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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1200)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call this meeting to order.

This is meeting number 55 of the Standing Committee on Health.

I want to thank all our witnesses for coming today. I apologize for the delay; these things happen here. I hope it doesn't inconvenience you too much, and I want to thank you for your patience. We will go later than we had planned. I hope that's all right with everybody.

Today, first we'll be studying Bill C-211, an act respecting a federal framework on post-traumatic stress disorder.

Our witnesses today include Dr. Anne-Marie Ugnat, executive director of the centre for surveillance and applied research in the health promotion and chronic disease prevention branch of the Public Health Agency of Canada. Welcome.

By video conference, we have Dr. Jitender Sareen, professor of psychiatry at the University of Manitoba. Thank you very much for taking the time to do this.

As an individual, we also have Natalie Harris, advanced care paramedic in the county of Simcoe.

We'll offer you the opportunity to make a maximum of 10 minutes of opening remarks, and after that we'll go to questions.

We'll start with Dr. Ugnat.

Ms. Anne-Marie Ugnat (Executive Director, Centre for Surveillance and Applied Research, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada): Mr. Chair and honourable members, thank you for the invitation to address this committee regarding its study of Bill C-211, an act respecting a federal framework on post-traumatic stress disorder.

Let me begin by reiterating a statement by the World Health Organization in 2004: that there is no health without mental health.

Mental illnesses, including post-traumatic stress disorder or PTSD, are recognized, medically diagnosable illnesses that result in the significant impairment of an individual's cognitive, affective, or relational abilities. Mental illnesses are the result of a complex interaction of biological, developmental, and psychosocial factors. Environmental factors, such as exposure to trauma, can precipitate the onset or recurrence of a mental illness.

Mental health in Canada is a complicated issue that has both direct and indirect impacts on a significant number of Canadians every year.

The federal government has a role to play in the coordination and collaboration of mental health activities. It also has a role in understanding scientific evidence related to the scope of the challenges and what works best to address them. This evidence informs the development of resources for information on best practices and innovation.

While the federal government also has responsibility for mental health services for specific federal populations, such as serving members of the Canadian Armed Forces, veterans, serving and former members of the Royal Canadian Mounted Police and the Correctional Service of Canada, indigenous populations, newcomers —including refugees—and federally incarcerated individuals, the Public Health Agency of Canada, where I work, is mandated to serve the broader Canadian population. As such, we work with other government departments, stakeholders, and partners in the promotion and monitoring of mental health for all Canadians.

Several federal and national partners play a role in mental health promotion.

Statistics Canada has a federal responsibility to collect data on the Canadian population, including through the census and population surveys. The Canadian Institute for Health Information, CIHI, holds and manages national-level health administrative data, such as hospital billing data. Health Canada manages the Canadian drug strategy, which includes the monitoring of the use of illicit substances. The Mental Health Commission of Canada coordinates a network of partners through the Mental Health and Addiction Information Collaborative, of which, we, Statistics Canada, CIHI, Health Canada, and other partners are members.

The Public Health Agency of Canada contributes an important piece to the understanding of mental health in Canada by conducting national monitoring of mental health, mental illness, self-harm and suicide, and family violence, and related risk and protective factors. These areas often have strong associations with PTSD, either as potentially precipitating factors in the case of the trauma experienced with family violence, or as outcomes with mental illness and even suicide.

Mental illness monitoring is a core public health activity relying on population surveys, such as those conducted by Statistics Canada, and on administrative data collected by the provinces and territories, which includes physician billing claims and hospital discharge records linked to health insurance registries.

Bill C-211 proposes improving the tracking of the incidence rates and the associated economic and social costs of PTSD. Currently, monitoring of PTSD in the general Canadian population relies on data from national population surveys conducted by Statistics Canada, such as the Canadian community health survey of 2012 on mental health.

In 2012, 1.7% of the population aged 15 and over reported that they had PTSD. This is an increase from 2002 when 1% reported that they had PTSD. This increase is primarily due to an increase in prevalence among women. It went from 1.2% in 2002 to 2.4% in 2012. It is important to note that estimates of self-reported diagnosed PTSD from survey data are thought to underestimate the true prevalence of the disorder.

● (1205)

Another consideration for the monitoring of PTSD is the use of provincial and territorial health administrative data, which has been successful for other chronic conditions, through the Canadian chronic disease surveillance system. The CCDSS is a collaborative network of provincial and territorial chronic disease monitoring systems led by the Public Health Agency of Canada and relying on linked physician billings and hospitalization data.

For PTSD specifically, physician billings are not available in all provinces and territories as not all provinces or territories go to the same level of specificity. Coding standards are jurisdictional issues in which CIHI plays a role. However, it could be possible to conduct monitoring for a few provinces and territories that can currently identify PTSD. At the national level it may be possible to establish monitoring using administrative data for broader categories, for example, adjustment disorders that include other conditions related to adjustment reactions to stress, such as but not limited to PTSD.

PTSD is often treated through therapy methods that are outside the publicly funded health care system, such as occupational therapy, psychologists' services, and social work. Therefore health care administrative data would underestimate the disease prevalence and be an indicator of health service utilization rather than disease prevalence. Currently no monitoring system captures data from community-based services outside the health care system.

It is important to note that while national population surveys have previously asked respondents to indicate whether they have PTSD, estimates based on self-reported diagnosis are thought to underestimate the true prevalence of the disorder as people may not have been diagnosed or may be unwilling to divulge their diagnosis.

Surveys that rely on the reporting of individual symptoms consistent with PTSD rather than self-reported, physician-diagnosed PTSD however, may be able to provide accurate information on the prevalence and the impacts of living with the condition for the purpose of monitoring. For example, in 2001 McMaster researchers conducted a study using symptom-based survey tools and reported a lifetime prevalence of PTSD of 9.2%, which is higher than the prevalence reported from the Canadian community health survey of 2012 on mental health. Due to the large sample of respondents that would be required as well as survey content and length, this would be costly to conduct.

Moving forward, as I've outlined, there may be opportunities to enhance the monitoring of PTSD using surveys and/or administrative data.

The Public Health Agency of Canada is committed to working with partners and stakeholders to develop ways of measuring and reporting on the burden of PTSD in Canada.

Thank you for your attention. I would be pleased to answer any questions you have.

● (1210)

The Chair: Thank you very much for your submission.

Now we go to Dr. Sareen from Manitoba.

Dr. Jitender Sareen (Professor of Psychiatry, University of Manitoba, As an Individual): Thank you so much. It's a pleasure to be here.

For the committee to understand the context of my comments, I want to tell you a little bit about myself. I'm a psychiatrist and head of the department of psychiatry at the University of Manitoba. I have provided psychiatric consultation and treatment at the Veterans Affairs operational stress injury clinic in Winnipeg as well as at the Health Sciences Centre in Winnipeg.

Over the last 17 years, I've had the opportunity to help and learn from people who have suffered with post-traumatic stress, as well as mood and anxiety conditions. I've also held Canadian Institutes of Health Research grants on military mental health as well as first nations suicide prevention.

Currently I'm working with and leading a team of researchers and clinicians in examining the impact of trauma and post-traumatic stress among Canadians. One of the studies is a large survey with Statistics Canada that follows the Canadian military over 15 years.

I want to comment that I'm very supportive of Bill C-211 that has been brought forward. As I understand it, this bill would increase the conversation federally as well provincially in developing a federal framework for recognizing and treating post-traumatic stress disorder.

I will summarize my understanding of the current knowledge of PTSD in Canada as well as internationally. There is increasing recognition around the world about the substantial impact of traumatic stress and PTSD. We know from studies around the world that PTSD is associated with enormous cost to the individual as well as society. We know that approximately 60% to 80% of Canadians, at some point in their life, will be exposed to a severe traumatic experience. Most people exposed to that traumatic experience will be resilient and will not require treatment. Social support is the most important protective factor after exposure to trauma.

However, we do know that 20% to 30% of people exposed to a serious traumatic event will develop a trauma-related condition, for example PTSD, but also other conditions like depression, another anxiety disorder such as panic disorder, or a substance-use problem.

There is more and more knowledge that is accumulating that shows that exposure to repeated trauma over time can increase the risk of PTSD. We also know that physical injuries, assaultive trauma, motor vehicle accidents, and rapid onset of critical illness are associated with PTSD.

Our group has shown that people with PTSD have about three times the likelihood of developing suicidal behaviour compared with those who don't have PTSD.

Women, refugees, public safety officers, health care professionals, military and veterans, as well as indigenous groups, are at higher risk for PTSD. This knowledge comes from some Canadian studies, but mostly from U.S. and other populations.

Most people who have a traumatic injury at work who develop PTSD have difficulty and have complex return-to-work issues.

We also know that co-occurence of physical health problems, such as chronic pain as well as addictions, are common and are associated with morbidity and mortality.

We also know that people with PTSD can have a significant impact on their family, intimate partner, as well as their children, and we also know that relationship conflict, divorce, and separation can trigger suicidal behaviour among people with PTSD and depression.

We know most people with PTSD in the public sector have long delays in receiving evidence-based treatments.

Canadians have limited access to psychiatric and psychological treatment, as well as rehabilitation, in the public system. Many people with PTSD receive medications and treatments that are not recommended by expert consensus guidelines, such as benzodiazepines like Ativan, or medical marijuana.

● (1215)

Marital and family therapy can improve outcomes but is often not available. People in remote communities have limited access to psychological and psychiatric treatment.

We know that early recognition and treatment of traumatic stress symptoms in PTSD can reduce suffering and improve functioning. We also know that a combination of psychological treatments and medication treatment can help in reducing suffering for most people with PTSD.

There is more and more interest in using novel approaches to deliver psychological treatments, such as Internet-based cognitive behaviour therapy as well as large classroom-delivered cognitive behaviour therapy.

There has been a rapid expansion of mental health services in the Canadian Armed Forces and Veterans Affairs' clinics in the last 15 years. This rapid expansion has reduced waiting times and improved outcomes among Canadian military and veterans with operational stress injuries. In Manitoba, we're highlighting the need for similar interdisciplinary models for providing timely access for civilians suffering with PTSD.

Telehealth and telephone-based care have also shown efficacy in reaching those in rural populations who suffer from PTSD in the United States. These models of care have also been shown to be cost-effective.

Finally, any investment in improving recognition and treatment of PTSD requires strong evaluation.

Thank you so much. I look forward to your questions.

The Chair: Thank you for your comments.

Now we move to Natalie Harris for her 10-minute opening.

Ms. Natalie Harris (Advanced Care Paramedic, County of Simcoe, As an Individual): Thank you.

Good afternoon, honourable members of Parliament and your staff, members of the Standing Committee on Health, analysts, proceedings and verification officers, and honourable chairperson.

My name is Natalie Harris, and it is my pleasure to have this opportunity to share with you how important MP Todd Doherty's Bill C-211 is to myself and to so many first responders, veterans, military personnel, and corrections officers across Canada. Establishing a national framework to address the challenges of recognizing the symptoms and providing timely diagnosis and treatment of post-traumatic stress is essential to saving the lives of those who passionately care for and protect the citizens of this great country every day.

It has always been easy for me to share that I'm an advanced care paramedic with the County of Simcoe in Ontario and the mom of two beautiful children, Caroline and Adam, but it's only been over the last two years with the support of my family and friends that I have developed the courage to share that I also battle post-traumatic stress disorder and attempted to take my own life in 2014 when I had no hope of getting the treatment and support I needed to survive.

You may be wondering to yourselves what in the world this seemingly normal girl could possibly teach you today. I may not be representing an organization, but that's okay, because what I do represent is very important. I sit here before you representing what could be your sister, mother, daughter, wife, friend, or partner, who may be silently battling a world of darkness all on her own because she is too afraid to ask for help for fear of no longer being able to do the job she so dearly loves, for fear of being ridiculed and labelled with mental health stigma for the rest of her life, and for fear of not being heard.

In October 2014, PTSD had caused me to live in a world filled with fear and sadness that constantly undervalued my fundamental necessity to breathe. It caused me to live in a world filled with darkness, distorted thinking, and illogical reasoning. It caused me to live in a world that harboured powerful voices that told me that I should hurt myself because I was worthless, and that everyone would be better off without me. In October 2014, PTSD caused me to know for certain that I was going to take my own life. On that dreaded day, after swallowing half a bottle of muscle relaxants, I wrote a letter to whoever would find me, “I'm so sorry. You will be okay. I love you.” I then swallowed the rest of the bottle.

I started feeling tired. I knew the medicine was working. I lay in bed staring at the ceiling, more numb than I'd ever been in my life, while I was literally waiting to die. I remember feeling sick, and somehow in my haze I made it to the bathroom. That's all I remember. For all I knew, I would never wake up again. For all I knew, I was dead.

What I didn't know was that my colleagues had found me and brought me to the hospital where I remained unconscious for 12 hours. The doctors and nurses pumped litres of fluid into me with the hope of saving my liver. As the hours went by, my abdomen grew full of fluid, and I turned jaundiced as evidence that my liver couldn't keep up.

My family and friends were seriously discussing funeral plans for me, but somehow I survived. It wasn't time for me to leave this planet quite yet. I still had some pretty important work to do, which has brought me here today.

I went to school in 2001 to become a paramedic. Not long after graduating, I was hired by a service. Going to work was like a dream come true, even during SARS, which is when I was hired. Not very many people can say that about their careers. I learned something new every day, was financially stable, and made such a difference in people's lives. I was in my glory, but no matter how much I loved it, each year became a bit tougher for me to cope with, and I didn't know why.

Through difficult calls, I would silently say to myself, “I'm not going to let this amazing career slip away from me. I've fought too hard. I've conquered so many difficult circumstances in my life. I'm sure I'll be okay,” but secretly I began to develop a repertoire of illusions used to hide my true emotions even from myself. Back then, I barely knew what post-traumatic stress was, because we didn't learn about it in school.

I started to see tiny changes in myself in the early years, as days just seemed to go by and calls just happened to add up. I could let most calls move through me in a healthy way, but looking back now I can recognize the deterioration of my coping skills as life as a quiet paramedic took its toll.

Over the years, while being a full-time paramedic, I literally became very comfortable with uncomfortable. I became acclimatized to living a life that included horrific memories, relentless nightmares, and ingrained images of sadness and pain. That may sound barbaric to anyone who is not in the emergency services field, but it is literally a part of our lives almost daily.

● (1220)

Devil's advocates out there may be saying to themselves that we signed up for it, but we didn't. We signed up for an amazing career that allows us to help people on an extraordinary level. No one signed up for mental turmoil. We signed up for the chance to save people's lives. No one signed up for memories of patients screaming in pain. We signed up for achieving educational goals. No one signed up for drowning our sorrows in vices.

We thought we would be strong enough to avoid being uncomfortable, but no one is. Strength isn't measured by the number of deaths we pronounce. It's measured by the number of deaths we recognize we need to talk about in order to sleep at night. First responders are some amazing people, but signing up to be one didn't mean we signed our hearts away.

It's not normal to have a person ask you to just take their leg and arm off because they were experiencing so much pain from being trapped in a car with multiple open fractures all over their body. It's not normal to learn that the patient who hanged himself the night before had a second noose waiting for his wife, had his son not called 911 at the right time. It's not normal to witness a young woman, seven months pregnant, rub her belly with the only limb that could move as she had a stroke that would leave her disabled. It's not normal to see the cellphone on the road beside the obviously dead driver, crushed between the pavement and the car, who was texting and driving, and it's not normal to know he made the three sisters in the other car now two. It's not normal to experience and see the look of true evil when you learn how two innocent women were murdered. It's not normal to be handed a baby who's blue. It's not normal to watch a child have a seizure for 30 minutes because your drugs just wouldn't work. It's not normal to see someone die before your eyes more times than you can actually count.

What we do isn't normal, so why would we think it's okay to be comfortable with that? Why would it be any surprise to hear that first responders are dying every month because they can't take their often hidden memories any longer? I'm uncomfortable with how comfortable we've become.

Honourable members of the committee, we can't wait any longer to acknowledge and act upon the cries of heroes and their families that are happening right now coast to coast. They need Canada to step up to the plate and value their sacrifices in the form of education and support.

So much more needs to be done to prevent the deaths of community heroes, and MP Todd Doherty's Bill C-211 is where this can start. It's on the table, and we can't push it aside. If we do, time wasted will equal lives lost.

I would like to end my testimony by sharing a poem I wrote in memory of my friend and colleague Bob Cooke who died by suicide in September, 2014. We miss Bob, and we will never forget you.

I wish you'd see, but never feel,
This illness dark, to some not real.
I wish you'd know, it hurts to breathe,
My lungs collapse, when comfort leaves.
I wish you'd cast my scars away,
Repair the marks I formed each day.
I wish that answers existed near,
To rid my soul of unfounded fear.
I wish each tear was never there,
They drown my courage left to care.
I wish I'm brave enough to smile,
Sustain down heartache's endless mile.
I wish you'd camouflage each sting,
The blackness seems to always bring.
I wish I knew I'd be ok,
Believe tomorrow's a brighter day.
But I can wish with all my might,
It won't discount this ceaseless fight.
This wish will sail up to the sky,
With all the rest who've said good-bye.
I'll wish tomorrow, just for hope,
Or conjure up some way to cope.
Through darkness black, I'll make my way,
Exist again another day.
I wish...

I never had the opportunity to choose to hang up my uniform. Sadly, PTSD made this decision for me. I plead with you today to move forward with this bill and put Canada on the map with respect to having the best national framework for our heroes so that every uniform can be hung up when the time is right, with the hero's choice.

At this time I would like to present you, the committee, my own dress uniform. I hung that uniform up in my closet quite some time ago. I wasn't able to even look at it until yesterday. I was so sad, hurt, and heartbroken that I needed to end the job that I loved so dearly and still miss to this day. I'm asking you to please take care of my dress uniform. When this bill is moved forward, and we actually get to work on saving those lives coast to coast, would you please give it to MP Todd Doherty, so that he can keep it in his care?

Thank you for your time.

● (1225)

The Chair: Thank you for your testimony this morning.

As a coincidence, I met with representatives from the Mental Health Commission of Canada, and I told them that the most profound testimony that I've heard here, in my opinion, was from a paramedic from Vancouver when we doing a study on fentanyl and opioids. I'll never forget his testimony, and I'll never forget yours.

His testimony, like yours, really helped us put a face on this issue, more than anybody else can. Thank you.

We're going to go to seven-minute questions.

Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): First of all, I'd like to thank all the witnesses here. Natalie, thank you for the very moving testimony. I get emotional when I hear this kind of stuff. Definitely people are out there, and they're crying out loud for help. I think as a committee we should be doing something about it. Thanks again.

In the Bill C-211 preamble, it specifically refers to PTSD of "first responders, firefighters, military personnel, corrections officers and members of the RCMP".

My question is to Professor Sareen or whoever feels best to answer it.

Does the process of diagnosis and treatment of PTSD among these particular groups differ from the process for other individuals? Are there any factors that make an individual either more vulnerable or more resilient to PTSD? What other groups do you think would be suffering from PTSD?

Dr. Jitender Sareen: I think PTSD symptoms are across the different groups, so they're consistent. The hallmark symptoms of PTSD are reliving the trauma and nightmares of the trauma. That's the core difference between PTSD and depression and anxiety, that the person has repeated nightmares.

Among public safety officers, there is more recognition in our diagnostic categories that people who are repeatedly exposed to trauma as part of their workforce are more likely to develop PTSD. That's more of a recent change in the DSM criteria, the diagnostic manual.

The main risk factors for PTSD can be high levels of childhood trauma exposure, being female, not having social supports, difficulties with poverty. Physical injury is a major risk factor, so traumatic brain injury is also a very important factor. There's more evidence recently that people who are in intensive care units, who are severely ill, are at risk for PTSD and depression as well.

The key protective factors are social supports, higher levels of education, and stronger networks in the community.

● (1230)

Mr. Darshan Singh Kang: In your opinion, is this problem much more broad than we are looking at here?

Dr. Jitender Sareen: Yes.

Mr. Darshan Singh Kang: I think we're just looking at the tip of the iceberg.

You were talking about the costs with PTSD. Is there any number to indicate how much people who are suffering PTSD are costing society?

Dr. Jitender Sareen: There isn't good data in Canada on the cost. That's something that's not known in Canada, and it would be very helpful to have a better understanding.

Most of the studies are from the U.S. and Europe, and the estimates are millions of dollars in cost to society, in the form of loss of productivity but also health care costs. People with PTSD often have co-occurring physical health issues, and often access a lot of physical health services as well as mental health services.

Mr. Darshan Singh Kang: In your opinion, what could we do earlier to recognize what kinds of symptoms we should look for in people who could be suffering from PTSD? In your opinion, what could we do to catch it earlier on, so society benefits as a whole?

Dr. Jitender Sareen: We can really learn from the Canadian military and veterans that have really invested a lot in improving access to psychological and psychiatric treatments. They've shown and I'm submitting an abstract of a study that shows that earlier access to appropriate treatment improves outcomes. If you think about someone who has diabetes and they suffer for a long time, that can have a really negative impact on their life and their family. Similarly with post-traumatic stress, depression, and anxiety, if we can reduce the waiting times and improve access to evidence-based treatment...We know that treatments exist and are effective, but due to the fact that we don't have enough funding for mental health services in Canada in general, many people wait a long time for services.

Mr. Darshan Singh Kang: In your opinion, when a person suffers from PTSD, what kind of an effect is left on their families? Is it long term?

Dr. Jitender Sareen: Again, one of the things we're studying is the long-term impact of post-traumatic stress in the Canadian military. Many people have positive relationships with their family and the social support really helps them. We also know that PTSD can be associated with separation and divorce and a negative impact on the children. It's really important to help both the person and the family system, so the family can work through it, can understand that the person is dealing with a mental health issue, and can learn how to help them through it.

The Chair: Thank you.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair. I wanted to take this opportunity to thank the witnesses. I want to take this opportunity to thank Todd as well, as a first-term MP, to be able to bring such an important issue forward. The work he's done getting everyone on board with this is truly amazing and I want to thank him for that.

Natalie, your testimony was extremely emotional. To be present when you made the offer of your uniform...I think I'm speaking for everyone around the table when I say how honoured we are to have you here.

When Todd brought this bill forward, how did you find out about it? Were you in touch with Todd and was he able to engage you fully on this? How did that come about?

● (1235)

Ms. Natalie Harris: That's a great question. Thank you so much for asking.

I originally played a small voice in the provincial PTSD legislation, which is Bill 163 that Minister Flynn headed up. After that, through my advocacy with that bill, I was fortunate enough to meet John Brassard, the MP for Barrie—Innisfil, which is where I'm from. We became friends by helping each other with advocacy in the community and I was fortunate enough to meet Todd through MP Brassard.

Since then, it has been a wonderful relationship of trying to bring forth the education that needs to happen and decreasing the stigma. I play a valuable role by being a voice for Todd and John. Talking about even the potential of having symptoms before any kind of care is even available to someone is so important. That is something that took me a very long time to see and I became very sick. This bill is bringing education to Canada and decreasing the stigma. That is where I play a role.

Mr. Colin Carrie: Could you talk a little bit about the culture among first responders? My family is a military family, and a lot of police, and people didn't talk about things. It was considered a sign of weakness and things along those lines.

Would you be able to express to the committee what you think about the culture among first responders? Is that still a very prevalent way of thinking?

Ms. Natalie Harris: Once again, that's a great question.

Unfortunately it is still very prevalent. I've seen a lot of progress though over the last couple of years with amazing campaigns like Bell Let's Talk that are raising awareness and helping people not to feel weak. Sick Not Weak is another great campaign.

I'm fortunate to have a few of my paramedic friends here in the audience. We were speaking just before this meeting about how we never wanted to admit to ourselves that we could possibly be sick because of the passion that we have for this career. We didn't want to hang up our uniforms. It's not even that we keep it from each other; we keep it from ourselves. We don't want to see. That's what happens.

Unfortunately—I speak for myself—I turned to alcohol and drugs in the hope of coping with the demons that were in my mind and in my dreams so that I didn't have to hang up my uniform. Unfortunately that led to a suicide attempt.

I went to treatment. I've grieved the loss of my career; that is how much it is a part of who we are. It took a long time. With that being said, you can see how it's not an easy thing for first responders to admit. They don't want to have to admit it. Unfortunately, that's where we are, still.

With education, with this bill, with prevention, and with a decrease in stigma, I think we will have a lot more first responders with prolonged careers. I also give a lot of talks in colleges, and I present to peer support groups. One that I created is called wings of change. The purpose is to try to develop resiliency and awareness at the very beginning of a first responder's career, and to start the conversation then.

My daughter is in a police foundations program. People say, “Wow, how is that going to happen?”

You know what? I understand her passion. I support her for what she wants to do, but I'm in a wonderful position to be able to educate her. Hopefully with time, and a federal bill that brings a voice to not being weak if you are sick, it will improve and decrease the cost of the treatment that needs to eventually be addressed. I know that for myself, if I had had help earlier, I definitely wouldn't have had so many months in treatment, relapses, and so on. This is a great bill.

● (1240)

Mr. Colin Carrie: I think sharing your story, not only with the committee but Canadians who are listening in on this, really makes a big difference.

How exactly do you think that passing this bill is going help, let's just say, break the stigma of post-traumatic stress disorder in the workplace, specifically for groups that are in this legislation?

Ms. Natalie Harris: It's all about talk, being able to speak. From my personal experience I was so self-stigmatized. Being able to talk breaks down stigma, not only the stigma that other people put on us but the stigma that we put on ourselves. Being able to talk about something that is a federally acknowledged topic will expand the community of support.

Again, I'm from Barrie, and I have so many Ottawa paramedic and police friends—and now from across Canada—from the peer support group that I set up. It really represents how something federal plays such a role. You know, it's Canada. This is our nation. Having a bill that talks to and addresses the symptoms and the difficulties that we have with being first responders and the people that are listed opens the conversation immediately. That's what needs to happen.

Mr. Colin Carrie: Great.

Thank you very much.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): I would like to thank all of the witnesses today for such trenchant testimony.

Madam Ugnat, I would like to start with you. You testified that the prevalence of PTSD in women—if I have your statistics correctly—doubled between 2002 and 2012. I heard your comment that the numbers are likely under-represented, so I take it that it's probably even higher.

Ms. Anne-Marie Ugnat: Yes.

Mr. Don Davies: My research, if it's not mistaken, is that women are twice as likely as men to be diagnosed with post-traumatic stress disorder. I would like to ask if you're aware of any research that focuses on gender differences, or the prevalence of PTSD in women.

Ms. Anne-Marie Ugnat: Personally, I'm not, but I would turn that question to Dr. Sareen, who does research. What we do is more a monitoring of conditions across Canada in order to establish the burden and describe the condition in terms of people, so more women than men. Sometimes we have access to risk factors, so we can make connections, but we don't always have that. We describe the conditions so that we can inform policy.

In terms of research, maybe Dr. Sareen would be better placed to answer.

Mr. Don Davies: Sure. Thank you.

Dr. Jitender Sareen: The studies that have been done across the world show that women are twice as likely to develop PTSD compared to men. We're currently looking at this: in the general Canadian population and the Canadian military, if the person is exposed to the same traumatic event, are men more or less likely to develop PTSD? We are finding—and these findings are not published yet—that women, if they're exposed to the same traumatic event as a man, are more likely to develop PTSD.

Mr. Don Davies: I want to explore some of the other population groups a bit. I think you mentioned a couple of them, Dr. Sareen. You mentioned refugees and first nations. I want to start with indigenous people.

I have done some reading about, of course, the residential school experience, which was a period in Canadian history where I think we had trauma on people on a mass scale. I want to get your thoughts on the prevalence of PTSD in the indigenous population, and whether you think it's a significant issue that we should be looking to incorporate into this framework.

Dr. Jitender Sareen: I think it's a very important issue to incorporate in this framework. At this time, we don't have any epidemiologic studies of mental health problems in first nations communities in Canada. The limited studies that are there are from the U.S., where they showed that about 30% of women on first nations reserves in the U.S. had PTSD. At this point, we don't have a mental health survey that's been done in first nations in Canada. We do know, as you've described, that residential school trauma and exposure to trauma in indigenous women is quite high, but we don't have estimates of PTSD in Canada.

● (1245)

Mr. Don Davies: I think one of the many virtues of the bill before us is that it calls for us to establish a national medical surveillance program to use data to track incident rates, as well as, I think, to increase diagnosis. Would that be something that you think would be particularly useful in terms of maybe gathering this data in communities, like the data the United States published?

Dr. Jitender Sareen: Absolutely. I think it's really important to have policy that's driven by data. We know that the military and veterans have invested in state-of-the-art community surveys that are done by Stats Canada. Statistics Canada has great survey methodology. I think it's really important, if we're going to invest in treatment and recognition, to have a good sense of how common these conditions are.

Mr. Don Davies: I want to leave some time for Ms. Harris, but I have one quick question, if you can give me a quick answer.

Is there an intergenerational component to PTSD? I'm thinking of residential school survivors, and how that can express itself generationally. Is there such a thing?

Dr. Jitender Sareen: Yes, there is evidence that trauma exposure is also genetically linked, that impulsivity. Also the impact on the child of a parent who's dealing with trauma or PTSD is very important. There's more and more understanding that exposure to traumatic events actually could change our biology and genetics. So there's that interplay.

Mr. Don Davies: Thank you.

Ms. Harris, I just want to say that was incredibly courageous testimony. Not only was that profoundly affecting, but I can appreciate the unbelievable courage that you've expressed in being here, and I want to thank you for that.

I have a quick question for you. You mentioned that representation is very important—I wrote down your words—and that the "fear of not being heard" is particularly profound. This bills speaks absolutely importantly about the impact of PTSD on first responders, RCMP officers, veterans, and police officers. Would you have any objection to our broadening that to include women, indigenous people, and refugees to make sure that they're heard?

Ms. Natalie Harris: No, of course not.

When I was in treatment, one of the biggest lessons I learned from a person who is a perfectionist was to realize that the first thing we need to tackle is progress versus perfection. I think, obviously, there's always room for improvement with anything; that's our human nature. What MP Doherty has on the table right now will allow us to start progress now. The more we can include, the better—100%. The more help we can provide to our Canadians, the better. I still think that what we have on the table is a great start.

The Chair: Thank you.

Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much to all of the presenters.

Ms. Harris, thank you so much, as others have said, for the honesty and frankness of your testimony. I think, through you, we need to thank the RCMP, first responders, the military, corrections workers, and emergency response people, who, on behalf of our society, go into absolutely incredible circumstances. They witness events that none of us would want to witness in a lifetime, and there's mental health, stress, and anxiety that go with that work. I just don't think we often take enough time to recognize that grouping of people who do this voluntarily on our behalf.

● (1250)

Ms. Natalie Harris: Thank you.

Mr. John Oliver: Bill C-211, as a bill, basically deals with tracking of the incidence of PTSD. It ensures that there's a standard diagnosis and treatment set to manage it, and then education, and dissemination of that information across Canada. While I support that generally, I'm wondering if it really gets to the heart of the issue. I'm wondering if, at the heart of the issue, there is the reluctance of many organizations to acknowledge PTSD because of the burden it might put on them financially, and some of the issues where an employer might resist wanting to acknowledge PTSD because of it.

In Ontario, for instance, you mentioned, I think, Bill 163. The presumption is that if you have PTSD and you're a first responder, or in that category of workers, without any challenge, that is a work-related illness. Much more quickly, the treatment starts, and you're very quickly into treatment processes. WCB in Manitoba and Saskatchewan are both working on presumption clauses, that if you have PTSD, the assumption is it is work-related. There is already, I think, some pretty good case knowledge and understanding of how to identify and how to treat PTSD. Is it about better education on those things, or is it really about the receptivity of employers and other WCB agencies, potentially federal government and the military, to recognize PTSD as having a cause originating from workplace activities?

Ms. Natalie Harris: Again, that's a great question. I agree with both points. It's absolutely paramount that employers recognize that this is our injury, that post-traumatic stress injury should be presumed to come from our workplace. However, I think it will take some time, through data and evidence-based research, to really convince every workplace that this is what happens. Unfortunately, that does take time. I see that happening. With this being on the federal table, I don't think employers can turn away. They can't ignore it anymore, or hide behind the stigma that this is the truth, that this is what happens to people who put their lives at risk every day and are among trauma every single day. However, I am a huge proponent of evidence-based research as well, and bringing that forward, and using that for cost-effectiveness as well. I think, again, we have a long way to go in tackling progress versus perfection, and this is an excellent start.

Mr. John Oliver: Anne-Marie or other witnesses, is there anything you'd like to add to that?

Dr. Jitender Sareen: I think it is a complex issue: trauma, work, and the impact.

One thing I want to bring forward is the idea of equity. Whether you are a city police officer or a city paramedic, or you are in the Canadian military, you should have access to the same mental health services. Right now, because of the federal and provincial system and the complexity of work-related injuries, as you have brought up, it's hard for people to navigate the health system.

I think the presumptive diagnosis of PTSD has some benefit in that it reduces the onus on the patient to relate the PTSD to the workforce. We also have to be balanced, though. The aim is to try to help people recover to the best level of functioning.

This bill is very exciting, because it brings the federal and provincial people to the same table to have the conversation about PTSD and learn from what has been done with the Canadian military and veterans. We have been having conversations in Manitoba with the Workers Compensation Board to look at whether we can develop models of care similar to those that have been provided for veterans, because each person, each Canadian, should have the same access.

● (1255)

Mr. John Oliver: Thank you.

Anne-Marie, do you have anything to add?

Ms. Anne-Marie Ugnat: I would like to address the importance of evidence-based policy development. Being able to measure the magnitude of the problem, being able to look at it over time to see whether it is increasing or decreasing, being able to look at risk factors and who is most affected in the population, and learning from different communities and what they've done to address the issue are all extremely important. This would give us not only an estimate of the burden, but also an idea of what resources may be needed and where we need to target the resources.

Mr. John Oliver: Thank you.

At the end of the day, we as a committee have to approve or amend Bill C-211. One of the clauses says that the federal framework should include "the establishment of a national medical surveillance program to use data collected by the Agency", the Public Health Agency.

Anne-Marie, do you know whether the Public Health Agency is collecting data now that we would be able to create that from?

Ms. Anne-Marie Ugnat: The Public Health Agency is collecting data, but not specifically on PTSD. We have data on mental illness, but, as I said in my opening remarks, PTSD represents various challenges.

We usually work with our partners in order to establish good case definitions, which are not perfect—progress—but are suitable to satisfy the stakeholders and the experts in the field so that we can collect better information.

It would require working perhaps with StatsCan to develop specific surveys, or working with the provinces and territories to get them to help with the data they are already collecting.

Mr. John Oliver: So it's already there, but it's about improving the tracking to make sure we see the incident rate—

Ms. Anne-Marie Ugnat: It's about improving the tracking, the case definitions, and the level of specificity in what the provinces already track.

Mr. John Oliver: Thank you very much. I'm out of time.

The Chair: This completes our seven-minute round.

We'll go to our five-minute round, starting with Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): I echo my colleagues in saying thank you for coming and for being with us today, especially Ms. Harris. Thank you so much for your testimony. It's a privilege to be able to hear your story and how PTSD has impacted you and your family specifically. Again, thank you for being so vulnerable with us.

I just want to clarify a point here with you, Ms. Ugnat. If I understand you correctly, what you are saying is that a federal framework would better allow us to collect data with regard to the prevalence of PTSD, and then respond with proper programs and adequate treatment. Is that correct?

Ms. Anne-Marie Ugnat: There is still a lot of work to be done.

Ms. Rachael Harder: You don't know the prevalence of PTSD; you only know mental health in general.

Ms. Anne-Marie Ugnat: Yes.

Ms. Rachael Harder: Putting a national framework in place would allow us to specify PTSD stats, would it not?

Ms. Anne-Marie Ugnat: It would permit us to develop work to look at PTSD. It's not to say that we couldn't focus our attention on that now also.

Ms. Rachael Harder: Would a national framework bring unification to all the provinces and better assist that process for you?

Ms. Anne-Marie Ugnat: It could, but I think the devil is in the details. The information they have in the province is sometimes not specific enough. It probably would require provinces to work more or change their definition.

Ms. Rachael Harder: Again, a national framework could help bring unification to that, could it not?

Ms. Anne-Marie Ugnat: It could, yes.

Ms. Rachael Harder: Okay. Thank you.

Ms. Harris, if it came down to getting this bill passed the way it currently exists with a focus on first responders, or stalling the bill or perhaps not passing it at all in order to draft a new bill that was more comprehensive in scope, not just focused on first responders within the preamble, would you recommend that we take a step back and expand the scope of this bill before moving forward, or do you feel there is an urgency to move forward with regard to first responders?

Ms. Natalie Harris: I definitely feel there's an urgency. I 100% support moving through with this bill now. The reason for that, again, is not to make any life or family less important, but with this on the table right now, we will make progress with helping people who are listed. Those lives will be affected 100% in a positive way. Stalling it will equal lives lost.

● (1300)

Ms. Rachael Harder: Thank you.

Dr. Sareen, I will ask you the same question.

Dr. Jitender Sareen: As I think through it, I think it is very important to move it forward. We do know that first responders are at higher risk for PTSD than civilian populations. I'm absolutely supportive of moving the bill forward. I think the addition of indigenous women is an important one to consider. I think that will require more discussion and partnership with first nations communities. I think it is important to focus on the paramedics and first responders and learn from and work in partnership with the military and veterans to look at improving access and care.

Ms. Rachael Harder: Dr. Sareen, would you say that right now with regard to first responders and PTSD levels we're in an epidemic; that there is an urgency to this?

Dr. Jitender Sareen: Yes, there is an urgency to this. I think the rate of PTSD among paramedics is not well known in Canada. Dr. Nick Carleton from the University of Regina is leading a study on this. Soon data will be available in Canada, but certainly there is much more recognition both in Canada and the U.S. that people are exposed to significant traumatic experiences as part of their work. I think it is really important to address it. Just as with military veterans, there's been much more of an emphasis on helping the system in the last 10 to 15 years.

Ms. Rachael Harder: That's perfect. Thank you very much.

The Chair: Next we have Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses and to Ms. Harris for the very touching testimony.

Dr. Sareen, are you aware of any other clinical trials taking place in Canada or elsewhere of innovative treatment approaches for PTSD like virtual treatment or anything else?

Dr. Jitender Sareen: There have been trials in the U.S. using virtual reality exposure treatments so people can have what's called stress inoculations so they can be prepared to go to war. We have recently reviewed the literature on resilience training. Most of the studies that have been done around those trials have not been shown to be effective. We were funded by the Workers Compensation Board to develop an online cognitive behavioural therapy program for building resilience among public safety officers. We're just launching into that now.

Ms. Sonia Sidhu: I know there is a stigma out there and there are also barriers. Can you tell us about some of the main barriers to a diagnosis of PTSD?

Dr. Jitender Sareen: One of the first and most common barriers is not understanding that the symptoms the person is dealing with are related to a mental health problem. Often the symptoms start to come up as sleep difficulties or difficulties with irritability or concentration, so the person doesn't understand what they're dealing with and often blames themself. I think it goes back to what other witnesses are saying, that helping the public understand and recognize appropriately what is or is not PTSD is very important.

The second issue is around the impact on work. If the person is diagnosed with PTSD, what happens to their career advancement at work? Are they judged by other people at work? That's a major barrier that's been shown in military personnel.

The third barrier is not necessarily a barrier; it's the attitude that they want to handle the problem on their own. That is something we're supporting by creating self-help cognitive behaviour therapy so people can access help more readily.

There are three main barriers. One is not understanding that they might be dealing with a mental health issue; the second is the impact and stigma around work; and the third is not necessarily a barrier, but a wish to try to handle the problem on their own.

● (1305)

Ms. Sonia Sidhu: What is your recommendation to the committee regarding how to deal with that? I need a clear recommendation.

Dr. Jitender Sareen: I think the aim of the bill is really to increase the conversation about and awareness of PTSD in Canada. I really strongly support the bill.

I think education is really important in differentiating between what is normal and what is abnormal. One of the things I've learned is that if someone is exposed to a serious, traumatic event, such as seeing a suicide or the sudden death of a close loved one, and they're still suffering and not back to their normal self about one month after the traumatic event, that one month is an important time point. If they're still suffering, they probably need to look at getting treatment. We think it is important to really make treatment more available and user-friendly and that the treatment should come to the person rather than the person necessarily having to go to individual or group therapy.

We have developed what are called cognitive behaviour therapy classes with the idea of reducing waiting times for people waiting for CBT, because everybody has been in a class since they were four years old and people understand classes but they don't necessarily want to go into psychological treatment. That's one of the novel ways we have tried to reduce stigma and improve access.

Ms. Sonia Sidhu: Thank you.

The Chair: Go ahead, Mr. Webber. You have five minutes.

Mr. Len Webber (Calgary Confederation, CPC): Thank you all, and especially you, Ms. Harris, for sharing your story and for the work you're doing now as well. You're out in the community with colleges, I understand, and you're enlightening them on what they could encounter.

I just want to ask a little bit about your training. When you were training as a paramedic, were you instructed on and prepared with respect to what you would see out there? Was there any indication that you were going to see such horrible circumstances to prepare you for the traumatic events you would see, anything at all?

Ms. Natalie Harris: In school we had extensive training in a scenario format. We used moulage and actors to bring, as close as possible.... We had a 400-hour mandatory ride-out program that is linked to most paramedic programs, so we would ride with an actual paramedic out on the road. But how much we would see would really depend on the call volume of that station. I know, for example, that one of my friends, as a precepting student, had a VSA—vital signs absent—the first day on the road, and also delivered a baby. Those were two pretty impactful calls that some paramedics may not have for most of their career.

We learned psychology, but anything that was addressed on post-traumatic stress was very brief and was linked to the idea that we might be treating a veteran with that, so we never discussed that it was really something we should be looking at as part of our career.

Mr. Len Webber: Absolutely, no question, it should be brought up in the training of paramedics, and our military as well. I have a son-in-law in Mosul right now, in Iraq, and I'm concerned about not only him but everyone there. They should be made aware of PTSD. It could occur with them all. I think we should be proactive rather than reactive when it comes to PTSD.

● (1310)

Ms. Natalie Harris: We've come a long way. I definitely know, especially over the last couple of years, organizations such as the Tema Conter Memorial Trust bring scholarships into the college program, which asks them to do research, and again, will raise awareness and decrease stigma. The colleges are also focusing on peer support and acknowledging that it's part of our careers. We're getting there, but we still have a long way to go.

Mr. Len Webber: Good. Thank you for pushing that, for sure.

I'm going to pass it off to Mr. Doherty now. He has some questions.

Dr. Jitender Sareen: I just want to add one comment, that it is really important to evaluate any interventions around trauma. We do know that, for example, critical incident stress debriefing, which is a group-based intervention after someone is exposed to trauma, was created to prevent PTSD, but it turned out to actually not be helpful and potentially cause harm. The key thing we've learned in the trauma and PTSD literature is that everyone recovers from trauma differently, and that if someone doesn't want to go in a group and talk about the trauma, we don't force people to do that.

Mr. Len Webber: Okay.

Dr. Jitender Sareen: It's really important that this federal framework encourages evidence-based policy in interventions, because the challenge in trauma and PTSD is to remember that trauma is 80% of the population. So we really need to think carefully about the interventions.

However, I completely agree that training people when they're going in to work, to have skills to manage what they're going to be exposed to, is really important. I would just add the evaluation.

Mr. Len Webber: Absolutely.

Mr. Doherty.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you, Dr. Sareen; thank you to our guests.

Natalie, that was incredible testimony, as always. We know that.

I want to mention two points. We talk a lot about our first responders regarding the bill. In the bill, it's not just our first responders, but it is our veterans and our military, those who put their uniforms on every day to serve our communities and our country. I just want that mentioned.

Also, Dr. Sareen, you mentioned what the military, our Canadian Forces, have been doing very well in the last six or seven years. The R2MR program, the road to mental readiness, is exactly what our colleague Mr. Webber was talking about, and the framework of the bill or the gist of the bill is to get those best practices applied right across our country.

For the information of my colleagues who are here, an RCMP who is serving in Nova Scotia and is dealing with PTSD may not be eligible for services in British Columbia. So it's to make sure that there's consistent care and diagnosis right across the country. I'm just using that as one example.

I want to direct my comments to Natalie.

Natalie, you are an accomplished author and you have shared your experience, which is really changing the views of PTSD and giving people a look inside your head, if I can put it that way, during your darkest times. You have a blog that you started writing as you were hospitalized, and out of that you wrote a book called *Save-My-Life School: A first responder's mental health journey*. I would like you to talk a bit about both the blog and *Save-My-Life School* , if that's possible.

Ms. Natalie Harris: Of course. Thank you.

In 2014, I started my blog when I saw Clara Hughes, one of our amazing Olympians—a six-time Olympian—on TV. She was talking on the news about Bell Let's Talk. I can tell you that I felt stigmatized to the fullest extent. I was very proud of my career. I was a teacher for Sunnybrook Base Hospital for Georgian College. I was in the first advanced-care paramedic class in the County of Simcoe.

I really didn't want anyone ever to think that there was something I was battling with that would jeopardize my career. I saw Clara Hughes talking about how she battled with this, and it gave me the strength to start a blog. That blog started, I think, on my very first day of an out-patient course, which was through the Royal Victoria Hospital in Barrie. I documented every honest day and every up and down. I carried it on when I went to Homewood in Guelph, which is a rehabilitation hospital, for my PTSD and addiction.

Afterwards, I shared about my life now and how I manage symptoms that I still experience, and how my family and kids have contributed a little bit to the book as well. I have broken down the stigma for kids their age.

The foreword was written by our Olympian Clara Hughes. Also, an acknowledgement was made by our Ottawa councillor Jody Mitic. I was very fortunate to have a lot of amazing support, including that of Todd Doherty and John Brassard, for the book. It is opening a lot of eyes for people. As Mr. Doherty said, you don't need to have a mental illness, if you read my book. What people are enjoying is that it brings you into the mind of someone who has mental illness. It's very raw; it can be very dark. It's actually quite difficult for some people to read, because it's very truthful and honest.

Thank you for letting me share that part. I appreciate it.

● (1315)

The Chair: What's the name of the book?

Ms. Natalie Harris: It's *Save-My-Life School: A First Responder's Mental Health Journey.*

Mr. Todd Doherty: The blog is Paramedic Nat. I really urge the committee to have a look at it. It should be part of your study.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

I'll address this question to Dr. Sareen and Anne-Marie, or you can all answer this, please.

With Bill C-211 we are trying to address PTSD. We are a diverse country, and different communities have different approaches to address PTSD and mental health. Do you think this bill should be broadened to include different cultures and different communities? What steps can we take to ensure that the framework on PTSD respects these different cultures and communities?

Perhaps Dr. Sareen can go first.

Dr. Jitender Sareen: As Ms. Harris has pointed out, it's really important to move the conversation forward. The other issue is that it engages work-related injuries. That is a very important issue.

We know that post-traumatic stress is very important. Children, women, first nations communities, and refugees all suffer from it. This bill will raise awareness of PTSD in Canada. Because it's work-related, I think it brings up some of the complexities that one of the other committee members mentioned. It brings in the question of how much it is the responsibility of the employer and how much of the public system, and that is a complex discussion that is required.

Mr. Darshan Singh Kang: Do you want to add something to this?

Ms. Anne-Marie Ugnat: In terms of gathering surveillance information, it would depend on the quality of the information we could gather and on the level at which we could identify the different communities.

I would agree with my co-witnesses that the important part is to move the bar, to move forward, and then learn from the different communities that we're able to look at in enough detail to understand this, which will help us to develop a relationship with the other communities and to help them too.

Mr. Darshan Singh Kang: I agree with you, but my concern is that we don't want to do this piecemeal. If we can broaden it as much as we can now, we won't have to come back and maybe address this issue in the near future. There may not be another opportunity for a long time to come.

If we could broaden it and include other people who could be suffering from PTSD, I think that would be a good idea, and I would request Mr. Doherty to look at that.

That's my concern. Do you agree with me on this?

● (1320)

Dr. Jitender Sareen: I don't know enough about the process, but I agree with you that PTSD affects many Canadians, and limiting it in some ways can be a challenge.

I think one of the important things to consider is that this is a work-related mental health issue. It brings a different framework to it if the violence or assault is not at work. I think it really advances, step by step, moving from military and veterans to public safety officers. I'm all for recognizing the importance of PTSD across the different groups, but I think the challenge there could be that if you're trying to bring together indigenous groups and refugee groups, and you're looking at trauma and PTSD, it requires a different approach than if you're just dealing with issues from around the workplace. That's why I'm seeing it as requiring that level.

The Chair: Now we'll go to Mr. Davies for three minutes.

Mr. Don Davies: Dr. Sareen, I want to pick up on that. I think everybody around this table is very supportive of this bill. What is becoming somewhat clear to me is that there's a discrepancy between whether this bill is meant to create a federal framework on post-traumatic stress disorder for work-related PTSD or whether it's to create a federal framework for post-traumatic stress disorder, period. There are indications of both in the bill. The description of the bill indicates that it's for all Canadians who suffer. Then there are certain limiting words that seem to indicate that it's only for people who experience work-related PTSD. That's something that I think this committee will have to go one way or the other on.

It seems to me that there may be some differences between, for instance, first responders or paramedics or firefighters who experience trauma daily, weekly, or on an ongoing basis versus someone who may have an episodic PTSD function—a woman who's raped, a child who witnesses her parents being murdered. It is no less traumatic, I would imagine, and it can lead to the same condition, but I would imagine that perhaps there are some separate considerations.

Can you help me understand whether these things ought to be separated or whether a federal framework can be constructed to broadly encompass all of those different causes of PTSD?

Dr. Jitender Sareen: I think a broad framework can cover the range. There is now more recognition in the American Psychiatric Association's diagnostic and statistical manual. The most recent edition added the criteria of trauma exposure related to work. Before that, it wasn't really recognized. Repeated trauma exposure among paramedics, firefighters, or the police wasn't part of the criteria. They've now added that because it's recognized.

You're absolutely right that it can have different impacts if someone is exposed to repeated trauma as part of work and if someone has a motor vehicle accident, and they're reliving the experiences. I'm—

Mr. Don Davies: Dr. Sareen, could I interrupt? I'm going to run out of time.

I want to get your views on a third category. I'm thinking of refugees and veterans, refugees who are often fleeing conflict or war zones. I'm thinking of someone in Syria who has been in Aleppo for three years and who would have been subjected to exactly the same kind of trauma and violence as a veteran or a soldier would have been. That would not be work-related trauma, would it?

Dr. Jitender Sareen: No.

This goes back to the point that PTSD is PTSD across the different populations, but certain types of work put the person into the situation over and over again.

Senator Roméo Dallaire talked about the helplessness in observing and not being able to respond to the terror he saw in Rwanda.

I think there is a bit of a difference with a worker exposed to trauma and feeling survivor guilt or responsibility for doing something, or not doing something, that could have prevented death or injury.

● (1325)

Mr. Don Davies: Thank you, Dr. Sareen.

The Chair: Time is up.

That completes another amazing meeting of our health committee. We appreciate the witnesses very much for their contribution.

I want to clarify a few things with Ms. Harris. You have a uniform. Are you sure you want to part with it?

Ms. Natalie Harris: Absolutely.

Again, it is an honour for me to choose where I hang up my uniform. It's a part of my recovery. It's really an honour that I have that opportunity.

The Chair: Our esteemed messenger Mr. Dan Dumais has proposed.... He has a bag for it, a container for it. He has proposed that all the members of the committee sign it. Then when the bill passes, we will present it to Mr. Doherty, at your request.

Ms. Natalie Harris: That is wonderful. That would be great.

Thank you.

The Chair: We'll do that, if all members are in agreement, and I think they will be.

I have one question. You talked about your treatment. I know it must be a complicated treatment. What's the one single thing that helped you the most?

Ms. Natalie Harris: It was being able to freely talk about needing help and not feeling embarrassed by it, feeling empowered eventually. That's what talking and raising awareness, decreasing the stigma, is. In my experience, with so many different people who battle the same injury and illness, it's feeling that they're not alone, that they can talk about it, and that there is hope.

The Chair: Thank you very much for all of your contributions.

Thank you for contributing from Manitoba. I appreciate it very much.

That will bring our first part of the meeting to an end. I'm going to take a two-minute break, and then we'll come back. We have a little bit of committee business.

● (1325)

(Pause)

● (1330)

The Chair: We're going to reconvene for a few minutes.

We have a few business items here to deal with.

Our next meeting is on June 6. We need witnesses for Lyme. The clerk would like to have proposed witnesses by this Friday for the Lyme disease study, the framework.

The amendments for Bill C-211 should be in immediately. We're going to do clause-by-clause on Thursday. If you have any amendments to propose, you should let us know and get them in.

We have a public health effects of pornography, M-47, bibliography of studies and sources submitted by Mr. Viersen, but it wasn't translated into French. Is it all right with the committee if we accept it only in English? Do I have consensus for that? Okay.

Mr. Kang.

Mr. Darshan Singh Kang: Would there be any issue with just accepting it in English?

The Chair: I don't think there's an issue because it's just a bibliography, just the names of the articles and the dates. It's not even text, really.

Mr. Darshan Singh Kang: As long as there are no issues.

The Chair: Thank you very much.

The meeting is adjourned.