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Chair

Mr. Robert Oliphant

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● (1145)

[*English*]

The Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): I'm going to call the meeting to order, with our apologies to our witnesses for our absence for voting.

I'm going to suggest to the committee, and we'll see if we have its approval, that we hear first from the Paramedic Chiefs of Canada and the Paramedic Association of Canada, as planned, and then when Mr. Head arrives, to hear from him as well. We'll have three 10-minute presentations. The RCMP has only two minutes of comments because they've spoken about these issues before, so that would be 30 minutes of presentations, and then 45 minutes of questioning. I'm only concerned that we could invite the Correctional Service of Canada folks back, because they're Ottawa-based, but I want to give full time to the paramedics to make sure. Is that a good solution for today?

We'll try to get the whole meeting done. If Mr. Head arrives, he won't have heard the first two presentations. However, he has prepared remarks, so I don't think he's going to adapt them anyway.

We're going to begin with the Paramedic Chiefs of Canada, and then we'll have the Paramedic Association of Canada with Mr. Poirier. We will begin with Mr. Mellow and Mr. Charbonneau.

Mr. Randy Mellow (President, Paramedic Chiefs of Canada): Good morning, Mr. Chair, and members of this committee.

We'd like to thank you for the invitation to appear before you today and for this opportunity to contribute to this crucially important focus on the effects of operational stress injuries and post-traumatic stress disorders upon public safety officers and first responders. It's my distinct pleasure to represent the Paramedic Chiefs of Canada today. It is an association that represents the paramedic chiefs in leadership across all of our provinces and territories.

We're pleased to participate in this national dialogue on this important issue that is crucial to the safety of our men and women on the frontline, regardless of the role they assume, and crucial to their families as well, who are often affected.

Our association recently participated in a round table on this important topic hosted by the Honourable Ralph Goodale, Minister of Public Safety. We prepared for that meeting by polling and interviewing a number of colleagues across Canada in trying to address three fairly simple questions. What is the problem? What are we doing about it? What do we need?

While the feedback and the answers are likely as complex as the overarching issue at hand, there certainly were themes that prevailed. I'm pleased to try to outline these to the best of my ability here today.

The message that we heard clearly though from our community is that this is a complex issue. To state that the impact is significant would definitely be an understatement. In terms of scope, we feel there is some difficulty in terms of the accepted definitions and terminology or measurements. Based solely on the limited research to date, we can easily surmise that the impact is alarming.

For perspective, Ontario has about 8,000 paramedics, and with some studies predicting that PTSD or OSI affects 22% of them, we can estimate over 1,700 of our medics are suffering from operational stress injuries.

Speaking from the paramedic community, initial steps have been and are being taken to get a better understanding of the magnitude of the problem, but that work is in isolation of a broader scope, and the research is difficult to verify. The magnitude of the problem appears to be growing in terms of its human effect, system performance, and financial burden.

The overarching message heard from our community is that there is a need to treat the problem as a whole, and not just the disorder or disease—or worse yet, an event or a symptom. With frontline work, the damage is likely to be cumulative from multiple exposures, and more research is required to determine just how the multiplicity of stressors experienced by first responders manifests into disorders or syndromes, and what we can do to intervene.

As system leaders and practitioners, we feel that it's imperative to have a coordinated and collaborative effort among and involving the first responder communities, who are here at a national level, in order to stop the hemorrhage of emotional and psychological damage that's occurring.

Peer support and critical incident stress management teams and training are needed to be supportive in the field. I think that's clear and broadly accepted, but further research is needed to employ effective methods of intervention in the field, with a greater understanding of the impacts and limitations. We feel there are gaps evident around treatment options, which are relatively new. We feel there doesn't appear to be a lot of peer reviewed literature around the efficacy of these treatment options among our paramedic community.

These identified concerns have led the paramedic community to express a need for greater understanding of the problem at hand, and for our leaders to have access immediately to tools to begin an effective and evidence-based approach to addressing the situation.

We also see the need to address gaps that have been missed, such as workplace reintegration. Presently workplace health and safety programs are challenged as to how to reintegrate some staff into the workforce safely. Small collaborative programs exist in some areas, but in many areas the only programs that exist focus on reintegrating persons with physical injuries back into the workplace, and a gap certainly exists.

Broadly, our community has concerns about the lack of coordinated research in all areas surrounding operational stress injury topics. We feel that efforts should be made to find opportunities to share research more broadly and effectively.

What is our association and our community doing to date? The Paramedic Chiefs of Canada, along with our partner here today, the Paramedic Association of Canada, have been trying to frame the discussion around mental health and wellness, both physical and mental, and not just the manifested PTSD. We believe that mental health incorporates a holistic approach that recognizes mental health promotion as part of preventing the disease's symptomatic progression to a state of disorder.

Our association has been collaborating on the following projects: the national EMS research agenda, the national research gap analysis, and the Canadian safety and security program's paramedic community of practice. Each of these has priorities that recognize that research is important for the health of the profession and, in particular, this area of focus. As an example, a current study is underway, supported by CSSP, examining mental health wellness through Queen's University, and with Frontenac as our municipal partner.

● (1150)

Our association has joined others to form a tri-services working group collaborating with Public Safety Canada and other key partners in an effort to continue toward meeting the federal mandate to form a national PTSD strategy.

The Paramedic Chiefs of Canada have also created an ad hoc committee and drafted a report dedicated to operational and psychological stress injuries. We've provided a copy of that today.

The scope of the report was to examine how organizations themselves can best respond to operational stress injury. As with other forms of injury, we believe that the paramedic services at the forefront of proactive action on this issue must address the following four core elements: first, comprehension and championing of the issue within the paramedic service; second, developing prevention strategies that target those who may be at risk, their environment, and the sources of injury; third, creating intervention services and strategies for those who are at risk; and fourth, ensuring that treatment and recovery programs are accessible to those affected by an operational stress injury.

Our community continues to focus on these areas, but we know that we would be much more successful with broader collaboration. We need wholesome programs that span the first responder's career and provide support at any position they may currently hold within the mental health continuum, whether they be healthy, reacting, injured, or ill.

Support needs to be holistic in its approach, spanning readiness for career, resilience training, exposure response, critical incident recovery, restoration and and return to work, and retirement/career changes or returning to the workforce as a non-first responder. These ideas and best practices need to be evidence-based, bolstered, and shared among our communities, covering pre-evaluation, prevention, resiliency, and recovery throughout the mental health continuum.

We think it's clear that broad collaboration will be the key to having a significant impact in addressing this problem and supporting the people in our communities who do great things to protect us each and every day.

A multi-pillar strategy or approach for the support of mental health for first responders is critical from the day they're hired until well after they retire. We need research, and we need the funding and support required to pool our resources.

Once again, the Paramedic Chiefs of Canada applaud the right hon. Prime Minister Justin Trudeau for calling in his mandate letter to Minister Goodale for him to work with stakeholders to develop a national action plan on post-traumatic stress disorder, which disproportionately affects public safety officers, our people.

We welcome the opportunity to work with the federal government and partners to assist in coordination, research and communications, to ensure the safety of our first responders and the citizens of Canada in providing evidence-based national standards for the assessment, treatment, and long-term care of public safety personnel.

Thank you, Mr. Chair.

The Chair: Thank you very much.

Thank you for the work you do every day, not just the work you do when you come to committee.

Mr. Poirier.

[*Translation*]

Mr. Pierre Poirier (Executive Director, Paramedic Association of Canada): Mr. Chair, I would like to thank the committee for giving me the opportunity to talk about the health and well-being of paramedics in Canada.

[*English*]

I'd like to frame our discussion in terms of what the Paramedic Association of Canada is and isn't, and to talk a little bit about mental health. Paramedics are in distress, and I have some information that highlights the severity of the issue. I'll also talk about some good initiatives that are taking place. Lastly, I'll speak about how we can work together. I think there are some great opportunities to work with the chiefs, the different levels of government and, in particular, the Canadian safety and security program.

First, the Paramedic Association of Canada is an association of paramedics. It's not the union. That's a distinction I'd like to make. We take care of the competency profile of paramedics—the things that define paramedics. We determine the skills, abilities, and knowledge of paramedics as well as the roles they undertake in providing service to the community.

It really is about the education that a paramedic needs to do the job and do it well. By the year 2025, we hope to be at a baccalaureate level in the training that's required. The job has changed that much.

There are 20,000 members of the Paramedic Association of Canada, and there are around 40,000 paramedics in the country. Often we say it's about 1,000 paramedics for every million people. That's a broad number but it's pretty accurate. This makes the paramedic community the third-largest health care provider group in the country.

In defining paramedics, the terminology is usually primary care paramedic, advanced care paramedic, and critical care paramedic. We have those three designations. The nomenclature surrounding paramedics has been consolidated in the last 15 years or so. Across the country there's a fair bit of uniformity in the terms and the titles.

Where we work is an important thing. People used to think paramedics worked strictly in ambulances. Today you see paramedics in helicopters, in clinics and hospitals, and you're starting to see them in community health centres. A great example of that is the Health Bus in Saskatoon, where paramedics form part of a team in the community paramedic program. In the spectrum of health services, the job of a paramedic has evolved from being focused on urgent care to also providing preventative care.

Mental health has become important for paramedics. There has been some fantastic research done over the last number of years. Dr. Lori Gray and the Paramedic Chiefs of Canada did a fantastic report a couple of years ago looking at occupational stress injury in paramedics. Since then we've identified that the disease process at the end of the spectrum is not the only thing that matters. We also need to focus on general wellness. We are investigating how to build up people's capacity so that they don't fall into the illness category. This is important. With PTSD, in some ways there has been a failure. We still haven't figured out how to take care of people so that they don't fall into this category.

Most distressing of all is the number of suicides that have been related to mental health and mental health issues. I think the number was 14 or 15 last year. My apologies, I don't have the exact number, but that is a wake-up call. It's a flashing red light for us that more has to be done. Recently, the Paramedic Association of Canada did an online survey of paramedics, and there were 6,000 respondents. The numbers are startling. Thirty per cent of paramedics have contemplated suicide, sixty per cent know of a colleague who has contemplated suicide, and seventy per cent are concerned that a paramedic colleague is at risk of suicide. So in spite of all the evolution in what we do and where we do it, paramedics feel that in some ways they haven't been taken care of. All of us, really, are accountable. I'm not singling out any one group. It's a societal issue that we have to address. That's why both Randy Mellow and I are so appreciative of the mandate letter that was given to Minister Goodale. This is an issue for all first responders, including paramedics.

● (1155)

Talking about some of the good initiatives that have taken place, there has been presumptive legislation with respect to PTSD in several provinces, including just recently in Ontario, but also Manitoba and Alberta.

There's an initiative with the University of Regina, and a round table took place at the beginning of this year, which we think is a great foundation for the first responder community to work together on this issue. That's an important piece. Recognizing that paramedics still have their own uniqueness, there's a commonality among the public safety occupation, or the first responders, that this round table is addressing quite well. We advocate that those kinds of initiatives be supported.

Recently Queen's University did a study to solicit how paramedics “feel”, but it's about understanding the scope of the issue in a research-based study. Dr. Renée MacPhee and Queen's University started this process. Other good work is going on about rooting out and defining the problem and the problem space.

The whole idea of that first responder community coming together and this committee being willing to listen to us is an important piece of starting the process of understanding what the problem is, so that we can work back. We can deal with the disease process, but we can also look back at the wellness component.

With respect to the ask—and Randy Mellow and the chiefs and the Paramedic Association are very much on the same page on this—we continue to support initiatives such as the round table at the University of Regina, and what's come out of that round table.

Recognizing that paramedics still have a unique job—we're not firefighters; we're not police officers—the understanding of how we get to the illness phase, whether it's cumulative or whether single events are triggers, we don't know. There's research to be done there.

There's an opportunity with the Canadian safety and security program, which has been very much an advocate going back the last 10 years or so in support of our community. Targeted investments could be coming from that group in support of research for paramedics, not just on PTSD but also on mental health and wellness.

Thank you very much for the opportunity to speak. I'm willing to answer any questions.

● (1200)

The Chair: I'm going to suggest that Mr. Head, Madame Chateauvert, Assistant Commissioner White, and Deputy Commissioner Dubeau join us at the table.

I understand that Mr. Head has a 10-minute presentation and that the RCMP has a shorter presentation. Am I correct in assuming that?

D/Commr Daniel Dubeau (Deputy Commissioner, Chief Human Resources Officer, Royal Canadian Mounted Police): Mr. Chair, I don't have a presentation. We'll just open it up to questions whenever Mr. Head is done.

The Chair: That's perfect.

We'll hear from Mr. Head.

Is the committee in agreement with this?

Thank you.

Mr. Don Head (Commissioner, Correctional Service of Canada): Mr. Chair, I think everybody has a copy of my brief in English and French. If it facilitates the question period, I could just pass on reading it out and allow more time for questions.

The Chair: Why don't you give us a few highlights, and then we will take this into evidence.

Corrections officers have become quite an important issue for us. I'd like you to have at least a few minutes to highlight your report and point us to the most important parts.

Mr. Don Head: Thank you, Mr. Chair, and members of the committee.

I'm pleased to be back here before you. I always enjoy appearing in front of this committee and all the honourable members to talk about this serious issue that you've taken on to study, because it does affect a number of staff in Correctional Service Canada.

Mental health in the workplace has always been a difficult topic to address, both for those who struggle with mental health issues, as well as from a management perspective. Addressing this topic in a meaningful and effective way is very important to me personally and professionally. I am very happy that we are starting to see an increase in the awareness of the importance in maintaining a healthy workplace, and that there have been a number of concrete steps taken to improve the situation across this great country of ours.

This committee's decision to study operational stress injuries and the effects of post-traumatic stress disorder, for example, has placed a spotlight on this issue, and hopefully this will continue to foster more open dialogue in society to allow those who may be struggling in silence to come forward. One of the best approaches to improving understanding of afflictions such as PTSD is awareness and prevention, and in this regard, maybe I'll just share with you some of the highlights of the work that CSC has been undertaking.

As most of you are aware, our staff members operate in a unique environment, which can often take a significant toll on the mental well-being of the staff. Given the nature of the work performed by front-line correctional staff, they are likely to witness stressful and traumatic events, including death and violence. In our 180-year history, we have had 34 members who have been killed in the workplace, 33 of those within the penitentiaries, and one in the community.

Consequently, employees are vulnerable to developing operational stress injuries. While CSC recognizes the significant challenges associated with working in a correctional environment, we are committed to providing a workplace that is conducive to the health and safety of all of its employees, including their mental health. I am proud of the work done by the Correctional Service Canada staff on a daily basis. Particularly of note is their dedication and commitment during the stressful and potentially dangerous circumstances that are common in a correctional environment.

CSC openly encourages employees to seek assistance in dealing with any personal or work-related problems that may impair their well-being. To this end, we have established an employee assistance program to encourage employees experiencing personal or work-related problems to voluntarily seek assistance, recognizing that our staff are the strength and major resource of the service, and that the well-being and productivity of employees can be affected by personal or work-related problems.

Also, CSC employees have access to the critical incident stress management program. This is a joint labour-management initiative, which was introduced to employees in the 1990s. Currently, the CISM teams, as they are referred to in short, comprise mental health professionals, chaplains, and peers from various disciplines who are trained to conform to national standards. They are used whenever there is an incident that meets policy guidelines for the provision of CISM services, such as an event that includes death, suicide, injury of any person during use of force in the conduct of duties, being the victim of physical violence, or any other incident deemed critical by management in joint consultation with our EAP coordinators.

Most recently, we have also taken steps to educate CSC employees about the potential mental health injuries that can happen as a result of their work in corrections by offering the road to mental readiness training. As you know, this was first pioneered by the Department of National Defence for its staff. This leading-edge training equips our CSC employees with the same tools and knowledge as other first responders across the country.

We formed a steering committee for workplace mental health injuries in May of last year, and we are developing an integrated mental health strategy using the new psychologically healthy workplace standard developed by the Mental Health Commission of Canada and the Canadian Standards Association as a framework. We have produced a new and comprehensive internal web page for our employees who experience a mental health injury, where they can find information about what to do and where to go if they need assistance. Just last week, we shared with all our CSC employees across Canada an internal publication about workplace mental health injuries within CSC. This publication includes CSC employees sharing their personal experiences in written format, contributions from an institutional CISM and EAP agent and a registered psychologist, a poster to help staff determine where they are on the mental health continuum, as well as a video about CSC's Steering Committee for Workplace Mental Health Injuries.

● (1205)

I will cut it short there, but I could talk more about the employee assistance program, our return to work program, or our duty to accommodate program. There is no question, from my perspective, and I've been in corrections now for over 38 years, that this is a very meaningful topic and one worthy of discussion.

Although I represent the federal correctional system, I'm glad to see this applies equally to provincial and territorial correctional workers. I'm glad to see that they're being recognized in these discussions going forward.

To give you a sense of some of the stress that we do deal with, last year alone, I had 27 employees or former employees either commit suicide or attempt to commit suicide. To the greatest extent possible, this is a reflection of what they've had to deal with throughout their career. Being in the service as long as I have, I know a lot of these people, and so it's a very troubling situation.

Once again, I'll cut it short there. I'm glad to see the committee doing this review, and I look forward to answering any questions that you may have.

The Chair: Thank you very much.

Thank you for being here as well, Deputy Commissioner Dubeau, from the RCMP human resources area. Do you have any opening comments?

● (1210)

D/Commr Daniel Dubeau: No, I do not not, Mr. Chair.

I thank the committee for taking an interest in this, and I will echo all of my colleague's comments.

As you know, we've been at this for several years now, and we've had our mental health strategy since 2014. I'm willing to answer any questions about some of the systems we've deployed, and comment on what you've heard here, as well as some of the research that we're considering in future to advance this in our organization.

The Chair: Perfect.

We're going to begin with Mr. Spengemann, for seven minutes.

Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.): Thank you, Mr. Chair, and I'd like to pass any of my remaining time to my colleague, Mr. Mendicino.

Thank you all for being here and for your incredible work and service. Through you, we'd like to thank all the people you represent who are in the field, day by day, shift by shift. We're grateful for what you're doing.

I'd like to start with the representatives from the paramedic community. I have a number of questions in the areas of definition, awareness and prevention, and then also treatment.

As the committee moves into the stage of contemplating how to frame our report, I'm wondering if you could tell us, with respect to definitions and terminology, what do we make part of this exercise. We've put the label “PTSD/OSI” on it, but there are a number of things and concepts embedded in it that we need to be very mindful of.

Monsieur Poirier, you spoke about wellness, and that takes us all the way along the spectrum into the most unfortunate outcome, namely suicide or attempted suicide. Some of the things include depression, substance use or substance abuse, panic disorder, and other diagnosable mental health injuries, if you will, that we need to be mindful of and potentially bring in.

I wonder if you have some comments on how we can not only be as precise as possible, but also as comprehensive as possible, in our terminology and definition of the problem.

Mr. Randy Mellow: I think that's a question we're struggling with as paramedic service leaders. Part of the ask in our presentation today was around the assistance we need to help identify those. As I said in the presentation, we are involved in a number of different areas of research, as I believe all of our colleagues are sitting around the table, but my fear is that it is being done in isolation, siloed, and not being pieced together.

While as my friend, Mr. Poirier, said, we are a unique community, we have many similarities with the others in the first responder community. Again, our ask around having that support for collaboration would help us to answer that question for you. I do believe that the work that started with a round table in Regina, particularly the work that's going on with the university and the proposed Canadian institute for public safety research and treatment, would answer those questions for us.

This is something that we're really striving to find ourselves, as we transition from our traditional role of rule-maker and enforcer into almost being some sort of a practitioner or a health care provider to our own staff. We need to answer exactly those questions that you asked in order to fulfill that role.

Mr. Sven Spengemann: I have a quick follow-up on that first area.

Is the label “PTSD” in your profession one that evokes negative stigma?

Mr. Randy Mellow: Through you again, Mr. Chair, that term to me is troubling and I don't actually like to use it. I prefer to look at it as an operational stress injury. We know that we need to focus before it becomes a syndrome or a disorder, and that's what PTSD really is. As I stated earlier in my remarks, we need to look at the situation across the entire spectrum of both the career and the mental health continuum, and to focus on a disorder is too late, in my opinion.

I don't know if my colleagues would have anything else to add to that, but that's certainly our position on that.

Mr. Pierre Poirier: I would concur with that. That term is stigmatizing. As much as we talk about the initiatives through Bell's Let's Talk and Clara Hughes, we have to reduce the stigma. By actually attaching this label, we've actually probably done a disservice to the broader sense of mental health and wellness.

Mr. Sven Spengemann: That's helpful.

Moving on to the second area that I've labelled, awareness and prevention, how aware do you think the Canadian public at large is of the problem that your colleagues are facing? Without being too scientific about it, just give a general sense of public awareness of this issue.

Mr. Pierre Poirier: I think there's an awareness through several issues and I know from Let's Talk through Bell that there is a problem out there, but I don't think it's known necessarily that well within the community. I look at the approximately 40,000 paramedics in the country. Their training really doesn't include wellness training or an understanding of mental health issues at this time, and that's something that we're moving forward on. Our community is just building that awareness. I think that's something so important—and once again coming back to the mandate letter—because I think the dialogue is so important right now to get that message out.

● (1215)

Mr. Sven Spengemann: Maybe you could be a bit more specific in terms of awareness of new recruits. If a young person were contemplating joining the organization, how much knowledge would she have of the hazards of mental distress or, conversely, of the importance of wellness when she goes through the recruitment process?

Mr. Pierre Poirier: I can speak to that. Just in the last two years or so, we've been revising the knowledge, skills, and abilities of paramedics and paramedic education, and that's been one of the focuses of the renewal of our body of knowledge and the training programs. So yes, I would say that new recruits are given that information, but what's lacking is even our understanding of all of the component pieces in that continuum, so we're working with that.

Mr. Sven Spengemann: Then just moving to the last area that I've called treatment, could you outline for us some of the exacerbating factors that are not necessarily evocative immediately as OSI, but some of the hazards of the work environment that may amplify somebody's propensity to suffer mental distress?

Mr. Randy Mellow: Again through you, Mr. Chair, I think my colleague Mr. Charbonneau may want to add to this, if that's okay. I'd like to start by saying that those exacerbating factors are exactly what I referred to earlier as the multiplicity of stressors. Each of our communities is very different. If you look at the paramedic community, we have critical incidents that we're exposed to that we have limited control over. We know that's going to occur, as do our partners in the first responder community.

We also have increasing operational stresses as we look at the aging population and the demand on our paramedics. Our paramedics are missing their lunch breaks or they're not getting done at the end of their shifts. Then we have organizational stresses when you look at us being one of the most legislated professions or regulated professions in comparison to the first responder community. So again, those exacerbating factors, as you described them, are unique to each of our individual services. That's one area where I think that the paramedic services need to have a little bit of a distinct overview or look.

If it's okay with the Chair, I'd like to just pass to my past president and see if he has anything to add to that.

Mr. Paul J. Charbonneau (Past President, Paramedic Chiefs of Canada): I think the stressors are becoming more and more visible to our community, which is very important. Just to add to the comments about the young paramedic recruit, 40 years ago when I became a paramedic in Toronto, we didn't talk about this in my training of four weeks. Some 15 years ago when my son became a paramedic in a one-year program, they didn't talk about it very much.

I have a grandson who I think maybe some day might want to following in his father's and grandfather's footsteps. I sure hope that there's a whole course on how to look after yourself during a career of 40 years.

The Chair: Mr. Poirier is smiling at that.

Mr. O'Toole.

Hon. Erin O'Toole (Durham, CPC): Thank you to all of you, and through you to your members, for the important work you do for the public, and for taking the time to be here today to represent your members on the issues impacting them.

Chief Mellow, I was struck by the number you quoted: 1,700 members of the 40,000 that Mr. Poirier referred to, who right now are dealing with operational stress injuries. How did you ascertain that number and how many of those 1,700 would be off work versus working and persevering with an injury?

Mr. Randy Mellow: Mr. Chair, I could answer that question, but first I'd like to clarify that I referenced roughly 8,000 paramedics in the province of Ontario and the rate of 22% coming from just one of these studies, and there are many of them in different, I suppose, silos. One study we saw predicted 22%. That's how I came up with that 1,760 here in the province of Ontario alone. That doesn't include our communications officers in the ambulance world and then, of course, the other first responders in the community.

Mr. Poirier quoted 40,000 paramedics across Canada, and I agree with that number. If you take 22% of that, it's a much larger problem. I wish I could answer the question as to how many are off work. I wish I could tell you what the financial burden is that's associated with that. I wish I could tell you how many medical errors or risky behaviours we see in our communities.

Those are all types of research projects we've been embarking on and we would like to give you further information on, but again, as I stated earlier, we need broader collaboration to bring those research projects together so we could answer that question more clearly for you.

● (1220)

Hon. Erin O'Toole: We've heard from some fire services, and I spoke to their national convention not long ago. York, for instance, is rolling out resiliency training through the Road to Mental Readiness document, which originally was a DND document that has been adapted for first responders.

Have any of your forces engaged in resiliency training using that document or another road map, and have you had any success from that?

Mr. Randy Mellow: If I could pass that to Mr. Charbonneau, I'd appreciate it.

Mr. Paul J. Charbonneau: Thank you, and through you, Mr. Chair, the Road to Mental Readiness program has actually just been adopted for the paramedic world. Tomorrow, in Toronto, the Ontario Association of Paramedic Chiefs is holding a whole day of meetings around mental wellness, and this will be brought to us by the Mental Health Commission of Canada.

It is being looked at very favourably, as it has been for fire services and police, and indeed, for our military personnel. We're keenly interested in it, because we hear great results about how it has been used, particularly with the RCMP, which was the first police force to use it in Canada. We're very excited about it, and I think it will be one of the very good programs for our staff, just as it is for firefighters and police officers and corrections officers.

Hon. Erin O'Toole: A number of you commented on the suicide challenge that we've seen in a number of uniformed services in recent years, along with mental wellness and stress generally.

One thing I think it's important to note— and we heard this from some witnesses who were here at our last meeting—is that you can actually demonstrate through MRIs people who may be predisposed to operational stress injuries. Among your members, do you find there are cases of depression and a range of mental illnesses that may not be related to operational stress but may occur with the same sort of incidence found in the general population?

In some cases, are you able to distinguish which it is? Obviously, for somebody who develops a mental illness that is not related to operational stress, resiliency training and a range of other things won't actually help them. How detailed is the mental health discussion? I found this with Veterans Affairs as well. The military, the RCMP, or any force will have people with personality issues and a whole range of mental illnesses unrelated to stress, and if they're just given resiliency training, it's not going to help them.

Mr. Pierre Poirier: I have probably a couple of comments.

One was that we did take a look at the incidence of suicide among paramedics and compared it to that for the general population. I'm not sure I'm answering your question directly, but the rate of paramedic suicide was over and above that of the general population.

What I think you're alluding to is that there may be people who become paramedics who are already predisposed to that. That is a possibility, but recognizing that there's a differential between the general population and paramedics because of what's happened to paramedics, our belief and our assertion are that the job and all those activities related to the work we do are related to that differential in mental health issues.

Hon. Erin O'Toole: I agree.

The issue is more about treatment. If somebody develops an operational stress injury or something that's diagnosed clinically, like PTSD, the treatment regimen for that injury and that disorder is quite different than someone who would have a general anxiety disorder.

What I worry about is that the stressful environment that does lead to higher OSIs, in your service and in the RCMP and others, leads to this resiliency approach. However, that's not going to help everyone, because some people will be suffering a general mental illness and may need accommodation outside of training.

We're at such an early stage with discussions on OSI and PTSD and these sorts of issues, I'm wondering whether we are able to distill and tailor treatment regimes or accommodation for people on a range of issues.

Mr. Pierre Poirier: I work with the City of Ottawa, and that's been an interesting recognition or kind of alarm bell that's gone off internally within the city. I think it's true across the country that EAPs, employee assistance programs, are really set up for—and please don't take it the wrong way—the run-of-the-mill depression or other kinds of mental illness. They are not necessarily able to focus on what we describe as mental health issues related to the job.

Over the last couple of years, that's been recognized within the City of Ottawa. They've had to revise the EAPs to be specific to first responders. That work is ongoing, not just with the paramedic community, but within the fire community within the city. That's taking place across the country. Until recently, EAPs did not understand the mental health issues related to first responder work.

● (1225)

The Chair: Mr. Dubé.

[*Translation*]

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

I would like to thank all the witnesses for being with us today.

A lot is said about tackling the issue of post-traumatic stress, and it is very important that this be done, but I think that in some cases, we also have to tackle the incidents and events that can cause it.

My question is for you, Mr. Head, and it relates to prisons.

I remember reading an article—I think it was in 2014–that talked about an increase of around 60% in workplace accidents in prisons. We know that some of these accidents are related to violence. Situations like double-bunking can create dangers for correctional officers and additional violence.

Is there something that can be done about this? We want to offer them mental health help, but should we also, first, be looking at reducing the number of events that can cause post-traumatic stress?

[*English*]

Mr. Don Head: I think there are definitely things that can be done in relation to the specific items you mentioned. We've reduced levels of double bunking, which relieves some pressures in the institution —those kinds of things.

One of the things that's important to remember in this discussion is that what we're calling “occupational stress injuries” can come as a result of many things, some of them more physical in nature, such as assaults and seeing others assaulted, to situations where.... I'll give you an example. In our admission units across the country, we have clerical staff who read the police reports, the criminal profiles of individuals, each and every day. Some of the crimes committed by people who come into our system are horrific. Those reports are very graphic, very detailed. Until now, we would never have thought that doing this kind of work could result in a mental health issue or an occupational stress injury.

We need to be careful that we don't pigeonhole things into these easy categories. What people physically experience is one category, but there are a whole range of issues, particularly within our environment. Our psychologists having to deal with some of the most difficult mental health cases in this country, day in and day out, can take its toll on people. There are the parole officers, who have to weigh all kinds of information in relation to an individual's crime, his or her progress, and make recommendations about whether this individual can be released. All those things come into play.

Within the correctional world, it's more than just the physical altercation piece. There are all kinds of other factors that come into play.

[*Translation*]

Mr. Matthew Dubé: Thank you.

You talked about people who have been killed. There was a person in the community. Was that at work or was it someone who went looking for the person and knew where they lived? What were the circumstances in that situation?

[*English*]

Mr. Don Head: The situation in the community was the murder of Louise Pargeter in Yellowknife. She was doing what we call a home visit, following up with an offender who was in the community and who had been released by the parole board. He was serving a life sentence already. During that home visit, he went off to make a cup of tea, came back, murdered her with a hammer, and then sexually assaulted her body afterwards.

Mr. Matthew Dubé: In other words, it's so important not to forget parole officers when you hear a story like that.

Mr. Don Head: Exactly.

Mr. Matthew Dubé: Fantastic.

With regard to paramedics, Monsieur Poirier, you talked about how you're essentially the third-largest health care provider. What does that element of being part of health care, basically, but also working alongside first responders who deal with very different situations as well...? You mentioned it a bit, but could you get into some of the specifics around the challenges that those two realities can present and the kind of work we need to do to make sure that you have better structure around the help you need?

● (1230)

Mr. Pierre Poirier: First off, I appreciate the question, because going back to 1981 and the Canada Health Act, paramedics were not envisioned within health care from a national perspective. That's always been one of our long-term visions, I guess, that when you look at health care it will include the paramedic component, as in, right after that 911 phone call, when you start to touch the people who can provide the care, it should be considered within health care. But I know that's another tangent.

I think the uniqueness oftentimes is that paramedics do develop relationships with their patients. That has an emotional context, too, which oftentimes isn't seen with the fire community, for example— although that may not be in the same.... That's what I refer to as us having a unique relationship. Oftentimes there's an emotional attachment—or maybe detachment, however we want to work it.

We are engaged emotionally with our patients in their treatment. We see the ups and downs in terms of our interventions. I think that really does add to the level of complexity, or to what makes so unique the work we do. It's not that we're better than; it's just that it's different.

[*Translation*]

Mr. Matthew Dubé: Thank you for that answer.

My last question concerns the data and is for all the witnesses. I would like you to answer as briefly as possible because I have very little time left.

The question of data is something that comes up very often. This is an easy recommendation that the committee could make. We have to have more data to identify workplace incidents, mental health problems, and incidents that result in post-traumatic stress. I would like to hear all the witnesses as quickly as possible in the thirty seconds I have left.

D/Commr Daniel Dubeau: I will talk about it as it relates to the RCMP.

We have data about incidents that happen in the workplace. There is also the Veterans Affairs Canada data that gives us an idea of the number of people who apply for a pension. There is also data from our insurance companies. We have a lot of data, but what we do not have is internal data. We do not have data about our members who are ill. That is really the data we are missing. We are in the process of buying a computer program to collect that data, a

[*English*]

case management tool for health care.

[*Translation*]

When it is in place, it will give us more data and information about this.

Mr. Matthew Dubé: What is the situation for ambulance attendants?

[*English*]

Mr. Randy Mellow: Just very quickly, to give you the paramedic perspective, as you're all aware, we are very much a provincially based organization. That causes some fracturing in our data. We have data, as our friends in the RCMP do, in each of our provinces, but we need a better way to come together nationally to collaborate on the sharing of that data and then, more broadly, to use it across the entire first responder community so that we can support one another.

The Chair: Mr. Mendicino.

Mr. Marco Mendicino (Eglinton—Lawrence, Lib.): I'd like to thank the rather large group of witnesses we have in the panel. I would echo and contribute to some of the statements made by my colleagues. We're very grateful to all of you for the service you provide.

I want to explore some of the statistics we heard earlier around the very difficult issue of suicide. I just want to make sure I have the numbers right.

Mr. Head, I understand that 27 of your CSC staff either attempted to or did commit suicide in 2015.

Mr. Don Head: That's right, and it includes not only existing staff but staff who had retired as well.

Mr. Marco Mendicino: And of that 27, are you able to break down how many were successful in committing suicide?

Mr. Don Head: It was 12 who committed suicide, of which seven were existing employees.

Mr. Marco Mendicino: Do you know where these suicides were committed, in other words, in connection with particular penitentiaries, like maximum security?

Mr. Don Head: They covered the range of security levels, and they were across the country.

● (1235)

Mr. Marco Mendicino: Mr. Poirier, I understand there was an online survey that was conducted, and just to quickly review some of the statistics, 30% of those within the paramedic community actually contemplated suicide. That is of what larger number of total paramedics? Was it 17,000?

Mr. Pierre Poirier: That was a group of 6,000 respondents.

Mr. Marco Mendicino: Okay. But 6,000 respondents representative of what population...?

Mr. Pierre Poirier: Of our total community—

Mr. Marco Mendicino: Which is?

Mr. Pierre Poirier: That is 40,000.

Mr. Marco Mendicino: Okay.

Mr. Head, it's back to you. Are you able to say with some degree of confidence that these suicides were in connection with either occupational stress or PTSD?

Mr. Don Head: I can't say definitively. In a couple of cases that I do know, there were issues that had been going on throughout their last couple of years at work, so to draw a parallel, I would say yes. But to definitively say in every case, I can't do that. I can't make that statement.

Mr. Marco Mendicino: Mr. Poirier, I gather there was some context to this online survey that made reference to either occupational stress or PTSD. Are you able to shed any light on the correlation, not necessarily the causation but the correlation, between the 30% who personally contemplated suicide and the pre-existing OSI or PTSD?

Mr. Pierre Poirier: My apologies, but I'm not sure if I follow you.

Our survey was of 6,000, with 30% who had contemplated suicide; and the number that we reported from last year, I think, was 14 suicides of paramedics. That was a separate data point. It wasn't related to the survey itself. I'm not sure if I'm answering your question, so my apologies.

Mr. Marco Mendicino: So, 14 of the 40,000...correct? Okay.

And are you able to shed any light on whether or not you think there is a correlationship between the 14 who successfully committed suicide and PTSD and OSI?

Mr. Pierre Poirier: I think that goes back to Mr. O'Toole's inquiry with respect to the fact that the incidence of suicide amongst paramedics is higher than the general population, so our assertion has been yes, it is related to mental illness. Is it directly related to PTSD? I cannot state that, but it is related to mental illness, yes.

Mr. Marco Mendicino: I'd like to ask you about your definition of “critical incidents”. How do you define critical incidents?

Mr. Head.

Mr. Don Head: We have a series of issues that are listed in our commissioner's directive. We can make a copy available, but it includes everything from violent assaults, inmates assaulting each other, assault on staff members, responding to individuals who have attempted suicide, responding to a death of an inmate, and issues where any sort of violence has been involved, including individuals who have been taken hostage. We have quite an extensive list.

Mr. Marco Mendicino: Mr. Mellow, do you have a similar working definition of critical incidents?

Mr. Randy Mellow: We do not really attempt to define a critical incident. A critical incident for each individual person is very different. For someone today, it may be a trauma. For someone else, it may be a death that we would experience in the line of duty. In our normal routines, it's the other stressors within that person that make that a critical incident. So we don't define them.

Mr. Marco Mendicino: Lastly, I'd like to ask you about whether or not you think there is merit to really centralizing a lot of the research and the efforts to address OSI and PTSD. I take it from some of your earlier testimony that you do, but I'd like you to elaborate on that in the time we have remaining, because the words that I jotted down were “broader collaboration”, and I think that as a member of this committee—and I've said this before—we have a fair bit of research out there. It comes from different areas and from different experts. Would you just take a moment or two to explain why it is that broader collaboration is so important in this area?

Mr. Randy Mellow: I did stress in my presentation that I think that broader collaboration is critically important. My colleague, Mr. Poirier, described something earlier regarding a foundation that we need to build to support our first responder community. I think that foundation is made up of a lot of different elements, and these research pieces that you acknowledge exist are each blocks within that foundation. We know they're out there. We need to bring them together.

A project like the Canadian institute for public safety research and treatment is absolutely an option for us to bring all of that together. In isolation, I'm afraid that we are not putting evidence-based programs in place. I think R2MR is great. We don't know yet if that's the perfect solution for our community. It's working, I think, in others. We need to add building blocks to that foundation, find out those successes in the other communities, and bring them together. I think that's an example of how it could work.

● (1240)

Mr. Marco Mendicino: I think my time is up. I just wonder if in 10 seconds I could ask whether or not Mr. Head echoes those sentiments.

Mr. Don Head: I agree. The more that we can do things in collaboration, the better use of resources we'll get. The dollars for addressing this kind of issue are thin. If we have research going on all across the country and it's not being matched up, we're not going to have the right answer. We need the right response for the right people at the right time with the right treatment base.

The Chair: Just to let you know where we are, we have time for a second round of five minutes each, so you can prepare brilliant questions.

Mr. Miller, Mr. Di Iorio, Mr. Rayes, and Ms. Damoff, I think we'll be able to get you each in for five minutes.

Mr. Miller.

Mr. Larry Miller (Bruce—Grey—Owen Sound, CPC): Thank you to all of the witnesses for being here today. They were very good presentations, and good information has come out of the questions.

If a first responder has a traumatic incident, or as stated here, “a critical incident”, how does a small force of paramedics or firefighters deal with, say, two members who show up at one of these treatment bases? How are they treated—that has come up in the conversation—and to what extent, before they can actually be redeployed on the job?

This is what I'm thinking, and correct me if I'm wrong: where there are few people on the whole job, does it just happen that if you're short of people, back they go? How do you deal with that?

Mr. Paul J. Charbonneau: That's a very good question.

I've worked across this province all the way up to James Bay, where there were four of us looking after Moosonee. The young aboriginal paramedics who worked with me often picked up their family members, and it was very traumatic to them. We would try to support them as best we could. I often saw that with the OPP there would only be a certain number of officers there, but if something happened, as quickly as you could you would bring other officers in.

I think we're very good at supporting each other. I'm from Kingston, and if my neighbouring service, a little Napanee service in Lennox and Addington County, has an incident, I'll send paramedic officers over to offer relief and all kinds of assistance, but it certainly is a problem. It's not only a problem of getting them off and making sure that they have some down time. It's also a question of where the resources are in some of the remote areas of this country. How do you deal with an incident somewhere in Yukon? Is there a psychologist available, or do we have to parachute one in from somewhere? Those are some of the concerns that we also see. What level of treatment do we need to bring so that they can get healthy and get back to work? Each one is individual. Two partners may see the same incident and one may be off for two days and one may be gone for two months. It's a matter of how you're affected. It's a question of what that incident meant to you personally.

Mr. Larry Miller: To your comment about supporting each other very well, I came up through municipal politics. You have your volunteer firefighters and local paramedics. I certainly echo that because you guys do look after your own and that's good.

I would like to move to another topic that was touched on here.

Mr. Mellow, in your presentation, you talked about mental health and dealing with PTSD. While they are separate to a degree, they still become one in the same. Whether it's a physical injury, workmen's comp, or what have you, there's compensation for anybody who has a workplace injury—and, correct me if I'm wrong, but that should be the same whether it's a mental or physical injury. How do you separate, or maybe the question is, should you separate, pre-existing mental health conditions out there?

I think there is a need for that discussion. It's not one that everybody wants to talk about, but there are probably some people in jobs who had pre-existing physical injuries. I'm sure there are people who move on to jobs and who have pre-existing mental conditions.

Do you have any comments on that, and how do you go with that? It's a tough one.

● (1245)

Mr. Randy Mellow: First of all, in my opinion, the Province of Ontario has done a pretty good job of looking at that question when they introduced the bill around presumptive legislation. That legislation requires a diagnosis by a psychiatrist or psychologist using specific tools, a DSM-5 categorization. That's the way to identify it.

That's an example of a measure we would applaud, as it sets out that sort of safety net for those people, because we do have to support both the physical and mental injuries.

The Chair: Mr. Di lorio.

[*Translation*]

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

My question is also for Mr. Poirier.

Before asking my question, if I may, Mr. Head, I want to add my voice to the chorus of comments, praise, and thanks expressed to you, of course.

Mr. Poirier, I was particularly disturbed by the suicide figures. I would like to know whether your association has done any studies on the circumstances of those suicides, the situations that may have brought them about, and methods to prevent this from happening?

Mr. Pierre Poirier: Mr. Chair, I am sorry that I have not done any research on that subject. The Paramedic Association of Canada does not know the reasons for these suicides and does not have complete information about them. We lack data on this subject Canada-wide.

Mr. Nicola Di Iorio: I would like to be very clear; I am not criticizing you in any way. I would just like to know whether information on this subject exists, so we could have access to it, of course.

Mr. Head, does the Correctional Service, itself, do studies about these issues?

[*English*]

Mr. Don Head: We have not looked at it in any great detail. Part of the challenge is the fact that these situations occur off the work site, and getting access to information is challenging at times.

We have done a couple of studies over the last 20 years—nothing in great detail, but we've identified with correction officers some of the stressors or challenges around their work. We have a good sense of the kinds of things that impact people psychologically and have continued to find ways of minimizing those situations.

I'll just give you a very quick example. In the early days when we had individuals who were involved in lethal force situations, the typical response of the service 30 years ago was to take that individual out of the workplace and send him to the staff college to become a trainer with no other support.

Almost every individual I knew who was involved in one of those incidents went on to suffer significant psychological problems and mental health problems. It was only probably in the last 10-plus years that we've started to look more seriously at what is the right response. How do we put the right envelope of support and treatment around those individuals, and not force them to have to make a decision about just sucking it up and coming back to work, or going off and being forgotten?

There are some things that we know we need to work on, but in terms of in-depth research, no, we don't have the capacity to do that nor is the information readily available.

● (1250)

[*Translation*]

Mr. Nicola Di Iorio: My question is for each of you.

We will be preparing a report, with recommendations, and submitting it to Parliament. We will then ask the government to take action in response to the recommendations. I would like you to tell me any recommendation or recommendations that you would like to see included in that report.

I will start with Mr. Head.

[*English*]

Mr. Don Head: I have a series of things you may want to consider.

Part of it is looking at how we make available standardized awareness training for people to eliminate the stigma and to allow people to come forward and freely engage the supervisors. We also want to look at how we prepare managers to deal with situations of staff coming forward. These are very difficult situations for managers to deal with. How do we prepare managers to deal with those types of situations?

There is also support for family members. Through our road to mental readiness training, not only are we looking at staff and managers but we will, in our second and third phase of our initiative, also look at how we provide assistance to family members.

Regarding the issue of standardized accessible treatment, we're talking about everybody, and not just certain categories of first responders. It needs to be standard across the country. We can't differentiate between the military, the RCMP, corrections, paramedics, or whatever the case may be. There needs to be a standard approach and proper funding to support that.

We need to find a way through provincial WCB bodies to help people navigate through the system when they come forward. One of the most significant challenges we find is that people do not come forward.

We're talking a lot now about the statistics of individuals who come forward. We're not talking about the silent majority who do not forward because the system is very complicated. WCB processes are so complicated that within our own organization, we have to dedicate individuals to help people try to navigate through a system that we do not manage.

Thinking about those kinds of things will go a long way.

The Chair: Mr. Rayes.

[*Translation*]

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

I would like to thank the witnesses for being here with us.

Last week, one of the witnesses told us that, after people are diagnosed with a post-traumatic stress disorder and once they start treatment, a third of patients respond positively, another third have a mixed response, and another third responds completely negatively.

Awareness is an aspect that is of considerable concern to me, particularly when I see these results and I think about the time the research will take before we can progress on this. I would like all of you to tell me, not what your organization is planning to do in the next few months, days, or weeks, but what it is doing right now. What are you doing about awareness and education on this subject? Ultimately, what are you doing to raise people's awareness before they join your organization?

I would like to hear from the representative of each of the organizations.

D/Commr Daniel Dubeau: That is a very good question.

The Royal Canadian Mounted Police has had a complete mental health strategy for the past two years. The first year, templates were used to help managers communicate with our members. It really meant being sensitive to our members and their stories.

Constable Neily, in Cornwall, has produced some videos about this. He has done some very good work.

[*English*]

Constable Neily stepped up and became the face of mental health in our organization. We had members step up in the grassroots. What we noticed is that there was an appetite, and our members stepped up to talk about their experiences. That speaks more to our members than anything else, where they have a fellow member or a fellow officer saying, “Here is what's happened to me, and here is how I got that”. That was the first year it was released.

We had tool kits, and we had a lot of emphasis on destigmatization. For post-traumatic stress disorder, we do not use that terminology in our force. We avoid that terminology. We call it an “injury”. It's an operational stress injury, and we have to stop calling it a disorder. It's an injury, because otherwise it's a stigma.

The second part is training. Similar to everybody else, we are rolling out R2MR. We had tried it in New Brunswick, and we tried it before that unfortunate tragedy in Moncton happened. We had rolled out that program. We had research to show it was effective. We did roll it out, and we're rolling it out currently.

We have a peer-to-peer network that we have deployed across the country. These are members who are trained, employees who are trained, to pick up on these issues. Within the training component itself, we have it at our induction training. We start talking about this at the first stage, and then we supplement it as we go along throughout their careers.

It's still a work in progress, and that's where we are right now on that. We're doing the research project, and we're saying that we now have to go to a broader research project to find out, in our members' lifetimes—starting from training at Regina, and throughout the lifetime—what happens. What happens to an individual?

I believe a lot of people are asked, do you walk in with preconceived notions of what police work is? Yes, you do. Do you have certain conditions that may cause you to have this injury happen to you? Yes, you do. We're trying to find what those indicators are, so we're able to build resiliency or deploy better strategies to treat the members.

That's where we would be with our organization.

● (1255)

[*Translation*]

Mr. Pierre Poirier: Mr. Chair, I am going to speak in English because I will be better able to answer the question.

[*English*]

I'd like to address it in three phases: the education, the recruitment, and then when an event happens, because I don't think we've spoken about that piece.

On the education, I spoke earlier about the changes in the educational structure of how we teach and educate paramedics, *la formation des paramedics*. It's evolving right now to recognize that mental health is an integral part of that educational process. That's taking place today.

Colleges have already started to adopt it, and it's becoming a greater portion of the whole educational structure. As we recognize that and as we move toward baccalaureate education, we look at the roles paramedics take. As part of being a professional, self-reflection is part of that concept. That's an important piece to understand where you are in your context, so the education is evolving to address mental health issues.

How paramedics are recruited across the country is a mixed bag, including their initial education with respect to how they understand themselves, their mental health issues, and how they fit into the organization. I think Randy Mellow spoke earlier about all of those other impacts upon our well-being from shifts, the hours of work, the randomness of incidents, and how they affect us.

The last piece—and we've seen a fair bit of change in this area, and haven't spoken a lot about it today—is when an event happens. My apologies, because I'll use a sudden infant death event. That event may affect different people in different ways. Right now, we don't know exactly how to support our paramedics in that regard, and that's an interesting piece that's going on.

There is critical incident stress management, and there is critical incident stress debriefing. There has been a lot of research about the best way to help that individual. We don't know specifically what the answer is.

Different services across the country have chosen different methodologies. Critical incident stress management appears to be the most common, but we don't have the research to say it is the best. That's an important piece if we're looking for an understanding of what the best intervention is. We don't know. I think we all struggle with it, and I think the first responder community struggles with it because of how individualized that event is to each individual *intervenant*.

A paramedic, a police officer, or a firefighter who attend to that event may each have a different perception of it. That is an area where we—

The Chair: Thank you. We're well over time.

There are a few minutes left for Ms. Damoff. If we have the indulgence of the committee, we'll continue for a few more minutes.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thanks to all of you for coming and for your work in this field.

R2MR has come up quite a bit, and I have three questions on it for each of you.

Recognizing that first responders and public safety officers are working in different conditions from veterans, which is what it was designed for originally.... Regarding veterans, I think it was CAMH that said here that they go from a safe zone to an unsafe zone and then back to a safe zone, whereas all the people you deal with are living in that unsafe zone every single day.

What modifications were made to R2MR for your various communities, how long have you been using it, and is there any research that shows it's effective for first responders and public safety officers?

Maybe we can start with the RCMP and work across, if that's okay.

● (1300)

D/Commr Daniel Dubeau: The foundation is the road to mental health readiness, and we thank the CF every day for this, as well as the Canadian Mental Health Association. We use that as a foundation. We haven't changed the core piece of it because we find that it fits very well with our organization. What we have changed, though, is where we start talking not only to our employees but also our leadership structure, where we incorporate what's unique to our organization.

Ms. Pam Damoff: Sorry to interrupt you, but isn't there a post-deployment component in R2MR? Have you changed that part of it?

D/Commr Daniel Dubeau: We didn't have that post-deployment part of it. Post-deployment is when they're going to deploy overseas. We don't have that. We have a post-deployment structure when we do deploy our members overseas, so we do that then, but I'm talking about a standard R2MR for all veterans.

You're right that we are constantly deployed. We are on full deployment all that time. I've lived in communities where it doesn't matter if you're in uniform or not; they're still calling you “constable”.

Ms. Pam Damoff: So you're using it exactly as it was.

D/Commr Daniel Dubeau: We're using the foundational piece. What we have changed, madam, is on how the services are available in the organization, the policies we have within our organizations to deal with mental health issues and the other occupational issues, and how you will deal with the employees, as well as what and to whom the employees should be reaching out to. That's what we've changed to modify, where you go in our organization to get the help you need.

How long have we been using it? We accepted this as a standard in October of last year and made it mandatory for everybody. Prior to that we did have it in New Brunswick. Our pilot project in New Brunswick was the first time we ever used it, both in Moncton and across New Brunswick. There was a research project that followed that to see if it was effective. The subsequent report concluded that it was an effective way to build resiliency amongst our members. It allowed them to actually monitor before and after the Moncton event. Unfortunately, we had that tragedy in the middle of it, so we were able to see that, yes, the number one shock for any of us was losing a fellow officer. We saw that as the number one shock; it happened and we were able to monitor and get the people help. We do have research data that would show this. Dr. Julie Devlin and part of our team did do research that is available. If you would like to see it, we can share that with you.

Ms. Pam Damoff: Our paramedics.

Mr. Paul J. Charbonneau: Thank you for the question.

Through you, Chair, we'll find out tomorrow.

Ontario is going to be the lead on this. R2MR has just been “paramedicafied”, if I can call it that. As we understand it, it's about looking out for each other and knowing if you're in that stop, caution, or go zone. As the Paramedic Chiefs of Canada, we'll be watching very closely what Ontario does. We'll have some conversations at our national conference in Saskatoon in June.

From speaking to the people who are using it already, my hope is that it will really help our members to help each other.

Ms. Pam Damoff: You're not using it as the only thing though. It's part of a toolbox.

Mr. Paul J. Charbonneau: It's part of a toolbox. I can speak from my own personal experience. Last year we put all the paramedics in Frontenac County through compassion fatigue training with a psychologist, and it was very well received. It was awareness not only of yourself, but of your partner and everybody else in the service.

There are lots of tools in our toolbox. I think the thing that's exciting about it is that we can improve those tools so much over the next few years.

Ms. Pam Damoff: Mr. Head, are you using it?

Mr. Don Head: Yes, we've been using it since the fall.

We're rolling it out across the country. It will become a national training standard for every employee.

Ms. Pam Damoff: How did you change it for your—

Mr. Don Head: Similar to the RCMP, basically all that we did was to adopt the framework presented to us. There were modifications made to some of the scenarios and videos to make them more corrections specific. The version we were working with was the one that had been developed for the Calgary Police Service. The scenarios were police officer-based. Now they've been modified to be correctional officer and correctional employee based.

We have an evaluation planned to assess it effectiveness in relation to the goals that we set. But the early response from staff has been that they wished they had had this at the time they became CSC employees. It's been very positive feedback in the early days. We'll see what that means in the long run when we go through the evaluation.

Ms. Pam Damoff: Do I have any time left?

The Chair: We need to end there. It's been over five-and-a-half minutes, just to let you know.

Again, our apologies for losing 45 minutes, but also my thanks to the committee for staying an extra four minutes for this meeting. Thank you.

I will just mention to the EMS folks, if there's something out tomorrow from Ontario that you think would be helpful for our committee, we'd be happy to receive it. Keep that in mind. We may be in touch with you if there is an appropriate person for us to talk to in Ontario. I think that could be helpful.

We'll see you folks on Thursday.

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