brain.

I want to talk a little bit about some recent technologies, especially neuroimaging, that have allowed us to transform an invisible injury —which is traumatic stress—to a visible injury. Neuroimaging can look at which areas of the brain activate when people recall traumatic memories, for example. I think this is really important to reduce the stigma of traumatic stress disorders, but also of other mental illness.

I just want to give you a case example of a couple who were involved in a car accident recently. They were driving down Highway 401 from London, Ontario, to Detroit and they hit a thick wall of fog. The husband was the driver and the wife was in the passenger seat, and when they hit the wall of fog, the husband slammed on the brakes. Within seconds, a huge tractor-trailer hit the back of their car. Within minutes, this was a several-hundred-car pileup, and a van was pushed into the couple's car. The van caught fire. There was a teenager in the van, and the couple heard the teenager scream while she burned to death.

It was a horrible accident, but it allowed us to really study the different reactions people can have in response to a trauma, and how those manifest in the brain. During the accident, the husband was really anxious, hyperaroused, and he was planning how to get himself and his wife out of the car. He smashed the windshield and was able to pull his wife out. After the car accident, he suffered from PTSD, which was later treated, and he recovered.

We were able to look at what happened in his brain while he recalled the traumatic event, the car accident, a month after the accident.

This is what we saw. Just to summarize for you, we saw a lot of emotional reactivity in the brain. When he was in the scanner and was having a flashback, we saw the front part of the brain activating, which might have been involved in planning and might have been activated because he was [*Technical difficulty—Editor*] again planning how to get himself and his wife out of the car. The visual part of his brain activated, which may have been related to the fact that he was actually seeing the accident over and over again while he was in the brain scanner.

His wife reacted very differently. She shut down. She was numb. She was barely able to move during the accident. She froze. She said that if it hadn't been for her husband, she never would have gotten out of the car. We also scanned her, and her reaction was very different when she was in the scanner. As in the accident, she froze, numbed out, and was barely able to move. If you compare her brain image to his, it looks very different. You see a total shutdown of brain response, which may reflect the fact that she was so shut down and numbed out.

This I think helps us understand that people who have the same trauma can really respond very differently. Some people have really high emotion after a trauma, and some people numb out and have very low emotion. People with low emotion are often harder to recognize, and they're also harder to treat, because first you have to bring online their ability to feel again, and often people cycle between high and low emotion as well.

What are some of our treatment options? We've come a long way in really developing some good treatment options. There are two arms of treatment choices. There's a medication arm, and there's a talking therapy or psychotherapy arm. Both have been shown to be effective. Some people prefer one or the other and some prefer to engage in both. I think we really have to move more to an individualized medicine approach to help people pick what their preferred choice may be, of course with a recommendation from their treatment team.

On treatment targets, I think it's important to treat the PTSD symptoms but also related problems. People often also have depression when they have PTSD, or they have alcohol and drug use. Often, people get so overwhelmed with feelings that they turn to drugs or alcohol to help them decrease their intense emotional states. People also often turn towards disordered eating. Also, traumatic brain injury often can be associated with post-traumatic stress. We've heard a lot about that in the military.

I think it's also really important, of course, to treat the disability and the quality of life and really help people to experience pleasure and joy again at the end of treatment. It's really about being in the optimum zone of emotional arousal. As we saw with this couple, people can have too much or too little emotion. They can be in the upper part of this curve where they're too hyperaroused, unable to think and react rationally, and unable to stand back and reflect, or they're too low on this diagram, where they're frozen and numb and they can't engage.

If you're too high or too low, you can't engage in optimum work functioning or optimum social functioning, so it's really about getting people back into the optimum zone of emotional arousal so that they don't have too much or too little emotion and they don't circle between having too much and too little emotion.

I think that in terms of priorities we're looking at education, and I think that especially with the recent legislature this will be implemented: really educating people about the risks of their jobs, getting them to become aware of early symptoms, and then really engaging in early intervention. Also, I think we have to continue to reduce the workplace stigma. Again, I think we've come a long way, but we still have a ways to go, because we don't want people to think, for example, the way this man on the diagram does. Which was worse for Phil? Depression or having to hide it?

I think we've come a long way. There's a lot of hope. We need to empower and keep reducing the stigma of those who suffer from trauma-related disorders.

● (1220)

The Chair: Thank you very much, Ms. Lanius. That was both hopeful and interesting.

Ms. MacDonald and Mr. DeJong.

Ms. Lori MacDonald (Assistant Deputy Minister, Emergency Management and Programs Branch, Department of Public Safety and Emergency Preparedness): Thank you, Mr. Chair and members of the committee, for inviting us to discuss our ministerial round table on post-traumatic stress disorder.

[*Translation*]

My name is Lori MacDonald, and I am the assistant deputy minister of the Emergency Management and Programs Branch at Public Safety Canada.

I would like to introduce my colleague, Michael DeJong, who is the senior director of the Policy and Outreach Directorate in the Emergency Management and Programs Branch.

[*English*]

As you are aware, Public Safety Canada hosted the ministerial round table at the University of Regina on January 29, 2016. I want to provide a brief overview of the round table, its outcomes, and next steps.

The round table was attended by over 50 participants, including senior representatives from the police, fire, and paramedic organizations, as well as union representatives from these services.

Other representatives included the parliamentary secretary to the Minister of Public Safety and Emergency Preparedness, Mr. Michel Picard; cabinet ministers from Saskatchewan, including the minister of Corrections and Policing, the minister of Labour Relations and Workplace Safety, and the minister of Health; and senior officials from the federal family, including the Public Safety Canada portfolio, the Health portfolio, the Department of National Defence, and Veterans Affairs Canada.

We were also pleased to be joined by leading academics, some of whom have already testified before this committee.

The Minister of Public Safety and Emergency Preparedness actually opened the day with his video remarks. He was in La Loche that day supporting a community trying to heal from the shootings that killed four individuals and wounded seven others.

[*Translation*]

The intent of this roundtable was to hear from the experts and stakeholders about the problem definition, and discuss options for assessment, treatment and long-term care of public safety personnel suffering from post-traumatic stress, or PTSD.

● (1225)

[*English*]

Round table participants also stressed that PTSD is just part of the spectrum of operational stress injuries or OSIs, which are defined as persistent psychological difficulties resulting from operational duties.

We learned that many public safety organizations, including those at the round table, have implemented a number of initiatives such as peer support, employee assistance programs, and the road to mental health readiness program to help address the issue. A federal role is needed to help support public safety organizations big and small to tackle this complex problem through a more unified approach.

Within the public safety portfolio, the RCMP has undertaken several measure to increase understanding of PTSD and OSIs and to reduce stigma. Going forward in our work we will look for similar opportunities to reduce the stigma associated with mental health issues across a full range of public safety officer communities.

[*Translation*]

Prevalence of PTSD among public safety officers is hard to track, partly due to stigma. Based on available data, it is estimated that in Canada, between 10% and 35% of first responders will develop PTSD.

Key takeaways from the roundtable can be divided into three broad areas that have informed our efforts to begin developing the coordinated national action plan.

[*English*]

The first take-away is a need for a unified grassroots approach to both defining and identifying PTSD. Public safety officers and the organizations in which they serve vary greatly across Canada in location, size, and culture. There was very clear consensus at the table that public safety officers need to have access to diagnosis, treatment, and care resources that take into account their unique experiences.

While the biological underpinnings of operational stress injuries may be similar to those in the Canadian Armed Forces, public safety officers operate in a different environment, often near the communities where they live. Public safety officers are repeatedly exposed to potentially traumatic events over the entirety of their careers and, unlike serving and retired military personnel, do not have a dedicated system to turn to that provides assessment, treatment, prevention, and support.

We also heard from the Canadian Association of Fire Chiefs about the lack of consistency across Canada in recognizing PTSD as an occupational hazard to ensure treatment coverage and compensation.

Public safety officers face obstacles to accessing treatment, including long wait times and costs. This is particularly true for public safety officers in remote and first nations communities that can often lack robust services when compared to larger urban communities.

The second key theme was the importance of resilience, treatment, and reintegration into the workplace. As mentioned by the Paramedic Chiefs of Canada, there is no all-encompassing, off-the-shelf solution for prevention or mitigation of PTSD.

[*Translation*]

Resilience speaks to the need to build PTSD into the everyday dialogue of public safety organizations, ensuring that public safety officers and families have the tools to recognize early symptoms, are aware of coping mechanisms, and know when to seek professional support.

[*English*]

Participants also supported the development of innovative, flexible, and accessible evidence-based treatment options. This illustrates a need to reach public safety officers operating in remote locations or needing access to care at unusual hours. In addition, many participants expressed the importance of supporting reintegration into the workforce after seeking treatment.

Perhaps the biggest take-away was that evidence-based research was viewed by participants as key to ensuring a holistic approach to resilience, treatment, and reintegration. Participants stressed that public safety officers are not the only ones who suffer when a public safety officer is diagnosed with PTSD. Their support systems such as family, friends, and colleagues are also greatly impacted. Whether it's through education or awareness, guidance for this important network also needs to be considered.

This leads nicely to the third theme, the need for national coordinated research. Support was expressed for a dedicated institute to provide integrated cutting-edge research to public safety organizations across Canada. Many participants expressed the view that having a centralized area of expertise on PTSD research for public safety officers would better inform decision-making at all levels.

We heard from the chiefs of police that evidence-based research is needed to assist in developing policy to effectively deal with issues and to ensure that they are doing their best to assist their officers and civilian staff. This could be accomplished in many ways. For example, at the round table, the RCMP provided a debrief on its work to design and undertake a longitudinal study that would study new recruits in an effort to help identify underlying causes of PTSD and OSIs. This is valuable baseline research that can also be applied to the public safety community.

● (1230)

[*Translation*]

Ultimately, participants were strongly supportive of the government's commitment to develop a coordinated national action plan to address operational stress injuries, such as post-traumatic stress injuries.

[*English*]

The national round table was just a starting point. Since January, Public Safety Canada has continued to advance this work through strong partnerships with the health portfolio. In the coming months a second round table will be held to further advance our work. All these conversations will contribute to the framework of a coordinated national action plan.

Thank you, honourable members, for your time today.

The Chair: You're both short. Very good.

We will begin our questioning with Monsieur Di Iorio.

[*Translation*]

Mr. Nicola Di Iorio (Saint-Léonard—Saint-Michel, Lib.): I would add this to our chair's comments: your presentations were not only concise, but also very relevant. Thank you, and I would also like to thank you for the time you spent to prepare for your testimonies.

Post-traumatic stress disorder doesn't occur only in the workplace, nor is it limited to the workplace of first responders. However, it's that last fact that we are studying here.

Post-traumatic stress occurs in a context in which incidents that arise in the workplace cause work-related injuries and illnesses. Prevention is the number one rule to follow at all times. We must constantly act with prevention in mind. We aren't helping anyone if we let situations degenerate and incidents disrupt people's lives, knowing that this will continue and intervening only when the damage is done.

Could you please tell us what can be done to prevent this disorder? I would also like to know which best practices for prevention your professional activities helped you establish.

Dr. Lanius, perhaps you could answer first, then Ms. MacDonald.

[*English*]

Dr. Ruth Lanius: I think the key to prevention is education, really being aware of what post-traumatic stress disorder is. It's also having a top-down approach so that the leaders—for example, the fire chief, or the leader in policing—are on board, are educated about the consequences of the job, and are supportive. They facilitate the education, which then, I think, can lead to early intervention.

In terms of education, we need programs to help educate people even during their training. What are some of the symptoms of post-traumatic stress? What do I need to be aware of? I think this is currently being done. The military has modelled such a program. This is currently being adapted for the paramedics and for the policing force. That way both leaders and workers are very familiar with the symptoms, and they can track their own well-being. Then, if they get into trouble, if they get increased symptoms, they have access to treatment very quickly.

I think if firefighters or policing officers had a special service available to them, that they could access very quickly, through which they could get support and their family could also get support, that could go a long way to really decreasing both the morbidity and the mortality of this devastating disorder.

[*Translation*]

Mr. Nicola Di Iorio: Dr. Lanius, in the context of your work, have you been able to determine whether certain businesses were more successful than others in terms of prevention?

[*English*]

Dr. Ruth Lanius: I've seen certain fire departments that have been more open towards trauma-related disorders than others have. I think it really depends right now on the openness of the leader of a facility. If the leader is open to these problems, then the atmosphere for both recovery and the return to work is much better. I think we really have to train the leaders, and then have this effect trickle down to the whole organization to make this more effective.

Does that make sense to you?

● (1235)

[*Translation*]

Mr. Nicola Di Iorio: Yes. Thank you, doctor.

What about you, Ms. MacDonald?

Ms. Lori MacDonald: Thank you for your question.

[*English*]

I would very much support the comments Dr. Lanius made. Education is key to prevention. It is one of the big pieces that we have to move forward on in terms of being able to educate, and not just the community. Many people lack awareness of what post-traumatic stress disorder even is, including the people who are suffering from it themselves.

I echo Dr. Lanius' comments with respect to leadership. We heard that very loud and clear from the chiefs who were presenting at the round table. They felt very strongly that leaders needed to be more involved to appreciate and understand what post-traumatic stress disorder is and how they can help the staff that are serving them to move forward.

I will give you two quick examples. The RCMP is about to launch a longitudinal study, a 10-year study with respect to post-traumatic stress disorder, and one of the things that study will do is to help identify areas in which we can develop prevention. It will look at areas where we see PTSD being more prevalent, to be able to say that this is where we need to invest time and energy in prevention as we go forward, but also in terms of treatment in response to those kinds of issues.

The other one is about best practices. Maybe I would just cite the Road to Mental Readiness, which the Department of Defence has put in place. It is a very good educational short-term program with long-term benefits that assists people in the very beginning who are identified or identify themselves with post-traumatic stress disorder types of symptoms, and some of our public safety officer organizations are adopting that now.

[*Translation*]

Mr. Nicola Di Iorio: Ms. MacDonald, you seem to have anticipated my next question.

I'd like to know what we can learn from the work that has been done in the armed forces, how we might use it and which best practices we should follow. Could you also tell us about what we can't take from the army's experience because it would not apply to first responders?

Ms. Lori MacDonald: Thank you.

[*English*]

I would say that, first of all, one of the things that became very clear to us is that we have to have an integrated approach. The more we work in silos, the less effective we will be, so we should be working with DND, with veterans, with the Health portfolio, with our own department, and with academics. There has to be a very broad integrated approach to this so that we can learn from each other and build on each other's experiences, whether from a research base, a program base, or a lessons-learned perspective.

What have we learned from Defence? Really importantly, we have learned some of the biological underpinnings. We have learned that you need to act immediately, and that we have to put resourcing in place to address this issue. What we have learned from maybe an adverse perspective, but a positive perspective, is that we can't wait much longer. We have significant impacts in our country in terms of first responders, people who are really traumatized on a daily basis by major issues, and the longer we wait, the more negative the situation will become for those people.

The Chair: Thank you.

Mr. Miller, go ahead.

Mr. Larry Miller (Bruce—Grey—Owen Sound, CPC): Thank you, Mr. Chair.

Ms. Lanius, Ms. MacDonald, and Mr. DeJong, thank you very much for very interesting presentations.

I think we would all probably agree that PTSD seemed to come to light or that it is at least more prevalent. I think it is well known now that it has been with us for a long time; we recognize it and what have you. I think it was probably through the Afghan veterans that it really came to light, and of course as well through paramedics, firefighters, and police, who, we all know, see some very disturbing things through their careers, which is unfortunate but is a fact of life.

Ms. Lanius, when I was listening to your presentation with regard to a strategy for PTSD—and Ms. MacDonald also kept coming back to this—workplace operational stress injuries was the term that kept coming up. The strategies seem to be pointed at dealing with that.

Ms. Lanius, you mentioned the husband and wife who were in a terrible crash. That didn't happen in the workplace. I think people definitely handle stress and those kinds of things in their life differently. Are you suggesting that your overall strategy not be for just work-related PTSD? Is that something you would want to include from the beginning in your thoughts, or is that something that may lead from dealing with work-related PTSD to dealing with PTSD in society in general? Could you comment on that a bit?

● (1240)

Dr. Ruth Lanius: Thank you for your question. I think it's a very important point. We know now, and we have an incredible amount of data, that early adverse experience is a tremendous risk factor for all mental illness, not just post-traumatic stress but depression, alcohol and drug abuse, and you name it. Early adverse experience is also, for example, associated with the 10 most common causes of medical death in the U.S. I think that's a very important piece. I think if we can factor that in right at the beginning, that would make a lot of sense.

We've also seen in a recent study that has been really well covered by the media that our veterans in Canada have twice the amount of early adverse experience compared to that of the civilian population. This is a risk factor. I think people are often afraid to deal with it. As our brains develop when we're growing up, these are the foundations of our emotional development. I think if we could also put in place some early intervention for high-risk caregivers, we could decrease the occurrence of trauma-related disorders down the line.

Mr. Larry Miller: Just carrying on from a comment you just made about high-risk caregivers, I think of nurses and doctors who try to help people. That's what their job is all about. Unfortunately some people pass away—for example, in seniors homes it's a regular occurrence. I have some friends who work there and they get quite attached to the residents, and yet death in seniors homes is a common occurrence. It's a fact of life. So would you include that type of care?

You could even carry that into agriculture, especially livestock farming. I come from that field. I'll tell you I've had times, and my wife has always been involved. She'd be caring for a sick calf sometimes for days or a week at a time. When it would pass away, she took it very hard.

Is that part of PTSD, or is it just a fact of life, or whatever? You could carry this on into that. Would you agree or disagree? Could you comment on that?

Dr. Ruth Lanius: I think you have to be careful about what you define as post-traumatic stress. I think often it can be related to grief as well. The people doing these jobs often have burnout. I think we have to be careful about what we call post-traumatic stress and what we call grief and burnout.

Mr. Larry Miller: That's fair. I think you kind of spelled out the difference there. I'm glad you did.

Ms. MacDonald, Mr. Di Iorio mentioned a strategy for prevention and what have you. Could you comment a little more on what that strategy might look like?

Ms. Lori MacDonald: Thank you very much. We had some very good conversations at the round table around prevention. A couple of key points came out of that. The first point was on early intervention, just to support Doctor Lanius' comment that the earlier we can put prevention in place, obviously, the more longer-term positive impact that can have. So our strategy has to involve targeting the front end of any kind of strategy even including the national action plan in terms of PTSD. It would look at everything from what we put in place with respect to recruiting front-line safety officers to how we support families and friends.

I can use a quick analogy. When someone is suffering from post-traumatic stress disorder, not just one person is impacted. It's also the people around them. If you throw a rock into the water, you have this big ripple effect. Often you see that in people who are suffering from post-traumatic stress disorder; it affects their wife, their children, or whoever that happens to be. So prevention also has to include people who are in that surrounding community. It can also include those others who are touched by that.

We had a question earlier about trauma that happens in the workplace. Prevention should not just be specific to that person but should be on a continuum involving those people who could potentially be impacted, looking at immediacy at the front end and then building that as part of the strategy going forward.

● (1245)

Mr. Larry Miller: How much time do I have?

The Chair: You have 10 seconds.

Mr. Larry Miller: I think I'll probably just end it there.

Thank you very much. It's a very interesting topic. I appreciate your comments.

The Chair: Thank you.

Mr. Julian, welcome.

Mr. Peter Julian (New Westminster—Burnaby, NDP): Thank you very much, Mr. Chair.

The Chair: We're honoured to have you here.

Mr. Peter Julian: I'm honoured to be here. This is a very important subject.

I'd like to thank all three presenters for stepping forward and providing us with this information.

I'm interested in the overall budget applied to PTSD. I note with interest that the ministerial round table talks about Public Safety working with Health Canada, the Department of National Defence, and Veterans Affairs Canada to develop options. There's a budget to develop a national action plan. I'm assuming there is also an ability to pull together the resources currently applied to providing support for people with PTSD.

Could you give us a sense of what the overall resources are now and the number of people who are clients, either first responders or those in the Department of National Defence or Veterans Affairs, who are currently undergoing treatment? Would you have those figures?

Ms. Lori MacDonald: Thank you for your question. I'll give a couple of answers to that.

First, budgetary pieces are spread across different departments. Within Public Safety, my particular area, I have some resources that are working towards that. Within the portfolio itself, the RCMP would have some resources associated with that, as would Corrections, as an example, or CBSA. I don't have those numbers in front of me, but that's something we could get for you.

More broadly, the health portfolio through the CIHR, the Canadian Institutes of Health Research, has money associated with that as well.

Different pots of money are spread across a number of different spectrums. Sometimes though it's divided up for mental health as opposed to specifically being dedicated to post-traumatic stress disorder. We'll get you some more detailed information on that particular piece.

Mr. Peter Julian: The first part of the question was on the overall budget allotted to pulling together this national strategy.

Ms. Lori MacDonald: Right now we're working with a small budget within Public Safety, and most of the engagement we're doing involves consultations through things like the round table. We have just stood up an assistant deputy minister's steering committee. We'll do the next round table sometime in summer and then come up with a plan after that. We are also engaged in a number of different forums that we have in place with our provincial and territorial counterparts.

We have a small budget using a number of different mechanism that are already in place to leverage the work we need to do.

Mr. Peter Julian: What is that budget?

Ms. Lori MacDonald: That's part of what we'll get back to you with.

Mr. Peter Julian: I think that would be helpful for the committee.

Has there been any estimate of the number of people requiring support through the Department of Veterans Affairs or National Defence as well as first responders?

Ms. Lori MacDonald: I can speak specifically to the global number of first responders, and I'll give you some percentages. I don't have that data for Veterans Affairs and Defence with me today, but I'll speak to Public Safety.

Approximately 250,000 people would fall into the category of public safety officer: approximately 69,000 police officers; 110,000 firefighters, of which about 80,000 are volunteers; about 20,000 paramedics; and about 18,000 volunteer search and rescue workers. Then in the broader public safety portfolio, you would have the RCMP with around 16,000 members, correctional officers at around 8,200, and then CBSA workers.

● (1250)

Mr. Peter Julian: I'm specifically thinking of the number of cases of PTSD among them. I imagine you wouldn't have those numbers at hand, but could you provide those to the committee?

Ms. Lori MacDonald: We have a few. As an example, we know from some surveys we've done that about 36% of male correctional officers have identified as having post-traumatic stress disorder. At the lower end we have about 7% of police officers, but numbers vary, depending on the study or the survey that's been done.

We would identify this area as a gap, because we don't have good data collection. People don't always identify because of the stigma associated with it. People know it's personal, private information and they don't want it known.

Mr. Peter Julian: Thank you very much.

Dr. Lanius, I'd like to move to you. You talked about the fact that we've made a lot of progress in terms of treatment options and treatment targets. You also said treatment is different depending on how people respond to those traumatic events, whether it's with a heightened sense of reaction or whether it's with a numbing.

Could you run us through what a treatment plan that is very effective would require, such as the number of months, or weeks, or years of treatment, and with what regularity? I understand there are different cases, and they require different treatments. If we were to provide a top level of support for those who are suffering from PTSD, what would that look like in terms of resources?

Dr. Ruth Lanius: We have several evidence-based treatments right now, and usually people recommend about 12 sessions of treatment. If we look at the reality of, for example, the veterans who start these treatments, over half of these veterans don't finish these treatments. I think there's a big individualized response to different treatments. I think the next step in improving treatment outcome is to develop individualized treatments for different people given what symptoms they present with and what difficulties they have. Generally speaking, right now, 12 sessions is generally recommended.

Mr. Peter Julian: That's 12 sessions over a month or a year?

Dr. Ruth Lanius: Those would be weekly sessions.

Mr. Peter Julian: Okay. When you say half the veterans don't complete the treatment, is that because they don't feel they need it anymore, or because the veterans and the professionals feel they've run the full course of treatment, or is it because the treatment isn't working? What are the reasons for that?

The Chair: Be very brief, please.

Dr. Ruth Lanius: There are a number of reasons. Some feel the treatment is not working, and some have difficulty engaging in the treatment. There seems to be a problem with some of the standard treatments, and with people completing them, and being able to engage in them. There's some important literature coming out on that.

The Chair: Thank you very much.

Ms. Damoff.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thanks to all of you for coming out today.

Dr. Lanius, I'm going to start with you. We know first responders and corrections officers are more at risk for developing PTSD and operational stress injuries. Do you think there's enough data and that enough research has been done on that, and if not, do you see a role for the federal government in helping to improve the data we do have?

Dr. Ruth Lanius: Absolutely. I think there's very little research on this topic, and we could certainly really benefit from learning more.

Ms. Pam Damoff: From your research, and from what you've discovered in terms of the way individuals react differently to stress, how do you see the federal government playing a role in sharing best practices? For example, you have lots of great programs going on across the country right now, but there doesn't seem to be a coordinated effort to share those. I'm wondering if you see a role we can play as a federal government to facilitate the sharing of best practices.

Dr. Ruth Lanius: I think setting up a committee that comes up with best practice guidelines that are flexible and that promote an individualized medicine approach would be very useful. Then the whole country could refer to those in the treatment of these disorders.

● (1255)

Ms. Pam Damoff: I know the Road to Mental Readiness is something that's being adapted from Defence for various first responders and fire departments. What are your thoughts on that program?

Dr. Ruth Lanius: I think it's an excellent program, and I think it's had a lot of success in the military. I think all areas of occupational stress really benefit from that. I'm happy to see that it's been individualized to the different professions.

Ms. Pam Damoff: I'm going to turn over to you, Ms. MacDonald. You had talked about the round table, and I'm really happy to see the federal government taking some leadership on this issue. I'm wondering if you see your department as a place through which some of these best practices in research can be coordinated?

Ms. Lori MacDonald: Thank you for the question.

Actually, we're very fortunate in Public Safety to have such a huge responsibility in terms of our public safety officers. Our minister has a pretty significant role in terms of the Emergency Management Act and his responsibilities in working with the provinces and territories, so we do think we're uniquely situated to support this initiative and provide leadership to it.

We have a number of different forums and opportunities in place to actually support this through our relationships with the provinces, territories, and municipalities and through our responsibilities under the portfolio. So yes, we think we can provide some leadership to this through Public Safety.

Ms. Pam Damoff: How can we ensure that our corrections officers are also included in this conversation? I was quite shocked and disturbed by the number that you provided to us. I think they're sort of the forgotten group when we talk about post-traumatic stress and operational stress injuries. How can we ensure they're included when we are talking about these strategies? I know they fall under your department, but....

Ms. Lori MacDonald: It's a very good question. When we looked at some of the numbers for first responders and we looked at our responsibilities in our portfolio, we made a definitive decision to include them as part of our steering committee because we have to have their voices there.

Their numbers are very high, and they face a unique situation given that not only is it their community that they go into that experiences trauma, institutions are like a community within a community, so they go back into the community within a community every day to re-experience those same traumas. It's a really important issue for correctional officers and so, from our perspective, we needed to have them front and centre with respect to the steering committee.

Ms. Pam Damoff: If we were to come up with a national action plan, would that help within your department then? I'm assuming the answer's yes.

Ms. Lori MacDonald: It would.

Ms. Pam Damoff: Okay.

Turning back to you, Dr. Lanius, your colleague Dr. Frewen has a PTSD-based practice that is focused on mindfulness and emotion. I think it's called the Working Mind. Can you speak to that a little and let us know if you think that would be something we as a government could be sharing as a best practice?

Dr. Ruth Lanius: Absolutely. There's evidence now that mindfulness is also effective in the treatment of post-traumatic stress, and Dr. Frewen has developed a website that is available. I can't speak for him, but he's made it available to a lot of different populations, and if you contact him I'm sure he would....

I think it has been a very helpful tool for a lot of people to help them improve their attention, to help them be in the moment and not get pulled into flashbacks, and to improve their quality of life.

Ms. Pam Damoff: There's a term that's used for family members and children of people who are suffering from post-traumatic stress. I can't remember what it is, but they actually start suffering from post-traumatic stress themselves.

Can you speak to that just in the remaining time we have?

Dr. Ruth Lanius: Yes. Often, when somebody comes back into the family with post-traumatic stress, they're really dysregulated and they're angry and they can't control their emotions. That can be very traumatizing for the whole family, so sometimes you can have this intergenerational piece to the trauma, and children suffer from psychological difficulties because they can't cope with the disruption in the family.

I'm so glad Ms. MacDonald mentioned this. In treatment it's also a priority that the treatment be geared not only towards the person suffering from PTSD but also towards the whole family structure.

● (1300)

Ms. Pam Damoff: Family members need to be aware, to look out for that type of thing, right?

Dr. Ruth Lanius: They do absolutely. Awareness is key.

The Chair: I'm afraid we need to end there for today.

Ms. MacDonald, could you do one thing for our committee in a written response? We're wondering how Public Safety Canada defines first responder and public safety officer. Who's included in each of those definitions and who is not? We're struggling a little with some of those definitions with regard to the federal responsibility, so that would be helpful for us. Thank you very much.

Thank you to all our witness. I'm learning something there. I think I'm going to need to pay a trip to western Ontario.

Thank you very much, committee. We'll see you on Tuesday.

The meeting is adjourned.