HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Public Safety and National Security

SECU • NUMBER 073 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, September 26, 2017

Chair

The Honourable John McKay

Standing Committee on Public Safety and National Security

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● (0845)

[*English*]

The Chair (Hon. John McKay (Scarborough—Guildwood, Lib.)): Ladies and gentlemen, let's commence our meeting.

Before I formally welcome our witnesses, I wanted to suggest to the committee that, because of the uniqueness of this meeting, we be a little less formal than we would otherwise be, and conduct it as more of a caucus-like meeting rather than a meeting where we go formally from side to side, etc. I just want to make sure that this is all right. Okay.

Also, the subcommittee did meet, and the subcommittee's report is now obsolete. It appears that we will not be receiving Bill C-21 in a timely fashion, so we will not be commencing our review of that bill. The consequence of that is that next Tuesday, we have two choices: to continue with the migrant information that we may receive on Thursday, with a joint meeting with the immigration department, or we may start the indigenous studies meeting. I am not going to ask for commentary just now. I'm going to let you ruminate about that, and possibly toward the end of the meeting, call the meeting a little early and see what the will of the committee is.

With that, I'd like to welcome our witnesses. There has been some discussion as to how this presentation will take place. I don't know the order, but to Michel Rodrigue, Nicole Boisvert, and Liane Vail, welcome all. We look forward to what you have to say, and what order you have to say it in. I'll let you proceed from here. Thank you very much.

Mr. Michel Rodrigue (Vice-President, Organizational Performance and Public Affairs, Mental Health Commission of Canada): Mr. Chair, and distinguished members, thank you for the time that you have allocated in your busy schedule this morning.

The Mental Health Commission of Canada is thrilled to be able to present a snapshot of a program that we deliver for first responders, police forces, and health care practitioners, to help build resiliency in the work they do.

[*Translation*]

I will shorten my opening remarks to allow my colleagues to speak to you more directly about the programs offered.

With that, I will turn things over to Ms. Vail.

Ms. Liane Vail (Master Trainer for Road to Mental Readiness, and retired Royal Canadian Mounted Police, Mental Health Commission of Canada): Thank you very much, Mr. Rodrigue.

[*English*]

Good morning, ladies and gentlemen.

[*Translation*]

Thank you very much for your invitation to the Mental Health Commission of Canada.

[*English*]

I'll tell you a little about me. I am a retired RCMP officer. I did all my service in New Brunswick. I am originally from Montreal, and so when I got to a little place called Neguac, New Brunswick, it was quite a rude awakening, to say the least. After my 13 years on the road, I went into VIP work where my unit was the first to have a full security detail on the Premier of New Brunswick, who at the time was Bernard Lord. After a couple of years of that, I derailed more into looking after the members themselves, and became the EAP coordinator for the division in the province of New Brunswick for a few years, and then I moved on to being the return-to-work coordinator. I also finished my master's in counselling psychology at UNB.

I noticed a big gap, not for those who were getting the help they needed, but the walking wounded, those out there who didn't know where to get help. Essentially, I became involved in this program years ago, and I have a lot of passion for it. I believe in it, and I can certainly answer any questions in French or English.

● (0850)

[*Translation*]

The other representatives from the commission can answer your questions as well.

To start, I would like to tell you about the Mental Health Commission of Canada.

[*English*]

Essentially, the Mental Health Commission was created in 2007 based on a report on mental health, “Out of the Shadows At Last”, which came out in May 2006.

As you can see on the screen, it is a non-profit organization funded by the Government of Canada, but operating at arm's-length. There are key areas in mental health: workplace, recovery, peer support, suicide, first nations, Inuit and Métis, and opening minds. Today, I'll be discussing the road to mental readiness, R2MR, which is directed to the workplace, in particular to first responders.

Some of the projects and initiatives we have been involved in include the mental health strategy for Canada, as well as the national standard of Canada for psychological health and safety. We often look at the physical health and safety, but more and more research has shown us that we have to look at the psychological health and safety as much as we do for the physical.

Opening minds is an initiative where essentially we looked at all.... They didn't want to reinvent the wheel. They wanted to look at what is out there to determine what is of value. They looked and took an evidence-based approach. They didn't reinvent things that were already out there, like the R2MR. The four target groups they looked at were health care providers, youth, news media, and the workplace. Specifically, R2MR is in the workplace. However, it has a secondary effect of bringing the tools and things they'll learn through this program home to their spouses and their families, which quite frankly is the secondary advantage of having this program rolled out.

Why is mental health important? This is where I'd like this to be a little interactive. Before we start some of the questions with some statistics, we're going to look at a video.

[*Technical difficulty—Editor*]

Ms. Nicole Boisvert (Manager, Business Planning and Operations, Mental Health Commission of Canada): Is there sound?

Ms. Liane Vail: Having done this presentation many times, I can give you a Coles Notes version as you look at the video.

Ms. Nicole Boisvert: We'll animate it for you.

Ms. Liane Vail: Yes, we will definitely animate it for you. It's pretty straightforward.

There's a gentleman going across the road and he gets hit by a car. If that was a physical injury, you would have people running up to him, looking at him, and looking for help. What you see here is a group of people. Some people are standoffish, while some are hands on. They're saying things like, “Look at him. He's not even bleeding.” “I don't have time for this.” “What am I supposed to do?” “He's probably faking it.” These are all things that affect somebody with a mental illness. It's the stigma that's attached that makes people not want to say anything because of those exact words. At the end, it says, “Imagine if we treated everyone like we treat those with mental illness.”

The next slide is going to be a little interactive. It gives you the answer. However, one in five Canadians will struggle with a mental illness throughout a year. We do the math. There may be 20 or 30 people here and one in five of us will be affected directly or indirectly. Are we going to develop a mental illness? Not necessarily, but one in five will be affected directly or indirectly.

Here's one. You saw the circle. What percentage of adults living with mental illness say the onset occurred before the age of 18? Do you have any guesses?

● (0855)

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): I would say 85%.

Ms. Liane Vail: It's 70%. In other words, 70% of adults who suffer from symptoms had already experienced them before the age of 18.

[*English*]

What percentage of parents say that they would not admit to anyone that they had a child with a mental illness?

An hon. member: I would say 60%.

Ms. Liane Vail: Why do you think that? Why do you think it's so high?

[*Translation*]

Mr. René Arseneault: It's because they feel ashamed.

Ms. Liane Vail: Right.

[*English*]

They're embarrassed. They're ashamed.

An hon. member: The stigma.

Ms. Liane Vail: There's the stigma, absolutely.

What percentage of youth under the age of 25 that have been treated for a mental illness reported being affected by stigma?

[*Translation*]

Mr. René Arseneault: It depends on what generation we're talking about. The percentage might be much lower for the current generation, given that it is accepted in schools, but I think it would be 60% for our generation.

Ms. Liane Vail: That's right.

I'll give you the example of my 12-year-old son.

[*English*]

He came to me one day, and he said, “Mom, I'm going to kill myself.” Having the experience I have, I asked him the appropriate questions.

There's the way of doing it and there's the thought. A lot of times people will say suicide is the end all and be all, but there is suicide ideation.

So, I asked the appropriate questions and I said, “Okay buddy, you have a plan. You know how you're going to do it.” Off we went to the hospital. Of course, that's when you need the special care. That's when you need the specialists to come in. I'm not afraid to disclose that because he is now a champion. He is now out in the school telling his story, that it's okay not to be okay all the time, and that there is help out there.

It's important, and it's like you said. The younger generation are more free to tell you how they feel, how they're thinking. Oftentimes, I ask my son what his heart says, how he is feeling. We often negate our feelings and hide them. What happens is that we are scared to come out and say what is wrong. The biggest factor is stigma.

Only 13.9% of Canadians talk to their health care professional about their mental health. Stigma is the number one reason, if not the largest reason people don't seek professional help. What would you say are the worries of stigma? Stigma is a very large umbrella with many factors underneath it, but why would stigma be a factor for somebody with a mental illness?

[*Translation*]

Mr. René Arseneault: This can have an effect on the empowerment of a person in the labour market or on access to better positions, such as management positions.

● (0900)

[*English*]

Ms. Liane Vail: The number one worry is what people are going to think.

The importance of reducing stigma is actually like opening a door or a floodgate, and there is a wave attached to it. When we reduce stigma, we get early intervention. We get a better prognosis and outcome. We increase productivity. Oftentimes, we hear about absenteeism. There is also what we call presenteeism, where somebody shows up at work, does about three tasks for the day, and is done. Why? It's because that person feels obligated to go to work, but is not well enough to be at work. Essentially, there is the positive financial impact of increasing productivity.

There's also a cultural shift in thinking and attitudes. When we introduce this program, especially to managers, what I notice is light bulb moments. The shift in thinking and attitudes is not just black and white. We'll show you a little bit about that later on in the slides, but there is a shift because it's not a black-and-white topic. There's a lot of grey in the middle. Basically, there's a continuum model that is colour coded to simplify and to increase the anti-stigma, and there are positive outcomes for those with mental illness because they're a lot more open and they feel safer and comfortable in disclosing to their peers, to their managers, what's truly going on inside them.

This is a great analogy. People often ask, “Why does it take so long for somebody with a mental illness to come back to work?” Quite frankly, they don't know that they're not well for a very long time. You look at an incident, let's say a sprained ankle or a broken leg, and you're looking at the injury. Well, the injury can happen simultaneously. If a police officer goes to a car accident and gets injured at that car accident, he has a physical injury and he has a mental injury, because of the trauma he was exposed to. However, that physical injury is going to be looked after, diagnosed and treated, and he's likely to go back to work. But is he well when he comes back to work? Has he dealt with the trauma? Maybe not.

You see a very much longer line that goes under the mental injury going to the diagnosis. Why is that? There's a lot of reasons: they don't know themselves; they haven't identified it; they don't know where to go; they don't know what to look for. Essentially, when it gets to the diagnosis, there's a longer term of being not well emotionally that is going to take quite some time to get better, compared to a physical injury where it's one thing after another and you're back to work. The treatment will happen and there will be a return to work. However, it takes that much longer based on the fact of not knowing what to identify, not knowing what to look for.

Some numbers and figures that are quite alarming is that 500,000 people in Canada will not go to work this week, based on the fact that they're struggling with symptoms or signs of mental illness. There's a $51-billion cost to that. If you were to compare a mental illness to a physical illness, like a respiratory illness, you're looking at a cost of $8,000 to $9,000 for respiratory care and 11 days off. If you were to compare that to a mental illness, you're looking at $18,000 per case and 65 days off. How do we fix that? What's the solution?

These are some stats. Oh, I skipped one. This research was done by a group, a case study, and again I've really explained the difference between respiratory and mental illness. You're looking at the number of days, which is 11 days, based on a respiratory infection as compared with a mental illness.

Do you have any questions so far?

[*Translation*]

Mr. René Arseneault: Yes, I have one.

I imagine that the statistics relate to a definition of mental illness. What symptoms are included in the definition?

Ms. Liane Vail: We'll talk about that in a few moments. I will describe the set of symptoms and warning signs. The commission has divided this into different parts. We will talk about the warning signs and symptoms and describe the information that officers receive during training.

● (0905)

[*English*]

Let us look at the prevalence rates of PTSD in Canada. You'll see the general population is 7% to 12%. This was taken by the Royal Ottawa Health Care Group in 2016. Essentially, police and military are at 8% prevalence rates, and then you have fire, and you have corrections, and paramedics. Quite honestly, if I speak to this slide, I have to thank the commission for doing their due diligence in the police world, because when it first started, one of the employees, Sue Mercer, was at the forefront of targeting police. I truly believe that it's thanks to the commission and the hard work they've done so far that has decreased that percentage in the policing world.

As far as the military goes, R2MR has been around since 2009 and I truly believe it has made a difference.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): A study that was just done had the self-identified rates much higher than that. We heard in our study, as well, that the prevalence rate of both operational stress injuries and post-traumatic stress disorder was considerably higher than the numbers shown there. Because there really aren't any statistics across Canada, one of the things we recommended was that we should be looking at it. The Royal Ottawa Health Care Group is tremendous and at the forefront of this, but I don't know if those numbers for the police at 8% are representative of police across the country.

Ms. Liane Vail: I agree. There is a lot of research being done in separate entities, but nothing has been correlated together. You are going to get a variance in percentages. This is one group saying that they've looked at it; they've done their study, and they think it's 8%.

I'll give you an example. I was heavily involved after the Moncton shootings, when we lost three members and two members were injured. The year before, we had the R2MR in place, and we followed them afterwards. We used the OSI clinic in Fredericton to partner with and do some research. Based on just that incident, it was at 14%. Your statistics are going to vary, but I truly believe that this program really makes a difference in self-management.

After Moncton, we had seven days to prepare for the funerals. There was a lot of admin being done, but my job was to look after the membership, the trauma, and the crisis. We actually had a university wing that was a drop-in centre for all first responders who were directly or indirectly.... Just because I wasn't part of the shooting, that doesn't necessarily mean I was not affected. We had debriefings. We had psychologists, doctors, and so on. There is a perfect example that I use. This very big, rough and tough officer came in. I said, "What do you need?" He looked at me, and said, "I don't know what I need, but I know I'm not well." That's what really touches me. The self-management tool of this really helps identify early intervention faster so that they can get the help they need. It's not a miracle cure, and not everybody is going to buy into it. I know that, but what I can say is that it has made a huge impact on a lot of people.

Ms. Nicole Boisvert: I'll just speak for a second, if I could. I think part of the difference that you are seeing with the statistics.... The recent study, if we're talking about the same one, was, as you said, self-reported. Those numbers are not actually representative of diagnostics, because there was no mental health professional involved. It was purely a screening tool; whereas these ones here, done by the Royal Ottawa, are actually diagnoses by a mental health professional. I think that's why you're going to see a discrepancy. Those that are self-reported are going to be a lot higher, potentially because there are more people involved.

Ms. Pam Damoff: Also, this is just looking at PTSD.

Ms. Nicole Boisvert: Yes, this is also just PTSD.

Ms. Pam Damoff: It's a subset of the mental health issues. That's why we looked at operational stress injuries, not just PTSD.

Ms. Liane Vail: Exactly. The way I look at PTSD—and I do have PTSD. I was diagnosed in 2012. I can honestly say that PTSD is kind of an umbrella, because my signs and symptoms were more anxiety and depression. There are prevalence rates with anxiety and depression, so if you don't look after those, the end result is PTSD.

There are also social phobia. Those are some of the more common mental illnesses that you will see in first responders.

What is the cost of doing nothing? There's absenteeism. We talked about presenteeism. There are the disability claims—that $51 billion—your injuries, the grievances, the turnover in your staff, and the legal implications based on the fact that it's no longer only physical injuries that we have to look after, but there are also the emotional injuries that can be affected within your workplace.

So what is the solution? The road to mental readiness was developed by the Department of National Defence in 2008 and 2009. Basically, this stems from Afghanistan where they noticed a higher increase in mental illness, so the chief of personnel and the surgeon general decided to pull their resources together. This was unique, because they brought in not only the specialists, the subject matter experts, but also the soldiers. The soldiers could speak to soldiers, just as police can speak to police. There's a peer piece in this program, which is vital to the presentation. A psychologist can get up and name a whole bunch of stuff on symptoms and signs, but if a peer who has lived experience and who is obviously not in crisis is able to talk about it in a way that resonates with their audience, it's much more profound and it has a huge impact on the group that they're presenting to.

What are the objectives? These are the objectives of the road to mental readiness. One of the modules looks at stigma of mental illness. What is stigma? What is prejudice? The program promotes good mental health. It will reconceptualize how participants think and talk. It helps participants identify poor mental health not only in themselves but in others, and it teaches coping skills that we'll go through later on in the presentation. It creates a more supportive environment for all.

The incident that I use is the Moncton shootings, in which we created that supportive environment for those who wanted to come. It wasn't mandatory. It wasn't necessary, but they knew it was there and that was half the battle, knowing that there was support out there for them.

In the past, we've looked at mental health and mental illness, and we've looked at them as being more black and white: either you're fit for duty or you're off sick. In this case, it's green or red. When you're healthy, you're functioning normally; you're able to bounce back and there's recovery from mental illness. You are in the green. Then the other end of the spectrum is the red, being ill, that diagnosable mental illness. The question I ask you is if you have a mental illness, can you go back to the green? Can you bounce back with a mental illness and be healthy and function well?

● (0910)

[*Translation*]

Mr. René Arseneault: We would like the answer to always be yes, and it is probably the case, but it depends on the mental illness.

Ms. Liane Vail: Yes, it does.

More serious mental illnesses require more work and therapy, and perhaps more medication. In the case of anxiety, depression, social phobia and post-traumatic stress disorder, it is possible to resume work. This is not the case for all mental illnesses, but it is true for those common to police officers and first responders.

Mr. René Arseneault: I was referring to mental illnesses like acute schizophrenia. Some of my family who suffer from it can't work at all.

Ms. Liane Vail: That's right.

[*English*]

Here's the mental health continuum. This is really the highlight of the road to mental readiness where it's an introduction of a new continuum model that really breaks down what is healthy, what is reacting, what is injured and what is ill. The important things to look at on this slide are colours: green, you're good to go; yellow, you're reacting. The self-limiting distress; it's something you can look after yourself. Then if you move to the right of the continuum, you're looking at orange and then red. In the orange, it's more severe functional impairment and when you get to the red, it's a diagnosable illness.

That being said, I often in the presentation compare it to a physical illness, which is that light bulb moment where if one of you were to twist your ankle, is it common and self-limiting distress if you twist your ankle? Can you look after it yourself? Absolutely. Would you be reacting to something that you've done to your body? Yes. It's the same thing with mental health. You can have more stress in a week or two weeks and that could put you in the reacting stage. When you go out and you sprain your ankle, maybe it's a more severe functional impairment. Maybe you need to see your doctor, go to physio and get some treatment, see an occupational therapist to help you get back to the healthy stage. When you get to ill, that's a break. It could be a shattered leg or knee. Is that going to take more treatment and more professional help to get you back into the green? Absolutely. Can you get back to the green if you've shattered a knee cap? Yes, you can. You can also get back to being healthy after being diagnosed with a mental illness.

The important factor here is it moves from good to poor mental health along a gradient. It emphasizes the possibility to back and forth along the continuum, and eliminates the need for stigmatizing labels and non-professional diagnosis. I often call it Dr. Google, where behind the scenes we're checking out on Google that we have this and that. I laugh because as soon as I call my in-laws and say that my son has a cold, they think that he has to be hospitalized and that he has pneumonia. There is an extreme. What this continuum model does for mental illness is it takes away the stigmatizing labels. It also takes away all the Dr. Googles in the world because you can actually see for yourself where you are on that continuum.

Last, each phase outlines signs and indicators for self-assessment.

● (0915)

[*Translation*]

Mr. Arseneault, you asked what the warning signs or indicators were. We have divided this topic into sections.

First of all, there's the change in mood.

[*English*]

When we look at change of mood, you're going to see a fluctuation intensity in severity and a decrease in productivity. Essentially when you move from the right to the left of the continuum, you're in a normal mood when you're in the green. You can become irritable or impatient and that can disappear and you can go back to the green, or you're angry and anxious because of something that's more stressful and you can move back to the green. You don't necessarily go directly to the red. Some people do, and in that case you'll see them easily enraged. You'll see excessive panic. You'll see depressed mood and even a numbness where they feel nothing.

We're looking at the second piece of the signs and symptoms and that's often changes in thinking and attitudes. When we look at thinking, that's more of an internal thing. What are our thoughts? Are they positive or are they negative? What's going on in ourselves when we're looking at our partner who we're working with and we're thinking, “Oh my God, do I have to work with this guy again”, when really on other days everything is fine. Here we look at thinking as internal and attitudes as external.

Is there anybody here who's been sarcastic or is sarcastic, who uses that as a normal kind of humour? Nobody. That doesn't happen.

Then I'm going to ask you, have you ever been sarcastic with an edge and then thought that maybe you shouldn't have said what you said?

● (0920)

Mr. Glen Motz (Medicine Hat—Cardston—Warner, CPC): Every day.

Voices: Oh, oh!

Ms. Liane Vail: Every day? Okay.

I'm going to go into the reacting stage of every day and ask if it is displaced sarcasm, intrusive thoughts, or sometimes distraction or loss in focus. What we see in thinking and attitudes is that as we move to the right of that continuum, we lose our sense of humour. It perhaps becomes displaced sarcasm and can easily turn into a negative attitude, and then we have somebody who, if they're in the red, is non-compliant.

We don't want to get to the red. The whole premise of this program is to identify those signs and symptoms before we get there.

It's also important to explain some of the signs and symptoms of our thinking and attitudes when we are in the red. There are suicidal thoughts that may not lead to suicide, but then there is suicidal intent, and there are people who have taken their life by suicide.

In terms of the inability to concentrate, loss of memory, and cognitive abilities, let's say you're standing there in the kitchen and asking, “Why am I here and what was I supposed to get?” Now, if that happens on occasion, we're okay, but if that starts happening over and over, we're going to have to question where we are on that spectrum.

Then you're going to see physical changes. If you look at the screen here, you'll see that we talk about sleep patterns, appetite, energy, and weight. What do you think is the number one physical change that people will be affected by more than other signs and symptoms in our physical state? Everything else goes if we lack what?

Ms. Pam Damoff: Sleep.

Ms. Liane Vail: Yes. Sleep is very important.

When I was in charge of the return to work, people who were off duty would come into my office and talk about either a medical discharge or a plan for a return to work. Oftentimes, the first question for me to ask was, “How are you sleeping?” Sleep affects everything else.

Then we have changes in behaviour and performance. If somebody who is physically active all of a sudden is a hermit over the course of two weeks to a month, we might have some concerns. Or maybe somebody who has never missed a day of work suddenly is missing one day a week or calling in sick.

These are things that we have to identify. Then we look at patterns. Performance is one. There's procrastinating. Normally speaking, if we're procrastinating, we're reacting to something because we don't want to face it. Then, once you get into the injured, there's avoidance and there's tardiness, and obviously your performance is going to decrease.

In the red, there's the withdrawal and the absenteeism. I also talk about presenteeism, because a very good friend of mine, who for a very long time didn't realize he wasn't well, would come to work because he had to come to work. He would sit in front of his computer and he would answer those three emails and then he was done. You would see him for coffee, and he would look very happy and very content, but inside he was a mess. When he did get the help that he needed, he came back to the green. It's very important to realize that presenteeism is also a sign and an indicator.

We talk about substance use. I'm talking about the legal ones, not the illegal ones so far. Changes in substance use are something that we have to keep track of as well. These are signs and symptoms. This relates to medical prescriptions, as well as alcohol.

All of this is fine. You can look it over, but my clear point here is that what you will notice with substance use, albeit my substance use is shopping.... I love to shop, but I know something's wrong when I'm shopping too much, right? What I'm thinking is, what am I covering up?

When this starts to affect you socially, economically, legally, or financially, it becomes a problem. When there's no impact on any of those venues in your life, then it should not be a problem. Once it starts leading to some trouble, increasing trouble, or affects social, economic, legal, and financial matters, that's when you know that there is something going on and a clear sign of symptoms moving along that continuum.

I'm going to hand out these cards. We pass these out to all of those who participate in this program. There are two different programs that I'll go through. Here you are looking at the five different characteristics. This is where it's important to look at mood, your thinking and attitudes, your physical behaviour, and substance abuse. You can do a quick check in on yourself and see where you are at on that continuum. However, just because you might be in one of those categories in one of those subsections doesn't mean that you're mentally ill. It means to check in and see how you are doing and why. Does that make sense?

● (0925)

Ms. Nicole Boisvert: Apparently, the sound is going to work now.

We're going to try this again.

Ms. Liane Vail: Okay.

This program is education based, and there are videos throughout. We're going to show you this one.

[*Video presentation*]

● (0930)

It's very impactful. Videos like that really resonate with those sitting in the room in this workshop. The big four.... The Navy SEALs in the U.S. were struggling with the passing rates of their applicants. They introduced these, which were borrowed by the Department of National Defence, and they effectively increased the success rate of their Navy SEAL applicants' getting into the program.

With each of the four that are set out as goal setting, there is a definition. There is an activity for the group to go through. They use the SMART goals. How do you reach a SMART goal? It's very interactive. Visualization, also known as mental rehearsal, is where we do a guided visualization and we often give examples of where you could use a visualization that might help to decrease the anxiety level in a difficult situation or talking to somebody about something...dealing with a conflict.

Then there's the self-talk. There's negative self-talk, where most of the time that's what we're saying to ourselves, and then looking at the thinking traps. We're talking about thinking traps that we use as habits and trying to change them into more positive self-talk.

The fourth one we go into is what you could call tactical breathing. You can call it yoga breathing. You can call it calming or deep breathing. But in effect, you practise what I call box breathing, where you take four breaths, then hold for four, then exhale for four, and hold for four again. Again, you can go to Dr. Google and read about it. It's extremely effective in decreasing anxiety right away in a moment of anxiety or crisis.

Mr. Glen Motz: That's what I do during question period.

Ms. Liane Vail: Do you put your arm up and breathe for four and hold for four?

Mr. Glen Motz: I don't put my arms up. I just breathe.

Ms. Liane Vail: That's what my son says. We have two rules in the house. We take a breath before we're going to say something that we're going to regret, and if it gets really bad, we put the microwave timer on for 20 minutes and walk away until we're okay to come back and talk about it rationally.

Ad hoc incident review is another leadership tool that DND uses. It's to reduce the stress in your team. It is not to replace a debriefing. It is a very quick check in, especially with managers, if you've had a crisis or a negative situation in your workplace. You want to check in with your employees to see how they're doing. Quite simply put, it is “How are you doing”, to acknowledge that it was a tough situation or to say “I'm struggling too.” It gives them the opportunity to feel that they're in a safe environment and are able to reflect on how they're reacting, and if they are reacting over a longer period of time and they're not getting back to their normal, then obviously they can self-manage and get the help they need.

In terms of scenarios, I worked with Suzanne Bailey, who was instrumental with the Department of National Defence in this program. She by far says that in order for this to be successful you need this piece. In the leadership package, you have eight examples for leaders. The primary package...and the only difference, why there's less in one than the other is that your primary package is four hours, and your leadership package is eight.

We're going to give you a scenario, and I'd like to take a look at it. If you'd like to discuss it with the people beside you or as a group, we can certainly do this. It will give you an idea of.... When we talk about scenarios, you can say, “Oh, okay, that's what they're talking about.”

In the setting of the R2MR workshop, we divide the groups into four or five people, and they're each given a scenario. For the questions that are going to follow this, we're not looking at the team; we're looking at Elizabeth. You learn that the daughter of your subordinate Elizabeth has been diagnosed with terminal cancer. You've noticed that Elizabeth is distracted at work, and tearful at times. Her work is beginning to suffer, and you are concerned. She has been making errors, missing a lot of work, been rude to her co-workers, and refuses to take on any new work assignments.

Those who are working with her are obviously very frustrated, but they don't really know how to approach her. They're also concerned and want to help, but they don't know how.

I'm going to give you a couple of minutes to discuss it. You have your—

● (0935)

The Chair: Ms. Vail, let me intervene at this point.

There was some discussion about what this would be about. There was an expression of discomfort, if I may say, among colleagues with respect to actual scenarios and engaging.

Ms. Liane Vail: Okay. Very good.

The Chair: So I'm—

Ms. Liane Vail: We can certainly do this as a group, and I can guide the conversation—

The Chair: Or not do it at all.

Ms. Liane Vail: Okay. All right. So we—

The Chair: Excuse me for a second. I just want to engage my colleagues here, because there was a level of discomfort expressed to me, and I want to respect my colleagues.

Ms. Liane Vail: Absolutely.

The Chair: Monsieur Picard.

[*Translation*]

Mr. Michel Picard (Montarville, Lib.): In my opinion, the importance of the presentation is obvious. At least I speak on behalf of my colleagues and me; you will be able to share your needs.

Ms. Vail, it is essential to understand your methodology and approach. You can summarize how this is normally done. Committee members want to know what you are doing and understand what is going on. However, it seems to me inappropriate for a public committee meeting to become a public laboratory for the exercise you are proposing. For the benefit of this committee, I invite you to introduce the mechanics you use in training and summarize what happens in training.

Ms. Liane Vail: Yes, certainly.

Eight scenarios are provided in the kit for managers. There are four in the basic kit. We provide questions related to the scenarios.

Here, we are not yet comfortable enough to do that, and that is understandable. Often, this is done at the end of the training and it works better, because we have already given participants an opportunity during the day to talk about mental health.

[*English*]

Destigmatizing the stigma around talking about it works well.

The next part of the program is about returning to work. It's not only about returning to work for the person who has struggled with the mental illness; it's also for his peers. Oftentimes, when somebody comes in from maternity or paternity leave, there's cake, balloons, and a welcome back. People want to see the baby pictures and everything. But does the person who comes back with a mental illness get the same sort of welcome? Not necessarily. It's no fault of those employees, because what's happening is that they don't know how. Having this education in the program gives you the opportunity to debunk the myths of this video.

[*Video presentation*]

● (0940)

It's the fear of not knowing what they're going to say.

Regarding the evaluation results, based on quantitative results of the pre-workshop survey, the commission has looked at R2MR and the working mind, which is the civilian version. They've done post-workshop surveys, and reassessed at three and six months. The evidence shows quantitatively that there has been a decrease in stigmatizing attitudes in managers, a decrees in employees pre and post, and the majority of the gains are retained for up to three months at follow up. There is a significant increase in resiliency skills, as well as overall resiliency, mental health and well-being.

With the qualitative results, you're looking at what people have said about the program: “I liked the program.” The workshop “dispelled myths and common misconceptions”. It was an “eye-opening experience”. It “was very interactive, well presented” and “excellent videos”. They are lived experiences, so people are really open to it and it resonates with them.

Who are we reaching? Well, with the R2MR we've reached over 59,000 people. There are 1,238 trainers. The number of people trained in the working mind to date is about 14,000, of which 330 are trainers.

In terms of partnerships, R2MR has been partnered with several police organizations and more than 250 first responder groups. I was part of the implementation of the R2MR in the RCMP. I went to the senior executive committee in front of our commissioner, Bob Paulson at the time. He actually made this program mandatory across the country.

The importance of this is vital. It's not the be-all and end-all, but it opens the door to a wave effect that can produce a significant increase in self-management and a significant decrease in the number of dollars that we put into mental health at the moment. It will make a difference.

We have a four-hour delivery format in an eight-hour day. There's one week to train the trainer, where we'll go in and teach how to teach the program by using the managerial program. Normally speaking, the number of participants is 12 to 36, the reason being that we don't want it to be too big. There's some intimacy in the fact that we can talk about mental health and debunk the stigmas. Yes, it is an uncomfortable conversation. It is the elephant in the room at the beginning, but when we get into this, throughout the day you will notice that people are more open to having that discussion.

The primary package is four hours. It targets the same modules as the leadership package. The difference is that the leadership package does the shield, sense, and support, for which the group is divided into three.

One group will look at “shield”. How do we promote positive mental health in employees? The commission is not there to give them the answers. They are there to guide them to find their own answers that will be appropriate for their own environment.

One group is on a sense of early recognition. What do you do, and how do you do that?

● (0945)

[*Translation*]

When it's in the red, you have support, but what kind of support? Where can we get the support? What treatment would be required, based on the situation?

[*English*]

Oftentimes, especially in policing, they've struggled with a trauma. Whether or not they go to the appropriate health treatment...is a big indication of whether or not they're going to get the appropriate treatment to get back into the green.

Then, there are the practical skills and application, which we showed you in the scenario.

That's it for my presentation. Thank you very much for listening and participating. I've been working with the commission and the R2MR program for many years. It has championed a lot of follow-up in looking at the wellness of our employees, specifically on the mental health side of things.

The Chair: Thank you, Madam Vail. I appreciate the presentation. It's certainly very interesting.

We're going to go to formal/informal questioning.

Monsieur Picard.

[*Translation*]

Mr. Michel Picard: Thank you very much for your presentation and, most of all, congratulations on your work. I know there is still a lot of work to be done; it's work that has no end. On behalf of those who benefit from your services, I thank you very much for your dedication.

According to your slide comparing treatments for a physical health problem with those for a mental health problem, it's quicker to diagnose a physical health problem than a mental health one. However, depending on the break-down you make, after diagnosis, the treatment of a physical health problem lasts about as long as the treatment of a mental health problem.

I'm surprised. In the case of depression, people are treated for more than three months. In the case of a physical health problem that is not too serious but that requires care, or even a heart attack, the person will recover within a few weeks or months. I would have thought that some mental health problems, without being extreme, required care over a period of years. So I was somewhat surprised that your assessment of treatments for mental health problems was virtually the same as for physical health problems.

Could you tell me more about that?

Ms. Liane Vail: In other words, you're surprised at how long it takes to recover from a mental illness, compared to the time it takes to recover from other illnesses, is that correct?

Mr. Michel Picard: The slide in question has four lines—

Ms. Liane Vail: Right.

Mr. Michel Picard: After diagnosis, the duration of treatment seems to be almost the same, within a few millimetres. I'm surprised. I would have thought that the treatment for mental health illnesses would be much longer, since some of them require much more care.

● (0950)

Ms. Liane Vail: Right, I understand.

Actually, it depends. In the case of depression, it's important to know whether it is something recurring or an isolated incident.

Let's take the example where, after the death of a spouse, a person shows symptoms of depression. The signs and symptoms may last a very long time if the person does not recognize them as symptoms of depression.

The data here is collected from the moment the treatment begins, and I stress the fact that the right treatment needs to be given. If the person is referred to a professional who specializes in treating children, do you think they will get the right treatment? No. It is important to refer people with signs and symptoms to the appropriate professional. For me, it was the clinic specializing in operational stress injuries.

According to research, eight to ten sessions can normally cure an incident of depression or anxiety.

The difference with police officers is that they may have had not one, but several incidents of depression since the beginning of their careers. When I started in Neguac, there were many cases of suicide and all sorts of other things. I stayed on. Then there was more and more trauma; it was an accumulation of problems.

To answer your question on that slide, I would say it's related to an incident.

Mr. Michel Picard: I have one last question.

You mentioned the reality of police officers and soldiers. When police officers get in their cars, their stress levels are higher than those of the average person.

Ms. Liane Vail: Absolutely.

Mr. Michel Picard: In the same way, as soon as soldiers put on their uniforms and go into the field, their stress levels are necessarily higher. The context is completely different.

So, the percentage of 8% to 10% is somewhat surprising, since the base is not the same as for a shift in other trades.

Does your intervention begin when a mental health problem is diagnosed, or are you asked or would it be justifiable to ask that you intervene in cases where people are in a grey area?

Everyone knows people who are not doing well at one time or another. The latter do not necessarily suffer from a mental health problem. There is no standard. It is impossible to determine precisely from what point an individual is considered to be suffering from a mental health problem and not merely a little crazy in the good sense of the word. However, for a mental health issue, it is often advisable to consult a professional, simply for follow-up. It is not necessarily that things are going so badly, but we don't want to get to the point of no return.

Do your interventions cover these grey areas? Do you intervene during yellow or orange periods, or only when they turn red?

Ms. Liane Vail: Do you want to answer that?

Mr. Michel Rodrigue: At the commission we don't intervene on the ground. That is really not part of our mandate. However, we are doing prevention. Many of our programs are focused on prevention.

We all know about the first aid program, which allows us to intervene when a person gets injured and to stabilize the situation until help arrives. For our part, we offer the first aid in mental health program, which allows us to do the equivalent. We are able to determine whether or not someone is in a crisis or about to be, whether to intervene, to determine where they should be directed, or to decide whether to take them there straightaway or to call for help. That is one of the programs we offer. We really work in the area of prevention.

We believe that by offering promotion and prevention programs, we can have the greatest impact. With this in mind, we offer the mind to work program. This is the version received by those who do not work in the military or police fields. Having attended this training with senior officials, I can confirm that this finally gives people the tools to better deal with staff who are receiving treatment or experiencing difficulty. I believe this initiative is relevant. It allows for prevention. However, when people are experiencing difficult times, support programs are needed.

● (0955)

Mr. Michel Picard: Thank you.

[*English*]

The Chair: Thank you.

I appreciate that I'm running a formal/informal clock here. I see that your presentation has stimulated a lot of questions.

[*Translation*]

Mr. Dubé, you have the floor.

Mr. Matthew Dubé (Beloeil—Chambly, NDP): Thank you for your indulgence, Mr. Chair. I will be brief.

First of all, I would like to thank you for being with us and for your presentation.

Mr. Rodrigue, you just spoke about prevention. I know that operational training issues, meaning specifically what happens on the ground, are outside of your mandate. However, with regard to the events in Moncton, which have been mentioned several times, it has been pointed out that training and available equipment could perhaps have prevented this incident and post-traumatic stress in some members affected by this tragedy. This has even been the subject of a lawsuit. It's obviously a more controversial issue.

To what extent are you involved in more practical matters, such as ensuring that working conditions prevent you from having to intervene afterwards for cases of mental illness?

Mr. Michel Rodrigue: I will respond briefly and then turn to an expert in the field.

We have developed the National Standard of Canada on Psychological Health and Safety in the Workplace. It is the first of its kind in the world. This standard has been adopted by thousands of workplaces. It creates healthy environments. Last year we were pleased to hear from the Clerk of the Privy Council announcing that all workplaces in the federal public service would adopt this standard. Large companies have done that. This includes a number of measures that create a healthy workplace free from harassment and psychological stress.

[*English*]

Ms. Liane Vail: If I could answer in English, essentially we talk about Moncton—I brought that up—and yes there are other factors. There are investigations and so forth. But the fact is that this R2MR was provided to them the year before that incident. I would hate to think of what would have happened with their mental health if they didn't have those tools already in place.

This program is essentially because I had people coming to me or to that drop-in centre saying, “I'm in the red. I'm not doing well.” If we didn't have something like this in place where we've identified what's important in prevention and self-management, we may have had a bigger crisis on our hands.

Does that answer the question?

Mr. Matthew Dubé: Sure.

I don't want to go into it too deeply, because we're being mindful of time. I think it's also just understanding sort of where the mental health issues join with what's actually—

Ms. Liane Vail: In place.

Mr. Matthew Dubé: Yes, making sure that officers are properly trained, not just on dealing with mental health issues but in terms of the physical intervention, equipment, things like that.

In other words, if we have a construction worker who is up on the scaffolding and the scaffolding is rickety, obviously you can deal with the aftermath of the injury, but you want to make sure that the scaffolding is not rickety to begin with.

Ms. Liane Vail: Absolutely.

Mr. Matthew Dubé: I am wondering if your organization also makes sure that you can avoid even getting to the point where R2MR is necessary to begin with.

Ms. Liane Vail: I can only speak to the experience that I had with the RCMP. They obviously developed a psychological health and safety strategy and identified the R2MR from the commission as one of the important factors in their pillars to help their members psychologically.

That's what we're talking about. There are different safety things. One is your physical safety and one is your mental safety. The R2MR and the commission are working at pairing the two together so that they merge, so that not only.... I oftentimes say, “Sure you can fill those boots, but are those boots well?”

● (1000)

Mr. Matthew Dubé: Sure.

Thank you.

The Chair: Ms. Damoff.

Ms. Pam Damoff: I want to first thank you for coming today, and also for all your efforts to reduce stigma and present a program to our public safety officers to highlight the issues that are out there.

As you know, our report was called “Healthy Minds, Safe Communities”, because we recognize that if our public safety officers aren't mentally well, then our communities aren't as safe.

We heard clearly that veterans versus first responders versus corrections officers are all different, and very clearly that veterans and public safety officers need to be treated differently. I know this program was initially developed for the military and then adapted for public safety officers.

Even within that subset, if you have paramedics versus corrections officers, police officers, do you adapt this program for each group that you're presenting to?

Ms. Liane Vail: Yes. It's quite a process, and the commission can speak to it.

I've been involved with the policing, with paramedics. I've been involved with quite a number of groups. My understanding, and what I like about this program, is that they tailor it to their audience. With regard to those videos that you see, they'll be paramedics if we're speaking to paramedics. I was in St. Catharines last year and presented to paramedics. We did the one-week train the trainer course, and they came from all over Ontario.

They really tailor it. When I went to Quebec and I was doing the corrections officers program, we were talking about corrections issues. Those are the focus groups and the behind-the-scenes conversations before the program is even rolled out to that organization. It is definitely tailored.

Ms. Pam Damoff: You mentioned in your presentation that this is one tool. Certainly that's what we said in our study as well. This isn't the fix. This is one tool in the tool box to deal with it.

When you're doing these presentations, do you focus on that, in particular with the managers? I'll be honest with you. One of the things I've heard is that, in some cases, managers feel they've done this training and therefore the problem is fixed within their department, without dealing with all of the other things that are necessary.

I'll give you the example of Halton where they have an organizational wellness unit. They're dealing with all the things that they need to be doing. They're doing an excellent job. They have peer-to peer-support. They have a lot of different options to deal with the officers.

How much do you deal with that when you're doing the training? I'm sure you've heard that as well.

Ms. Nicole Boisvert: That question is normally addressed even before we deliver the training. When somebody approaches us when an organization is interested in having this training, one of our team members has a conversation with them about what the needs of the organization are and why exactly they are looking for this. What need are they thinking it's going to fulfill for them?

We have a conversation with them that this is one piece of a whole suite of things that the commission offers and that they should be implementing. That conversation with the management and the executive that this is just one piece happens even before we get to the training.

We also present them with other things that the commission does and also advise them that, if they present us with needs they are thinking this is going to fulfill, and we feel like it doesn't, we let them know that, and we say they need to get those pieces elsewhere.

Ms. Pam Damoff: Certainly we had recommended that we need a national strategy on this, and we need to be able to provide some guidance to public safety officers across the country.

What are your thoughts on that? Do you have any?

Ms. Liane Vail: I'm here representing the commission. However, if I were to look at the broader spectrum just based on experiences, I think this is a very good tool, and I know the commission is looking at booster sessions. If you noticed in the statistics, at three to six months—you have even said—they think they have it and now everything's good to go when in fact retention has been proven at three months.

The commission has even gone further than that and developed booster sessions that would be provided by those who are already trained going into their own organizations and redoing a booster on the priorities of the things they have seen in either the leadership package or the primary package.

Then there's also the fact that you have people who have taken the primary who are now managers, so having both.... I think it's a very internal question to each organization, but as a whole of public safety, there also has to be a monitoring system in place that will differ within organizations.

What happens is, first responders are very untrustworthy. They don't trust much, let's put it that way. I can speak for myself. They question everything. The bottom line is that these are programs that are peer-related that will help them trust that the process is going to work.

● (1005)

Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.): My thanks to you for being here and for the important work you're doing. Over the course of the last decade, there has really been some terrific work done, and we're getting somewhere in this very challenging issue and domain.

I have a question and comment relating to the exportability of what I see as the emerging Canadian approach. A couple of weeks ago I had a chance to visit UN headquarters in New York, the United Nations civil service. The context was International Day of Democracy, but I had a chance to have some side discussions.

I connected with a former colleague of mine who is now a senior official in the UN medical service. He and I served in a combat zone for more than five years as civilian UN employees, and we've lost colleagues to suicide, in the vast majority of cases because of access to a service weapon, either military or civilian issued.

I was very excited to learn that the UN civil service is now taking this issue head-on and is commencing initiatives that are long overdue. I think there's an opportunity to potentially connect with the Canadian approach. He's very interested in the “Healthy Minds” report which this committee has issued, but I think there may also be an opportunity for the commission to connect with the UN.

I have three questions relating to that. The first one is to drill down a bit more into the question my colleague Pam Damoff had on the connection between the civilian and the military component of this work. Is there a set of factors you could differentiate? The UN, as you will appreciate, is right on the pivot of that, right? We have operational peacekeepers who are armed forces, we have security officers, and we also have purely civilian employees who are doing work in the war zones and facing all the violence that's surrounding them, so there are very different dimensions of this. Are there some factors that you could point to that differentiate the military side from the civilian side in terms of how you deliver this particular program?

The second and third questions are, what do we still need in terms of data, and is there a gender dimension to the work you're doing?

● (1010)

The Chair: Good luck with that.

Ms. Liane Vail: I'll do my best to answer the three questions.

The first question is whether or not...I think Nicole mentioned how it can be tailored. There would be a lot of communication between the commission and the UN as far as what their wants and needs are, and perhaps even doing a little bit of research as far as what the trauma is, what are the prevalence rates of what. I'm sure there is a whole psychological department in the UN that monitors the wellness of their employees, so what are you looking at? That again is a conversation with the commission.

Is there a gender issue with respect to mental illnesses? The research that I know of shows that certain mental illnesses affect females more, like depression, just based on more responsibilities, being at work and looking after families and so forth. But I would say that is not a statistic written in stone anymore because of paternity leave; there are fathers who are staying home with their child and so forth. There are some mental illnesses that you will see are symptomatically different between genders, but at the end of the day, more research needs to be done.

Mr. Sven Spengemann: Mr. Chair, with your indulgence, on the data gap, to your knowledge what are we still missing in terms of reliable data to help you improve these programs or to approach areas that we're not too—

Ms. Liane Vail: It's more Canadian research. If you're looking at what happens to a police officer or a first responder in Canada, you're looking at research that's dated from the U.S. Unfortunately, though there are lots of excellent researchers out there, the problem is that these research studies take time, sometimes 10 years, and being part of another umbrella of the Mental Health Commission, there is the SPARK training program, which is knowledge transfer, where you're immediately taking an innovation and creating an implementation. Sometimes the research is good and qualifies or quantifies something, but what is the innovation and what is the purpose?

The Chair: Thank you.

Mr. Paul-Hus.

[*Translation*]

Mr. Pierre Paul-Hus (Charlesbourg—Haute-Saint-Charles, CPC): Thank you, Mr. Chair.

I served in the military for 22 years.

Ms. Liane Vail: Thank you.

Mr. Pierre Paul-Hus: My experience was very different from how it is now, which is also true for some of my colleagues who are former police officers with over 30 years of experience. At the time, in the 1980s and prior to that, there was a form of military and police selection. The methods used were very harsh. During basic training, it was sort of the mental predisposition that was evaluated and that made it possible to screen out many people.

Then came the Canadian Charter of Rights and Freedoms. Changes were subsequently made in the early 1990s.

Do you think screening based on mental predisposition should be important? Should we re-establish a more rigorous form of assessment before enlisting military or police officers? In some cases, police or military personnel must live with post-traumatic stress disorder. If you did a screening assessment, you would avoid having to deal with such situations.

Ms. Liane Vail: Mr. Rodrigue, do you want to answer the question?

Mr. Michel Rodrigue: I will begin by making a broader comment, and Ms. Vail can round out my answer.

As we saw earlier, the statistics show that one in five people will experience a mental disorder or a mental illness at one age or the other. More than 500,000 Canadians are not able to report to work week after week.

I am not convinced that screening is the answer. The solution is to make sure people can recover as quickly as possible.

I will give you a practical answer. What motivates some major employers to implement the National Standard of Canada on Psychological Health and Safety in the Workplace and to train their staff in first aid and mental health is that their long-term disability costs are very high. The reason for the high costs is the lack of access to mental health services.

Sadly, we also found that after eight months to a year of absence, the return to work becomes more and more difficult.

So there is an economic imperative and a social imperative to ensuring the recovery of people with mental illness and to focus our efforts on that side.

Ms. Liane Vail: I cannot answer your question, and the reason is the Canadian Charter of Rights and Freedoms.

According to the statistics, a good number of adults affected by depression have had symptoms, warning signs, or episodes before they are 18. Now, does that mean that everyone with symptoms of depression before they become adults will not be able to be a good soldier or a good police officer? We cannot make that assumption. It is very difficult to know whether those screening tools help us to identify people who may be susceptible to such problems.

Mr. Pierre Paul-Hus: Screening could be done during training. Once they enlisted, soldiers used to go through basic training. The training was really difficult, which allowed people to see which of them were cut out for the job.

Ms. Liane Vail: Absolutely.

Mr. Pierre Paul-Hus: Now, you have to be a lot more careful. I know that human rights are important. I am not saying that you have to do the same thing as in the past, because that would no longer be appropriate. However, if you want soldiers who are ready to go into combat or police officers who are ready to go into the field, and you want to avoid problems, should there not be a very rigorous selection process like the one that the Joint Task Force uses? If someone does not pass the test, they can't be part of that force.

To the extent possible, we want to have armed forces members and police officers who will not have problems later.

● (1015)

Mr. Michel Rodrigue: I hope I can communicate this next message properly.

We are all susceptible to mental health problems. It is not a moment of weakness and there is no predisposition. Of course, some people can be predisposed to problems of that kind. If we add a medication or an illicit substance, marijuana for example, to that predisposition, it can act as a trigger. But that aside, we are all at risk, just as we are all at risk of having an accident and breaking an arm.

The best thing to do is to put institutional mechanisms in place to support people and to make sure that they can be rehabilitated as quickly as possible and return to work.

[*English*]

The Chair: Mr. Motz.

Mr. Glen Motz: I'm thankful for the world of first responders in my world of policing. When Dave, Michel, and I started policing many decades ago, we did not have the training on mental illness that we do today. For that, we are heading in the right direction.

Due to the experience we've had, we screen people before we recruit them and that has been very helpful. We train them in mental readiness as part of our recruits' training. The key is to add resilience. You want to build resilience over time and you do that early on in someone's career.

This program works well. We rolled it out a few years before I left policing. It is having a positive impact in that it allows police officers to speak with each other about the trauma they are seeing or the opportunities where trauma can exist. That in itself is great.

I remember early on we took the PTSD training, the debriefings and defusing and the peer-to-peer counselling work that's been done in the U.S., and we were certified in that. This, to me, is more of a hands-on, everybody can do it, makes a difference program, and I applaud the commission for doing that. I think it's a step in the right direction.

I think it's important to recognize that some studies are to be done. A paper was released last year entitled the “Blue Paper” by a doctor out of Regina. His paper is a review of our police wellness programs in our country. He indicates there needs to be more research. There has to be continuity between services. Sometimes I think that's the current breakdown. We are going in the right direction. It's just a matter of allowing agencies to make sure we all participate in some way.

I think two of you have commented on this. This is not a single event, one training opportunity that fixes the problem. This is an ongoing, annual part of professional development days. We incorporate some mental health training every year, and it's important that we do that.

Matthew, you asked if the scaffolding can be fixed before it's broken. Sometimes you can and sometimes you can't.

We are on the right track. We're going in the right direction. We do need more work. This isn't a fix for everything. It's a first step. You're to be applauded for the initiative.

I don't have a specific question, Mr. Chair.

● (1020)

The Chair: Mr. Fragiskatos.

Mr. Peter Fragiskatos (London North Centre, Lib.): Thank you for the work that you're doing.

I have a question about family members of first responders and where they fit into the R2MR approach.

A second question relates to challenges of implementation. I was reading an article, which was published just a few days ago, that looked at a situation in Manitoba where paramedics are implementing this very approach. There's a bit of a challenge, it would seem, when it comes to implementing the strategy in rural areas as compared to urban areas. I wonder if you could touch on that as well.

Ms. Nicole Boisvert: Certainly, I can talk to that.

With regard to families, the commission actually just developed a family package that is specifically for families of first responders because we understand that they don't leave this at work. This flows into their family life and whatnot. We are currently piloting that package across a couple of first responder groups that we've worked with in the past. That package is geared towards any type of family member, spouse, partner, parent, sibling, child, as long as they're an adult. The package is not yet designed for youth. The package is being piloted over the next several months and, hopefully, will be rolled out sometime in 2018 across the board.

Mr. Peter Fragiskatos: My question was provoked by the video with the OPP officer who talked about his family.

Ms. Nicole Boisvert: Yes, exactly.

Mr. Peter Fragiskatos: Obviously, he was going through challenges. He's the primary focus, but the family goes along with him.

Ms. Nicole Boisvert: It's a pared-down version of the program—

Mr. Peter Fragiskatos: The family suffers with him, I should say.

Ms. Nicole Boisvert: —that focuses a lot on the continuum and on recognizing signs and indicators that family members might see in their spouses or whoever, whatever the relationship is with the first responder. It takes away some of the return to work and those kinds of things, and it focuses a lot on recognizing the signs and indicators in their family members.

Your second question....

Mr. Peter Fragiskatos: It was on the challenges of implementation: urban areas compared to rural areas.

Ms. Nicole Boisvert: It is definitely a reality that a lot of the groups we've worked with have been in major cities. The first reason is funding. Those in smaller, remote communities often have a lack of funding to pay for a program like this. For some of them, especially firefighters, a lot of them are volunteers, so there is no funding at all. The other issue is just accessibility. For example, when somebody attends training like this, they have to, obviously, not be on shift and active at that point. Taking those people off shift to attend training like this is sometimes hard with scheduling when there aren't a lot of people. We're saying that a class has 12 people in it. To take 12 people out of rotation for a half day, or a day if they are managers, is often difficult in smaller communities.

It's something that we're addressing in a number of different ways. For example, we're hosting. Typically, the sessions are run within an organization by the organization. The commission has started delivering sessions that are hosted by the commission. Those 12 to 24 people who attend are individuals from various organizations, so an organization can send maybe two or three people at a time instead of having to host a full class of 12. One, it reduces the cost because they don't have to host it themselves, and they don't have to pay for space and all that stuff. Two, they can send just a couple of people at a time instead of having to have a whole class.

We're also doing it with larger organizations, in a sense, lending their trainers to smaller organizations. They're volunteering their time to go into those remote and rural places. We're also looking at changing some of our business model to allow for partners that specialize in delivering training to first responder organizations. We've licensed a couple of those types of organizations that specialize in training to then go off into these remote and rural areas. They might go and deliver multiple types of training, not just ours, but ours would be a piece of it. That way they have easier access to those places because they have people in those areas.

There are different ways of addressing it, but it really does come down to funding.

● (1025)

Mr. Peter Fragiskatos: I have one final question. The commission, I would assume, is not the only body involved in implementing a training strategy across the country. I'm going to assume there are others involved. Is there collaboration between the commission and other organizations? I ask the question because one worry I would have, or one concern that may exist, is perhaps a fracturing of efforts, so that training and the content of that training might not be consistent across the board. Obviously, it's going to be different, but you wouldn't want it to be different to the point that you're having completely different approaches implemented and what that means in terms of results. Could you touch on that?

Mr. Michel Rodrigue: I'd be happy to. As an organization we're very proud that whenever we deliver training it is informed by evidence. We are quite pleased to be able to share that knowledge as we develop programs. Perhaps I could give you a short summary of how we deliver the programming.

When we first thought of rolling this out, we asked ourselves how we could have the biggest reach right from the start. That's how we decided to work. With large organizations, we train the trainers. That way they can roll it out on a consistent basis internally. We also work with incredible people like Liane, who deliver the programming on our behalf. For this program we have well over 1,200 trainers. We're always looking to expand through partnerships. As an example, for mental health first aid we're working with a number of partners to expand our reach and they are delivering the program. But we are maintaining the consistency. I think fidelity to the program is critical for one simple reason: some people may have some wonderful ideas, but they can do a lot of harm if the approaches aren't validated, tested, and ensured. We're quite pleased to partner, because our aim is to broaden the field.

I hope that answers your question.

Mr. Peter Fragiskatos: Thank you very much.

The Chair: I want to thank each of you for your presentation.

That's all the questions the committee members have, but unfortunately, this committee is afflicted with a chair who likes to ask questions. First, do you have, or would you like to have, or is there now a longitudinal study of the people you are presenting this program to? It seems to me it's almost a tailor-made population for a longitudinal study. Second, is there a criterion for success? When will you know if you have success or failure? The third question is on the mix of terminology. What is a diagnosable mental illness? I hear all kinds of things. Is PTSD a diagnosable mental illness?

Hopefully with the indulgence of my colleagues, you can answer those questions briefly; otherwise, they will rebel against the chair.

Voices: Oh, oh!

An hon. member: Again.

The Chair: Again, yes.

Ms. Nicole Boisvert: I will try to be brief in my answers.

As to the first question, we did conduct evaluations for the programs, as Liane said, pre-, post-, three-month and six-month follow-up. There are follow-ups being done with the organizations that have ongoing training. They're still being done after six months. As Liane mentioned, we just launched the booster sessions. We were seeing that after six months some of the results were starting to drop off, and so we launched the booster sessions in July. We are now working with some of the organizations that had previously rolled out the initial program and that are now starting to roll out the booster sessions to make sure they're meeting the goal.

The Chair: That's not a longitudinal study within the concept of a longitudinal study. A longitudinal study goes 5, 10, 15, 20 years.

Ms. Nicole Boisvert: No, we don't have one.

The Chair: You don't have one. Really. That's interesting.

● (1030)

Ms. Liane Vail: As far as PTSD is concerned, I'd just like to elaborate on that because oftentimes when you're talking about an illness, you automatically assume that you have the illness and you're diagnosed. How it really works is that you can have signs and symptoms and never be diagnosed because you've got the appropriate treatment, and it hasn't lingered.

In order to be diagnosed, you have to go to a subject matter expert, a psychologist who does an evaluation based on questionnaires, pre-testing, and who then has an interview with you. For somebody to say that they have PTSD, it means that they've gone through all those hurdles to be diagnosed with the illness. Can somebody come to you and say, “I have PTSD symptoms”? Absolutely. I'm sure everybody in this room could look at the diagnostic manual and say, “Well, I've had that before.” In order to really say that you have a diagnosis of PTSD, or whatever mental illness it is, there are many hurdles that you have to go through, like meeting with a psychologist, like filling out questionnaires, and even more questionnaires, and having a formal interview. Then that subject matter expert will give you his professional opinion of whether or not you meet the diagnostic criteria. Everything up until that point is signs and symptoms.

The Chair: Yes.

Mr. Michel Rodrigue: Mr. Chair, on the last portion of your question, which is the most important criteria, it's not going to be surprising to you that, as in any change management process, the firm commitment of the leadership is the most important criteria for success.

I'll give you an example. If living with a mental illness and going to recovery remains a career-limiting move, this program is not going to have the impact we want. So that commitment from the leadership will be required, and it's a key portion of the success.

The Chair: On behalf of the committee, I do want to thank each and every one of you for your work, your presentation. It is greatly appreciated and certainly acknowledged by your elected representatives.

Thank you. You're free to go.

Colleagues, we do have a problem on Tuesday. We have the joint meeting on Thursday with the immigration committee, and the notion was we could potentially do a Tuesday meeting, also with a meeting...or we could commence an indigenous studies meeting, which I think is four....

Michel, I have your opinion, but the clerk says that's going to be a little tough to set up for witnesses.

Glen.

Mr. Glen Motz: Mr. Chair, on behalf of our group here, we would certainly support the continuation of Thursday's meeting for Tuesday. It is a pressing issue nationally, and it certainly is for Quebec, and I would say that we continue on with the immigration and migrant issue.

Mr. Matthew Dubé: I have no problem with that either. I'm just wondering how we know that Bill C-21 will not be here on Tuesday, because I have a different understanding of that situation.

The Chair: My assistant just whispered to me that Bill C-21 is on the Order Paper today. As of last night at five o'clock it was nowhere to be seen. So we appreciate the flexibility.

My attitude will be that if Bill C-21 cannot be before the committee on Tuesday, then we will postpone it until after Thanksgiving, because I would rather have us do a continuous approach to Bill C-21, rather than piecemeal.

Michel.

[*Translation*]

Mr. Michel Picard: We are speculating on hypotheses. If Bill C-21 does not come to us for study on Monday, we would then have another meeting available, given that we will probably not be able to work on it on Thursday either. That leads me to recommend that we work on the First Nations study, because it is already scheduled into the agenda. The study can be interrupted when Bill C-21 arrives. We could set aside one, two or three meetings for that study, until everything is taken care of.

I understand completely that immigration is a hot and delicate topic. The fact remains that, in my opinion, it is an issue that involves immigration first and public safety operations second. The reduction in the number of arrivals makes immigration a prime concern for the committee that deals with immigration. At that point, the idea of having a single meeting on the issue, as scheduled, is enough for me. We could then start our study on First Nations as soon as possible.

● (1035)

[*English*]

The Chair: Peter, go ahead.

Mr. Peter Fragiskatos: Mr. Chair, I take the point on the asylum issue being pressing. At the same time, I think we need to understand that the indigenous peoples of this country make up 4% of the population yet represent 25% of the prison population. That is also quite pressing. I would say that we need to begin looking at this on Tuesday.

The Chair: Thank you for your range of opinions. I take the general view that I do not wish to cancel meetings for lack of things to do, but I am in a bit of a flux position. Thursday I will likely have more clarity for the committee, and we'll move forward from there.

Thank you for your contribution.

The meeting is adjourned.