



HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Public Safety and National Security

SECU • NUMBER 008 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, March 22, 2016

—
Chair

Mr. Robert Oliphant

Standing Committee on Public Safety and National Security

Tuesday, March 22, 2016

• (1105)

[English]

The Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): I call to order the eighth meeting in this session of Parliament of the Standing Committee on Public Safety and National Security.

Before we begin, I want to welcome our visitors at the back of the room, who are high school students from Montreal, Toronto, Ottawa, Winnipeg, and perhaps other places. They are here with CJPAC. We promise to be on our best behaviour as you are watching us. Thank you for being here.

We are continuing our study of the issue of operational stress injuries and post-traumatic stress disorder, particularly as they affect public safety officers and first responders. We're continuing with our study, gathering information, and really trying to lay a foundational understanding of PTSD/OSI as it affects public safety officers.

We've invited witnesses to come and share their understanding, from a theoretical or research point of view but also from their clinical experience. On our first panel, we have with us Nicholas Carleton, associate professor in the Department of Psychology at the University of Regina, and Mike Dadson, clinical director at the Veterans Transition Network, from Langley, B.C.

We'll begin with you, Dr. Carleton. If you could take about 10 minutes to give a presentation, we'll go immediately after that to Mr. Dadson. Then we'll open the committee to questions.

Dr. Nicholas Carleton (Associate Professor, Department of Psychology, University of Regina, As an Individual): Thank you very much for inviting me to speak with you today. I'm a registered doctoral clinical psychologist and professor at the University of Regina. I have expertise in anxiety, trauma, and pain, having worked with traumatic responses for the past 15 years.

My research is supported by the Canadian Institutes of Health Research and the Saskatchewan Health Research Foundation, among others. I maintain a small private practice, primarily treating RCMP officers and other public safety personnel who have PTSD and other operational stress injuries.

Canadians have recognized the need for ongoing dedicated efforts to support our military; our public safety personnel, which include a wide array of personnel, such as police, firefighters, and paramedics; and also corrections officers, 911 dispatch operators, veterans, and their families. As you heard from my colleague, Dr. Sareen, we've come a particularly long way in supporting military mental health, but we have a similarly long way to go in supporting the mental health of our public safety communities.

Our public safety personnel have unique workplace environments, where trauma exposure is the rule rather than the exception. That exposure is different for public safety personnel than for military personnel, not better, not worse, but different. Our public safety personnel are deployed at home in an environment of ongoing uncertainty, often for decades. They have complex roles, such as providing protection, law enforcement, and community development. Accordingly, they require dedicated and specialized resources to ensure their mental health.

I have seen, recently and consistently, exceptional mental health leadership from our first responder communities. Indeed, we are seeing increasing demands from all public safety personnel to provide ready access to evidence-based solutions, interventions, and preventive strategies for improving mental health. The rationale is clear: they are reaching a tipping point. The dramatic increase in reported operational stress injuries is starting to overwhelm the stigma that has silenced so many of these citizens for so long. However, these same citizens have also underscored the need for evidence-based solutions informed by expert research.

Our government has set a mandate to develop a coordinated national action plan on PTSD and other operational stress injuries for our public safety personnel. That mandate was followed by the January 29 national round table on PTSD hosted by our Minister of Public Safety at the University of Regina.

The round table brought together leading researchers with leaders from government and public safety, all of whom supported the urgent development of a coordinated national action plan with a heavy focus on research.

Canadians have an established national mechanism for supporting, coordinating, and communicating health research. The Canadian Institute for Military and Veteran Health Research, CIMVHR, represents a 40-university network and facilitates the development of new research, capacity, and effective knowledge translation.

For the past 18 months, the University of Regina, a founding member of CIMVHR, has been working closely with research leaders from other member universities, international academic leaders, and our public safety leaders to develop a dedicated Canadian institute for public safety research and treatment, to support evidence-based policies, practices, and programming for public safety mental health.

The rapidly developing institute includes a host of academically diverse leaders from universities across Canada. The institute's leadership also includes key representatives from the Mental Health Commission of Canada, CIMVHR, the RCMP, the RCMP Veterans' Association, the Canadian Association of Chiefs of Police, the Canadian Police Association, the Paramedic Chiefs of Canada, the Paramedic Association of Canada, the Canadian Association of Fire Chiefs, and the International Association of Firefighters, to name only a few.

Institute members are already assessing the impact of implementing the road to mental readiness program with Regina Police Service and others, researching formally integrated mental health into policies, education, practices, and support, concluding the first of several program evaluation reports after assessing the evidence base for and the deployment of crisis intervention and peer support programs for Canadian first responders.

Right now the institute is poised to, first, conduct a coordinated national mental health prevalence survey to refine the widely varying estimates associated with public safety personnel.

Second is to conduct a Statistics Canada feasibility study supporting a gold standard epidemiology survey for public safety mental health.

Third is to conduct a pilot study exploring high-fidelity simulated traumas and training scenarios, so that we can empirically and experimentally better understand risk and resiliency variables for operational stress injuries, therein informing traumatic stress procedures.

- (1110)

Fourth is to implement a comprehensive and ongoing biopsychosocial assessment of RCMP cadets and officers using state-of-the-art technologies to evaluate the impact of integrating evidence-based interventions throughout their initial training, during their service, and as part of lifelong learning. The research will be globally and historically unprecedented, providing crucial information about risk and resiliency variables to inform mental health physicians for the RCMP, other public safety personnel, all of their families, and eventually all Canadians.

The institute can also build solutions to help address new challenges in meeting demands for mental health services, such as those recently underscored by the military ombudsman. The solution requires that we do three things: first, ensure patients can and do access appropriate specialists who are correctly using evidence-based treatments; second, support the training and accreditation of more specialists; and third, support research that improves evidence-based care and innovates models for care delivery.

To that end, the institute is also poised to extend work done at the University of Regina on Internet-delivered cognitive behavioural therapy, ICBT, which can increase our access to highly effective, private, popular, and broadly deployable evidence-based treatment as part of a national stepped care system for all public safety personnel. Pending resources, pilot testing for that system in Saskatchewan and Quebec can begin as early as 2017 with pan-Canadian access for our public safety personnel as early as 2018.

The institute can also help to emphasize evidence-based practice. Indeed many public safety personnel appear to be receiving care that is not empirically supported and that is not good enough. Accordingly, members of the institute have worked with the Alberta Paramedic Association to develop new standards for mental health provision for their members. We have also seen efforts to improve mental health care quality and access through the Canadian Association of Cognitive and Behavioural Therapies, which is working to certify practitioners and ensure access to evidence-based care. These are only a couple of examples of people working hard to ensure that our evidence-based practices are made available to those who need them most.

Solutions for public safety personnel inform solutions for all of us. Moreover, they are our community leaders and role models who can facilitate transformations in attitudes and actions towards mental health at a grassroots level in communities across Canada. We have leaders, including all of you, who want to build on the initiatives I've highlighted today.

I suggest that a full and proper response to the Prime Minister's mandate requires that we do the following: First, invest in the Canadian institute for public safety research and treatment; second, ensure the institute remains at arm's length while engaging federal and provincial governments, academics, policy-makers, and key stakeholders; and third, support ICBT treatments and stepped care clinics that are funded through partnerships between federal and provincial agencies with workers' compensation boards.

The institute can then do four things: first, use evidence to guide a national action plan for research and treatment dedicated to public safety personnel that incorporates leadership from our public safety personnel; second, facilitate cross-sectional and longitudinal interdisciplinary research projects so we can speak with authority about variables associated with risk, resiliency, and recovery; third, develop nationally recognized online evidence-based resources for operational stress injuries to support our clients, their families, and their providers; and fourth, work collaboratively to facilitate pan-Canadian access for public safety personnel to minimum standards of evidence-based prevention, early interventions, and programs for treatment.

We can do better and we must do better. These solutions are no longer aspirational; they are achievable. Working with our public safety personnel as role models in all of our communities, we can develop and proliferate better assessments and better interventions, and engage in preventative strategies that reduce risks, increase resiliency, and improve mental health, first for these critical members of our communities and then for all Canadians.

We look forward to your support. Thank you.

•(1115)

[Translation]

The Chair: Thank you, Dr. Carleton.

Mr. Dadson, go ahead.

[English]

Dr. Mike Dadson (Executive and Clinical Director, Veterans Transition Network): Thank you.

I'm Dr. Dadson. I'm the adjunct professor at the University of British Columbia on the advisory committee for the centre of group therapy and trauma. I'm also the clinical director and the national director of the veterans transition program. As well, I'm a board member of the International Society for the Study of Trauma and Dissociation. I'm an ordained chaplain and I operate a trauma treatment centre and training centre here in Langley, British Columbia, that services about 200 folks a week.

I'm here to speak to the committee primarily as a clinician and through my experience in the veterans transition program. The veterans transition program is a group-based experiential program that's been operating for 18 years. It was researched and developed through the University of British Columbia. In our experience, we have seen the struggles for veterans and first responders in accessing mental health treatment. We see that there are several barriers that prevent them from accessing treatment. We actually would take the view that there are a lot of effective, empirically based, research supported treatments available but that many first responders are unable to access these treatments because the job that they do requires them to operate at such a high level of competency and high pressure that if they begin to crack, show weakness, or ask for help, they're perceived as failing or being weak and unable to continue in their work. Seeking help may pose a risk to their careers. We've seen this regularly with veterans where, even though they are suffering clear occupational stress injuries or even post-traumatic stress, they'll continue to work in their field and they will resist seeking treatments early because they believe that it could threaten their career, where early treatment may actually prolong their career.

They deal with situations that are far outside the norm. They are not only experiencing a single incident or event but they are exposed to multiple traumatic or high-impact stress situations. They often express that, even in speaking to therapists, they fear that they will damage their counsellors because of the horrors that they've seen. The way that these traumatic experiences, or these occupational stress injuries, intersect with the masculine gender role or the masculine expectations of their position, because they're very highly.... The expectations are that they are to behave in accordance with masculine norms, which is that they are strong, hard-chargers, capable, independent, and don't seek help. They're not the lambs,

they're the ones who go and actually provide the help. When they need help it's very difficult for them to actually seek help because that contradicts the very culture in which they are working.

The way that the veterans transition program has addressed this is, first, it was developed in accordance with first responders. We met with first responders, we worked with first responders, and we asked them what would help them to be able to address these concerns. We offer a multidisciplinary program that focuses on a strength-based and peer-helping approach. We work in groups and we don't just help or provide therapy for individuals, we show them some very basic techniques and very basic communication skills that can help them support each other. This, in itself, normalizes the experience, which is really important for those first responders because it helps them to recognize that they can still be the warriors that they see themselves to be but they can incorporate the possibility that they also may need help.

They also find it easy to communicate to one another the experiences, the horrors that they've seen, because they know that they've each seen them. They're not saying anything new when they speak in a group to one another. That normalizes their experiences and it makes them available to receive help. We buffer them from the experiences by providing a very caring and supportive environment, which actually reduces the anxiety and the avoidance so they are able to go deeply into their experiences with one another in a shared way. This actually helps them normalize the experience and then do the work that they need to do.

•(1120)

In effect, they challenge one another to do the work because they see that as part of their new battle, or their new career or their new job.

We use de-stigmatizing language. Instead of using language such as "seeking therapy", we use language such as "trying to drop the baggage" or "just trying to move through a situation". Instead of talking about emotional experiences, we'll talk about sensory experiences. We'll begin with the body and their physical reactions, and normalize those reactions.

We believe that one of the reasons our program is so successful is that 50% of the folks who are recommended to our program are actually recommended by other veterans or first responders. That means they come in already expecting that they're going to receive some help that's a bit different from what they've seen in the past. In other words, they won't experience the barriers they've experienced.

Here's an example of a barrier for a veteran. For veterans to apply to be treated for PTSD, they need to demonstrate that they have PTSD, which means they need to retell the story several times, again and again, to a variety of folks who have a pretty clinical mindset. They're not there to actually do therapy; they're there to assess whether the people actually qualify, whether they meet the standard for PTSD. Telling the story in this context again and again actually is unhelpful. It creates avoidance, and they actually avoid even applying for help.

We see many veterans who aren't even a part of VAC services, because they can't go through the process. Their injury is a barrier to their going through the process. That means they don't get treatment.

So 50% of our participants have not accessed services from Veterans Affairs Canada. We have a 90% retention rate, which means that, of the people who have gone through our program, very few have dropped out. When they do, it's usually because of family or because of medical concerns. I'm aware of only one person who's dropped out of the program because they decided not to continue on; it wasn't right for them.

We screen participants, so we don't take everyone. If someone is highly suicidal or psychotic, then we're not going to see them in our program. They need to first get some of those things in check. But our program has a high success rate. Not one participant, of over 600 participants who have gone through our program, has committed suicide.

Our concern primarily is that, at this moment, for us, in our program, we have waiting lists across Canada that can mean some veterans can wait a year and two years, depending on their region, to go through our program. Yet if they go through our program, we're confident that the possibility of suicide will be significantly reduced, to the extent that now we.... Our research demonstrates depression has dropped and their suicidality is minimized.

My concern is that, as these folks wait to get through our program, if any commit suicide while waiting to get into our program.... It troubles me to know we could have helped them significantly, and they're waiting to access our services.

We're kind of boots on the ground. We're here to communicate to the committee some of the challenges we see veterans facing as we're working with them therapeutically.

I think that's where I'll conclude.

The Chair: Thank you very much, Dr. Dadson.

We're going to begin our seven-minute rounds with Ms. Damoff.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thank you both for being available to our committee for this very important study.

Dr. Carleton, you had mentioned that first responders face challenges beyond those faced in the military. I wonder if you could explain that a little bit more, why you think that is, and also whether it makes first responders harder—or different, perhaps—to treat than those who have served in the military.

Dr. Nicholas Carleton: Sure. I should make sure that I'm very clear about that. I don't think they are experiencing traumas that are beyond what's happening in the military; I think that they're experiencing things very differently.

When we deploy our military to Afghanistan, for example, we're taking them from a safe zone and we are deploying them to an unsafe zone, and then we are bringing them back to a safe zone. There's an important distinction between that framing and what we do with our public safety personnel or our first responders; we deploy them, effectively, to an unsafe zone for 25 or 30 years. They're in a constant state of uncertainty. On day one they might be

out for a coffee with someone, and on day two they might be responsible for arresting that person, resuscitating that person, or rehabilitating that person. We're really deploying them to their own communities, which makes for a very different form of exposure.

We're also asking them, as Dr. Dadson said, to experience trauma on a very regular basis. Paramedics, for example, are called out to manage a current and urgent traumatic event, and they're asked to do that day in, day out, sometimes several times in a day. When we consider how that's impacting our first responders and our other public safety personnel, we need to understand that there's a dose-response that's going on there that's much higher than something we would see in most other cases.

With our military, you might see a very extreme, very intense dose-response, for example, during a specific period; but they're brought back to a safe zone that they can believe is safe and is kept safe by our public safety personnel; whereas for our public safety personnel, they're the ones keeping it safe.

• (1125)

Ms. Pam Damoff: On operational stress injuries versus PTSD, I understand that PTSD has a fairly specific definition. Is there a connection between those two? Are we doing enough to treat people before they get PTSD or if they're suffering from depression, anxiety, or addiction issues?

Dr. Nicholas Carleton: “Operational stress injuries” would be best defined as a really broad umbrella term that includes a variety of things: post-traumatic stress disorder, certainly, but also depression, substance use, and panic disorder, just to name a few. There are a lot of potential sequelae following traumatic exposure, the most common sequelae actually being recovery. The vast majority of people, even our public safety personnel, actually recover.

That said, I don't think we're doing anywhere nearly enough with respect to what we could be doing, and certainly not nearly enough with imminent treatment provision and ensuring that we have effective treatment provisions. I agree with Dr. Dadson that one of our biggest challenges is the huge delay between when the person actually experiences the injury and when we begin effective treatment. That's something we need to address, because, as with any form of health care, the sooner you address the injury or the health care concern, the more likely you are to experience a positive overall prognostic outcome.

Ms. Pam Damoff: Have either of you done any work with our correctional services officers? That's one area that we don't seem to talk about very much. We talk about our first responders and our veterans, but we don't talk about people who are working in corrections services. I'm wondering if either of you have had any experience with that.

Dr. Mike Dadson: I have had some experience with corrections. In our programs, we invite first responders to join, so there may be one or two first responders, and sometimes a corrections officer joins us.

A corrections officer is just like responders in the police or ambulance or fire. Their context is different, so the way the trauma affects them depends on the context they're in.

As my colleague stated for veterans, they're like a blunt instrument. They'll go into a situation and experience something that's horrific and traumatic. They'll do it with buddies, and they'll leave with buddies. That often is a buffer to their experience, because they're a part of a strong community or a pack, where they have strength.

Police officers, though, are a bit different, because they're walking the streets every day and using social engagement as a means of crowd control. They're constantly scanning their environment and looking for a perceived threat, and when they see it, they're actually withholding a blunt instrument response. They're going for something more nuanced. They're using their social skills to try to play down an incident or to keep an incident from erupting into something violent. When it goes violent, it goes violent very quickly, and they then need to jump into a fight-or-flight or an active role of aggression to be able to match the aggression and to be able to restrain or to control the situation.

For firefighters, the context is different. In the same way, for the folks who work in our prison systems, their context is different, whereby that becomes, really, the place where they're living. They can experience things such as inmates who are self-mutilating, slowly trying to take their lives, and trying to torment the guards as they do it. They have to experience that daily and try to provide a measure of care for those individuals as they deliberately try to psychologically injure them.

Dr. Nicholas Carleton: I agree.

Ms. Pam Damoff: I have a slightly different question. A gentleman in Oakville was suffering from depression following a heart attack, and he credits physical activity with bringing him out of depression. Do you see physical activity playing a role in dealing with some of these issues, with the operational stress injuries and PTSD?

• (1130)

Dr. Nicholas Carleton: I think so. I have a colleague, Dr. Gordon Asmundson, who is currently running a study on exercise therapy as a component intervention for PTSD specifically. Exercise, generally speaking, is a really good thing, full stop, especially if it's being done appropriately.

That said, I think we need to be very careful to understand that exercise alone is not a panacea. It's not going to resolve everything but, full stop, is it a good idea to engage in exercise, and will it help with depression, mood in general, and mental health and anxiety? All of the evidence seems to suggest yes.

Dr. Mike Dadson: I agree with that as well. Exercise is great, but sometimes when someone is so depressed that they can't get out of bed, exercise is not an option for treatment. Or if because of their occupational stress injury they also face physical injuries, and they can't operate physically in the way they once did, exercise in itself can be a trigger for the loss of what they were able to do once and are no longer able to do. It's contextual.

The Chair: Thank you very much.

Mr. Rayes.

[*Translation*]

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

I want to thank the witnesses for joining us today to share their experience in this area.

We often talk about what happens after the event and the treatment. You also mentioned it. However, I would like to hear you talk about what happens before. When it comes to the culture of organizations, first responders, our soldiers, the army and the RCMP, is everything being done to prepare for the potential risks?

I will make a very simple analogy with an athlete participating in a competition. They will be psychologically and physically prepared for unfortunate situations that could happen during a competition. Is anything being done before the problem even occurs? Is awareness being raised among employees and stakeholders of all sectors? Can you tell us about any relevant studies or research?

[*English*]

Dr. Nicholas Carleton: I can speak to some of that and to one of the biggest challenges we have right now.

First of all, yes, I think we could be doing more. Second, I think there are some organizations that are working towards those preventative measures.

One of our biggest challenges has been and continues to be that if I can only afford to do a handful of things, and you ask me which things I can do to buy us the best possible prevention, to build the most resiliency, and to reduce the risk, we don't have those empirically supported answers in as robust a fashion as we need for any of us to make those statements.

We can make some general statements for you, but one of the challenges we've seen is that it has been very difficult to engage in prospective longitudinal research, so that we can measure people before they're injured, identify what things are associated with each individual in large groups, and then track them over years and years. Then we could say to you, "This variable was associated with resilience and this one was associated with risk." This requires a tremendous commitment on behalf of researchers, clinicians, government, and public safety agencies. It's a team effort. It's one of the things that we're excited about being able to begin shortly with our RCMP, because those are critical answers.

That doesn't mean we can't give you generalities. But specifics, so that we can then provide really good information, require investment in long-term research, and that requires big collaborations. That's what we're trying to do and trying to start, beginning this year, so that we can give you a smarter answer, hopefully very soon.

Dr. Mike Dadson: If I could add to that, as my colleague said, it's difficult to achieve and to get the research. One of the reasons that I see for this is that for the organizations—the military, the RCMP, firefighting—their mandate is to serve and protect. For the military, it's “mission, team, self”, with the self coming last. That's embedded in the culture. That's a part of that hypermasculine culture that is necessary in order for them to do their jobs. That is part of the buffer, but unfortunately it also prevents us from being able to go in and gather the research, because it can produce a culture where the focus is not on prevention and recovery. The focus is on getting the mission done or protecting the public.

When veterans, RCMP, or firefighters are unable to achieve or to live up to the same standard, they start to be on the outside of that culture, and that really begins their descent. They've already become injured before they've been identified, but when they can no longer hide the injury, they start to move out of that culture. They start to become alienated from the group that once helped buffer their symptoms. As they move out, you then start to see the effects of the occupational stress injury or the PTSD.

It's difficult for an organization such as DND to research and to protect people from getting occupational stress injuries when their focus and their mandate is on the mission, not on the protection. Obviously, there's life protection, but it's not keeping people from getting occupational stress injuries, because they're constantly under stress: their mandate is to achieve the mission.

What we see for veterans, particularly when they start to move out and often can no longer operate at the same high level of functioning, is that they're given roles or jobs that are far less than what they're accustomed to, and they already see themselves as “out”. Now they're the injured ones, and they're perceived—and seen in the culture—as the injured ones, which actually exacerbates their symptoms. They really need to begin to be treated right at that point, before they can actually leave the military and even apply for VAC assistance. I don't yet see these organizations and agencies being highly invested in helping their people identify their injuries and treating them before they've actually become problematic.

Dr. Nicholas Carleton: If I can, I'll build off what Dr. Dadson said for a moment—

I'm sorry. Go ahead.

• (1135)

[*Translation*]

Mr. Alain Rayes: If I may, I would like to say something about this. I will then let you continue.

If I have understood correctly, there are no studies or research on the topic. There isn't really any basic training to prepare those employees, soldiers and first responders for the potential risks. Do you know whether—before research is even conducted—some work is done at the outset with those people during their basic training and in various educational institutions, including universities and vocational schools?

[*English*]

Dr. Nicholas Carleton: I should make sure that I'm clear here. Yes, there is some research. It's just that there's not enough, and it's not enough prospective longitudinal research, which is pretty critical.

There is research we've engaged in that is being started by team members across the country to try to get some of those answers.

Just to underscore this, the RCMP leadership, since we brought this to their attention and brought the prospect of the research study to their attention, has been extraordinarily supportive, in part because they also recognize, I believe, that these types of data will allow us to recognize injuries much, much earlier and to turn what might have been a debilitating and excluding injury into something that we can help the person recover from. It's just as important for those organizations as it is for the individuals—and as it is for all of us—to make sure that we can keep them active and healthy.

The Chair: Thank you, Dr. Carleton.

Monsieur Dubé.

[*Translation*]

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

I want to thank the witnesses for participating in today's meeting.

Before I ask my questions, I would like to specify that I am asking them in the all-important context of recommendations we will make to the government. In that spirit, we clearly want to improve the situation. I will briefly continue talking about research, more specifically about the available data.

If I remember correctly, at our last meeting, we heard a former psychiatrist say that Veterans Affairs Canada and the Canadian Armed Forces were 15 years behind when it came to first responders compared with correctional officers or parole officers. Do you find there to be a large gap between what is available to people affected by our study and what is available to the members and former members of the Canadian Armed Forces, veterans? If so, what do you think we can do to remedy the situation?

[*English*]

Dr. Mike Dadson: I think there is a significant gap, particularly for veterans, between when they know that because of occupational stress or PTSD they're going to be transitioning out of military life, and when they're actually out. Sometimes it can take two years before they're actually out of the military. They know they're on their way out and, to them, their job becomes less and less significant or meaningful, because they know they're not going to be doing the thing they love to do. They can't do it anymore.

It takes two years for them to get out, and then sometimes it has been six months to a year before they could access VAC services. This is far too long. This is a three-year gap in treatment for some of these folks, who are sometimes in critical condition psychologically, and also physically, because there are difficulties that can go along with it. That affects their family lives, their confidence, and their ability to engage in their career. It supports substance abuse, depression, and anxiety.

I've worked with veterans who have been home from Afghanistan for six years. One fellow was unable to take his children for a walk because of what he had seen; he had been seeing his psychologist for six years, but had yet to tell the psychologist about the injuries he had faced in Afghanistan that were preventing him from doing so.

To me, this becomes a critical issue. How do we help these folks get help immediately rather than having them wait the three years or the six years before they can actually begin the process of recovery? There are treatments out there that can help them. We know that we can help them if we can get them into services—

● (1140)

Mr. Matthew Dubé: I'm sorry to interrupt you, but my time is limited.

Perhaps I didn't pose the question correctly. The gap I'm referring to is about the data that's available concerning PTSD, among other things, for veterans, versus the data that's available for correctional officers or first responders. The point I was making is that we heard in the last meeting that there is more and more data available for our veterans, but there is not very much data—if any at all—available for first responders, correctional officers, and parole officers.

That's the gap I'm referring to, with all due respect to the great points you've made. Does that gap exist between those folks? What can we do to resolve that issue?

Dr. Nicholas Carleton: The quote is from Dr. Jitender Sareen, a colleague of mine, and I believe the quote is accurate.

If you want to close that gap, and I believe we absolutely must, one of the critical things the government needs to do is invest in an institute like the Canadian institute for public safety research and treatment so that we can have a pan-Canadian, interdisciplinary, interuniversity expert team that collaborates with public safety leaders and public safety members to give you the best data possible, as fast as possible, so that we can close that gap, build better treatment options for you, and resolve some of even the basic questions, such as giving you an epidemiological set of stats that you can rely on to know how large the operational stress injury problems are. We can't even give you that basic data, at this point, in a robust fashion.

So yes, I would say 15 years is probably accurate. I would say the best thing you can do at this point is invest in a team research response. That's what will get you the fastest, best data at this point. If you invest in individual silos, you'll get the data, absolutely. But we can do better when the government helps us to work together across Canada as a team.

[Translation]

Mr. Matthew Dubé: Thank you very much.

I would like to come back to the question my colleague, Ms. Damoff, asked, as I found it interesting.

I'm talking about the issue of safe zones versus unsafe zones. I find that to be an interesting element. You talked about it briefly, but I would like to hear more about it.

In what way should the approach differ for first responders and correctional officers compared with Canadian Armed Forces

members? Does the peer-to-peer relationship become more important? It has to be something that is constant and routine, while that happens in the case of veterans when they return home.

[English]

Dr. Nicholas Carleton: Yes, I think the peer support and the ongoing peer interactions are pretty critical. Again, I think we need to do some additional research to provide you with some data to answer those questions, because the kinds of traumatic exposure are different—not better or worse, but different because it's prolonged.

They need to be better able to manage uncertainty. They need to be better able to manage ongoing states of low-level stress. There's been long-standing research showing that daily hassles, for example, in the general community cause more and more distress than big and significant issues. Big and significant issues certainly are important, but those daily hassles that sort of edge on us, day in, day out, also have a significant impact.

For our public safety personnel who live that—and for them, the daily hassles are in some cases traumatic stress injuries—we need to come up with better solutions. They need to be different. We're really talking about building better teams. I think peer support will be important, but we don't have a lot of research to know what kinds, in what doses, and in what ways.

So yes to peer support, but we also need a broader, different set of solutions to deal with these kinds of ongoing exposures.

● (1145)

Mr. Matthew Dubé: Thank you.

Mr. Dadson, you spoke about changing the language to take into account the existing culture that makes it more difficult to talk about these issues. I'm just wondering if there is something we can do to maybe change that culture so that we don't even have to get to the point where we have to speak about it in those terms, and we can actually make it so that folks do feel comfortable speaking about it in the appropriate terms. Is there something we can do to change that culture?

Dr. Mike Dadson: It's probably outside my knowledge base to discuss how to go about changing the culture of the institutions. I can more accurately address changing the culture around the treatments.

In terms of therapists, research shows that sometimes the way we approach therapy is much more feminine, because women access therapy several times more than men. The agencies we're talking about are largely populated by men, and they don't necessarily address men the way men need to be addressed in treatment. Take, for example, an hour of treatment for a guy who is an RCMP or who is a first responder. By 40 or 50 minutes they're just starting to get into what they've been talking about. They're used to working really hard. In our program, we will work with them for four days straight in therapy, with each other, so they can work hard together.

So that's what I could speak to more, the way therapy is delivered and how cultures are shaped. I actually think the military needs to shape culture the way they do in order to give these guys and gals the best shot at survival when they're in those battle situations. It's getting them out that the military doesn't know how to do. They know how to get them in. When they're in there, they know how to help them survive. They're excellent at it. They just don't know how to help them get out. I wouldn't ask the institutions to be the ones that can allow them to do that, because that isn't their expertise.

The Chair: Thank you, Dr. Dadson.

Mr. Mendicino.

Mr. Marco Mendicino (Eglinton—Lawrence, Lib.): Dr. Carleton, I have a series of focused questions I'd like to ask you about cognitive behavioural therapy and the prevention of PTSD. I think there is broad agreement that people who suffer from PTSD need to be able to access the correct support and treatment. Is that right?

Dr. Nicholas Carleton: Yes.

Mr. Marco Mendicino: One of the recommendations I heard you refer to during your oral presentation just a few moments ago was that part of the suite of treatments needs to include evidence-based treatment and CBT. Yes?

Dr. Nicholas Carleton: Absolutely.

Mr. Marco Mendicino: CBT has been proven to be effective?

Dr. Nicholas Carleton: Yes. There have been multiple studies, hundreds now, probably thousands, that suggest that it is efficacious, although nothing is perfect, and that it can in fact improve symptoms quite substantially.

Mr. Marco Mendicino: Implied in all of what you've just said is that it's been validated. Is that right?

Dr. Nicholas Carleton: Many, many times.

Mr. Marco Mendicino: It's been used across many cultures and work sectors?

Dr. Nicholas Carleton: Yes—across the planet, actually. It's probably one of the most robustly delivered and empirically assessed treatment protocols we have for mental health. It's actually a broad suite of treatment protocols. It's not a single treatment. To refer to it as a single treatment would be erroneous. It's a suite of protocols.

Mr. Marco Mendicino: Would you tell me what some of the factors are that contribute to the retention in cognitive behavioural therapy of people who suffer from PTSD? Afterwards, could you say a few words about the factors that contribute to premature dropping out of those who undertake CBT?

Dr. Nicholas Carleton: I don't know that I have time to give you all of it, so I'll pick some highlights.

• (1150)

Mr. Marco Mendicino: You're best to give me a nutshell within the next 60 seconds, because I have some additional questions.

Dr. Nicholas Carleton: Okay.

Rapport, the capacity to actually engage with an individual, is probably the most critical component for maintaining anyone in a treatment protocol. It doesn't matter what it is, the person has to feel like they have a relationship with that person. Whether you're

offering CBT or whether you're offering any of the other protocols that could be available, it doesn't matter; you have to be able to build a relationship. The person has to believe you have a relationship. For the most part, as long as that relationship is supportive and maintained, I think you'll see good retention. I think a failure of retention occurs when you have a failure of that relationship.

Broadly speaking, I'd say it's about that relationship. Most success and failure of therapy, I believe, does still require that relationship. It's just what you're doing after you have that relationship that I think differentiates between really effective treatments and treatments that could be more effective.

Mr. Marco Mendicino: Does revisiting some of the trauma experienced erode the confidence and the trust in the relationship?

Dr. Nicholas Carleton: Not if done correctly, no. In fact all of the evidence we have so far suggests that when it is done appropriately, when it is done within the correct context and with someone with the correct experience, revisiting the trauma is actually a critical component to engaging in successful long-term treatment. I think one of the key elements is that you have to begin with a relationship with that person. Then you build trust, and then you can engage in the evidence-based treatment protocols that are necessary to help them with symptom reduction.

Mr. Marco Mendicino: What are the top two protocols that help insulate against the potential for an erosion of that relationship?

Dr. Nicholas Carleton: Protocols that help to protect against the relationship eroding?

Mr. Marco Mendicino: That's right.

Dr. Nicholas Carleton: I'm not sure there are protocols for protecting against rapport erosion. I think part of that comes down to clinical experience in clinical practice, and having good supervision when you were being trained. At this point, the top two protocols for providing evidence-based treatment overall, though, for post-traumatic stress disorder would be prolonged exposure and cognitive processing therapy.

Mr. Marco Mendicino: Prolonged exposure, and what was the second one?

Dr. Nicholas Carleton: It would depend on who you asked, but prolonged exposure would certainly be your top one. Cognitive processing therapy would probably come in at number two. Possibly EMDR would come up somewhere in there as well.

Mr. Marco Mendicino: Okay.

Could you talk to me a little bit about the use of CBT to prevent the onset of chronic PTSD? Is there a way to provide CBT in a prophylactic and pre-emptive manner as part of the training of individuals who will either be first responders or responding to other natural disasters?

Dr. Nicholas Carleton: I believe there is.

I don't know of any evidence whereby we have explicitly tested it over the long term yet. That's one of the things we want to do with the up-and-coming research study, but there's no good reason at all to believe that appropriately integrating some of the core what we call "psycho-educational" components as a part of training would be anything other than beneficial.

Mr. Marco Mendicino: This is an experimental area that hasn't really been explored or studied or validated.

Dr. Nicholas Carleton: I don't think it has yet. We have seen some evidence from expert Canadian researchers like Dr. Keith Dobson, for example, with the road to mental readiness program, and including that as part of some initial training work that's done. I think we would want to see a far more pervasive integration of some of the CBT protocols into training earlier and more often.

Mr. Marco Mendicino: We don't have time to get into the details, but I would be interested in receiving a few additional written comments on the very specific subject I just asked you about, namely CBT and prevention. If you could just make a note of that, I think my committee colleagues and I would be very grateful.

Finally, are there any characteristics that make a person more prone to PTSD or OSI?

Dr. Nicholas Carleton: I don't think that we have a set of individual characteristics that make someone more or less prone to developing PTSD.

Very quickly, consider the following two possibilities. An officer approaches a scene after a week where they've been well rested well supported by their team, when no one has been off sick, and they've had lots of resources available to them. If they come upon a car accident, they're going to have a very different interaction with that traumatic exposure than they would if they've had a week that was really hard, in which they hadn't slept much, and they'd been having trouble at home and had been working too much because somebody had been off sick. Now instead of the car looking unfamiliar, the car is the same colour as their spouse's car; the kids look very much like their kids, and everything becomes familiar, but it's not them.

You have the same human encountering two different traumatic exposures and they're going to have two very different responses, as I'm assuming you can intuit. This situation makes identifying specific individual variables very difficult to do. We can give you broad strokes, and we hope to be able to do that fairly soon, in the next few years, but saying this person is always more vulnerable or this person is always less vulnerable is not something I think we're ever going to do.

• (1155)

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

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

We're told that the sooner an individual is treated for PTSD, the greater the chances of successfully overcoming it are, and therefore early detection is key.

With some first responders, for example the fire departments, after a fire or some incident, they all gather together at the fire hall and talk about what just happened. Before leaving, they're all handed a brochure to take home to their spouse so that they have a list of symptoms or behaviours to watch out for, and if they get four or more check marks, they're told through their commander or chief that they need to get some help.

The Canadian Forces don't have access to that when they have a situation in theatre, but it would seem to me that the RCMP does.

Are you aware of whether or not it is a practice in the RCMP to have an after-incident sit-down with everyone who was involved?

Dr. Nicholas Carleton: I think what you're talking about is referred to broadly as critical incident stress management and more specifically as critical incident stress debriefing. There's a lot of discourse going on about those areas right now.

I know that the RCMP does engage in some debriefing. It doesn't happen for the RCMP or for any other organization after every single event that might be considered traumatic; doing that would be logistically impossible.

As for the efficacy of doing that, we just finished a fairly large review of critical incident stress management and critical incident stress debriefing and peer support models and implementation across the country for public safety personnel, specifically our first responders. The evidence in support of or against any specific model or even broadly speaking is actually extraordinarily limited at this point.

We're not saying that it doesn't work and we're not saying that it does work; we're saying that when people ask us whether they should do these things and which ones work, the best answer we have is that the research is limited and we don't know yet.

Mrs. Cheryl Gallant: Personal experiences, including traumas occurring prior to joining the forces, can have an impact on whether or not someone will develop PTSD after an incident.

I can't speak for your province, but in Ontario we have a shortage in general of medical doctors, specialists, and even psychologists, and in fact in order to see a psychiatrist or one of these practitioners or in order to have your insurance company—if you're lucky enough to have insurance—cover it, you need to have a referral from a family physician.

Could part of the problem be, at least in the background, the fact that the basic medical services just aren't available in some provinces?

Dr. Nicholas Carleton: I would suggest that it's certainly part of the challenge. I think it was Pierre Daigle, the military ombudsman, who said that they can't hire enough psychologists fast enough in order to meet the demand. I have no reason to believe that it would be any different for anywhere else in Canada. You're looking for people with some fairly high levels of specialization, so there are a lot of barriers there.

If the person has met up with their physician—assuming that they made it there, keeping in mind everything that was mentioned before—they now have a referral, and now they have a wait list. Now they're going to go into that, and you get some programs, like the one in Langley, that are highly integrated and really well set up programs, but they have massive wait lists, and they exist very geographically. I can't ship everybody from one part of the country to Langley or to anywhere else.

I think we're seeing a basic shortage, I think we're seeing a specialist shortage, and I think we need to very seriously consider how we're going to innovate solutions for that if we're going to provide evidence-based support for public safety personnel. There are available options. There are options that we've seen around the world for how other countries have managed this. I think we need to take some lessons from them and consider whether we want to use those same kinds of solutions here at home.

Mrs. Cheryl Gallant: The same would hold true, then, for that transition period, that long gap between the person leaving the forces and perhaps having treatment and then going through Veterans Affairs and having to find a civilian doctor.

The Canadian Armed Forces have made giant strides. What I'm wondering is why you aren't—or they aren't, in general—taking the Canadian Armed Forces models of treatment and applying them to the RCMP when there have been so many studies and people in these various programs. For example, we have the war horse project, the Courageous Companions program, and CAREN, which is here in Ottawa, and there are the studies. MSAR is coming out with one in Manitoba on Monday or Tuesday of next week that will be describing the different types of PTSD.

• (1200)

The Chair: Would anyone like to respond very briefly?

Dr. Nicholas Carleton: I think we are taking the evidence-based.... Certainly, I work with the researchers who work with the military and study these kinds of questions, and I can tell you that, where it's applicable and appropriate, we are certainly sharing information. We are doing that in part because of the relationship we have with the Canadian Institute for Military and Veteran Health Research. Dr. Jitender Sareen, among others, works with me and the broad Canadian team.

We are doing it, but just because it works for the military doesn't mean that it's going to work the exact same way for our public safety personnel. We need more longer-term studies in order to make sure that we are providing those evidence-based pieces of information to support our policies, broadly speaking, because we want to move carefully.

The Chair: Thank you, Dr. Carleton.

We were about six minutes late in starting, Mr. Di Iorio, so we have maybe two or three minutes if you have a couple of quick questions.

[*Translation*]

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

Dr. Carleton and Mr. Dadson, thank you for being here and for your invaluable contribution.

[*English*]

Dr. Carleton, at the outset of your presentation, you referred to “evidence-based solutions” for PTSD. Could you share some of those solutions with us?

Dr. Nicholas Carleton: For the treatment-based solutions, we have a variety. There are a lot of evidence-based treatments, including prolonged exposure and CPT. As for evidence-based

protocols of long standing, as I said, there's a paucity of research to suggest what will and will not work as prevention strategies. There are also the integrated treatments like those being offered in Langley. There's a variety of those evidence-based treatment protocols that can be put into place.

Mr. Nicola Di Iorio: I'd like you to share some of those with us, please, those that you've observed, or found, or read about that were most effective.

Dr. Nicholas Carleton: Prolonged exposure, delivered by somebody who is experienced in doing so and has been supervised in doing so, tends to be probably the most robustly supported treatment for post-traumatic stress disorder. There are also cognitive processing therapy and EMDR. There can be dialectical behaviour therapy. Those are the ones that are the therapies after the fact, so when they are appropriately implemented by someone who has the appropriate skill set, those are evidence-based solutions that are supported by the research evidence to provide reductions in PTSD symptoms.

Mr. Nicola Di Iorio: What about “prolonged exposure”? Could you expand on that and give us more insight as to how that is being applied and why it is effective?

Dr. Nicholas Carleton: Prolonged exposure typically is applied at an individual level, one on one with a psychotherapist who has the appropriate training. You begin with a series of sessions on psycho-education. You might include progressive muscle relaxation. You might include interoceptive exposure depending on the patient-specific symptom set. Thereafter, you would go about a series of what we call exposures, usually imaginal exposures, so the patient begins re-engaging with the trauma.

One of the key things that we know supports ongoing maintenance in post-traumatic disorder symptoms is avoidance. It makes perfect, reasonable sense that if you had a traumatic experience, you are not interested in thinking about that traumatic experience again and again. Unfortunately, that avoidance behaviour can often also cause the symptoms that we see associated with post-traumatic stress disorder.

So it becomes a facilitating mechanism. You engage with that trauma in an appropriate way, and in an appropriate environment, by having the patient retell the trauma, having the patient imagine the trauma, and work with the psychotherapist in order to take some of the sting or the edge off, if you will. It doesn't remove the memory, but instead of having it be debilitating to consider what had happened, we can make it distressing. Eventually, hopefully, we can make it an unfortunate memory as opposed to something that the patient is having to re-engage with daily.

That is prolonged exposure in a nutshell.

The Chair: I'm afraid I need to end this panel. We could go significantly longer, I think, but we have other witnesses.

Thank you very much for your time today. Stay tuned, because we may be back to you with some other questions very specifically when we get to some of the treatment or the things we may be wanting to recommend from further study.

We'll take a short break while we change our panel.

•(1205) _____ (Pause) _____

•(1205)

The Chair: We now have, by video conference from Toronto, Donna Ferguson, a psychologist at the Centre for Addiction and Mental Health, CAMH. In the room with us, we have Judith Pizarro Andersen, who is from the Faculty of Medicine at the University of Toronto.

Thank you to both of you. We tend to start with our video conference guest in case we have a problem and have to reconnect, so we'll start with you, Ms. Ferguson, for ten minutes, and then we'll go to you, Ms. Andersen.

Thank you.

Dr. Donna Ferguson (Psychologist, Work, Stress and Health Program, Centre for Addiction and Mental Health): Members of the House of Commons Standing Committee on Public Safety and National Security, thank you for the opportunity to appear before you today to share my perspective on this important topic.

My name is Donna Ferguson. I am a clinical psychologist and practice lead at the Centre for Addiction and Mental Health in Toronto. CAMH is one of Canada's largest mental health and addictions academic health science centres. We combine clinical care, research, and education to transform the lives of people affected by mental illness or addiction.

Post-traumatic stress disorder or PTSD is an important area that we focus on at CAMH. PTSD occurs when an individual directly experiences or witnesses a traumatic event or has first-hand repeated or extreme exposure to aversive details of a traumatic event. PTSD causes a disturbance in social and occupational functioning and in other areas of life. Symptoms include avoidance of traumatic events; intrusive thoughts, flashbacks and nightmares; and increased arousal, including heightened irritability, sleep disturbances, and hypervigilance.

One in 10 Canadians develops PTSD, but the numbers are twice as high in first responders due to the risk of routine exposure to traumatic stressors. Suicide rates amongst first responders are also high. Between April 29 and December 31, 2014, 27 first responders died by suicide. As of March 2015, 40 first responders have died by suicide in Canada. This is a growing and urgent problem that we must address.

How do we make sure that first responders with PTSD get the help they need to become healthy and return to work? We do not have all of the answers, but today I will share with you three recommendations that I believe will help first responders with PTSD on their road to recovery.

First, all provinces need legislation that gives first responders faster access to workplace insurance benefits. Many first responders have had to prove that their work-related traumatic events directly contributed to their PTSD symptoms and diagnosis, which has made it difficult for them to access timely, appropriate care. In February 2016, Ontario introduced legislation that would create the presumption that PTSD diagnosed in first responders is work-related. Removing the need to prove a causal link between PTSD and the work-related event will expedite claims through insurance compa-

nies and lead to faster access to treatment and resources. If passed, this legislation would also require employers to implement PTSD prevention plans within the workplace. We need to ensure that all Canadian first responders are covered by similar legislation.

Second, first responders must be able to work in psychologically safe, stigma-free environments. Many first responders have undiagnosed PTSD. Some may be living with the symptoms on a daily basis and experiencing the distress of PTSD, but they are afraid to come forward to their friends, families, colleagues, or superiors for fear of reprisal. They worry that their colleagues will ostracize them and that their superiors will unfairly demote them.

Mental illness is a very difficult topic for people to discuss, particularly for first responders whose occupation requires them to be constantly stoic. First responders are part of a culture that frowns upon weakness. There is a belief that the job comes first and their lives, feelings, and families come second. The expectation comes with a great deal of pressure on individuals who see demise, destruction, death, and carnage on a regular basis. It is difficult enough to work this way every day, but even more so for those with PTSD who are dealing with symptoms of intrusive memories, traumatic events related to work, distressing dreams or nightmares, sleep disturbances, and hypervigilance. It is especially difficult when your colleagues or superiors think you should "suck it up" and get over it.

It is important to create a positive work environment for first responders that prioritizes mental health, addresses stigma, and provides psycho-education on PTSD. Such measures will prevent PTSD from becoming worse, possibly prevent suicides, promote a healthy recovery, and support a successful return to work or maintenance at work. Creating a positive work environment can include having each service work with, for example, the Mental Health Commission standards for a psychologically safe workplace, or even developing an employee mental health strategy that includes providing training in psycho-education with a focus on PTSD symptoms and the challenges related to PTSD.

•(1210)

The following is a case example. A 48-year-old woman was employed as a police officer for approximately 21 years. She was suffering from undiagnosed PTSD symptoms for the first five years of her career. She continued to work with these symptoms, constantly experiencing one traumatic event after another until the final straw. She was faced with a traumatic event after which she felt she could no longer cope and went off work. She saw her family physician who prescribed her medication for her PTSD symptoms and was formally diagnosed with PTSD.

Within a few months her claim was accepted by WSIB, the insurance company, and she was referred to a psychologist in her community for treatment. After one year she returned to modified work on a full-time basis. She was assigned to desk duty and was not allowed to work on the road in her front-line capacity for at least two years. She had a difficult time returning to modified work as she was teased by her colleagues who would constantly play pranks on her. She was also mocked by her superiors and was constantly accused of shirking her duties. They inundated her with most of the paperwork and said it was now her job to do the extra paperwork. This was a very difficult time for her as she lacked the support she needed to get well and maintain work successfully. She was receiving treatment from a psychologist and had been recovering prior to return to work, but now experienced a setback. She was demoralized and her symptoms deteriorated due to lack of support at work.

My third recommendation is that all first responders have access to evidence-based treatment for PTSD. It is important that first responders with PTSD be able to access not only support and treatment but that they be able to access the right treatment to enable them to recover.

Evidence-based treatment for PTSD includes cognitive behavioural therapy, CBT. This treatment is also called prolonged exposure, which involves imaginal exposure, having the client process the traumatic event to assist with reducing the intensity and frequency of intrusive thoughts, flashbacks, and distressing dreams.

The other CBT and intervention is in vivo exposure or what we call real-life exposure. This involves having the therapist help the client to develop a step-by-step ladder or hierarchy of the distressing traumatic situations that the client is actually avoiding while rating the distress levels for each situation and working to reduce the distress level over time.

When a first responder diagnosed with PTSD is able to access these treatments, their chances for successful return to work and productive life are good.

A U.S. study that looked at CBT and long-term outcomes for PTSD indicated that patients who received CBT reported less intense PTSD symptoms and particularly less frequent avoidance symptoms than did those who received supportive counselling.

This is another case example. A 40-year-old male police officer employed for approximately eight years was suffering from undiagnosed PTSD from a traumatic event in which he and his family were threatened by a suspect he had arrested. The threat and alleged stalking by the suspect went on for many months before he began to experience many of the PTSD symptoms mentioned. Finally, after a year, he visited his family doctor and was formally diagnosed with PTSD and prescribed medication for his symptoms. After a few months, his WSIB claim was approved; he was signed off work; and he was referred to me for psychological assessment and treatment. I have been seeing him in treatment, using CBT interventions, in addition to some anger management and social skills training techniques to decrease his heightened irritability, which was one of the main problems for him. After almost a year of treatment, he was ready to begin the return-to-work process, a step-by-step gradual return to modified work initially, followed by a return to his pre-incident role as a full-time police officer.

Since his return to full-time employment, his quality of life has improved. He now has a better relationship with his family. He is socializing again with his friends. His anger is under control, and he's fully functional at work again, even handling some of the issues related to stigma in the work environment. He has been receiving praise from his superiors for his work performance, and he has also told me that the CBT I provided him has saved his life. He is very grateful to me for helping him to resume his life with his family and friends, and to return to an occupation he's very proud of and successful at.

● (1215)

Committee members, thank you again for the opportunity to speak with you today. We are grateful that you are developing a national framework or action plan for first responders suffering from PTSD. I hope that the information and recommendations I have provided will assist you as you move forward with your work.

I would be happy to take any questions.

The Chair: Thank you very much.

We trust you to stay there, because we'll have questions for you in a moment.

Now we'll hear from Dr. Andersen.

Dr. Judith Pizarro Andersen (Assistant Professor, Department of Psychology and Affiliated Faculty of Medicine; Director, Health Adaptation Research on Trauma Lab, University of Toronto, As an Individual): Thank you for inviting me here today.

I'm here to speak about evidence-based interventions to prevent OSI and PTSD among first responders. My background includes more than a decade of working with first responders, combat veterans, and police, both as a research scientist in two U.S. veterans hospitals and most recently as an academic at the University of Toronto. My research is focused on the health and performance costs of severe and chronic stress experienced by trauma-exposed first responders. I will cover a number of key points and then provide recommendations.

First, operational stress injury and post-traumatic stress disorder are associated with significant health costs, physical disease, and early mortality. My colleagues and I have demonstrated that officers are two and three times more likely to develop chronic health conditions, such as cardiovascular disease, diabetes, and even cancer, when compared to the general population. The U.S. Department of Veterans Affairs data says that the cost of health care for treating a first responder with PTSD is almost five times higher than it is for treating a first responder without PTSD, due to the costs of comorbid physical and mental health treatment.

Second, research clearly indicates that first responders are most likely to develop OSI and PTSD following highly stressful critical incidents in which they are exposed to traumatic material, such as a severely abused child, or when they are forced to use lethal use-of-force options. Yet, during use-of-force training, first responders do not receive adequate training in managing the severe psychological and biological stress responses that do put them at risk for OSI and PTSD.

My colleagues and I have witnessed this first-hand. We've collected thousands of hours of biological and psychological data with first responders, both during their training and in active duty emergency calls. We've collected data on things such as heart rate, breathing, body movements, sensory distortion, fear responses, and stress hormones. Our research indicates that these extreme stress responses actually negatively affect their performance, raising the risk that during a lethal use-of-force encounter they may not use the de-escalation techniques that are available to them and may make a lethal use-of-force mistake. These are directly the types of incidents that are related to getting OSI and PTSD.

Third, scientifically validated resilience interventions for addressing the stress associated with critical incidents in use of force are essential in preventing OSI and PTSD. Science-based methods are the only way we can test that an intervention is working and achieving the intended outcome and worth the financial investment.

Canada is at a critical juncture in deciding the best course of action to address OSI and PTSD among first responders. This committee will be considering the available and proposed interventions with limited training dollars, so it's critical to clarify what we mean by an evidence-based resilience intervention. Large-scale resilience-building programs, originally developed for military personnel, such as the road to mental readiness, have been rolled out in some police organizations. However, there are no randomized, control trial, evidence-based studies showing the efficacy of this for preventing OSI and PTSD among first responders.

An issue is that classroom-based material, as research has shown, is not easily transferred when you're trying to learn motor movement skills in such things as use-of-force training and so forth, so it may be misleading to assume that resilience programs delivered in classroom environments would generalize the use of force and behavioural outcomes in the real world. In fact, our biological objective data show that if we want to reduce the maladaptive stress physiology that is associated with OSI and PTSD, we must intervene directly in the training for these high-stress critical incidents, and this entails use-of-force training.

There are few researchers globally working on evidence-based—meaning randomized, control trial evidence—OSI and PTSD prevention programs. I know of one group in the United States. As far as I know, our group is one of the only ones in Canada doing this type of work. I'll present for you the basics of our program.

- (1220)

First, our science-based method, based on all the objective data we've collected, has shown that use-of-force training and de-escalation techniques are best delivered by use-of-force trainers, not in classroom settings by health professionals or so forth. You get the best buy-in from the actual officers in this very tough environment if

it's taught by use-of-force trainers. The topics should be helping officers consider their full range of options, including verbal de-escalation and less lethal use-of-force options, so that encounters do not escalate unnecessarily, leading to potential OSI and PTSD.

Second, we use strategies that maximize how humans form brain pathways to learn new information and retain it. This is critical, because in high-stress encounters, responses result from the most automatic, instinctual reactions. Applying some of our techniques for physiological control during critical incidents can override these natural human responses that block an officer's ability to consider all their use-of-force and de-escalation appropriate options.

Third, training should be personalized and individualized, tailored to the individual officer. In our program, devices for officers were taking advantage of new developments in technology, which can analyze an officer's sensory nervous system readings during highly realistic police training scenarios—events like hostage-taking, school shootings, and calls to distressed persons. It's very important that they are exposed, in training, to these highly realistic scenarios.

When they receive their own information about their own body and their stress responses, the expert use-of-force trainers then can create an individualized use-of-force instruction for them so that they can learn what their triggers are and how to overcome those in the use-of-force situations. Currently training for use-of-force situations is in blanket form. Everybody gets the same. Clearly some officers' needs are not being met in this form. We found this even with the most highly trained tactical teams on the federal level. They still benefited from personalized training. They were less likely to shoot the wrong person, such as a person holding a phone and not a gun. Those are directly the events that lead to OSI and PTSD.

We have recommendations based on this data. We need greater support for scientific evidence-based research and intervention. We need more just-in-time funds allocated for researchers. Currently, grant cycles of eight or nine months are too long. We are missing opportunities to work with organizations that are trying to answer the public's outcry for more police training and end up adopting non-evidence-based training programs. We don't have funding in to actually provide them with evidence-based training.

Second, we need to develop minimum standards for assessing performance outcomes of police training programs in terms of the quality of the training program offered and the value returned for the officers and the public they serve. There are programs available, as I mentioned, but they are not evidence-based. Standards regarding program quality need to be established. Things like evidence, scientific studies, and randomized control trials are critical, as are data from pilot studies. We need funding for large-scale longitudinal follow-up to understand how often and how intensely we need to be training these officers before they have OSI and PTSD, in order to avoid it. There are ever-changing threats in society for police officer safety and wellness. We need to take advantage of the most current technological devices and neurobiology of learning in order to meet these changing demands in society.

Three, we really need to establish a centre for excellence in evidence-based police training. Surprisingly, currently there's no global centre for excellence in police training. By establishing a national centre, Canada is poised to take an international lead in developing the highest quality police use-of-force training and critical incident stress management. Canada can create and export new police training programs, further benefiting the field of law enforcement internationally and building Canada's reputation and goodwill.

Finally, we need to require certification for police trainers and facilities based on high quality standards and best practices.

• (1225)

We recommend that police trainers be required to be certified regularly and to maintain a high degree of current knowledge through continuing education programs much like what is required of health professionals and physicians. There is a cost benefit to doing interventions for OSI and PTSD. A U.S. program, though not as comprehensive as our program currently, did find a 14% reduction in annual health care costs among first responders, so as you can imagine, if it's over \$1,000 per year per employee, in an organization of 500 officers, that would be a cost savings of over half a million dollars that could be redirected to police training.

Thank you.

• (1230)

The Chair: Thank you very much, Dr. Andersen.

For our questions we'll begin with Ms. Damoff for a seven-minute round. I should just let people know that I think we're going to have to end at about three minutes to one, as I have a budget we have to approve as a committee.

Ms. Pam Damoff: Thank you very much.

Dr. Andersen, you spoke a lot about police training.

Have you done any research with other first responders and, in particular, with our corrections officers? You mentioned how you have to treat veterans differently from how you treat first responders. Is there a difference as well with our corrections officers?

Dr. Judith Pizarro Andersen: Just to clarify, there is a difference between prevention training, that is, before someone has OSI and PTSD, and post-therapeutic training. I know Ms. Ferguson can speak about the "post" and the "pre". Since we're looking at the biology of

stress responses and intervening at that level, I would imagine everybody's stress response physiology is similar. I've worked with veterans with PTSD in the U.S., and they have shown that they have the high risks of the physical health disorders, but I haven't done actual prevention interventions with them. The interventions I did were with police, special forces, tactical teams, police recruits, and first-line officers.

Ms. Pam Damoff: We heard previously about the use of online resources for treatment. Are there similar opportunities to use online resources to help with prevention?

Dr. Judith Pizarro Andersen: Again, I would caution the committee on this, because there's no evidence base that shows that. Online, PowerPoint, and web-based training can bring awareness about PTSD and OSI, but we know from the neurobiology of learning that if you want to link rational thought—how you should do something, or what you know you should do—with the motor movements and how you should do those in high-stress incidents, you have to practise them together, and that means actively. Again, in high-stress critical incidents, you start relying on your automatic fight-or-flight response, so if you haven't trained that automatic fight-or-flight response to be doing the correct thing, then it's going to go back to instinctual behaviour, which often puts you at risk for OSI and PTSD and mistakes. Really, a wise use of money, at least for prevention in the use of force, is to do these two things together rather than to sit and listen to something.

Ms. Pam Damoff: I have a question for both of you.

It has to do with something we have in the federal government called gender-based analysis plus, or GBA+. I'm curious, with regard to treatment and prevention, to know if there have been any studies or work looking at how men and women are different in terms of the prevention and also the treatment. Is there any relation to age or any other social circumstances versus coming up with a one-size-fits-all treatment?

Dr. Andersen, maybe you could go first.

Dr. Judith Pizarro Andersen: I'll just speak to the prevention side.

We've studied both women officers and men officers. We've hooked them up with the biological data. We find that when they're starting to encounter training or real-world critical incidents, all of their physiological responses and stress hormones—cortisol and adrenaline—as well as heart rate and breathing, can skyrocket similarly. They're very intense depending on the complexity of the situation. So those are similar. I would recommend that any intervention before they get OSI and PTSD and use-of-force training would be similar, but I think it may be different for treatment afterwards.

Dr. Donna Ferguson: In terms of treatment, I know I've seen some research. For example, I believe Ruth Lanius has looked at some neurobiological differences in the brains of men and women in terms of how they experience PTSD. There's some evidence showing that men experience an increased level of arousal in different parts of their brain, whereas responses by women's brains are more dampened down. From my perspective, in terms of treating and targeting PTSD, it's very much an individual thing and not a one-size-fits-all thing for sure. Whether we're talking about gender differences or even just individual differences between different first responders who come into my office, whether they are firefighters or police or correctional officers or paramedics, I think you really have to look at the symptoms they're presenting with. If, for example, there is somebody presenting with fewer re-experiencing symptoms like nightmares, flashbacks, or intrusive memories and they're experiencing more avoidance and heightened irritability, then I would really be looking at focusing on that hierarchy for avoidance of situations and helping them through that as well as at anger management and social skills training techniques to really help to dampen the heightened irritability.

• (1235)

Ms. Pam Damoff: You had talked about the crisis with suicide and about how many there have been, which is really quite tragic. What programs do you believe are most effective in preventing these mental health issues from getting to the crisis level?

Dr. Donna Ferguson: I think it starts with assessing the culture of the workplace. I really think the stigma in the workplace is a major problem for people. I think the lack of support that first responders feel they experience in the workplace is a really big issue, and even before they admit they have PTSD or go for treatment, it really starts with that piece. A lot of people won't come forward and actually admit they have PTSD, and they will go on for a long period of time and they sometimes feel as though suicide is the way out because they have nowhere else to go. They feel that if they do come forward, there's going to be some bullying or reprisals, and they are really just not able to deal with or handle what could come with saying they're dealing with PTSD.

Ms. Pam Damoff: You keep referring to just PTSD. Is that the only cause of the suicides or is it also depression or some of these other operational stress injuries? Are you using that as a broad umbrella?

Dr. Donna Ferguson: That's a good question. You know, when we're looking at PTSD, we often see comorbidity. So, we often see co-occurring depression, other anxiety disorders, panic disorder, or concurrent issues like alcohol or substance use as well. There are a number of other issues that come with PTSD or OSI, so we're looking at all of those together. I say PTSD because that's primarily who we see in our program, but we are dealing with a lot of co-occurring or concurrent issues as well. Those all definitely contribute to suicidality as well as to deterioration of symptoms overall and recovery.

The Chair: Thank you.

Mr. O'Toole.

Hon. Erin O'Toole (Durham, CPC): Thanks to both of you for your testimony here today. I'm going to pick up on the subject Ms. Damoff left off on.

Dr. Ferguson, I want to say a personal thank you. When I was Veterans Affairs minister, we often consulted many of the resources CAMH produces, particularly with respect to suicide and, in fact, we consulted CAMH a few times on how we publicly presented reporting of suicide and that sort of thing. Your world-class reputation and the tools you provide are very much appreciated.

On that specific subject, we've run into terrible instances—and we saw this just last week—of someone feeling that their only option is suicide. Of course, we're all trying to break down the stigma so that it is not the only option and so that they will seek other treatment. With regard to media reporting of these instances, particularly, as we found a few years ago with several veterans or service members, the Canadian Psychiatric Association and the suicide prevention network have media reporting guidelines. What does CAMH recommend on how to properly report on this issue but to do it in a way that reflects that there's treatment available and also doesn't glorify or lead people who are struggling towards that outcome?

Dr. Donna Ferguson: It's a good question. I am involved in some media work with public affairs, and from what I understand from my personal experience, they're very good, first of all, at vetting interviews that they think we should do and interviews that we should stay away from, ones that might lead to glorify the issue more and not really put the issue in the right perspective. That's one thing I know they're very good at doing.

The other thing is that when we do prepare for these media interviews, we really think carefully about how we do want to promote, understand, and educate on the issue of PTSD, or mental illness and suicides. Obviously we don't know the individual cases. We really need to be careful with that. We really just explain some of the relationship between mental illness and suicides. We also talk about areas in which we can improve and prevent, and really focus on evidence-based treatment for people who really need help to access appropriate care.

• (1240)

Hon. Erin O'Toole: Yes, I'm always concerned when I read reports on it. It's important to not hide these statistics or anything like that, but sometimes the same reports then don't detail treatment options, such as the Veterans Transition Network and some programs you run. The reports provide just the sad end of someone, not the treatments that we should have been promoting.

I may share my time with Ms. Gallant. In my next few minutes, I'd like to discuss one thing I struggled with when I was minister. That was the concept that some families, first responders or military, would like to see a monument to people who served but who died via suicide. I struggled with that personally. To some families who want to know their member is remembered, they see this as a way to do that. But my fear, and I told them this, was that this could lead to more families going through the turmoil they were facing, because a monument like that could be something that pushes someone who's struggling over the end, thinking if they take this route, they'll be remembered through this monument.

Could you comment on that?

Dr. Donna Ferguson: You know, I guess I'd be torn as well. I think I can see that side of it, where people might think they would be revered, almost, if this is the route they would go. On the other hand, I've actually had first responders say to me that just seeing that somebody goes through suicide, even if they were kind of put on a pedestal, actually reminded them that there was a reason for them to live, and that was not the way they wanted to go.

I think people have different perspectives on how that would look for them. I do think we have to be very careful about how we do promote that, so we don't give people ideas that this is the right way to go and that this is what will happen if you do complete your suicide.

I'm torn on that as well, because you do also want people to be remembered.

Hon. Erin O'Toole: Dr. Andersen, I'm intrigued by your experience in the U.S. I wish we had time to compare the veterans hospital experience in the U.S. with our integrated public health system here.

Specifically, you seem very evidence-based and randomized control study-based, which I love, by the way. In the last session, we had a psychiatrist from Winnipeg speak about medicinal marijuana and how, while there are a lot of anecdotal reports on its impact for symptom relief and things like this, there's virtually no clinical support for its benefit in treating PTSD. In fact there is some evidence that it can be harmful for people with PTSD.

Have you studied this at all? Would you care to comment?

Dr. Judith Pizarro Andersen: Actually, one of my advisers at one of the veterans hospitals I worked with was studying substance use and PTSD. To summarize her research, not mine, she found that sometimes when you take something like that, or alcohol, it can calm the symptoms in the moment, but then there can be bounceback anxiety. That's all I'll say on that.

What I will say is that in moving forward with any intervention, I really believe in collecting objective biological data. If we want to know if marijuana treats the symptoms, we can't just rely on self-reports. In the data I've collected, I've always asked the officers to self-report: how stressed they were, how confident they were about the situation, how well they were going to perform. Often those self-reports were opposite to what I saw going on in their bodies and in the mistakes they made.

It's the same with a program like road to mental readiness. I know there have been surveys about how beneficial it is for transferring to use of force by self-reports, but my concern is that they're saying these things because they want to appear well in the organization. When I've actually spoken with the use-of-force first responders, with the very macho attitude among them, it's not taken as well as their surveys indicate.

•(1245)

The Chair: Thank you.

Monsieur Dubé.

[Translation]

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

Ladies, I have a question for the two of you.

A lot has been said about available data. I would like to know whether there are many gaps in that area. I actually put the same question to the previous witness. It seems there is a difference between the data available for veterans and that available for first responders or correctional officers, and that there are gaps when it comes to that.

Do you agree? What are your observations on those issues? I will let the two of you answer the question.

[English]

Dr. Judith Pizarro Andersen: I think there are gaps because there has been so little research, so we don't know. If there were more funding to do research, a number of researchers would be happy to start working with all of these different areas and collecting objective data so that we could know the differences between them.

Again, if you're talking about stress physiology, both in treatment and in prevention, similar biological stress physiology patterns can be seen in all individuals, but targeted personalized intervention, I think, based on their particular display of symptoms, as Dr. Ferguson was saying, is critical. We'd need more research.

Mr. Matthew Dubé: Dr. Ferguson.

Dr. Donna Ferguson: I also agree that there are always gaps in the research and that we need more research. Even with me scouring the research more on the treatment side and more on even outcomes with evidence-based treatment, for example, a lot of what I've read has indicated that there's still room for more research, and that we still really need more research specific to first responders and veterans. I think this is an ongoing issue, and it's ongoing research that we require in this area.

Mr. Matthew Dubé: I want to move on to this whole issue of culture that has been brought up a couple of times, the culture that makes it difficult to talk about stigmas and so forth. Once again, I'd like to hear from both of you.

I'm always wary of comparisons because they can be a bit of a slippery slope, and this might sound kind of silly, but I think of how in hockey they have to at some point force players, when there's the potential for a concussion, to go through a certain process. Is that the kind of avenue we should be exploring when there's concern that PTSD might be there? That we have to at some point impose a process to make sure folks aren't going back to work with those symptoms?

Dr. Judith Pizarro Andersen: I'll just say that for the prevention part, a lot has been about the language. I mean, coming from a psychologist background, at first when I started working with first responders, with police, I used words like "mental" and "relaxation" and so forth, and it was clearly no. They didn't accept that. They thought it was a yoga thing or something.

After I changed my language to "tactical" and "combat-related", these more macho words, they're now accepting these same principles that we're teaching. We have to be careful about the words that we use and the way we explain. I don't think that forcing anyone.... Well, I'll let Dr. Ferguson answer that question.

Dr. Donna Ferguson: I agree with that. It's actually what I do with my clients as well. I also think that we really need to help people and facilitate an environment where people can feel free to talk about how they feel and what they're experiencing.

Unfortunately, I think we've gone too long with people continually suffering from and dealing with these symptoms and being really afraid to talk about it in the workplace, because they're worried about what's going to happen. They're worried about their partners, or superiors, or colleagues saying that they don't want to work with them because it's almost like they're diseased.

That's the part I really worry about. Again, it's what I hear most commonly from the first responders that I work with, assess, and treat on a regular basis.

I agree that the language is a piece that we could work with. We could work with their language. I always feel that you should meet somebody where they're at, and if that works for them, then definitely. I also feel that we need to create a culture that is more welcoming in dealing with and talking about mental illness, symptoms, recovery, and return to work.

• (1250)

Mr. Matthew Dubé: I guess there's follow-up question, and again, it's for both of you. Language is one thing, but when you start talking about language, it's because there actually is a conversation happening. I guess that's my concern with what I'm hearing. My original question was about those who don't even get involved in the conversation to begin with.

It's one thing to talk about what kinds of words need to be used, but how do we ensure that those folks are even seeking the help, so that we can get to that point where we start talking about the language that's being used?

Dr. Judith Pizarro Andersen: I'm very hopeful that if we start in use-of-force training with these concepts, the physiological arousal, and when it gets to a certain level, and we use those words, those are the same kinds of symptoms—hyperarousal and so forth—that you see in PTSD. If we can start getting people comfortable with talking about these things when they're in their most macho kind of environment, in use-of-force training, then we can find ways of transitioning that into help-seeking behaviour peer to peer and so forth. Unfortunately, I have a case example. I work with a large police force in the United States that just received “road to mental readiness” training which directly addresses stigma. The use-of-force officers came back and said they knew there was somebody right there in their department who was suffering and still nobody would say anything. I said, “Well, you just had road to mental readiness” training so you know about it”. They said, “We won't say it. We will not help this individual.” So it hasn't been solved yet.

Dr. Donna Ferguson: I think even with things like employee mental health strategies, in which, first of all, you are assessing the culture and getting in there and providing some psycho-education, really getting people to start thinking about it and talking about it is a really good place to start. Again, you don't want to push or impose, but you really do want to start creating a culture that is, at the very least, comfortable with talking about it to start.

The Chair: Thank you very much.

[*Translation*]

Mr. Di Iorio, go ahead.

Mr. Nicola Di Iorio: Thank you, Mr. Chair.

Ms. Pizarro Andersen, Ms. Ferguson, thank you for your invaluable contribution.

Ms. Pizarro Andersen, my questions will first be for you simply because you are with us, but if you feel that Ms. Ferguson can expand upon your answers, I would ask that you invite her to do so.

You probably know that psychometric testing is now used extensively to select staff, whether we are talking about sports teams or various job positions.

Do you know whether psychometric testing is used to identify individuals most at risk?

[*English*]

Dr. Judith Pizarro Andersen: Well, I can't speak to a specific psychometric test that would identify individuals who are more at risk. We can see more risky biological trajectories. Among some of the officers I tested, there were those who were running at extreme stress responses for their whole workday, which is extremely risky not only for their health but also for getting OSI or PTSD.

There is debate about using these types of biological screening devices for employees at recruitment, of course, because then you get into ethical concerns regarding not allowing someone to have a job just because their heart rate and so forth are very elevated. I think maybe if we didn't do that at recruitment, we could do it in the early forms of training. You could see if you could personalize interventions to get that physiology down. If you couldn't then it might be recommended that the person take a different course of employment maybe within the police agency but not in front-line service.

[*Translation*]

Mr. Nicola Di Iorio: On another note, I would like to point out that provincial authorities adopted, nearly 100 years ago, perfect lines of accountability and responsibility for workers' compensation. Some 40 years ago, occupational illnesses were recognized. The discussion was not only about physiological causes, but also about psychological causes, and that made it possible to compensate workers affected by those professional illnesses and injuries. For example, victims of sexual harassment in the workplace were recognized.

I would like to know why, in your opinion, post-traumatic stress disorder is now a hot topic. Is it due to events in recent years?

Those measures were undertaken and other professional illnesses were identified 10, 20 or 30 years ago. Why is there so much talk now about post-traumatic stress disorder?

•(1255)

[English]

Dr. Judith Pizarro Andersen: I'll just say, and I think Dr. Ferguson can speak to this also, I think that with the upswing in media attention, as there has come to be more of a public conversation about shootings and use of force by police and the idea of police brutality and so forth, the mental health of officers has become more of a focus. I do know that the media has had a role in this as well.

Dr. Donna Ferguson: Yes, I agree. I also think that in terms of the suicides there's a lot of public attention, so it's sparking a lot of awareness and interest in this area.

There are a lot of first responders who are dealing with the insurance and disability issues, which again has prompted this Ontario legislation. It's just rolling in terms of trying to see how we can really understand this issue, how to resolve it, and how to work on treatment, recovery, and care.

I think it's been around for years and years. PTSD has been called a lot of different names, such as shell shock. Over the years, the names have evolved, but the symptoms have always been there. It's just that now we're looking at it differently and, for a lot of reasons, paying more attention to it.

[Translation]

Mr. Nicola Di Iorio: Mr. Chair, I would like to ask another question, if I may.

Ms. Pizarro Andersen, you talked about situations that can be avoided. Can you briefly tell us what employers, unions and employees can do to reduce the occurrence of that disorder?

[English]

Dr. Judith Pizarro Andersen: Again, I think it's critical that officers are given all the tools. We can't reduce the number of calls they have to go to, obviously, and they have to walk into situations that all of us would probably run from. That's just part of their job.

I think that what's critical for unions is to support evidence-based prevention interventions. They need to make a call for their employees to have this enhanced use-of-force training that is personalized to the officer, so that they can maintain an optimal mental and physical state and can respond in the calmest manner without escalating the situation, if possible, thus reducing the likelihood of getting OSI and PTSD in the first place.

Organizations need to invest in this type of training. There are training dollars, but the problem is that many organizations only train their use-of-force officers to minimal standards, such as for one day a year. Bill Lewinski, a researcher on this topic in the U.S., has said that college athletes actually receive more training in four years than police officers receive for their job in 40 years.

The Chair: Thank you. I'm afraid we need to end there.

Thank you very much, Dr. Ferguson and Dr. Anderson. One had a sense as you gave your testimony that you have callings, not only jobs. What you're doing is very much appreciated. Thank you for your research, for your clinical practice, and for your testimony.

We're going to take a minute or two, members. Hopefully, this will be pro forma.

We were delivered a budget for this study, members of the committee. It's a request for a project budget. This is within our overall projection for the year. It's not an unusual budget. There's no travel in it. I just want to see if you have any questions about it. If there are no questions, I'll entertain a motion first, if someone would move this budget, which is for the total amount of \$38,700, as presented.

Mr. Matthew Dubé: So moved.

The Chair: Monsieur Dubé has moved that. Are there any questions or is there any discussion? We can always revisit this as the study continues.

All in favour?

(Motion agreed to)

The Chair: Monsieur Dubé.

•(1300)

Mr. Matthew Dubé: As one of the NDP House leaders, I'll put on my other hat and ask about Thursday. The sense is that we will probably be on a Friday schedule, so perhaps you could tell us where we're going to be at for the next couple of meetings.

The Chair: I need to look at the clerk, because we haven't been told. Right now, we have a plan for Thursday to meet at 11 o'clock to do one hour of the study with one panel of witnesses. We have just two witnesses. The committee meeting would end at noon, and then the subcommittee would meet from noon until one to plan the rest of the study and look at witnesses. Would that change if it's a Friday schedule on Thursday?

An hon. member: Question period is at 11.

The Chair: Question period is at 11 on Fridays. Of course, so it will all change. This is like *Alice in Wonderland*. If Thursday is a Thursday, we'll meet at 11 for an hour and then have a subcommittee meeting for an hour. If Thursday is a Friday, the committee meeting, I assume, will not be held. Understood?

Mr. Matthew Dubé: Thank you.

The Chair: All right. The clerk will let us know.

Thank you. The meeting is adjourned.

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

SPEAKER'S PERMISSION

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

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

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

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

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

PERMISSION DU PRÉSIDENT

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

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

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

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