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Lundi 7 mars 2016

Standing Committee on Social Policy

Supporting Ontario's First Responders Act (Posttraumatic Stress Disorder), 2016

Comité permanent de la politique sociale

Loi de 2016 d'appui aux premiers intervenants de l'Ontario (état de stress post-traumatique)

Chair: Peter Tabuns
Clerk: Katch Koch

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 7 March 2016

Lundi 7 mars 2016

The committee met at 1400 in room 151.

SUPPORTING ONTARIO'S FIRST RESPONDERS ACT (POSTTRAUMATIC STRESS DISORDER), 2016

LOI DE 2016 D'APPUI AUX PREMIERS INTERVENANTS DE L'ONTARIO (ÉTAT DE STRESS POST-TRAUMATIQUE)

Consideration of the following bill:

Bill 163, An Act to amend the Workplace Safety and Insurance Act, 1997 and the Ministry of Labour Act with respect to posttraumatic stress disorder / Projet de loi 163, Loi modifiant la Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail et la Loi sur le ministère du Travail relativement à l'état de stress post-traumatique.

The Chair (Mr. Peter Tabuns): Good afternoon, committee members. I'm calling this meeting to order to consider Bill 163, An Act to amend the Workplace Safety and Insurance Act, 1997 and the Ministry of Labour Act with respect to posttraumatic stress disorder.

Pursuant to the order of the House dated Wednesday, March 2, 2016, each witness will receive up to 10 minutes for their presentation, followed by nine minutes of questioning from the committee or three minutes from each caucus.

I ask committee members to ensure that questions are relevant to Bill 163. It helps tremendously. Keep them brief so that witnesses have a maximum amount of time to speak. Is there any question before we start in?

There being none, I just want to note that we need to give instruction as to when the summary will come to you. I've talked with research. Realistically, we can have a summary by Monday the 14th. Is that acceptable to the committee? Done. Okay.

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

The Chair (Mr. Peter Tabuns): So, first witness: the Canadian Mental Health Association, Uppala Chandrasekera and Joe Kim. If you'd have a seat and introduce yourself for Hansard. Just before you get through your 10 minutes, I'll interrupt and say you've got to wrap up.

Ms. Uppala Chandrasekera: Okay, great. Thank you so much, Mr. Chair. Hello, everyone. My name is Uppala Chandrasekera. I'm director of public policy at the Canadian Mental Health Association, Ontario division. Here with me is Joe Kim, our director of communications. Our CEO, Camille Quenneville, regrets that she couldn't be here in person today, so we bring greetings on her behalf.

For those of you who might not know about us—CMHA—we are the largest community-based mental health and addictions provider in the country. We exist in 120 communities coast to coast. In Ontario, we have 31 branches, and that's where individuals can get front-line support services—anything from clinical services to counselling to case management, court support, housing, etc.

We commend the Minister of Labour, the Honourable Kevin Flynn, and the Minister of Community Safety and Correctional Services, the Honourable Yasir Naqvi, for proposing this legislation. We also commend all parties in the Legislature for unanimous support of this bill during second reading and especially MPP Cheri DiNovo for all of her efforts on this issue.

We understand that the intent of this legislation is to prevent and mitigate the risk of PTSD among Ontario's first responders. First responders face a number of unique stressors in their workplaces that make it that much more important to prioritize mental health and well-being. While any negative or unpleasant event can be stressful, exposure to crime, violence and other dangerous situations common in this field can be particularly stressful and can seriously impact one's mental health.

Exposure to these situations can be traumatic. They can be frightening, overwhelming or cause a significant amount of distress. Everyone can experience these situations, and people can react differently to them. They might feel nervous, have trouble sleeping, or revisit them in their minds. Such reactions are normal and tend to decrease over time, allowing people to get back to their daily lives.

When these reactions are more intense, last for an extended period of time or severely disrupt one's life and mental health, then PTSD may be present. When these reactions are a result of experiences in the workplace, PTSD can be classified as a type of operational stress

injury. An operational stress injury is any persistent psychological difficulty that results from operational duties, such as law enforcement, combat or any other service-related duties.

We are pleased that this proposed legislation would establish a presumption that PTSD, diagnosed in first responders, is related to their work, easing their access to Workplace Safety and Insurance Board benefits and better supporting their recovery. This important legislation marks a positive step towards ensuring that the mental health needs of first responders are adequately met in a timely manner.

CMHA Ontario understands the unique operational stressors that first responders face in carrying out their daily professional duties. Numerous studies have shown that these stressful situations can increase the risk of PTSD in first responders. The stigma that exists around the reporting of PTSD, paired with inadequate support, can have tragic consequences. By acknowledging the stress and trauma that first responders experience on a routine basis and providing them with accompanying support, we better promote and value their health as they provide Ontarians with their invaluable services every day.

While CMHA Ontario supports Bill 163, we believe that the list of identified workers it will apply to is too narrow and should be expanded to include additional groups. I am referring to "Application," subsection (2) on page 4.

Some workers not identified in the legislation may face similar operational stress injuries as first responders and be prone to a similarly elevated risk of developing PTSD: Probation and parole officers are routinely exposed to stressful situations and traumatic incidents as a result of their daily work and should be afforded the same supports through Bill 163. Privately contracted security professionals, especially those who are contracted to work in correctional facilities or detention centres, should be included in Bill 163. Further, individuals who provide security services outside of correctional institutions, for example in hospitals, regularly provide close assistance to first responders or perform similar duties in their stead in stressful and traumatic situations. Security professionals face the same heightened risk of developing PTSD and also merit support offered under Bill 163.

CMHA Ontario is also concerned about the proposed criteria that would entitle identified workers to receive PTSD-related-to-workplace insurance benefits. Here I'm referring to "Entitlement to benefits," clause (3)(c) on page 5.

Bill 163 would entitle an eligible worker to PTSD-related benefits provided that they have been diagnosed no later than 24 months after their last day as an applicable worker. This timespan deserves further consideration. A worker may begin to experience negative effects resulting from on-the-job exposure to stressful situations or traumatic incidents long after the traumatic event has taken place. The resulting symptoms of PTSD can thus begin to take place much later than 24 months and may take even longer to be noticed and diagnosed properly. The stigma surrounding the reporting of PTSD may additionally delay workers in seeking out a diagnosis after the initial experience of related symptoms.

We recommend that the Standing Committee on Social Policy further examine the time period when benefits provided by Bill 163 will be made available to workers following a diagnosis of PTSD.

CMHA Ontario would like to partner with the government of Ontario in the implementation of Bill 163. We have a long history of providing support to employers and employees in addressing mental health in the workplace.

Our Mental Health Works program, which is a social enterprise of the CMHA, has for the past 20 years successfully helped workers deal with operational stress and reduce the stigma associated with seeking help.

In line with the intentions of Bill 163, Mental Health Works has a new adaptation specifically designed for supporting professionals in the justice sector, including police officers, legal professionals, correctional employees and security professionals. The Mental Health Works program is tailored to meet the needs of each audience and provides practical strategies for addressing operational stress and promoting mental health in the workplace.

Thank you so much for the opportunity to respond to Bill 163. We'd like to offer our support as your committee deliberates on this further.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation. We'll go first to the official opposition: Ms. Martow.

Mrs. Gila Martow: Thank you very much for your presentation. What can you suggest not just to deal with post-traumatic stress once it occurs, but what do you think government can do to help people recognize the signs? I think that's where there's a lot of misinformation. People just don't seem to have the awareness.

Ms. Uppala Chandrasekera: From our perspective, talking about it is the first thing. There's so much stigma and discrimination surrounding mental health issues and people are very afraid to talk about it, especially in high-stress work environments. I think encouraging employers to talk about mental health and promoting mental health in the workplace is the first step. That's part of the work that we do through our Mental Health Works program but also on a day-to-day basis. We do a lot of education to say, "It's okay to talk about mental health," because that's the first step to getting help and support.

Mrs. Gila Martow: Do you feel that we could be asking, not waiting for people to initiate the conversation, but that there could be a regular protocol—maybe each year that people are asked, "Do you have any of the symptoms of post-traumatic stress?"

Ms. Uppala Chandrasekera: For sure. I think supervisors and managers have an added responsibility. They should be routinely checking in and seeing what's going on, because sometimes the impact of PTSD might not be

relevant for a while. It might be that the person is coming in late or missing their shifts, or it might pose as a work-related issue and, really, you need to sit down, have a conversation and see what's going on before you can understand what's really happening to the individual.

Mr. Joe Kim: Pardon me. If I could just finish that, through you, Mr. Chair: All the public discourse is great if we can reduce that stigma and discrimination, but we also have to make sure that there are supports available. What we're finding is that the more we're talking about PTSD or any mental health issue, the lack of that follow-up support is quite problematic when people are searching for the right supports.

The Chair (Mr. Peter Tabuns): Mr. Nicholls.

Mr. Rick Nicholls: Thank you so much for coming in and sharing with us your thoughts and viewpoints on this.

A question that I have for you is, when it comes to mental health work issues and so on, do you currently use any tools that will assist in, first of all, helping to identify PTSD in an individual and/or triggers that may in fact create a flashback of horrific instances that an individual may be experiencing?

Ms. Uppala Chandrasekera: Absolutely. Our Mental Health Works program is specifically that. We come into workplaces and educate employers and employees around signs and symptoms of what PTSD and operational stressors can look like. We also examine depression and anxiety, and we provide tools and tips: How can you have the conversation? Where are supports available in your community to support individuals? Especially for employers, supervisors and managers, it's very difficult to have that conversation. We don't live in a society where we talk about mental health every day, so we support employers in having those conversations.

The Chair (Mr. Peter Tabuns): I'm sorry to say that you're out of time with the official opposition. We go to the third party: Ms. DiNovo?

Ms. Cheri DiNovo: Thank you for your presentation. Can I call you Uppala? I feel like I know you from your days in Parkdale.

Ms. Uppala Chandrasekera: Sure. Thank you.

Ms. Cheri DiNovo: I have a question about protocols, because part of the bill is going to be that the minister has the ability to ask employers for protocols post a critical incident, for example, with employees. I'm wondering if you have developed such protocols at the association and if those might be useful for employers.

Ms. Uppala Chandrasekera: That's a very good question. Through our Mental Health Works program, again, we teach people how to have these conversations. Debriefing after critical incidents is very important. As a clinician myself—I'm a trained social worker—any time an incident happens, you do need to sit down and talk about what's happened and then immediately provide support and assistance. As a manager, it's important that if you're about to have this conversation with your employee, you have resources ready in your back pocket so you know where to call, you know the number for your local CMHA, you know where to go to get help, so that you're not talking to the individual without having some solutions and support in your back pocket.

Mr. Joe Kim: Ms. DiNovo, if I could just add that a significant strength of our organization is the fact that we have 31 branches across the province and each of them brings a certain level of expertise to certain issues. Development of this protocol—we might not be aware of it at the Ontario divisional level, but these things could be happening at the local level and it's easy for us to canvass out to our branches to find out.

Ms. Cheri DiNovo: I also just wanted to make a comment on your inclusion of probation and parole officers, something that we're certainly planning on acting on, and also of course extending the 24-month period. I think you're dead on on that.

I think that's it for me.

The Chair (Mr. Peter Tabuns): Ms. French?

Ms. Jennifer K. French: To your point earlier about this bill, that you would recommend that it be expanded: Whether it is or it isn't, I think certainly mental health is not going to be something that we stop talking about.

Moving forward, you've talked about operational stress. There are a number of other workplaces and jobs out there that maybe don't fall under the first responder umbrella. What would you be willing to commit to the government in terms of partnership and helping guide the next chapter of supporting our workers across Ontario?

Ms. Uppala Chandrasekera: For sure, our Mental Health Works program is a nationally available program. It's available through our 31 branches in Ontario. We do have extensive partnerships with law enforcement individuals and legal professionals. For example, we're just about to embark on Mental Health Works training for legal professionals because we recognize that in that area, there's an increased risk of suicide and self-harm in that profession. We're here to help in any way that government would like us to.

The Chair (Mr. Peter Tabuns): And with that, I'm afraid we're out of time with this questioner. We go to the government: Ms. McGarry.

Mrs. Kathryn McGarry: Thank you very much for coming in today. I know, as a health care provider myself, I very much appreciate your focus on prevention of PTSD in the first place. I know that Ontario recognizes that preventing PTSD in the first place is going to be very important. Having supports to look after those individuals who do end up with PTSD is also important, but also our focus on education and awareness is going to help to decrease the stigma of this in the first place, so I appreciate that.

The proposed legislation requires employers to submit to the Ministry of Labour, on request, a PTSD prevention plan for the workplace. I was wondering what your thoughts are on amending the Ministry of Labour Act in this way.

Ms. Uppala Chandrasekera: We certainly support that. Again, I think having the conversation around mental health in the workplace is really important. Our branches also offer training called safeTALK. It's

suicide-prevention training. We'd really encourage employers to take that. It's really practical tools and tips to assist employees in the workplace.

Mr. Joe Kim: Further to that, I think once a year for that reach-out point is certainly welcome, but the way we envision workplace mental health is that that process should be continuous, not just confined to one in the year where you're reaching out to find out about if your members or your employees are living with certain mental health issues. This should be an ongoing conversation at the workplace.

Mrs. Kathryn McGarry: That's great. As I said, I know that you know how critical it is to do that early assessment with critical incident debriefing sessions as needed. Diagnosis and intervention can—early enough treatment will certainly help.

But I'm just wondering if there's anything else you'd like to make sure that this committee is aware of, given your background.

Ms. Uppala Chandrasekera: I think certainly tracking, like you suggested, if it's once a year but maybe more regularly because that's how you will know what the uptake is and what the need is in the population of workers. That way, you can track. If there's an increasing need, you can provide increased supports to those populations. So I think data is very important in this whole conversation.

Mrs. Kathryn McGarry: And do you have any suggestions on how that data could be shared? Each organization certainly will be aware of what their members face, but do you see that there's benefit in sharing some of those tools with other organizations to get a more consistent approach?

Ms. Uppala Chandrasekera: For sure. WSIB data is shared already, right? So you would, I think, add that to this. That way, you could track over time: Is there a decrease in the number of claims around PTSD, or is there an increase? That way, use that as a planning tool to provide support to the employers.

The Chair (Mr. Peter Tabuns): And with that, I'm afraid you're out of time. Thank you very much for your presentation today.

Ms. Uppala Chandrasekera: Thanks very much.

CUPE ONTARIO

The Chair (Mr. Peter Tabuns): Our next presenters are CUPE Ontario: Chris Day and Jeff Van Pelt. As you probably heard, you have up to 10 minutes to present. If you'd have a seat and then introduce yourselves for Hansard.

Mr. Jeff Van Pelt: Hello, and good afternoon. My name is Jeff Van Pelt. I come to you from Durham region. I am a paramedic of 20 years. I am the chair of the CUPE Ambulance Committee of Ontario. With us today is my vice-chair, Chris Day, who comes to you from Renfrew county. Unfortunately with regrets is our president Fred Hahn, president of CUPE Ontario.

We represent approximately 6,000 paramedics in the province, as well as a large portion of the communication officers. You know them as dispatchers in this province. While I don't presently actively have a diagnosis of PTSD myself, I recognize that there is a significant chance in my career or the career of my peers that they may experience these symptoms. Having this legislation go forward is, I would say, essential to protecting paramedics and the paramedic workers in this province.

Every day we come to work and we come to work with one goal in mind, and that is to help people. That's the nature of our jobs; it's the nature of our business. Some days we come into work; unfortunately, some days we don't go home. Some days we come to work and we are fortunate enough to go home, but we go home a different person than that who came to work that morning.

1420

This legislation will allow for paramedics who are feeling the symptoms of PTSD to seek treatment—to seek treatment so they can continue to work and have a good home life. For those who are presently off work or those who would be off work fighting the effects, or the demons, associated with PTSD and mental health illness, this legislation will allow for them to return to work sooner than they would presently. That's beneficial to not only our paramedics; it's beneficial to our employers and, I would say, critical to our families.

Most important, I hope, is that this legislation will allow people to fight the stigma—the stigma that is associated with a mental health illness—so that we will never lose another paramedic or first responder in this province going forward.

Bill 163, we say, is a sign of hope. It's a sign of hope for each and every paramedic in this province. Should this bill pass, it will send a message that somebody will always be there for our paramedics when they need help, as they have been there for many countless years in their careers.

I think we'd be remiss if we didn't also thank Cheri DiNovo of the NDP for starting us on this path. We hope this culminates in the passing of this bill. We believe that without Cheri DiNovo initially being a champion for this cause, we may not be here today.

To the PC leader, Patrick Brown, we wish to thank him as well. From his first day speaking from the chair, he spoke up about being responsible and about engaging our politicians and recognizing the need for this bill. At that time, we were talking about Bill 2.

To Minister Flynn and to Yasir Naqvi, paramedics from across the province thank you for putting this bill forward. This puts the health and safety of paramedics and first responders at the forefront.

One critical change we would like to see is a retroactivity period from 24 months to a minimum of five years. We see a lot of members falling through the cracks today. We'd hate to see this opportunity lost and losing members because we didn't go back far enough. We're so close to passing a crucial bill that does nothing but good things for paramedics in our communities. Let's take that next step and welcome this bill in together.

The Chair (Mr. Peter Tabuns): Thank you very much. Our first question, then, to the third party: Ms. DiNovo.

Ms. Cheri DiNovo: I want to take a bit of my time to just mention that Shannon Bertrand, who is a paramedic sitting back in the audience—not coming forward to testify to us—was the woman who first brought this to my attention eight years ago by walking into my constituency office. So I wanted to acknowledge that she's here and say thank you yet again.

You mentioned the five years plus, and we're certainly in accord with you on that. We think that that 24 months needs to be lengthened.

Thank you for everything you do for us all the time.

A question about family involvement: Again, this goes back to the protocols that are part of this bill, which the minister has said that he's waiting to see from employers. It strikes me that a lot of first responders may suck it up on the job but may be acting out and showing their symptoms at home with their family. I'm just wondering if you had some insight around that, how to involve families more in this.

Mr. Chris Day: Sure. Thank you very much for the question. One of the things that we have noticed is that lots of paramedics across the province, and first responders in general, feel that they are not able to properly have the tools to be able to give spousal supports—whether it's mom and dad, husband and wife, children—and let them have an avenue to get the assistance that they potentially need and the tools to help learn about looking for the signs.

It's one thing if my employer sends a package to me through my county email and says, "Here you go. These are the steps you need to do." But if I'm not proactive and take that home to my partner, then she's not going to have those tools to say, "You know what? Chris is not sleeping well. These nights he's waking up with night terrors and sweats. He's angry with the kids. What do I do? Who do I talk to?" Some of those tools aren't there, and I think it's something that we definitely need to bring forward and address.

The Chair (Mr. Peter Tabuns): Ms. French?

Ms. Jennifer K. French: Welcome. It's nice to see you.

You had mentioned that dispatchers are underneath your umbrella. We see in the "Application" section, (2)12, "Workers whose duties include dispatching the workers described in paragraphs 1 to 5." Is that language appropriate? Are there other members who need to be included—that their description might be something other than dispatcher? I'm thinking of 911 operators. What would the language need to be to be appropriate?

Mr. Jeff Van Pelt: It's a fantastic question. When we talk about dispatchers—in CUPE, we call them ambulance communication officers—first of all, we need to be clear that our dispatchers are recognized from every board, not just paramedic dispatchers. We're talking about police dispatchers and anybody in the health care industry. If you're asking me a pie-in-the-sky question, in a perfect world, anybody in the health care industry would be recognized under this legislation.

When we first put this legislation forward, we actually didn't include our ACOs; we missed them, regrettably. Those are our members, and we recognize that they need to be seen and heard because they are a critical part of that chain of survival.

Part of that chain of survival also includes the people who take the call for us to pick up the patients, to the people who are receiving these patients when we see them in the hospital. We have only a short time with them. Some people in the hospital, such as nurses and physicians, spend hours and days with them, and ultimately—pie in the sky—we'd like to see them as well.

The Chair (Mr. Peter Tabuns): I'm afraid that we've run through your time with the third party.

We'll go to the government. Mr. Anderson.

Mr. Granville Anderson: Thank you, Chris and Jeff, for being here. This resonates with me. I have a daughter who's a paramedic—she just started in January with York region—so this is a welcome bill for me as well.

As you know, there continues to be a great deal of stigma associated with PTSD. As a CUPE member who represents almost 6,000 paramedics all across Ontario, as you alluded to, I'm interested to know what initiatives you think should be taken to reduce the stigma among your members.

Mr. Jeff Van Pelt: Again, that's a terrific question.

One of the first things we've recognized is education. If you had asked me five years ago about PTSD, I would have said it's something that's associated with our soldiers. I wouldn't have thought it was something we had in our industry. Education means that when someone says, "That person is burnt-out"—well, "burnt-out" has a different connotation to it nowadays. I heard the other member talk about talking. The first thing we can do is talk to somebody. In this industry, we've always been taught to suck it up; you don't take the job home. That meant that sometimes our families didn't know what we were dealing with, so they wouldn't have the tools to deal with it. Our employers didn't have the tools, and that's through no fault of our employers, because how would they know what PTSD was? Again, if I'm a front-line worker and I don't know what it is, how could they be expected to know that? So, certainly, we have education as a large component.

We did like what we heard in the announcement about how there would be the web page and other ways of educating people. We hope that that's not just a web page. Again, not knowing what's coming, we can only put our faith out there.

I think, number one, we look at outside agencies that have had a lot of success in this, like the Tema Conter group. They are the people who really started raising awareness and, some people might say, arguably, the experts in the industry. They certainly know more than, say, Chris or I would know about this. That's a beginning. We can't be afraid to ask questions in this industry about what would be better, and we can't be afraid to try

things, because it's better that we try things and they don't work than do nothing at all and continue to see what has been going on, and that's losing our members.

Mr. Granville Anderson: Can you explain how those initiatives, along with this bill, would impact the profession? You alluded to the signs. What signs should a family member, such as a spouse etc., look for? And explain about being proactive. What do you mean?

Also, you mentioned going back five years. Could you explain where that number came from?

Mr. Jeff Van Pelt: Well, if you asked me—again, pie in the sky—I'd say go back indefinitely. I think sometimes when we come in and we're asked to give a solution, we have to give a definite solution. I'd say, can we go back to 1950? I would love that. Paramedics go back probably to the 1970s. In a perfect world, we would do that.

I missed the other part of that question; I'm sorry.

1430

Mr. Granville Anderson: Yes, okay. In the education piece, how would you go about, when family members or a spouse etc. are identifying the symptoms—

The Chair (Mr. Peter Tabuns): Mr. Anderson, I'm sorry to say that you've run out of time. We'll go to the opposition: Mrs. Martow?

Mrs. Gila Martow: Thank you for your presentation. We keep hearing stories of first responders and police officers who spend hours and hours in emergency rooms waiting to get patients admitted. It could be a physical problem, but very often it's mental health problems; very often, it's repeat mental health crisis management that's needed. I think that adds to the stress of the job, and that's my question to you: that it's not just dealing with what people consider to be stressful situations such as a car accident, where you see somebody in horrific pain or distress, but it's also the frustration and the stress of the actual job. Do you have any comments on that?

Mr. Jeff Van Pelt: What you're speaking about is offload delay. It's something that is relatively new in this industry. We've seen it getting worse and worse. It does cause us to be sitting for countless amounts of time—and some services are worse. In a community like Toronto, the 416, you may see some paramedics not even leave the hospital in that shift, which unfortunately means they're not out doing the important work that they do in the communities. Some of that is related to cutbacks in the mental health industry.

I think a lot of our problems as well are that we're not educated on how to treat people with mental health injuries, so if we don't recognize it ourselves, how can we treat someone who has it in the field? Mental health illness and mental health injuries are not something we are going to deal with on an emergency basis. We have a short-term plan and we have a long-term plan. The short-term plan for us is we get them to the appropriate facility, and sometimes, not every hospital has the appropriate conditions or the appropriate doctors there. So maybe part of the plan is we have the right people going to the right hospitals to see the right doctors.

Mr. Chris Day: I think a follow-up to that is—we have it in Renfrew county. I'm pretty sure the previous speakers could address this even better than I can, but we did a program called the LEAD program, which was a multi-agency, two-day training program where we were given the phone numbers for the acute mental health crisis team, and we carry them in our trucks.

If we're seeing somebody that's in a mental health crisis, we can call that. It's a pager system, and we can activate that team. Lots of times, we've been able to have them come right to the residence and then take over care there so that they, who are the experts—the mental health counsellors—can make the decisions of what is best for that client, especially if there is not an acute emergency health issue.

If it's strictly more of an acute mental health concern, they're able to manage that patient better than we are, and they can possibly bring that person to the right facility instead of an emerg room, which is, as you stated in your question—whether it's us or the OPP, for example, or city police then having to stay on duty until the transfer of care actually takes place, which is something that happens quite frequently.

Those programs are something that is definitely a tool that can be used, and I'm not sure if they're 100% utilized throughout the province.

The Chair (Mr. Peter Tabuns): I'm sorry to say, but with that, your time is up.

Mrs. Gila Martow: Perfect timing.

The Chair (Mr. Peter Tabuns): Very good. On to the next presenter.

Thank you very much, gentlemen.

ONTARIO PROVINCIAL POLICE ASSOCIATION

The Chair (Mr. Peter Tabuns): I have the Ontario Provincial Police Association: Rob Jamieson and Chris Hoffman. Good day.

Mr. Rob Jamieson: Good day, sir.

The Chair (Mr. Peter Tabuns): As you've heard, you have up to 10 minutes to present, and then there will be three minutes per caucus for questions. If you're about to run over time, I'll let you know. If you would introduce yourself for the purpose of Hansard, and take it away.

Mr. Rob Jamieson: I'm Rob Jamieson, president and CEO of the Ontario Provincial Police Association. Hello. Bonjour.

Mr. Chris Hoffman: Good afternoon. My name is Chris Hoffman. I'm the vice-president of the Ontario Provincial Police Association, or OPPA for short. I'm joined today by my OPPA president, Rob Jamieson. We would like to thank the committee for providing us with the opportunity to address one of the most important issues facing our members today: PTSD and first responders.

We applaud and thank all three parties, the Minister of Labour, Kevin Flynn, and the Minister of Community

Safety and Correctional Services, Yasir Naqvi, for supporting Bill 163. Additionally, our special thanks to the MPP for Parkdale–High Park, Cheri DiNovo. She has been a tireless advocate for presumptive legislation to address PTSD in first responders. Her effort to date has played a very large part in advancing this legislation to where we are today.

While the OPPA supports Bill 163 and deeply appreciates the intentions of the government to address this issue, we respectfully suggest that there are a couple of areas that require further strengthening to ensure that the bill properly addresses not only the needs of our members who currently serve in uniform, but those members who serve beside them in parallel civilian roles. Additionally and not to be forgotten are our retired members who served the citizens of this province for decades.

Take, for example, a call taker and dispatcher at the Smiths Falls provincial communication centre. At 5:50 a.m. on May 17, 2007, she received a call from a woman asking for help. Her husband was drunk and yelling at her. The call taker spoke to both parties and instructed the husband to wait outside of the residence. He didn't comply. With our member still on the phone, the husband grabbed a knife and began stabbing his wife. She listened helplessly as a woman on the other end of the phone was stabbed to death.

Bill 163 proposes that paragraph 12 of subsection 14(2) provide the presumptive component of the legislation to workers whose duties include dispatching the workers described in paragraphs 1 to 5. A person acting as a call taker on a particular shift is not functioning as a dispatcher on that day. However, they are trained dispatchers who rotate between the call-taking and dispatching roles.

Although we trust the wording contained in paragraph 12 of subsection 14(2) would cover our members regardless of whether they're speaking with the public in a call-taking role or dispatching resources in the dispatcher role, we would like to see this amended to read "communications operators whose duties include call taking, taking calls for service from the public and dispatching the workers described in paragraphs 1 to 5."

This amendment would also cover off any members who have just started in a provincial communications centre, as their training begins with call taking but does not proceed to dispatching responsibilities until later in their training.

While the government has identified the need to include our civilian members working in communications centres in this legislation, it would appear that a vast number of our civilian members who work directly alongside our uniformed members have been forgotten. Civilian members of the OPPA are unique in that they perform parallel roles and duties to those of our uniformed members or are integral team members who are exposed to the same traumatic stressors on a regular basis.

For example, many members who work in our forensic units are civilians. Imagine being called to the crime scene where the dispatcher we just spoke of listened to the victim being murdered. Your job now is to process that scene. You take samples of DNA. You take photographs and measurements. Then, in the days and weeks ahead, you find yourself simply unable to cope with what you've seen. The memories of that day—the sights, the smells—overwhelm you to a point where you cannot eat or sleep, let alone come into work.

The uniformed officer who attended that scene may be having the same issues, but will have the benefit of this presumptive legislation. The civilian member, who works side by side with that uniformed member, would be left to plead their case through an exhaustive WSIB process which would force him or her to relive the trauma that they're desperately seeking help for.

The violent crime linkage analysis system's unit, ViCLAS for short, is another example of civilian staff working with uniformed members. I don't have to tell you the horrors that members of this unit endure on a daily basis in the name of protecting our communities. Detachment administration clerks and civilian data entry clerks coordinate graphic evidence for violent offences and record interviews conducted with witnesses of violent crimes. Those in the behavioural sciences unit deal with the worst of the worst.

And then what of our special constables, including members of the offender transport unit, who are a key part of this province's correctional system and are exposed to the same issues as workers in correctional institutions? This oversight needs to be addressed. Civilians and special constables working side by side with our uniformed members must be identified and afforded the same protections under this legislation.

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This leads to another omission in Bill 163: our retired members of the OPPA and those previously denied a claim for workplace PTSD by the WSIB. We know now that first responders are at least twice as likely to suffer from PTSD as opposed to members of the general population. In addition, research data provided by the Tema Conter Memorial Trust shows that the rate of PTSD in police services is between 10% and 12%. Think about that for a second. The OPPA represents almost 13,000 active uniform, civilian and retired members. This means that we may very well have approximately 800 current and former members who are at this very moment suffering from injuries that are not easily seen.

We also know that PTSD can result from a single traumatic incident or from a culmination of years or even decades of exposure to traumatic stressors. This legislation before us essentially allows for eligible, active and recently retired members who have been diagnosed with PTSD to be covered.

We need to ask ourselves, was it any different for our members who retired in the 1980s, the 1990s or even in the early 2000s? For our current members, is it really any different from being diagnosed with PTSD five, 10 or 15 years ago? It was further complicated with the stressors of a denied WSIB claim than it is for a member who was

diagnosed in the last 24 months. I submit that the traumas experienced by our members have not changed in the 61-year history of the OPPA and that to presume that PTSD in our members occurred while performing their duties is logical.

To make retired members go through the process of trying to prove to the WSIB that it was work-related is nothing short of a slap in the face to those who have spent, in some cases, decades serving and protecting their communities. PTSD is often suppressed, only to resurface later, with traumatic results. These members are no less deserving of our help.

To that end, we propose the insertion of wording into the legislation that would deduce that PTSD in all eligible uniformed and civilian police service employees, whether active or retired, arose from the performance of their duties. In addition, we'd recommend that section 14(9), "No refiling of claims," be deleted from this bill. This would allow our members who suffer with PTSD access to adequate resources under the new presumption. The amendments we're requesting will ensure that all at-risk current and former police personnel are afforded protections under this act.

In closing our submission, we'd like to note that it's our collective responsibility to act accordingly and work together to eradicate the stigma around PTSD and mental illness and policing without prejudice.

Again, thank you for this opportunity today.

The Chair (Mr. Peter Tabuns): Thank you for your presentation. We go first to the government: Mr. Colle.

Mr. Mike Colle: Thank you. I was just wondering: What is your association doing to reduce the stigma around PTSD?

Mr. Chris Hoffman: Our association has been actively involved with the OPP since 2012 and the release of the Ombudsman's report. We have one of our board members working hand in hand with the OPP Wellness Unit on programs to coordinate training and initiatives throughout the membership.

Mr. Mike Colle: How does the—

The Chair (Mr. Peter Tabuns): Mr. Colle, could you come closer to the microphone? We're not getting you the way we want on Hansard.

Mr. Mike Colle: Oh, sorry. How does the regular front-line officer get any information about strategies to remove the stigma? How are they included in this?

Mr. Chris Hoffman: One of the initiatives that has recently been undertaken by the OPP is the introduction of Road to Mental Readiness. Last year the OPP introduced this program, an eight-hour training program, to all managers within the OPP. In 2016 the OPP will be training all employees, uniform and civilian, in a four-hour Road to Mental Readiness program; it's an awareness tool.

Mr. Mike Colle: But up until now, there hasn't been any front-line—does that take more money or just a refocusing? What has to be done?

Mr. Chris Hoffman: Essentially, the resources have existed for some period of time. Employee assistance programs have been around; critical incident support units have been around—especially in policing—for several years. I look back early in my career; they've been around for 30 years in different forms. They have evolved over the years.

Any time a member is involved in a critical incident, the critical incident support unit is activated. All members have access and are made aware of the employee assistance programs that are available through the OPP and are actively encouraged to access those resources when they experience any of the issues or a critical incident that they're involved in.

Mr. Mike Colle: I guess what I'm trying to get at is this: The OPP are just like a reflection of society in general, but you're in the front lines. Not enough of us really understand the reality of this kind of trauma and how we deal with it as human beings to make sure that our fellow human beings get the attention and the sensitivity they need.

Mr. Rob Jamieson: I'm going to jump in, if I could, on that. Absolutely. I think it comes down to leadership and our association getting out in front, along with other first responder associations as well, addressing this head-on and being leaders within our communities to say, "Hey, listen. There's an issue here." Working with governments as well to bring forward the legislation and supporting that and to truly—

The Chair (Mr. Peter Tabuns): I'm sorry to say that we've run out of time with this questioner. We have to go to the official opposition. They may ask you to continue your thought. Mr. Nicholls?

Mr. Rick Nicholls: Thank you very much, Chair. Chris and Rob, thanks so much. It's good to have you here and to hear your reasons why we need to expand this particular bill.

One of the things that I've noticed—and I guess we've had some discussion on this in the past—is that you can't really write the script for a first responder. They can tell you what the duties and responsibilities are, but until you experience that very first incident, you really never know just what physical, emotional and mental impact that can have.

Chris, we could even talk about September 3, 1999, on Highway 401 at Essex County Road 15 and the impact, because you and I were both there: you as a first responder and me as being part of that accident. It's something I'll never forget.

With that, I looked at it, and I think that when it comes to, especially with your officers—again, I raised this question earlier about tools. For me, tools can be designed profile tools for police officers specifically that will assist in the determination of the effects that PTSD is having on one of your first responders, whether it be an officer or a special constable or even others. You had mentioned earlier your behavioural science unit as well. Are you looking at different ways of having a more specifically designed profile?

Mr. Chris Hoffman: Yes, there are a number of initiatives being undertaken. I had previously mentioned

Road to Mental Readiness, which is being offered to all employees within the OPP. It's actually expanding to the majority of police services across Ontario as well as the Ontario Police College, where that program has been introduced in recruit-level training.

The OPP Wellness Unit is also working on different applications, so to speak, to assist members in evaluating their mental health and wellness and being able to monitor that on an individual basis.

It's a continually evolving area of education. The biggest thing that we're doing now is talking about it. Simply having the conversation around the table that mental health exists in policing in our sector is the first step. Whatever we do, the biggest piece that we can do is create the awareness that it's out there and make individuals aware of the tools and access to care that's available to them.

The Chair (Mr. Peter Tabuns): With that, I'm afraid we have to go to the third party. Ms. DiNovo?

Ms. Cheri DiNovo: Thank you, Mr. Chair, and thank you so much for all that you do and for coming forward today, too.

We hear you about retired members. We absolutely agree with that. Particularly, those who were previously denied a claim or were prevented from refiling a claim: This goes to the hub of a real problem, I think, because in just about every case that I have in my office, from eight years going back, that's their situation. So we would be saying no in a sense to all of the folk whose stories we've been reading out in debate in the House if we were to say no to those who have already filed a claim and been denied. I think, again, that we really, really need that, so thank you for that.

I know Jen wanted to say something too.

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The Chair (Mr. Peter Tabuns): Ms. French?

Ms. Jennifer K. French: I'll echo that: Thank you for coming in and thank you for the work that you've been doing on this. I think that between now and when this bill takes its final shape, we need to push the government considerably on this issue.

I think that perhaps—and the Liberal members can correct me if I'm wrong—there is an understanding that if someone has a new diagnosis, even if it's an existing condition, that somehow qualifies them. We need to see the solution in writing, so that there is no guesswork and so that for anyone who has a PTSD diagnosis on this list of those who would be covered, it does need to be presumptive coverage. So let's work and let's push, please.

We understand the need for this to be presumptive coverage. I know that the member opposite, Mr. Colle, in his remarks on the day it was introduced, called having to prove that it resulted from the workplace "like the Inquisition." Can you speak to that process? Because if your retired members, your special constables and your civilians are not covered—they're eligible through WSIB, but what does that process look like? Why does it have to be presumptive for them?

Mr. Chris Hoffman: Currently, a number of the members who have gone through or are in the process of going through the WSIB process—it's long and cumbersome. The access to a lot of the information for these individuals, who are off work most times—they don't have the access to the internal reports and access to notes on their past history that the employers retain on their behalf, so providing that information as a request to WSIB is often cumbersome.

The questions and the interviews through the WSIB process begin to reopen fresh wounds, and many times cause the majority of these individuals simply to not respond, which becomes further problematic in their process because it delays the claim.

Just recently a member was requested to send further information on a WSIB claim that had been approved and is now being re-evaluated. For this member, the simple receipt of a letter from WSIB asking him to provide additional information that had already been provided reopened that wound to a point where that member said he didn't know, if he had to go through this again, whether he would continue on living. And—

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say that we're out of time.

Mr. Chris Hoffman: Thank you.

The Chair (Mr. Peter Tabuns): Thank you very much.

Mr. Rob Jamieson: Thank you very much. Nice to see you.

MR. SCOTT McINTYRE

The Chair (Mr. Peter Tabuns): Our next presenter is Scott McIntyre. Mr. McIntyre, sir, as you've seen, you have up to 10 minutes to present and then it's three minutes per caucus. If you'd introduce yourself for Hansard.

Mr. Scott McIntyre: I'm Scott McIntyre of the Ontario Ministry of Community Safety and Correctional Services, Probation and Parole.

Good afternoon, committee members, ladies and gentlemen. Again, my name is Scott McIntyre and I'm a probation and parole officer with the Ministry of Community Safety and Correctional Services. I'm also the Ministry of Community Safety and Correctional Services' provincial probation and parole health and safety worker rep. As such, I represent approximately 865 dedicated and professional adult probation and parole officers in Ontario.

I've been a correctional worker for over 25 years. For the first five years, I was a correctional officer at the Mimico Correctional Centre, which is now the Toronto South Detention Centre. For the following 21 years, I've been working as a probation and parole officer, living and working out of the North Bay office.

I'd like to thank you for allowing me to speak on amendments to Bill 163. As currently written, the bill is inclusive of first responders, such as police officers, firefighters and paramedics. It also covers correctional workers who supervise inmates in correctional institutions. Unfortunately, Bill 163 excludes probation and parole officers in its present state.

In Manitoba, Bill 35, the Workers Compensation Amendment Act, identifies post-traumatic stress disorder as "an occupational disease for presumptive workers compensation coverage" for a number of front-line workers, including probation and parole officers.

Probation and parole officers, also known as PPOs, are subjected to primary and secondary as well as vicarious trauma, all of which can and do result in symptoms associated with PTSD. Probation and parole officers are designated peace officers under Ontario legislation and, as such, they are responsible for protecting the public by managing offenders sentenced to serve their criminal sentence in the community. Probation and parole officers monitor offenders bound by probation orders, conditional sentence orders and parole certificates.

A PPO may supervise any one offender for years, three years being the maximum sentence that a single offender can be bound by a probation term. Probation and parole officers establish very close professional relationships with the offenders they supervise. They do their best to influence positive changes in their offenders' attitudes in order to bring about more positive and productive pro-social behaviours in those clients.

PPOs are exposed to crisis situations and traumatic events during the course of their work and in the execution of their duties. Examples of such trauma include assaults and threats on probation and parole officers made by offenders, offenders' family members and their friends, and suicides by offenders whom probation and parole officers closely supervise and work with in their attempts to rehabilitate. This includes receiving phone calls from suicidal offenders. Traumatic events such as sexual assaults, child sexual abuse cases and domestic violence are yet other examples.

One specific example that came to my attention in my capacity as the provincial health and safety worker rep for PPOs was in the fall of 2013, when a probation and parole officer at the Newmarket office was interviewing an offender under her supervision. Suddenly, the offender brandished a large knife in a probation office and began cutting himself with it, all the while telling her that he was going to kill himself right in front of her. Obviously, this was a very dramatic and traumatic event for not only her but the other staff in that office.

JOPIS is the justice officials protection and investigations section, which is a small 16-person unit in the Ontario Provincial Police whose mandate is to ensure the safety and security of justice officials. The correctional services incidents, as reported by JOPIS, in the six-year period 2009 to 2014, are assaults, threats, harassment and intimidation of correctional employees. In 2009, when they started collecting this information, there were only four incidents. Six years later, it skyrocketed to 114. That's a 2,750% increase in the number of incidents involving assaults, threats, harassment and intimidation of corrections employees during that six-year period.

In my written submission, I've referenced a large number of studies, reports and documents, some of which I've provided copies of for the committee. The studies are clear that probation and parole officers are subjected to trauma that can and does result in a diagnosis of PTSD. For that reason and on behalf of the hundreds of hard-working, dedicated and professional probation and parole officers, I respectfully request on behalf of my members that Bill 163 be amended to include probation and parole officers. Further, I would ask that the committee also consider amending Bill 163 to permit PTSD diagnosis by a medical practitioner, a psychologist or a psychiatrist. This would take into account officers who live in remote areas, particularly northern Ontario, where access to a family doctor can be very difficult. Getting access to a psychiatrist would be even more difficult, seeing as you have to be referred by a family doctor. Further, as Ontario public service employees, our benefits plan does not cover the services of a psychologist.

As you're aware, the DSM-5 diagnostic criteria identify the triggers for PTSD as exposure to actual or threatened death, serious injury or sexual violation. It must result from one or more of the following scenarios: directly experiences traumatic event, which would be primary; witnesses a traumatic event, which would also be primary; learns a traumatic event happened to either a close family member or friend, which would be secondary; and, most importantly, experiences first-hand and repeated or extreme exposure to aversive details of a traumatic event. As probation officers, we continually hear from our clients, from our offenders and the victims of traumatic events. That definition in the DSM-5, we submit, falls within the parameters of our duties.

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With the remaining time that I have, I just want to draw the committee's attention to a more recent study by Kirsten R. Lewis. She's a leading trauma researcher. She's also a veteran US probation and parole officer. In 2013, she attended the Probation Officers Association of Ontario symposium, where there were 156 full-time probation and parole officers employed by the Ministry of Community Safety and Correctional Services, representing approximately 20% of our membership.

During that symposium, she had the participants complete trauma surveys for the purpose of identifying their frequency of exposure to direct and indirect trauma. I'll share with you a few of the findings: 10% of those 156 probation and parole officers reported having been assaulted while on the job; 69% of those PPOs have been threatened on the job; 19% have received death threats on the job. In addition to that, 27% supervised offenders who had killed someone during their period of supervision; 61% had supervised an offender who had recidivated or re-offended against a young child; 69% reported having supervised offenders who, during the period of supervision, sexually recidivated; 61% reported having supervised an offender who committed suicide while under their supervision.

In conclusion, PPOs most certainly experience trauma that can and does result in PTSD and, as such, it is our respectful submission that PPOs be included in Bill 163.

I'll conclude my presentation and thank you. I'll be happy to take your questions.

The Chair (Mr. Peter Tabuns): Thank you, Mr. McIntyre. We go first to the official opposition: Ms. Martow and then Mr. Coe.

Mrs. Gila Martow: Thank you very much for your presentation and for joining us today.

This past year, a gentleman on probation—I think it was in Renfrew–Nipissing–Pembroke, John Yakabuski's riding—killed three women while he was on probation. In my mind, he was supposed to be attending anger management classes, but the probation officer unfortunately can't enforce him going to anger management classes, which I find very peculiar.

What could you make in terms of suggestions to alleviate some of the stress of the job of a probation officer, not just in that specific case? I think that by not ensuring that people on probation get the treatment they need, that is adding to the stress of the probation officer.

Mr. Scott McIntyre: Thank you for the question.

We have a committee called the peer mentorship committee. It's something that I actually co-chair. That exact issue is being raised at that committee. There need to be support groups. We're advocating for trauma counsellors to be included in our employee assistance program, our EAP, which they're currently not. They primarily have a master's degree in social work. When we do go and enact our EAP benefits, a lot of times we're not getting the proper treatment that we need.

The Chair (Mr. Peter Tabuns): Mr. Coe?

Mr. Lorne Coe: Thank you, Mr. Chair, and through you, thank you very much for your presentation. It was excellent.

Can you speak a little bit about the type of work you're doing? You mentioned the peer mentorship committee. To what extent do you take into account families?

Mr. Scott McIntyre: The families of probation and parole officers?

Mr. Lorne Coe: Yes.

Mr. Scott McIntyre: There are two committees: There's the peer mentorship, as well as the occupational stress injury committee. They're independent, but they're working toward the same goal of mental health.

We have not focused on a support program for the families. We recognize that the impacts of PTSD and trauma are equally impactful on them, as well. It's a work in progress.

Mr. Lorne Coe: So going forward—you just mentioned that you anticipate putting in place trauma counsellors—do you think that you'll be able to help some of the families who are experiencing PTSD, as well?

Mr. Scott McIntyre: The employee assistance program is also available to family members, so with the proper clinicians or professionals, that would be the primary avenue.

Mr. Lorne Coe: Thank you, Mr. Chair.

The Chair (Mr. Peter Tabuns): Mr. Nicholls, did you want to ask a brief question?

Mr. Rick Nicholls: Well, no. I'll defer. We've covered it. It's fine. Thanks.

The Chair (Mr. Peter Tabuns): Okay. Thank you very much.

I'll go to the third party, then: Ms. French.

Ms. Jennifer K. French: Thank you very much for coming in. That was a very comprehensive presentation. You mentioned that you have submitted copies of that.

Mr. Scott McIntyre: I have them with me.

Ms. Jennifer K. French: Okay. I'd like one. Thank you very much for the in-depth information. You referenced Manitoba and the presumptive legislation that probation and parole officers would be covered under as front-line workers. Interestingly, as this government was crafting this piece of legislation, they had both Manitoba and Alberta to look at. Alberta also includes peace officers, but in this case they've chosen to leave you out of this. Hopefully we can remedy that.

JOPIS: The statistics that you have are huge numbers in terms of the increase of assaults and whatnot. Who's keeping track of statistics when it comes to our probation and parole officers in Ontario?

Mr. Scott McIntyre: We have a statistics department with the Ministry of Community Safety and Correctional Services, and it is that department that gave the occupational stress injury committee those statistics.

Ms. Jennifer K. French: Okay. So the employer is keeping track of the number?

Mr. Scott McIntyre: Yes.

Ms. Jennifer K. French: Good. Also, I'd like to thank you for bringing to the attention of the committee the challenges of our northern neighbours in terms of accessing health care. Perhaps that's something that we should all take away, the accessing, whether it's a medical practitioner or how you can achieve the diagnosis in the first place, but also having that part of the process be covered in terms of your benefits.

I did have questions—not just to talk at you. Was there anything else that you would like to add—oh, yes, the trauma researcher that you had referenced, Kirsten?

Mr. Scott McIntyre: Lewis, yes.

Ms. Jennifer K. French: Okay. Those are American statistics or—

Mr. Scott McIntyre: No. It's an American probation and parole officer. She has authored and co-authored a number of studies and articles relating to anxiety and trauma specific to probation and parole officers. She came up to Ontario and made a presentation, followed by a survey with the Probation Officers Association of Ontario.

Ms. Jennifer K. French: Scott, what do you think it would look like if the government does not choose to include probation and parole officers under this piece of legislation? What needs to happen next?

Mr. Scott McIntyre: Well, it would be a double message. We want to provide services and benefits to those who are crisis workers—if you want to call it that—be it front-line workers or what have you. To exclude probation and parole officers I think would damage our profession. We take great pride in the work that we do and the services we provide not only to the public

through public safety but also to our clientele in rehabilitating them. I think it would really damage our relationship with the government. We wouldn't stop advocating for it.

The Chair (Mr. Peter Tabuns): Mr. McIntyre, I'm sorry to say you're out of time with the third party.

I go to the government: Mr. Colle.

Mr. Mike Colle: Thank you, Mr. McIntyre, for your presentation.

I think a lot of us and a lot of the population of Ontario probably never has an opportunity to listen first-hand about the work that front-line parole and probation officers do, so I thank you for doing this. Generally speaking, we only hear about probation and parole officers once there's some incident where somebody falls through the cracks or something happens.

In this case here, the astonishing thing is, you mention this dramatic increase in these instances of violence. What do you attribute that to?

Mr. Scott McIntyre: That's a great question. I thank you for it. Over the last 10 years, we've seen a trend where crime in and of itself has gone down, but the statistics show that the severity of violence in the crimes is going up. We also have statistics to support that the number of clients who are afflicted with mental health ailments is also going up. But we're averaging better than one to two incidents involving threats against probation officers, weapons being brought into our offices by these offenders. And it's not just the mental health; it's not just those under our supervision who are there on level 1 offences, violent offences. It's often low to medium offenders.

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I think that there's an element of frustration within our offender population with the lack of time that the probation officers have to dedicate to them. We obviously have workload issues that contribute to a certain extent.

Mr. Mike Colle: Is it workload because there are more people given suspended sentences? What is causing that bigger workload?

Mr. Scott McIntyre: The impact on workload and the amount of time that we can dedicate—and obviously, we prioritize who we dedicate more time to. Gone are the days of the little old lady shoplifter. Most of our offenders—I would say over 60%—are streamed high risk.

We have large administrative tasks, such as psychometric testing on all sex offenders and ODARA testing, which is a domestic violence tool that we've adopted from the OPP in determining risk. We now are mandated to provide victim services, whereas 10 years ago, we never did that. So for every domestic violence offender we get, we get two clients: We get the offender plus the victim as well.

Psychometric testing, enhanced risk assessment testing, ODARA testing: There are only so many hours in a day. It's all paper-generated—beautiful reports, but, in fact, the actual time we sit down to engage and actively work with our clients—and by the way, it's in the office; it's not in the community. Community corrections is not in the community. We're a community-based service, but we work out of an office. We're not in the offenders' homes. We're not in the offenders' neighbourhoods.

The Chair (Mr. Peter Tabuns): I'm sorry to say that, with that, we're out of time. We have to go to the next witness. Thank you very much for your presentation.

POLICE ASSOCIATION OF ONTARIO

The Chair (Mr. Peter Tabuns): We now have the Police Association of Ontario: Mr. Bruce Chapman and Michael Duffy. Good afternoon, gentlemen. As you've heard, you have up to 10 minutes to present, and then there will be three minutes per party for questions. When you've settled in, if you could introduce yourselves for Hansard, and then it's all yours.

Mr. Bruce Chapman: Good afternoon. My name is Bruce Chapman. I'm the president of the Police Association of Ontario. With me is Michael Duffy, our research and policy counsel. Thank you for having us here today to speak on this important bill, the Supporting Ontario's First Responders Act.

Post-traumatic stress affects every member of a police service. Every officer has faced a situation that stays with them and affects them in some way. A number of years ago, an Ontario police officer responded to reports of a motor vehicle accident. Arriving at the scene, the officer found an 18-year-old female in critical condition. While waiting for the ambulance to come, the officer stayed by her side, holding her in his arms until she died—before they could make it to the hospital. That officer will never forget walking into her parents' office to tell them about the accident and that their daughter had passed away. That officer will never forget the sweater that she wore and her last breaths. That officer will also never forget the comfort that he was able to give to her while she was trapped inside that car while they waited for other first responders to arrive.

I was, and I am, that officer. I am just one of the over 73,000 first responders in Ontario who are at risk of developing post-traumatic stress disorder at two times the rate of the general population. One in five responders will develop PTSD during the course of their career. The tools, services and support that they have when they need it most can mean the difference between life and death.

According to the Tema Conter Memorial Trust, since 2015, 50 first responders across Canada have committed suicide. In 2016 alone, 11 first responders have also taken their lives. Time and time again, police officers are there when Ontarians need them the most. It is great to see Ontario's elected representatives stand up for the police officers who put themselves in harm's way every day.

The Supporting Ontario's First Responders Act is a significant measure to help officers affected by post-traumatic stress disorder. The bill supports those whose duty and mission it is to protect those in need.

The Police Association of Ontario fully supports this bill. With this being said, I respectfully submit to the

committee that some amendments to the bill be considered.

In addition to the creation of the presumption of coverage for our officers, the bill should also create a duty on the board to provide or assist in obtaining care from a culturally competent clinician.

The PAO also supports the creation of an exception to the six-month limitation periods in cases of PTSD whereby patients would have up to five years from the date a diagnosis is learned to file a claim for benefits, or an option to apply for a waiver of the six-month limitation period upon, or following, the submission of a late claim.

Most vitally, the bill should recognize the essential civilian members of our organizations, like the special constables, communicator-call takers, investigative support staff, forensics staff and the garage personnel who work diligently to support our sworn officers and so, too, bear the trauma and witness the tragedy that first responders see and deal with every day. Our civilian members deserve the same treatment and care when they are suffering from PTSD. We cannot, as an organization that values its members, only protect some and leave others vulnerable.

Financially, this makes sense. The cost of untreated or underdiagnosed mental illness is a significant burden on Ontario's economy. Those who do not receive prompt treatment are at greater risk of acquiring chronic, publicly funded care throughout their lives. Additionally, first responders who remain on the job are less efficient and absent more often. By creating a measured and comprehensive system to address PTSD-induced work performance issues, we can bring our first responders back to work quicker, safer and healthier than we ever have before.

I have been deeply encouraged seeing this bill unite Ontario's elected members and ministers. In particular, I'd like to thank MPP Cheri DiNovo; the Minister of Labour, Kevin Flynn; the Minister of Community Safety and Correctional Services, Yasir Naqvi; and MPP Rick Nicholls for their tireless efforts and advocacy.

To the leaders of the parties here at Queen's Park—Premier Wynne, Patrick Brown and Andrea Horwath—thank you for making the mental health of first responders a priority in this Legislature.

The benefits of working together, along with firefighters, paramedics and corrections services, only heighten the good that this bill can do for front-line officers and police services over time.

Across Canada, other provinces have taken important steps towards dealing with the prevalence of PTSD within the first responder community. In Alberta, where similar reforms were passed in 2012, then-opposition member and now-Premier Rachel Notley noted that for persons seeking to make a claim, it's a huge hill to climb, because, of course, every injury that the person is suffering goes to the very heart of their ability to advocate for themselves, and nine out of 10 times, they don't advocate for themselves.

In British Columbia, where the media is reporting that PTSD rates among first responders are at crisis levels, representatives are pressing for action to create a presumption of coverage for first responders.

It is the Police Association of Ontario's position that Ontario has the opportunity to take a leadership role amongst Canadian governments and proclaim its support of both persons suffering from mental illness and those who serve the community and thereby expose themselves to greater risk.

Over the last decades, we've had success tackling and dismantling the stigma that surrounds post-traumatic stress disorder within the police community and society at large. We've learned that suffering from PTSD isn't a sign of weakness; it's an injury like any other in the line of duty, except it's not always visible and it doesn't heal so easily.

We're developing training and education, working with the families of those with PTSD to make sure that they have the tools and knowledge to address its effects at home, as well as peer support systems to ensure that our officers have the support they need from their own organizations.

1520

Some of you here today may have family members and friends who are first responders. Some of you, as well as your family and friends, have relied on and received emergency services care from our province's first responders. I encourage you to consider the amendments that I have mentioned today.

Passing Bill 163 will ensure that our first responders continue to help those in need by making sure that those suffering from PTSD receive the support and treatment to come back healthy and ready to make a difference in someone's life again. Please help make a difference in their life with these amendments and your vote.

The Chair (Mr. Peter Tabuns): Thank you very much for that presentation. We go to the third party: Mr. Gates.

Mr. Wayne Gates: Hi. How are you? Thanks for coming in today.

I've been here for a while. I've listened to the Ontario Provincial Police Association; I've listened to your association as well. Both have talked about the importance of doing amendments.

This is a bill that my colleague Cheri DiNovo has fought for for eight years, and everybody is pulling together on this. But it seems to me that when we're talking about retirees and we're talking about different classifications in work that are also affected by this, I would like—I know we're going to be hearing from nurses tomorrow, who obviously are exposed to this same type of stuff. I'm just wondering: Would your association understand that maybe we just need a little more time to get this right, to make sure that all classifications, all workers in the province of Ontario that are faced with PTSD, get it? I'm just wondering. My position is, let's get it right. If it takes a couple of extra weeks to get it right, let's get it right. Let's make sure that everybody

who needs to be covered in this bill should be covered in this bill. I don't think retirees should have to fight with the WSIB to be covered as well. I'd just like to hear your thoughts on that.

Mr. Bruce Chapman: Thank you, sir. Our position is that this bill is long, long overdue. We've heard in the House how long Ms. DiNovo has fought, the different bills that have been brought to government. We finally have the opportunity to pass a bill. The sooner the bill is passed, the sooner our members get help.

Our position is, we would like this bill passed as soon as possible. We would like all those included that can be included. We will continue to advocate on behalf of our members who work side by side with those who are included in the bill currently. But we need to get help for our members now. The longer the bill takes, the chances of them going through a process and not being approved or being denied and therefore not being eligible for the presumptive legislation are urgent for our members.

The Chair (Mr. Peter Tabuns): Ms. DiNovo?

Ms. Cheri DiNovo: Thank you for everything you do, Bruce, and hi, Michael. Thanks for appearing before us today.

I thought one of your suggestions about obtaining care—what did you say? A little bit more about WSIB and obtaining care from a competent professional—you raised that early on. A "culturally competent clinician" were the words you used—but say a bit more about that.

Mr. Bruce Chapman: What that refers to is, in Alberta, the board has a duty and responsibility to assist the member to get competent care from a clinician to be able to get that. We talked about our north and the lack of access to competent, trained professionals to deal with post-traumatic stress disorder and mental illness generally. This would be a requirement. It would assist the members to get help sooner and quicker.

Ms. Cheri DiNovo: Thank you.

The Chair (Mr. Peter Tabuns): Ms. French.

Ms. Jennifer K. French: I appreciated your list of amendments, and thank you for laying them out. I think we appreciate all of them and are on the same page.

One of the things that you didn't mention but we've heard from others is the issue of previously denied claims. Do you have thoughts on that and what you might like to see in terms of that for your members?

Mr. Bruce Chapman: We would like those who have been previously denied the opportunity to have the presumption applied to them. Those who suffer from post-traumatic stress deal with it in very different manners. Some are very open and are able to talk about it and discuss it, with the former fear of the stigma that was attached to it, but still are strong enough to be able to come out and go through the process and then have to relive that—

The Chair (Mr. Peter Tabuns): I'm sorry to say, but you've run out of time with the third party. I have to go to the government. Ms. McGarry.

Mrs. Kathryn McGarry: Thank you very much for your presentation this afternoon. In my past work as a critical care health professional, I can certainly understand the vital work that you and your members do, and I want to thank you, given this opportunity, for the work you do. I really do understand why first responders are more than twice as likely to develop symptoms of PTSD, so again, I thank you for being here today.

I also understand that the PAO has a prevention and resiliency program, and you're really considered leaders in this particular area. In saying that, I know that the Road to Mental Readiness program is being delivered through the Ontario Police College as well as a number of other police services throughout the province and that this program aims to increase resiliency and to reduce stigma. Do you have any thoughts that you might share with the committee about this program and its rollout?

Mr. Bruce Chapman: The Road to Mental Readiness is a 30-year program; it's not a one-time training program. The Road to Mental Readiness starts at the Ontario Police College. It goes to the individual police services as well. On their introduction to policing with their families, they get the basic components of what they will face, and the family members will get to know what those members could face when they leave to go to work every day and how they're going to change when they come home, leaving their uniforms at work at the end of a day. It also identifies peer support and supervisor support. It's the responsibility of everybody in the organization to see it, identify it and assist those members who deal with a traumatic event every day that they're employed.

Critical debriefs are essential as well. Although it's not part of the Road to Mental Readiness, it is a vital component that most police services and soon all police services will be doing as part of the prevention and resilience component. Those officers and civilian personnel are immediately debriefed on how they feel and what they went through. Any of those who need help will get it immediately. Some may not need it for a couple of days, until, I guess, the incident has sunk in.

Mrs. Kathryn McGarry: Is a legislative presumption an appropriate method by which to improve the timeliness and consistency of adjudication in respect of claims that are based on PTSD?

Mr. Bruce Chapman: We believe it is. The officers or those members do not have to relive the events. They get the presumption so that they can get the help. The sooner we get our members the help, the sooner we can get them back on the road to being healthy members of our community.

Mrs. Kathryn McGarry: So you think that this approach would help to get the individual through the claims process faster and to the treatment faster?

Mr. Bruce Chapman: Absolutely, and without setting them back by having to relive the event or events that they've gone through, yes.

The Chair (Mr. Peter Tabuns): I'm sorry. With that, you're out of time.

Mrs. Kathryn McGarry: That's all you ever say, Chair, but thank you.

The Chair (Mr. Peter Tabuns): I'm sorry to cut you all off. We go to the official opposition. Mr. Nicholls.

Mr. Rick Nicholls: Thank you very much, Bruce. It's nice to see you again. Thanks very much for your presentation.

A couple of quick things here: One of the things you had talked about was that the cost of untreated or undiagnosed mental illness is a significant burden on Ontario's economy. One of the things that I noticed in this bill that has been brought forward is the fact that there has been no mention of the Ontario government's assistance to—because I assume that municipalities will be bearing, perhaps, the burden of this thing. That's a concern that I have: that this government didn't bring forth any recommendations. Do you care to address or comment on that?

Mr. Bruce Chapman: What I can address is that spending $1 today by either municipalities or the government will save $10 in the future. The sooner we can get help for the members and invest financially into their well-being now, we'll get that six times back at the end instead of not having the resources to pay for it. We look forward to the passing of the bill and to working with both municipalities and the government on the funding formula for it.

Mr. Rick Nicholls: I also noticed, Bruce, that when you were sharing that story at the very beginning and that you were that officer—not to relive it, but what advice are you giving to members who perhaps have experienced post-traumatic stress disorder and are going through things that you, yourself, could probably personally relate to?

Mr. Bruce Chapman: Times have changed, and that's removing the stigma. It was a weakness back then, or considered a weakness. You were a weak first responder by having issues with what you saw and what happened.

1530

By us sharing these stories, Chris's story earlier, my story and a number of other first responders, that we're okay, we're healthy, we're active members of our community, we got through it—some need some extra help to get through it, and this bill will allow them to get that help earlier so that they don't have to sleep with the lights on for three nights till they can get the face of that young woman off your mind when you go to bed at night.

Mr. Rick Nicholls: I understand. Do you have a question, Lorne?

Mr. Lorne Coe: No, it's fine.

Mr. Rick Nicholls: Do we still have time, Chair?

The Chair (Mr. Peter Tabuns): You have 40 seconds.

Mr. Rick Nicholls: Forty seconds? Boy, I can't even say my name in 40 seconds.

The other thing that I want to commend you on—I know that we've had some quick discussion on it, and I've talked earlier with other presenters with regard to profiles. I'm a big believer in profiles, but a specifically designed police profile, so to speak, that will assist and guide. Have you had any further advancements in your research or in your discovery, something that's more police-specific?

Mr. Bruce Chapman: We're working with experts in the field of post-traumatic stress for identifiers in how to be able to assist our members and what tools we need to assist them. It's vital and important for our members as well.

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say, Mr. Nicholls, 40 seconds goes very fast.

Mr. Rick Nicholls: It does.

The Chair (Mr. Peter Tabuns): Thank you very much for that presentation today.

Mr. Bruce Chapman: Thanks very much, everyone.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Chair (Mr. Peter Tabuns): Our next presenter, then, is the Association of Municipalities of Ontario: Mr. Gary McNamara. As you may well have heard, you have up to 10 minutes to present, and there will be three minutes of questions per caucus. And if you'd introduce yourself for Hansard, it's all yours.

Mr. Gary McNamara: Thank you, Mr. Chairman. Gary McNamara, president of the Association of Municipalities of Ontario. Thank you for providing the association with the opportunity to contribute to your deliberations.

I'll begin my comments at the obvious starting point: Ontario's first responders do challenging and vital emergency services work in our communities. Municipal governments, as both their employers and as the elected representatives of each community, recognize that the health, safety and well-being of our first responders are essential to them, their families and the communities they serve. As employers, we do provide post-traumatic stress disorder support for firefighters, police officers and paramedics. Many of the best practices for PTSD prevention, treatment and return-to-work programs are already in the police stations, fire halls and EMS bays across the province.

We applauded the province when they announced the prevention strategy in February. It reflects the advice that AMO and municipal employers provided at the 2015 minister's summit on work-related traumatic mental stress and afterwards. Additional best practices, resources for municipal employers and further scientific research to help prevent and reduce PTSD in the workplace will be helpful. We also support creating resources that are suitable and scalable for smaller municipal governments, and we understand that these prevention resources will soon be available.

We have heard that the ministry may require that municipalities submit PTSD plans to the ministry so that the ministry can make them public. Municipal government is already open and the plans will be public locally. Creating additional and somewhat paternalistic control mechanisms would be an unnecessary and inefficient overreach by the province. Simply expressing the expect-

ation that these plans are public plans would be more than sufficient.

We recognize that the government, in drafting this bill, was seeking a fair and balanced approach for the implementation of this presumptive approach and one that is informed by research. In Bill 163, the province is requiring that a PTSD diagnosis is made by a psychologist or psychiatrist, and that there is a transition period of 24 months from the time the legislation comes into force. AMO sees both requirements as prudent and practical.

We support the requirement for a PTSD diagnosis to be made by a psychologist or psychiatrist. One concern is whether these health professionals are readily available in rural or northern Ontario. We have been assured by the province that these health services are available for our first responders throughout the province. Nevertheless, we recommend that the ministry monitor access against service benchmarks to ensure that expectations are met and that the health care system delivers timely access. If this part of the PTSD response is not there, the very foundation of this bill falters.

We realize that the length of the transition period may not satisfy all; however, we do understand that it is supported by evidence. Different studies have shown different times for the onset of PTSD after exposure to the traumatic event; however, all the available evidence indicates that delayed PTSD symptoms appear to occur within the first year of exposure. In providing a two-year window in this proposed legislation, the government's approach is both careful and fair.

In our view, these elements are a rational and reasonable way to balance the needs of our first responders and their families.

If the proposed legislation is passed, there will be some immediate unfunded financial impacts on municipal employers, as well as the provincial government, for their employees, such as the OPP. It is always tough to talk about financial impacts when it comes to the health and safety of our employees, but it's part of the equation. The province, if very serious about improving support for workers with PTSD, should be backing the legislation up with transitional funding to help municipal governments manage the unfunded costs that this legislation will create for the employers. There is no disagreement that there will be cost impacts.

As with the other fire services presumptive legislation already in place, we will see increased WSIB rates for schedule 1 municipal governments. Schedule 2 municipal employers will pay for actual presumptive PTSD claim costs as well as the very substantial WSIB administrative fees. Already, we have heard that some schedule 2 municipal governments are considering becoming a schedule 1 employer due to the ever-increasing financial exposure of presumptive policy.

Across Ontario, there are 324 OPP contracts for municipal policing services, mostly in rural and northern Ontario. We are awaiting an affirmative answer from the Ministry of Community Safety and Correctional Services that the province will manage any associated presumptive PTSD costs for its OPP employees. Many of these smaller communities are already delaying capital projects simply to pay for their OPP bills. They cannot be further burdened by PTSD-related costs.

Municipal governments do have the majority of the first responder employers covered under this bill through police, fire and paramedic services, and you need to understand how this unfunded mandate will occur within the municipal fiscal environment. As you are aware, emergency service costs broadly have been increasing at three times the rate of inflation annually since 2002. For example, our annual policing costs are likely to exceed $5 billion this year, which is two and a half times the value of the human services upload agreement we have shared with the province.

Fire service is similarly growing. Salaries are a major driver of these costs, and salary bands for emergency services already reflect the risk of their work, as is appropriate. But the public is struggling to understand why the cost-of-living adjustments are higher for this group of employees than any other municipal employee. Our other employees also want us to be fair and they want us to be balanced.

We hope that you have seen this concern prominently expressed in AMO's 2016 provincial budget submission. However, we know that many people saw it expressed on the front page of the Globe and Mail a couple of weeks ago.

Our research has revealed that if interest arbitration had produced the kinds of wage settlements that collective bargaining achieved for other municipal employees, police and fire costs would be almost half a billion dollars less than they were between 2010 and 2014, and the results would have been more fair for the rest of our employees. Ontario's interest arbitration system is creating unjust imbalances and indefensible costs in emergency services.

Main Street Ontario has woken up to a reality that this building is ignoring: Across Ontario, communities large and small are already concerned about the affordability of emergency services and the proportion of municipal spending that they are capturing. AMO's position is clear: All communities in Ontario need to have access to emergency services that are safe, effective and affordable.

With respect to PTSD, AMO's position is also clear: Municipal employers care about injured workers, and they will support their injured workers.

What isn't clear at all is this: What is the government of Ontario doing to ensure that all communities in Ontario have access to emergency services that are safe, effective and affordable?

At some point, this building is going to have to come to terms with the urgent need to manage Ontario's emergency service costs. We are already paying the highest per capita policing costs in Canada, and every editorial in every newspaper in every Ontario town and city already understands that emergency service costs are eating away

at the capacity of municipal governments to provide all the other programs and services that make our communities viable, prosperous and safe.

AMO, on behalf of our members, continues to call on the provincial government to help control the rising cost of emergency services so that municipalities don't struggle to support our first responders when they need it most. The province, and I think it is fair to say everyone in this building, should be taking a hard look at what the Ontario government can and will do to make sure that all Ontario communities feature emergency services that we can all be proud of and that we can afford without reducing other activities that the public needs and wants.

1540

I will end where I began: The health, safety and well-being of our first responders is vitally important. It is critical to them, critical to their families and critical to the communities they serve. Bill 163 takes a fair and balanced approach to make sure that first responders who are suffering from PTSD receive prompt diagnosis and treatment so that they can return to work and to their lives as soon as possible. We are supportive of the PTSD preventive strategy that this bill sits within.

We also implore this committee and Ontario's Legislature to support policy changes that address the dire need to ensure that all Ontario communities have access to emergency services that are safe, effective and affordable. To do that, this building must also consider the value and importance of all the other municipal investments, programs and services that Ontario's municipal governments provide to keep people safe, and whether we can keep doing this simply through property taxes.

The Chair (Mr. Peter Tabuns): We go first to the government: Mrs. Mangat.

Mrs. Amrit Mangat: Welcome to Queen's Park, Mr. McNamara, and thank you very much for your advocacy and support of this legislation.

You said in your statement: "The health, safety and well-being of our first responders is vitally important. It is critical to them ... their families and ... the communities they serve." You're right.

It is my understanding that this current legislation is not only responding to work-related PTSD but also to preventing PTSD. Would you mind sharing with the members of the committee your thoughts about prevention planning?

Mr. Gary McNamara: Thank you for that. Obviously, that is, I think, a piece that is critically important. It's not just a matter of putting people into those responsive jobs, but also preparing them and preventing these opportunities that could confront them in later years. So prevention is, I think, the very basis, and I certainly commend the minister when he made the commitment that prevention is critically important when he came to AMO.

I firmly believe that we see communities that are already active. I know that the OPP have a pretty active program in place now, and other communities. I think it's the right thing to do, to make sure we are not duplicating but that we replicate a good, preventative basis across the province. Making those public, I think, is the way to go. Municipalities are an open and public forum and are certainly looking forward to doing that.

Mrs. Amrit Mangat: It's also my understanding that this legislation talks about a comprehensive strategy that includes the resource tool kit to improve mental health. Any last thoughts you would like to share with the committee?

Mr. Gary McNamara: Well, I think this is why it's critically important that we have the help they need, through a psychologist or psychiatrist. I think that's the basis of good medicine.

Obviously, that's an issue: Probably the most difficult thing—or part of it—that most first responders will have to do is admit to mental illness, to be able to acknowledge that. That is very, very difficult. But I think that's why it is critically important that not only the help they're seeking, but the professional help is there to identify those particular issues.

Mrs. Amrit Mangat: Thank you.

The Chair (Mr. Peter Tabuns): We go next to the official opposition: Mr. Nicholls.

Mr. Rick Nicholls: Welcome to Queen's Park, sir. It's good to see you again, Gary.

Mr. Gary McNamara: Nice to see you again.

Mr. Rick Nicholls: Thanks, Gary. I appreciate that too.

I guess I made reference earlier to when we hear these things about affordability and the ability to pay, and I fully respect AMO's concerns. First of all, we do want safe communities, we do want to protect our workers and we do want to be able to provide them with needed help in order to deal with and live with and continue with a healthy life based on traumatic situations they have experienced in their lives.

What recommendation would AMO have, or that you'd like to bring forth on behalf of AMO, that would assist the government and assist us as legislators to deal more effectively with this, keeping in mind, again, that there are costs associated with everything?

Mr. Gary McNamara: Thank you for the question. Obviously, we didn't want to detract from the fact that the health of the first responders is first and foremost to all of us. We all agree with that. But there's a cost to that; there is no question. In my remarks, I certainly mentioned that unfunded liability piece and so forth.

I think a good start in order for us to be able to mitigate some of those costs is transitional funding from the government to help alleviate some of those costs that are going to impact, obviously, the bottom line of the municipalities.

Mr. Rick Nicholls: I know that when we're faced with something as new as this—and when I say "new," I know PTSD has been around for a long time, but now we have legislation that is, in fact, designed to assist and to help—this government seems to be very creative, or is finding creative ways of doing some things and how they perhaps can move some dollars around.

I certainly don't want to see this delayed at all. I don't think there's anyone here who wants to see it delayed.

I commend you for bringing forth the concerns of AMO.

Again, we talk about the arbitration system. I think most of us would agree that the arbitration system needs to be looked at because it is, as you mentioned, creating some imbalances and some indefensible costs. That needs to be looked at as well, but not at the expense of those who are especially suffering.

We certainly don't want to delay this bill. We want to try to move it through as quickly as possible. Again, thank you very much for that.

Lorne, do you have anything?

The Chair (Mr. Peter Tabuns): Mr. Coe?

Mr. Lorne Coe: Yes, thank you. Through you, Chair, to the delegation: Thank you very much for your presentation. Your presentation talks to how municipal governments do have a majority of first responder employers covered through police, fire and paramedic services. You'll know from our agenda that we had delegations earlier today. To what extent is AMO engaged with the paramedic association and the police association? Because your narrative in here talks about some of the—

The Chair (Mr. Peter Tabuns): Mr. Coe, I'm sorry to say, but you're over time.

Mr. Lorne Coe: Thank you.

The Chair (Mr. Peter Tabuns): I go to the third party. Ms. DiNovo.

Mr. Gary McNamara: The quick answer is yes, we have.

Ms. Cheri DiNovo: Thank you so much for your presentation. I'm glad you raised the issue of costs. I just wanted to clarify a few things. PTSD in our first responders is going to be paid for one way or the other. I guess our options really are, shall we pay for it with dignity or not? Because, ultimately, if it's not going to be under the WSIB or the municipalities' file, it's going to be under social assistance; it's going to be under long-term disability; it'll be under the justice system. I give an example of sending first responders to a first responder's house who has threatened suicide. That costs a lot of money.

The idea of getting early treatment is to get people back on the job much faster, right? This should not be a terminal illness. This should be a treatable disease like any other where that person can get back very quickly. Having said that, I understand the trepidation that you may have but I just wanted to reassure you that, from what we've seen in studies from other jurisdictions, it shouldn't cost any more. In fact, it should cost less. That's number one.

Number two: I hear you need help from the provincial government, and I think they should be helping you. There's no question that many of the services that were downloaded under a previous government have not been uploaded. You know that better than anyone; you pay for it. Has the government spoken to you about transitional funding? Have they offered you any money of any sort?

Mr. Gary McNamara: We've been asking and, obviously, as the bill continues to evolve, we certainly are going to continue to ask for transitional dollars.

The biggest piece for us—and I think there needs to be an awareness—is the OPP. Some 324 of our municipalities are policed through contracts. We certainly don't want to see an additional cost to the contracts because they are employees of the province. I think there is a responsibility of the province to take care of theirs as well.

I just don't want to see, especially for those small communities, northern Ontario communities and so forth, where they're struggling right now to choose policing or other services within the community. So I would ask, obviously, the government to make sure that that's not another requirement from the 324 municipalities that are policed by the OPP, that that be an additional cost to their contracts.

1550

Ms. Cheri DiNovo: Yes, okay. I hear you. Just again a cautionary note: It may not be an additional cost.

One of the things that we've heard from a number of presenters and that we certainly support is that those previously denied a claim should be allowed to make that claim. Is that something that AMO would support as well?

Mr. Gary McNamara: That's a pretty open-ended question and so forth. I don't know how far back you want to go. But in terms of the two years that the government has actually brought forward, I think it's based on solid research—

The Chair (Mr. Peter Tabuns): With that, I'm sorry to say you're out of time with this questioner too.

Thank you very much for the presentation today. I think we all appreciated it.

Mr. Gary McNamara: Thank you, Mr. Chairman, and certainly thank you to the committee.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, CORRECTIONS DIVISION

The Chair (Mr. Peter Tabuns): Our next presenters, then, are the Ontario Public Service Employees Union, corrections division: Monte Vieselmeyer and Gregory Arnold. As you know, you have up to 10 minutes to make a presentation, and then we'll go three minutes per caucus for questions.

When you've settled in, if you could introduce yourselves for Hansard, and we'll just take it from there.

Mr. Greg Arnold: Good afternoon. I'm Greg Arnold. I'm a MERC member with the Ministry of Correctional Services and I'm also a provincial bailiff.

Mr. Monte Vieselmeyer: Good afternoon. I'm Monte Vieselmeyer. I'm the chair of the corrections division for Ontario.

Mr. Greg Arnold: Thank you for allowing me to have this opportunity this afternoon. My name is Greg Arnold. I have been employed as a correctional services

worker for over 33 years. I am currently classified as a provincial bailiff and have held that classification for the past 27 years. I am speaking before you today because my classification of correctional services worker/bailiff, which is a uniformed officer, has been excluded from Bill 163.

My classification is defined under the Ministry of Correctional Services Act, clause 11(1)(b), as a class of persons "from among the persons described in clause (a), to be peace officers while performing their duties and functions." Further to that, in section 15.1 and subsection 16(2), the Ministry of Correctional Services Act clearly identifies bailiffs as an inclusion to the term correctional services worker by classification identification, and identifies our work location to be correctional institutions.

In subsection 19(1), "The minister may appoint provincial bailiffs who may convey an inmate in custody at a correctional institution to another ... institution or penitentiary in which the inmate is lawfully directed to be confined."

Further, in subsection 19(3) of the Ministry of Correctional Services Act, the "provincial bailiff has the powers of a constable when conveying an inmate under this section." Please note that it very clearly states "constable." It does not refer to special constables, who are also excluded under Bill 163.

Bailiffs are correctional service officers that meet all the criteria of the definition as stated in Bill 163. We are workers who are directly involved in the care, health, discipline, safety and custody of an inmate confined to our correctional institutions. We are assigned to correctional institutions but also have the added responsibility of maintaining the care, custody and control of the safe, secure transportation of approximately 40,000 offenders per year in Ontario. That includes Ontario and other provinces.

Bailiffs are appointed from the correctional officers' ranks. There are currently 30 provincial bailiffs in Ontario and this department is augmented with an additional 40 correctional officers trained as backfill, assisting our deputy bailiffs.

Imagine a critical incident where a correctional officer and a bailiff are working together and something terrible happens. The correctional officer would have protection under this bill; the bailiff would not. Bailiffs are correctional service workers and as such are members of our institutional crisis intervention teams, or ICIT. They are also critical incident stress management personnel. They are defensive tactics (COTA) instructors, and critical incident negotiators. Some of our most experienced correctional officers are classified as provincial bailiffs.

Several years ago two Quebec correctional service workers were murdered by biker gangs. They were executed while transporting offenders during an external assault on their transportation vehicle.

Manitoba lost a correctional service worker last year while transporting offenders between institutions; she died in a highway traffic accident when their transport vehicle left the road.

I'm totally confused. I do not understand why bailiffs would be excluded from the first responders bill when they clearly meet the criteria and definition of a correctional services worker. I have a fear that maybe the researchers have mistakenly identified a bailiff as a court services worker, someone who serves documents and repossesses property. If that is the case, this needs to be corrected before this bill becomes law. We truly are front-line officers.

The following are some of my personal experiences and stories, but there are many others amongst my colleagues:

In my career as a correctional officer and provincial bailiff, I've been bitten, choked, punched and been subject to having weapons and bodily fluids used on me.

I've dealt with suicides, suicide attempts, violent, mentally ill offenders, several riots, and two hostage-takings.

I've been a first responder in the institution and on the highways of Ontario with offenders at multiple traffic accidents, some involving fatalities.

I've provided first aid and dispensed medication to offenders who were too frail to provide their own insulin injections.

If bailiffs fail to provide the obligations and duties of their classification, they can be charged criminally for not providing the necessities of life to the offenders under their charge.

I've been a member of our tactical teams, our ICIT teams, for 16 years, stepping down in June 2014. I'm also currently an associate instructor with our corrections college, teaching defensive tactics and training new recruits—COTA—to become professionals. Prior to this, I was a trained ministry hostage negotiator for several years.

My partner and I were recognized by former minister Rob Sampson for our actions while on a bailiff transfer at a highway traffic accident in 2000. We were first on the scene of a terrible accident involving a burning double fuel tanker, another transport and a personal vehicle. The civilian in the personal vehicle died in our presence, but we were able to free the driver of the burning tanker truck to safety.

In 2012, one evening when I was off duty, I took down and detained a known offender on probation who was attempting an armed robbery of narcotics from a local pharmacy. For this incident, I was recognized for bravery by then-Minister of MCSCS, Madame Meilleur. I also received a commendation from the Governor General of Canada for my actions and was recognized by Thunder Bay Police Services and commended for my professionalism.

I find it very frustrating to sit here before this committee today to give a deposition on the services that bailiffs provide for this province. Bailiffs have earned the right to be included in Bill 163.

Bailiffs are uniformed correctional service officers. We meet all the criteria required to be included in Bill 163. I've been a first responder since the day I joined the

corrections ministry in 1982. Please amend Bill 163 to recognize bailiffs as the correctional services officers they are. Bailiffs are subject to all the effects of post-traumatic stress disorder and should be afforded the same protections.

Mr. Monte Vieselmeyer: Good afternoon. As I stated, I am the elected chair of the corrections division for OPSEU. I represent over 6,000 corrections professionals, who include corrections officers, probation and parole officers, bailiffs and several other corrections classifications.

I'm greatly appreciative of the introduction of this legislation and the assistance it will provide to my members who are experiencing PTSD. As a correctional officer with 25 years of working in Ontario's provincial jails, these amendments to the Workplace Safety and Insurance Act, 1997, are long overdue for the first responders and other workers who protect Ontarians every day.

I have been a participant, a witness and a third-party respondent to hundreds of incidents of assault, medical emergencies, fires, mental health interventions, deaths, and situations that do not fit into any defined category as a correctional first responder. Many of these incidents over the duration of my career stand out for a variety of reasons, and many more I have forgotten.

I raise this brief overview as I am included under this legislation. Today, I present to you as the representative of Ontario's probation and parole officers and bailiffs who are not included, and I am conflicted how to equally message these individuals' needs to have access to the legislative changes proposed by Bill 163. I have spoken to and read many of these members' professional working stories and the toll it has taken on their mental and physical well-being.

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These corrections professionals are the front-line workers who deal with the same individuals who come into contact with all justice partners. Probation and parole officers' experiences include physical assaults upon themselves; first-hand accounts from offenders of child sex crimes, murders and domestic abuse; secondary accounts of criminal acts in court documents; weapons being brought into their offices; and client suicides, to name some of the daily issues they encounter.

Ontario bailiffs have similar experiences to myself as a correctional officer. All Ontario bailiffs first start out and are trained as correctional officers. To become a bailiff, you need additional specialized training above that of a correctional officer. Many bailiffs are involved in and serve under specialized response teams that respond to crises within the institutions. Correctional officers backfill for the bailiff classification due to vacation, sickness and training. Several of my colleagues from probation and parole and bailiffs will be presenting to this committee a much more in-depth and succinct account of their working lives. Their information will give you a much better understanding of their profession and the rationale for inclusion in this legislation.

My request to this committee is to add these correctional professionals, probation and parole officers and bailiffs, to the language of Bill 163. This would give these individuals the same opportunity to have any diagnosis of PTSD under the DSM-5 addressed with a timely intervention and a healthier return to the workplace, serving Ontarians.

Thank you for your time and consideration.

The Chair (Mr. Peter Tabuns): Thank you very much. We go first to the official opposition: Mr. Nicholls.

Mr. Rick Nicholls: Gentlemen, welcome. You talked about the importance of probation, parole and, of course, bailiffs. Of course, I've been a strong advocate for corrections, obviously, as part of my critic portfolio.

We talk about PTSD, and to me, that's after the fact; they've experienced a traumatic experience. But one of the things that you might be able to help us with is, what are some of the things that the government is currently doing to ensure safety with our probation and parole officers? The reason why I mention this—I don't want to exclude bailiffs—is because I've spoken with many probation and parole officers. They come in and they tell me of their horrifying experiences with regards to their offices and about the weapons that some of their clients are carrying with them.

Do you know of anything that's happening in terms of safety for probation and parole officers in their offices that would perhaps help to alleviate some of this?

Mr. Monte Vieselmeyer: Well, right now, there are definitely challenges within our probation and parole offices. There have been orders through the Ministry of Labour that each office should have metal detectors installed to help lessen any metal items—maybe knives or other types of weapons—that may be brought in. The government hasn't followed through with those orders at this time. That's something that we're pursuing as quickly and efficiently as possible.

Mr. Rick Nicholls: One of the things that I appreciate our parole and probationary staff doing is that they help keep our communities safe by working with individuals who are out on probation or on parole. The concern I have for them, though, is the fact that they also live in our communities along with the people to whom they are providing a service. Have you heard of any incidents whereby parole or probationary officers are actually being threatened because it's the old story, "I know where you live"? Do they have those types of horrifying experiences as well?

Mr. Monte Viselmeyer: I think that's a threat for any justice partner, and specifically corrections. We've been pursuing to have our licence plates put into a database somewhere outside of where our homes are, so that they can't be followed up. Police officers, I understand, have that ability to put their licence plates to their work location. We don't have that ability, so that's something we've been pursuing for years. I think that's important to us.

Again, that's a danger to any of us that we have to worry about, that we may be followed by any criminal aspect. Probation and parole—because, again, they have

the ability to put these offenders back in jail if they don't follow what they're required to—sometimes have been attacked. I know a fellow correctional officer who became a probation and parole officer who was attacked in his office and had his jaw broken by one of his clients. Again, there's always a danger, whether they're in the office or in the community.

Mr. Rick Nicholls: Well, I guess the concern is prevent it first. Safety has always been the big concern for myself with regard to corrections, and parole and probation. But then, dealing with the issue of PTSD because, in fact, these—you're a human being; you're people. You deal with this situation but how do you deal with it more effectively? Of course, we'll certainly be looking very closely at the amendments put forth that would include—

The Chair (Mr. Peter Tabuns): Mr. Nicholls, I'm sorry to say you're out of time. You're honing in on it. Thank you, sir.

We'll go to the third party: Ms. French.

Ms. Jennifer K. French: Thank you very much, both of you, for coming. No offence, Monte, but I'm going to focus a little bit more on the bailiffs. We had a very comprehensive presentation earlier from your colleague Scott McIntyre, and I know that we've got probation and parole officers speaking to the committee tomorrow.

Greg, if I may focus in on bailiffs, to your point that you don't understand why they would be excluded and that your concern is that perhaps the government isn't really clear on the role—which I think is alarming, considering that they're the employer—I appreciate the deeper understanding of what it is that a bailiff does, but some points of clarification: You have said that there are 30 bailiffs now but there is a need to backfill, and you've got more backfill bailiffs than you've even got regular bailiffs. Could this be a scenario: If you were to have a bailiff and a correctional officer who is filling in—who is a backfill bailiff—both at a call, and a traumatizing event occurs, in that situation, if bailiffs are not covered, could you then have the correctional officer-backfill bailiff be covered by the presumption and then the other bailiff out in the cold?

Mr. Greg Arnold: Well, like I say, we do have 40 additional officers in the province, and even then we need more. Quite typically right now, when we're transporting offenders between institutions, we have two correctional officers actually facilitating the work of two bailiffs. So yes, my interpretation would be that. If the bailiffs were excluded and I was working with a correctional officer who was acting as a bailiff, he would be covered and I would not.

Ms. Jennifer K. French: Okay. Another thing, then, is that to become a bailiff, generally speaking—well, they all have to be correctional officers; it requires additional training, and, based on your notes, oftentimes they become bailiffs later in their career. Maybe they've had a long career as a correctional officer.

If they are not covered by the presumption, why on earth would a correctional officer want to become a bailiff if there's only a 24-month period? If I was a correctional officer, I'm covered by the presumption. If I shift into the bailiff role and my trauma sets in and I have a new PTSD diagnosis but I'm now in the role of a bailiff, is it your understanding of this legislation that then that individual would not be covered? "Too bad, so sad."

Mr. Greg Arnold: I would assume, yes.

Ms. Jennifer K. French: Okay. If your bailiffs are putting themselves at risk and serving on ICIT, which is a crisis team, as ICIT team members or negotiators, which I would imagine would put them in more traumatizing situations, what would be the incentive for them to take on those additional care and stress roles if they will not be covered by a presumption?

Mr. Greg Arnold: I think what happens is, especially in Ontario, the term "bailiff" seems to confuse people. We have correctional service workers and then, within that, we have classifications of workers, and this is one of those unique things where there are 30 bailiffs that are classified as bailiffs, not correctional officers. There are a lot of correctional officers that do aspire to be bailiffs, and I think that everybody has the assumption that we're all doing the same job—we all have the same clientele.

The difference is that, with bailiffs—I don't have the security and safety of an institution. I'm either driving a 40-seater bus or a 24-seater paddy wagon or a 12-seater van. When things go bad on the highway—I have an internal assault in the vehicle or between offenders, or an external assault or poor weather or whatever—I can hit that blue button. It's like hitting the Staples button. It just makes you feel good.

I don't have the backup of a facility with hundreds or 20 or 10 other officers coming to assist me. I'm out there by myself; I'm with another officer. We have that. We will take 35 federal offenders to Kingston in the 40-seater, and we have four officers. We're not armed. In other provinces—the sheriffs in BC are attached to corrections. They're corrections officers, and they have the lethal force option. We don't have that. I have the same weapons and the same training that the correctional officer has on the floor, yet I don't have the ability to have backup.

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The Chair (Mr. Peter Tabuns): With that, Ms. French, I'm afraid—

Ms. Jennifer K. French: Aww.

The Chair (Mr. Peter Tabuns): Yes, I know, it goes so quickly.

Mrs. McGarry?

Mrs. Kathryn McGarry: Thank you very much for your presentation. We certainly appreciate the vital work you do and role you play in keeping not only yourselves and your inmates safe, but those of us in the general public. I appreciate that.

We also know how critical it is for early assessment, diagnosis and intervention in terms of looking after those who may be experiencing PTSD—and PTSD is nearly twice as prevalent among first responders than among the rest of the population.

Certainly, we know that Bill 163 goes further than previous proposals, such as PMB2, which didn't include workers in correctional institutions for presumptive PTSD coverage. In Bill 163 we have actually included corrections workers.

As you know, one of the elements of this bill will be the proposed ability for the Minister of Labour to request prevention plans from employers. Could you please share some of the things your organization would do in regard to prevention?

Mr. Monte Vieselmeyer: I'll speak on that. Prevention is absolutely necessary. We would like to prevent these issues from becoming PTSD, so prevention is important.

Right now, I think we have very little in place from a corrections ministry standpoint. I've seen some police departments that are more progressive; they have psychologists or psychiatrists on hand that their officers can access. We don't have anything like that. We have schism teams that will meet if there's a critical incident. But it's a one-time thing; there's no follow-up. Also, the current concern is that if somebody has gone through a critical incident, you are not re-affecting them by the situation. Again, this is kind of a one-shot deal and then there's no follow-up.

So, if a person is having issues or it's becoming worse—a lot of times we talk about one critical incident. In corrections, it's dozens upon dozens, and everyone is affected differently. I definitely think that prevention is very important, and there are things that I would definitely like to sit down with our minister and discuss that would help the safety and fulfillment of our members, for sure.

Mrs. Kathryn McGarry: You bring up a good point: No member of any first responder group or organization can really point to what the incident was; it's often the straw that breaks the camel's back in these situations that produce the symptoms of PTSD. In saying that, is a legislative presumption an appropriate method by which to improve the timeliness and consistency of adjudication?

The Chair (Mr. Peter Tabuns): I'm sorry to say, Mrs. McGarry, that you're out of time, even though it was a good question.

Mr. Monte Vieselmeyer: Yes.

The Chair (Mr. Peter Tabuns): Well done, sir. Thank you for your presentation today.

BADGE OF LIFE CANADA

The Chair (Mr. Peter Tabuns): We go to our next presenters, Badge of Life Canada, Mr. McKay.

Sir, as you've heard, you have up to 10 minutes to present, and then three minutes of questions from each caucus. When you've settled in, would you introduce yourself for Hansard.

Mr. Brad McKay: Good afternoon, ladies and gentlemen of the standing committee. My name is Brad McKay. I am a senior police adviser at Badge of Life Canada. I am here to speak to you on behalf of this organization.

I am a retired staff sergeant, having served 33 years with York Regional Police. I am a trauma survivor, having been involved in a shooting in 1984 that resulted in a loss of life. I have been involved in peer support and peer support systems for over 27 years. I am a certified trauma services specialist. I co-created a multidisciplinary York region CISM team in 1996, covering police, fire, EMS and emergency room hospital staff.

In 2013, I created an internal peer support team for York Regional Police and I have conducted hundreds of interventions and coordinated over 1,000. I've been directly involved in numerous suicide interventions, many of which would have been completed if there were not a system of support in place. I am proud to say that I retired from a leading-edge organization, York Regional Police, where the leadership trusted me and allowed me to create peer-driven programs of support with an effective early intervention program. You may ask questions about that; I have a lot of answers for you. I continue to volunteer for two peer-support teams in York region, and I co-lead a trauma recovery group at the Trauma Centre in Sharon, Ontario.

Front-line responders are strong—stronger than most. When chaos hits and people are running away, front-line responders are running in. Every once in a while, though, an incident or accumulation of incidents can have the ability to break down the front-line responder's ability to cope. They are only human, and they deserve respect and effective assistance after a trauma exposure.

Stigma is a huge barrier to our responders asking for help. Sometimes asking for help that very first time is the most difficult thing a front-line responder has ever done. If they ask the wrong person or they have a negative experience, they can go back down into that deep hole of despair, sometimes for years, before surfacing with more severe mental illness—or worse: They may take their life.

In my experience, I can't tell you how many times I have had to support members who struggle with their real PTSD to find that they and their family need to spend pointless energy fighting the system of WSIB or their own organization. The only thing worse than PTSD is the feeling that you've been betrayed by an organization that you swore you would serve and risk your life for.

About Badge of Life Canada: The purpose of Badge of Life Canada is to promote health for the benefit of the public by providing active and retired personnel in First Nations police, municipal police, provincial police and correctional services diagnosed with an operational stress injury, including PTS, with access to counselling, including suicide prevention counselling. We (1) provide a national online resource hub; (2) foster the development of peer-led support resources; (3) develop a national training and resource network; and (4) advance the public's understanding of operational stress injury, including PTS and suicide prevention.

Badge of Life Canada is now nationally recognized as a not-for-profit organization that provides anti-stigma

presentations on the effects of OSI, PTS, suicide prevention, anxiety, and depression on police and correctional personnel. Presentations provide insight and understanding surrounding how compassion and discipline can greatly influence police members and their families who are suffering mental health concerns within the context of their public and private lives. The effects of social media and the moral injury dilemmas upon those members who suffer the effects are explored as well. Resilience, wellness, hope and recovery are emphasized to show positive post-traumatic growth with respect to how members can return to being effective members within their police organizations.

Since Badge of Life's inception in 2010, founded by Peter Platt, Badge of Life has been staffed by volunteers who walk the talk, and they've been solely funded by the hearts of the members paying it forward. This approach has been involved in the organization for offering a safe, confidential place where members can turn for immediate information that can assist, especially when in crisis. Our passion for the Badge of Life Canada mission is based upon legitimacy within the policing and corrections world by having travelled our own journey towards finding a new normal after exposure to various traumatic work experiences.

One experience that I'll tell you about is of our director, Sergeant Bill Rusk. He is one example of both the pitfalls of WSIB but also resilience and tremendous strength. On June 24, 1990, Bill Rusk was shot in the face, neck, shoulder, back and right hand during a foot pursuit in North York while a member of the Toronto police. He was treated for his physical injuries at Sunnybrook.

Between 1990 and 1993, WSIB's own medical professionals diagnosed Bill with physical impairments as well as severe, chronic PTSD. Even though Bill knew that there was something not right with his recovery due to PTSD, he wanted to return as soon as possible as a productive member of his organization.

Bill has shown tremendous resilience by being able to return to policing and has since had a distinguished career, with numerous recognitions and awards. He's a two-term member of the board of directors for the Police Association of Ontario and even sat as a member of the WSIB PTSD working group. Bill had the belief that things would get better for those who have followed behind with PTSD issues with the advent of presumptive legislation. However, in 2015, 25 years later with a distinguished career, Bill had to submit a WSIB recurrence claim for both his physical and psychological injuries as a result of the 1990 shooting.

Over the past 12 months, Bill has faced three separate WSIB claim denials, along with subsequent appeals. During this time, Bill was continually shuffled between various WSIB claims managers. He felt degraded and laughed at, and he was told by one worker that because he was working over the past 25 years, he should be able to suck it up and get back at it.

During this time, Bill had been told by a WSIB case manager that WSIB had no record on their computer screen indicating that Bill had even been shot in the face. Bill supplied this evidence to WSIB that was written on WSIB's own letterhead by appointed medical professionals, and subsequently Bill's file was located in a filing box somewhere. There was no apology made to Bill.

During this period, Bill was asked to provide additional proof that he had not been diagnosed with post-traumatic stress for five years prior to his own shooting incident. He had already been diagnosed in 1993, so I'm not sure why they need to go back to that again.

Finally, WSIB transferred Bill's claim to the WSIB traumatic mental stress injury unit, where it was finally approved. However, the approval was retroactive to applicable legislation from the time of his shooting incident in 1990. This legislation does not exist for active members even today, and no one is currently employed at WSIB as a case manager who is versed in this old legislation.

As a result, WSIB has finally recognized Bill's claim under the 1990 legislation, which amounts to 85% of his net earnings from 1990, where he gets about $600 a week. This has led to financial crisis for him, forcing him to sell his assets, his home, his farm.

In addition, Bill was working for another police employer at the time of his 2015 recurrence and WSIB is now charging his former employer, the Toronto Police Service, for his recurrence claim. As a result, Toronto Police Service has now initiated their own employer appeal regarding Bill being awarded injury recognition by WSIB.

That's the challenge and that's the difficulty that members are facing out there, and that's just one example.

Today, on a positive note, I'm pleased to announce that at 1:45 a.m. in Ottawa, Badge of Life held a relaunch with over 200 delegates from the Canadian Police Association in Ottawa at their general meeting in Ottawa. Information regarding Badge of Life Canada was dispersed to the delegates and members of Parliament.

Initiatives that Badge of Life is involved in: We partner with organizations for research projects. We've partnered with Nipissing University on proposed research on OSI and general health of former police officers, correctional officers and 911 communicators. We also have one of our members, my colleague Syd Gravel, who is now the course developer and instructor for a new online certificate course at Simon Fraser University entitled Organizational Structure and Stigma Reduction in the first responder trauma prevention and recovery certificate program.

Badge of Life Canada currently lists professional therapists across the country, listed by province and territory.

The Chair (Mr. Peter Tabuns): Mr. McKay, I'm sorry to say that you've run out of time.

Mr. Brad McKay: May I give you a brief summary, then—the conclusion?

The Chair (Mr. Peter Tabuns): You have actually run out of time. I'm sorry.

Mr. Brad McKay: Okay.

The Chair (Mr. Peter Tabuns): We'll start questions with the third party. Ms. DiNovo.

Ms. Cheri DiNovo: Yes. Thank you very much for your presentation. I noted that the case you talked about, Mr. Bill Rusk, having been denied a WSIB claim, would not be covered by this legislation—ultimately did have his claim recognized, but one of the amendments that I think we've heard from others who have brought this forward that's so critical is that those who have been denied a claim be allowed to refile. So I'm glad that you brought that up. Is that amendment something that Badge of Life would support? It sounds like you would.

Mr. Brad McKay: Yes, I believe so.

Ms. Cheri DiNovo: The other thing that I was really interested in was your peer-led focus. I met with the sister of Constable Garda, the young constable who killed himself recently. She's a phenomenal woman. She's been working on a list of very simple protocols that my office is going to happily share with the minister and with others who may be interested. One of them was exactly that: somebody to talk to, who had been through it before. Clearly, her brother didn't have that.

My question is, how do you work, in the sense that Constable Garda didn't have the opportunity? Nobody told him that he had that option to speak to someone who had suffered.

Mr. Brad McKay: Early intervention is such a key component: having a formal, peer-structured peer-support system that is not reactive but proactive, where you can pick off indicators.

Suicide is something that in 80% of cases is identifiable. In 20% of them, you might be able to get it picked off through some statistics or some other early intervention strategies. You should be able to pick off about 90% of it, if you're doing your job.

It's important that a peer-support system reaches out to people in need like that. I'm sure that situation would have been known by others, that he was struggling. The family element: Peer-support system can go into family, as well, and the family can be reached out to. There are systems of peer support that can take care of that.

Suicide, in most cases, does not have to happen if you know the risk factors, identify the risk factors and act, and you have the ability, the competence and the training to spend time and be comfortable in the uncomfortable zone.

You need to be in that uncomfortable zone, spend a lot of time there and find out exactly what's going on and devise a safety plan, and then determine whether you have to step it up and speak to supervisors. It can be done, and we know how to do it.

Ms. Cheri DiNovo: Obviously, getting the information out is part of the issue now in terms of protocols, because that was not the case with this young officer.

Mr. Brad McKay: That's very unfortunate.

Ms. Cheri DiNovo: One of the descriptors that she uses: He was given a book with a list of associations and everything else and—plonk—"Here, phone somebody," which clearly, for someone who has just experienced a critical incident, is not the way to go.

Mr. Brad McKay: If you know somebody has experienced a critical incident, somebody should be latching on to that person as soon as possible.

Ms. Cheri DiNovo: Yes. Thank you very much.

The Chair (Mr. Peter Tabuns): Thank you very much.

We go to the government: Mr. Anderson.

Mr. Granville Anderson: Mr. McKay, thank you for being here and thank you for your advocacy on behalf of the officers suffering from PTSD.

I know that you had a summation that you anxiously wanted to finish. I'll give you that opportunity to do so now.

Mr. Brad McKay: Thank you very much.

Badge of Life strongly believes that all first responders should be treated with compassion and care and have access to professional treatment, rather than face numerous appeals that waste time, energy and money on automatic claim denials by WSIB.

The majority of members who suffer want access to timely treatment that will afford them the opportunity of returning as soon as possible to their organizations.

PTSD should be viewed as an honourable injury. Although there are no slings, no crutches, no casts or bandages when dealing with a psychological injury, it is important to remember that PTSD is a result of "what's happened to you" through your employment journey, rather than the belief of "what's wrong with you."

Badge of Life continues to be committed to working with all parliamentarians and related stakeholders so that presumptive legislation can move forward to save the lives of those who are suffering in silence and to promote hope, wellness and recovery.

Mr. Granville Anderson: Are you through? Do I have some time left?

The Chair (Mr. Peter Tabuns): Yes, you do, actually. You have about a minute and a half.

Mr. Granville Anderson: Okay. I know you alluded to stigma during your presentation. You're saying that it's one of the great hindrances for treatment. Do you want to elaborate on that and what you would suggest to remove some of that stigma?

Mr. Brad McKay: Removing the stigma?

Mr. Granville Anderson: Yes.

Mr. Brad McKay: Oh, lots of training; Road to Mental Readiness; having your peer supporters reach out; having competent, trusted peer supporters in every area of the organization who come in and speak to the parades or speak to the groups.

The newer generation does not latch on to the stigma as much, so if we get at our recruits—and their families—as they're coming in the door and eliminate the stigma, that's a huge step forward. They know they have a place to reach out to; they know that they have an organization that supports them. That's part of the early intervention strategy.

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Another good early intervention strategy is that you have an early intervention analyst, who's like a crime analyst and who picks off things before you even know it: behavioural changes, sick time—all sorts of things that you can pick off. You know the top 10 terrible calls that the ICISF says are at a high risk to cause an operational stress injury? If your members go to one of those calls, there should be an automatic call. There should be an automatic contact. Nine times out of 10, it may be nothing, but at least you get the feeling that your organization cares enough to reach out to you. The more you do that, the more the stigma will be reduced.

The Mood Disorders Society of Canada has a beautiful program called Elephant in the Room, reducing the stigma. The fat, little blue elephant who's sitting in the room—you know that that's a safe place to talk about mental health.

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say that you've used up your time with these questioners.

We go to the official opposition: Mrs. Martow.

Mrs. Gila Martow: Thank you very much for joining us today, Mr. McKay, and for your service.

I wonder if you could just tell the committee and anybody else who's listening—specifically the WSIB—how, when your colleagues aren't supportive or a government agency isn't supportive, that adds to the stress of the situation and exacerbates the symptoms.

Mr. Brad McKay: It's unbelievable. From what I've seen and the reactions that I've seen from people, whether it's a betrayal or it's a perceived betrayal, it still cuts them right to their soul because they believed, and they joined an organization wanting to contribute, wanting to be a contributing member. When you are out in a situation where you are injured as a result of doing your duty and then your organization apparently bails on you and turns on you, it cuts you to your soul. Sometimes it's very difficult to come back from that. I'm supporting so many police officers and other front-line responders who are dealing with that very topic right now. Some of them may not even be able to come back to work because they feel so strongly against their organization or against the WSIB. There are two layers to it. It's significant.

Mrs. Gila Martow: I think the key word is "betrayal." I think that people—we have a limited capacity for what type of emotions we can overcome. I think that, so often, when we don't have the support, a small situation can have incredible symptoms, while somebody could be in a horrific situation, but, when their supervisor insists they get the proper treatment and get the time off and maybe continuously deals with the situation by ensuring what type of work they do for the time afterwards, that can mean that somebody can cope with a really traumatic situation.

Mr. Brad McKay: It's huge, yes. And where you can fill in the blanks is a competent peer-support system that takes your member's hand and helps them surf through that difficult time with supervisory support, management support and good peer support and follow-up.

We were talking about follow-up a few minutes ago. There always must be follow-up. The Ombudsman of Ontario talked about follow-up with their OPP investigation. There has to be follow-up, and you need to not only latch on to these guys, but hold on to them and follow up. There's nothing more important.

Mrs. Gila Martow: I'm just going to mention that the member opposite—this committee heard some horrific stories from women who miscarried or gave birth to, unfortunately, babies that didn't survive and the supports weren't in place, and how traumatizing that was. I think that the committee members and members of the public were so shocked to realize that there's no difference, physically, in giving birth to a live baby or a dead baby. The trauma that results from that baby not living is just so emotionally incredible.

The Chair (Mr. Peter Tabuns): Mrs. Martow, I'm sorry to say—

Mrs. Gila Martow: Thank you very much for your comments.

Mr. Brad McKay: Yes, children are our Achilles' heel, absolutely.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation today.

Mr. Brad McKay: You're welcome, sir. Thank you for having me.

ONTARIO ASSOCIATION OF PARAMEDIC CHIEFS

The Chair (Mr. Peter Tabuns): We go on to our next presenter, then, the Ontario Association of Paramedic Chiefs, and I have Mr. Neal Roberts.

Mr. Roberts, as you've probably heard, you have up to 10 minutes to present and then we have three minutes per caucus for questions. If you'd introduce yourself for Hansard, and then we can proceed.

Mr. Neal Roberts: Good afternoon. I would like to thank the committee for giving the Ontario Association of Paramedic Chiefs, the OAPC, the opportunity to provide you with our thoughts on Bill 163, the Supporting Ontario's First Responders Act.

My name is Neal Roberts. I am the president of the OAPC, which represents paramedic services leadership in 52 designated delivery agents, or DDAs, consisting of regional, county and municipal governments, and district social services administration boards across Ontario. Our membership includes Ornge, four First Nations emergency medical services, and every DDA in the province.

OAPC members oversee the work of 7,000 primary care, advanced care and critical care paramedics as well as 830 ambulances and 300 emergency response vehicles across the province. We are the leading authority for paramedicine design and delivery in Ontario.

Let me begin by stating our support for this proposed legislation. We support it because research shows that first responders develop PTSD at twice the rate of other Ontarians. By creating the presumption that all PTSDs

developed by a first responder are work-related, our staff will have easier and quicker access to proper diagnosis and proper intervention.

While we have yet to find a cure for PTSD, it can be managed with the proper tools. Bill 163 will expedite access to those tools for paramedics and other first responders in our province. This bill will also provide much-needed support and tools in advance of a critical incident and, hopefully, help lessen the impact of these situations.

We as an association met several times with Minister Flynn while this legislation was being contemplated and drafted. I'm pleased to tell you that the minister has listened to and heard, as well as acted upon, the information that first responders and their services provided to him and his office during those discussions.

The OAPC has been welcoming of initiatives that address staff workplace injuries, whether they be physical or mental. We applaud the government, and both opposition parties, for their non-partisan approach to this very important issue. Bill 163 will go a long way to improving supports available to paramedics across Ontario dealing with PTSD.

We are here today to thank you for bringing forward this proposed legislation, but we're also here to ask you to widen its reach.

Many of our members provide paramedic services in northern, rural and remote communities. We believe that the definition of "first responder" needs to be expanded so that Bill 163 addresses the unique needs of these communities.

By way of example, first-response teams have been an integral part of the northern emergency medical response landscape for nearly two decades. These teams are not comprised of qualified paramedics. Rather, they are comprised of volunteers who are trained and certified to provide immediate intervention and treatment in communities that are 20 minutes distant, or more, from the nearest staffed ambulance service. They use a non-ambulance vehicle to transport themselves and their equipment. Once they're on scene, they will render basic first aid and use many of the same tools for stabilization found on board the arriving ambulance. However, these teams do not move patients unless it is into their stationary vehicle and it is necessary to maintain the patient's privacy and warmth.

These teams are dispatched by local central ambulance communications centres and remain in radio contact with the central ambulance communications centres and the oncoming ambulance, to provide updates to both the paramedics and dispatch.

These teams are generally the first responder on scene and, in many cases, are the first to arrive. As a result, it is not uncommon for the first-response teams to be alone with the patient in rural and isolated areas for an extended period of time.

We also believe that the definition of "first responder" needs to extend to paramedic services management, who are required, from time to time, to respond on scene to a multi-casualty incident, providing support to responding paramedics.

Our recommendation to the government and to this committee is to revise the definition of "first responder" to include "chief," "deputy chief" or "commander," whose job description requires them to support or attend a call or an incident in the performance of his or her duties.

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First-response teams and paramedic service managers face the same dangers and traumatic scenes as paramedics. As currently drafted, Bill 163 does not extend to either group. We believe they should have equal access to WSIB benefits and treatments if they are diagnosed with PTSD by a psychiatrist or psychologist, as proposed in the bill.

The health, safety and well-being of our staff remain OAPC's top priority. As such, we believe that while Bill 163 is an important first step toward protecting the mental health of first responders in Ontario, much greater emphasis is needed on support for paramedics ahead of a traumatic incident. We need to better prepare paramedics for occasions where they have to respond to such situations. As the old adage goes, an ounce of prevention is worth a pound of cure.

Paramedics are on-site at some of the most shocking incidents that a person could witness. They also have a longer exposure to patients at traumatic events. For these reasons, we need more training for paramedics on how to ready themselves for such incidents, which are inevitable in our line of work.

Paramedics may never be completely immune from what they may encounter when they arrive on scene, but they certainly could be better prepared. That support not only needs to be ahead of a traumatic incident but throughout the entire career of a paramedic. It is about providing support in light of the cumulative effects of several incidents over their career, as well as ensuring that their training is kept up to date.

The OAPC is aware that this is no easy feat and will require cultural change within our first-responder community and at the WSIB, as well as with the general public. We will be an active participant in this important work and will continue to find new and better ways to support our paramedics.

Thank you for the opportunity to appear before you today, to let committee members know of the important work and our support for this legislation and how we believe it could be strengthened. Bill 163 is an excellent foundation on which to build. We hope you will carefully consider our input, make these important amendments and move quickly to enact this legislation.

I would be pleased to answer any questions you may have.

The Chair (Mr. Peter Tabuns): Thank you very much, Mr. Roberts. The first questions go to the government. Mrs. Mangat?

Mrs. Amrit Mangat: Mr. Roberts, thank you very much for bringing this to our attention. We do understand this issue.

You have said that managers should also be included under PTSD. Can you please clarify on that?

Mr. Neal Roberts: What we're referring to is that paramedic managers are required from time to time to be what we call a "duty officer." They are responsible to oversee the system on-call at home at night.

A good example that you may recall from many years ago in a rural service: There was a migrant worker with a van that had overturned, and there were a lot of patients on the scene. In that case, the chief or a deputy chief would have been the duty officer while at home, and would have been required to attend that scene because of the large number of patients on scene.

It's rare, but that's part of the duty officer role, and that's why we're proposing language such that if they're required to be a duty officer and potentially respond to a scene from time to time, then they should potentially be considered as a part of it.

Mrs. Amrit Mangat: So when you talk about managers, this means—just to clarify for myself—you're talking about paramedic chiefs?

Mr. Neal Roberts: Paramedic chiefs, deputy chiefs and what we call a commander or operational manager level.

Mrs. Amrit Mangat: So what you're saying is that they wouldn't be covered under this presumption?

Mr. Neal Roberts: At this time, our review indicates that there are some managers or chiefs in the field who are currently not active paramedics or communicators for the purpose of how the legislation is currently written. There are two chiefs who come from a communications background who are overseeing their service, and as such they may not be currently qualified as paramedics or as communicators, and may fall outside of the definition of how it's interpreted.

Mrs. Amrit Mangat: Do you have any examples of why they should be covered?

Mr. Neal Roberts: Again, as I indicated earlier, if they're on call as a duty officer, then they're required from time to time to attend a scene, especially if it's a multi-casualty incident, to provide support to their supervisors and paramedics on scene. Basically it's the old adage of "all hands on deck," especially if you're in a rural community, and that's more likely.

In a service of my size, in the city of London, the likelihood of me being on scene is less likely, but when you're in a more rural or remote community, that's when you're probably more likely to be called to assist.

Mrs. Amrit Mangat: Thank you.

The Chair (Mr. Peter Tabuns): Thank you, Mrs. Mangat. Mrs. McGarry, you have 40 seconds.

Mrs. Kathryn McGarry: Okay. I just wanted to touch on prevention, since you mentioned it in your remarks. Can you share how prevention in the workplace would be helpful?

Mr. Neal Roberts: Certainly. I can speak probably more locally versus systemically. It's about providing support not only to paramedics but to all staff within a paramedic service or first responders, on employee mental health awareness, so that they understand the various aspects, but also providing areas such as—as you've heard today—R2MR and that type of training, so that staff are well prepared.

I know that, in our service, we have a very robust EFAP—Employee and Family Assistance Program. It's not only available to paramedics; it's also available to their families because we know that—

The Chair (Mr. Peter Tabuns): Mr. Roberts, I'm sorry to say that you're out of time. I appreciate the questions.

We'll go to the official opposition. Mr. Coe.

Mr. Lorne Coe: Thank you, Mr. Chair, and through you to the delegation: Thank you for being here.

In your deputation on page 2, you talked about the first response teams up north. How many are there?

Mr. Neal Roberts: I don't have the exact number, but I can certainly get it for the committee. There are, I would suggest, probably under 10. The majority are probably covered under the First Nations designation, but there are a couple that fall outside of First Nations, and that's why this issue was brought forward to this committee.

Mr. Lorne Coe: All right. Thank you.

Do you get a first question?

Mr. Rick Nicholls: No, I'm fine.

Mr. Lorne Coe: All right.

One more question: In your discussion of the inclusion of the chief, deputy chief or commanders within the context of what we're discussing, to what extent have you also considered retired staff in that category as well?

Mr. Neal Roberts: If I could just ask for further clarification: "Retired" in the sense of, if they're on duty?

Mr. Lorne Coe: You refer here in your deputation to the chief, deputy chief or commander. There are going to be situations where those individuals retire and there's going to be a reoccurrence of what has transpired. What type of supports—

Mr. Neal Roberts: Certainly. The amendment that we put forward is for a chief, deputy chief or a commander who is currently in the system and is required, during their employment, to respond to a call while they're the on-duty officer. It wouldn't probably apply to somebody who has retired.

Mr. Lorne Coe: All right. Thank you, Mr. Chair.

The Chair (Mr. Peter Tabuns): Thank you. No other questions? None?

I go to the third party: Ms. DiNovo.

Ms. Cheri DiNovo: Thank you for your presentation. It was very informative. You brought forward an interesting aspect. I was just discussing with my colleague that, because people change titles in the role of first responder—people get promoted; they move on—that should not affect the diagnosis or the presumption of PTSD.

I thought that was extremely interesting. I'll let Jen go from there. It's something that we haven't thought about, so thank you.

The Chair (Mr. Peter Tabuns): Ms. French?

Ms. Jennifer K. French: Yes, it does beg the question of going back the 24 months: Is it just the title or the label that you're wearing in the current role, or can your previous role be considered? Anyway, food for thought for the government.

Thank you for bringing up support ahead of a traumatic incident because we've talked about prevention and we've talked about being proactive, but recognizing that the training pieces prepare for a traumatic incident, not just in the wake of—I think that's an important piece to the plans and to that prevention piece. So again, thank you for that.

You had brought up the northern emergency medical response teams. Again, we've been talking today about northern communities and some of the specific challenges up north, whether it's health care or, in this case, response times and those who would be responding. Are those teams volunteers, or are would they actually have WSIB coverage?

Mr. Neal Roberts: Thanks for the question. My understanding is that they are part of the ambulance service itself. While they're not direct employees, they are like a supplement or, in a more remote community, they're the first responder itself.

As to whether or not they're compensated, I can certainly look into that and get back to you. My understanding is that, if it's similar to a volunteer fire department, they are—if I'm correct—covered under WSIB. So I'm assuming there are some similarities as to how an emergency first responder would also operate.

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Ms. Jennifer K. French: Certainly. Not being familiar with it myself, if they aren't covered by WSIB, then there's a loophole there, and they would need appropriate coverage.

One other thing you had mentioned was the cultural change that we'd need to see across our first-responder community. Thoughts on what that cultural change could look like?

Mr. Neal Roberts: I think, as you've heard from your earlier speakers, it's about basically dealing with the issue but certainly providing the resources and the support in advance.

I realize that paramedics, as well as all first responders, have a very difficult job to do. Certainly, it's about supporting them and making sure that they have those supports in advance. They also not only have to deal with issues at work; they have issues at home, they may have financial issues, and all of that compounds it.

It's about making sure those supports are well in place in advance so when a critical incident does happen, it's obviously lessened. It's not going to take away what the paramedic or the first responders have to deal with—

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say, we've run out of time.

Ms. Jennifer K. French: Thank you.

The Chair (Mr. Peter Tabuns): Thank you very much for your presentation this afternoon.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, AMBULANCE DIVISION

The Chair (Mr. Peter Tabuns): We go next to the Ontario Public Service Employees Union, ambulance division: Mr. Jason Brearley. The Clerk is about to collect your presentation. Sir, you have up to 10 minutes to speak, and then there will be 10 minutes of questions, split evenly between the three parties. If you'd introduce yourself for Hansard, we can get under way.

Mr. Jason Brearley: Hi. My name is Jason Brearley. I'm coming to you from OPSEU's ambulance division. We represent approximately 2,100 paramedics and approximately 700 dispatchers working here in the province of Ontario. I myself have been a paramedic for 19 years. I currently practise as an advanced-care paramedic in central Ontario. I'm proud to be in the company of my fellow first responders as we speak about this vitally important legislation today.

I'll begin by thanking the government for introducing the legislation, all three political parties for supporting the bill, and those who have passionately pursued the legislation since 2010, when we had our first go at it.

The acronym PTSD hasn't been in paramedics' vocabulary for more than about 10 years. However, I can assure you that the condition has existed ever since kind people have been volunteering to put themselves in the presence of tragedy in order to provide care.

For responders and legislators, one of our challenges in dealing with PTSD is that the triggers are very unpredictable. A single call for a critically ill child who happens to have the same birthday as your own or who shares a physical trait with a niece or nephew can be enough to provoke a cascade and be a trigger for PTSD. Conversely, a paramedic or dispatcher can feel building pressure as weeks go by, where, once or twice a week, you end up on serious calls that further make you vulnerable to the signs and symptoms of PTSD.

At best, these stressors can ruin a day or a week, which has happened to almost anyone who has done the work long enough. But at worst, these stressors can cause deep depression, end relationships, and, as we've seen here in Ontario, result in the tragic loss of life.

This unpredictability challenges us all. As co-workers, we have a hard time knowing that the individuals we work with are suffering. Because of the stigmas around mental health, often those suffering from stress and depression are not forthcoming with their symptoms. Families don't understand what is wrong or what they can do to help. Employers in my line of work especially don't have day-to-day contact with their employees and are not as effective in helping identify problems or concerns.

This inconsistency extends beyond the care of the individual. It presents the leaders of the profession, as

well as the governing bodies, with a particularly difficult challenge in managing the problem on a systemic scale.

That there is a systemic problem is undeniable. In Canada, five suicides of paramedics were reported in 2014. That number tripled in 2015 to 15 paramedics. In the first two months of this year alone, 2016, we've had six suicides across the country. These alarming statistics are reflected in all of the careers considered in this legislation.

Our employer is always under pressure to find efficiencies. How taxpayer dollars are spent always warrants examination, but somehow it always results in paramedics doing more calls with less recovery time.

Our population is aging, and this is no secret in any of our workplaces. In my workplace alone, a study was commissioned that predicts an 80% increase in call volume in the next 10 years.

Ontario ambulance dispatch centres are in a staffing crisis. Some larger centres are seeing dispatchers answering and engaging in almost double the acceptable amount of 911 calls per person. This means they have little to no time to regroup before picking up the next 911 call. Further, there is limited training and support for first responders in the area of traumatic or emotional events. This guarantees that our systemic problem will only get worse.

Paramedics are a stoic group. I recently saw a meme on social media that showed a paramedic counselling her child, and her quote was, "No, son, you have a paramedic for a mother. You won't be going to the hospital unless you're dying." Dark humour, to be sure, and typical of my profession, but it illustrates our paradoxical reluctance to seek help. Just getting a paramedic or a dispatcher to acknowledge they need help and time away from work is very difficult.

Currently, when a paramedic or any first responder identifies that they have PTSD—a stage that many of us never reach—they are confronted with having to initiate a claim to WSIB. This means recounting their struggle and their triggers to their own physician and to someone in their workplace. In most cases, the next step is a denial of the claim by WSIB, often supported by letters from the employer encouraging the denial. This alone is a systemic barrier to getting treatment and a deterrent to asking for help.

The next steps usually include recounting the triggers to a WSIB adjudicator and to an independent assessment doctor who's not generally supportive in the process. It's well known in our workplace that this process is very difficult. I suspect it's why so many of my co-workers don't seek help until it's too late.

Further, it's counterproductive to an effective PTSD treatment plan to recount the details of your stressors since the very act of recounting can be harmful.

In my line of work, we talk about the risk/benefit analysis of treatment plans. That's because we're frequently confronted with unpredictable and inconsistent symptoms. In a very short period of time, we're required to consider a treatment plan and decide whether the benefits outweigh the risks of the proposed treatment.

In considering the solution to PTSD, particularly the part that applies to workplace insurance, the risk is not being fiscally responsible. We task the government with spending our tax dollars wisely, but we also expect you to look after us in our time of need. I would say that, most particularly, we expect you to look after us when that need arises out of serving the people of Ontario.

I and my fellow paramedics understand that when we are addressing a musculoskeletal injury, some extra assessment before treatment may be warranted. However, when further assessment is likely to do harm and expose the patient to prolonged suffering, the benefits of immediate treatment outweigh the risks.

There's no such thing as perfect legislation, but we all need to sleep at night. I implore you to consider how robust presumptive legislation on PTSD for first responders will decrease suffering and save lives. It's the right thing to do. We can no longer accept the risks of the path we're on. I'm convinced that informed taxpayers and legislators would agree.

My fellow paramedics and I know that the next shift might be the bad one, the one that keeps you awake for a couple of days or causes you to have a few tears when you get home. These are the days that come to mind inevitably when somebody asks you in a social situation, "What's the worst thing you've ever seen?" I almost never answer that question, and I'm not here to traumatize you with any of those stories. Rather, I want you to understand that all of us willingly bear these burdens. But when it gets too bad, when the memories start to pile up, when we find ourselves short-tempered or depending too much on the next drink, we need help and we need it before we lose our jobs, before we lose our families. The truth is, we need it before the next independent medical ordered by WSIB. Please believe me: If we ask for help, it means we need it, and it is that bad.

PTSD can be treated, and those suffering from it can return to being productive workers, often as better paramedics and dispatchers than they were before the diagnosis. But that treatment needs to be well timed and it needs to be accessible and without creating further suffering.

Please use your power to remove the systemic barriers and allow those who suffer from PTSD to seek help and remove themselves quickly before they do that last call that puts them over the edge.

The Chair (Mr. Peter Tabuns): Thank you very much for that presentation. We go first to to the official opposition. Ms. Martow.

1700

Mrs. Gila Martow: Thank you very much for sharing with us and for your presentation. I just want to mention that, as I'm listening to all these presentations—when you said that people ask you at a party, or ask first responders, "What's the worst that you've seen?", I was reminded, as an optometrist working in a hospital with my husband, who was an ophthalmologist, of when a

patient came in from the emergency room. He didn't wear safety glasses on a construction site, and a rivet went right into his eye and was sticking out of his eyeball. His friend brought him to the hospital, so you guys didn't have to deal with it. His friend literally had to take his friend to the washroom; that's how ill his friend became. He asked me how it was that my husband was able to take this gentleman into the hospital, into the operating room, remove it, and not seem ill.

I think that it's all about having the support. Doctors really have the support of the community. They have the support of the hospitals. They have the support of their patients. I think people recognize what they're dealing with. Somebody would never ask a doctor at a party, "What's the worst you've seen?" They don't want to hear about it. But somehow, it's considered a joke that first responders and police see these horrific things. It's not seen as the medical emergency that it is.

Who do you think is the best to diagnose and help treat—medical professionals, counsellors of some type, nurse practitioners? In your opinion, if you have one.

Mr. Jason Brearley: I do have an opinion, but it's not consistent exactly with the question. That is, in my limited experience, I've seen a really wide diversity, under all those titles, of knowledge of PTSD. Some of the doctors that I've seen speak and seen diagnose the people that I work with have a very high level of knowledge of the nuances, and some don't. So I wouldn't suggest that it's a title so much as it is somebody who is very experienced and qualified. It's my experience that, under the current regime, independent medical doctors are not assigned to these cases based on their experience with PTSD, so there seems to be a wide variance in who is able to do the best work.

Mrs. Gila Martow: So we need some kind of medical specialist.

Mr. Jason Brearley: Yes.

Mrs. Gila Martow: Thank you. Any further questions?

The Chair (Mr. Peter Tabuns): You have 20 seconds, Mr. Nicholls.

Mrs. Gila Martow: Make a quick comment.

Mr. Rick Nicholls: That's long enough, I hope.

The Chair (Mr. Peter Tabuns): To the point, sir, to the point.

Mr. Rick Nicholls: First of all, thank you so much for coming in. I have several friends in the Chatham-Kent area who are paramedics. I want to relate a story very quickly: 2007; icy conditions; Blenheim area; a paramedic responding to a crash was in fact involved in a crash himself, and he lost his life.

Mr. Jason Brearley: In the SUV. I'm familiar with it.

Mr. Rick Nicholls: That's right. I'm concerned about the fact that—what were the steps that could have been taken by the professionals—

The Chair (Mr. Peter Tabuns): Mr. Nicholls, I'm afraid you've gone over your time.

We go now to the third party. Ms. French?

Ms. Jennifer K. French: Thank you for joining us today. I appreciate it, and I very much appreciated your presentation.

One of the things that is before us is that list of who's on it and who isn't. Most of the presentations today have called to expand this piece of legislation to include those who will need that coverage.

I brought it up earlier. Is the language around "dispatchers" sufficient? I'm asking because, as you mentioned, 911 call operators—what does the language need to be to ensure that it is the person who takes the call and is on the call, not just the person dispatching the call?

Mr. Jason Brearley: I can only speak to the central ambulance communications centres. The 700 people that I am here representing work in the central ambulance communications centres. All of those people in that building, at one time or another, are taking a call or are involved in a call that could end up being traumatic. My understanding of the legislation, and not being a legislative expert, is that it includes all of those people.

I'm not familiar with the police or fire dispatchers. In each of the jurisdictions, one of those organizations is the actual first organization answering the call. I don't know whether the legislation is enough.

In my mind, anyone who is on that end of the phone, receiving a 911 call, should be included.

Ms. Jennifer K. French: Okay. Are all of yours called "dispatchers," per se?

Mr. Jason Brearley: I believe so, yes.

Ms. Jennifer K. French: Okay.

Mr. Jason Brearley: Communications officers—and, I believe, even the managers who are involved, who may answer a call, are also called communications officers, so I think it's adequate.

Ms. Jennifer K. French: And I think the spirit of the legislation is to include all those people, but we want to ensure, legally speaking, that we have this—

Mr. Jason Brearley: I can certainly get back to the committee and have somebody look at it.

Ms. Jennifer K. French: Okay, and I thank you. I appreciate, as you were saying, that you would have us look after you in your time of need and remove systemic barriers. This piece of legislation is obviously vital, but the system isn't going to change. This is the presumption for this group of people, but the system itself in terms of the WSIB system—those who are not covered by the presumption would still have to battle that system and be retraumatized potentially by that system.

What would you like to say about that system? Perhaps there's some learning that can be gained from this and we can strengthen the system outside of those who are covered by the presumption.

Mr. Jason Brearley: Right. If I were to strengthen the system in terms of mental health in particular, I would caution that it's very easy to say, "I broke my leg at work," and you have an X-ray and you have an acute event. I think it was alluded to at least in a couple of the presentations before: There's not always an acute event, and because it's a cumulative potential, it's very hard—

The Chair (Mr. Peter Tabuns): I'm sorry to say you're out of time.

Mr. Jason Brearley: Tread lightly.

The Chair (Mr. Peter Tabuns): And we'll go now to Mr. Colle and then to Mr. Anderson.

Mr. Mike Colle: Yes. Thank you very much for that very earnest, thoughtful presentation. You gave us the real goods on that.

Just to clarify, I think you're correct in terms of dispatchers are covered, and if you wanted further details on that, we can—

Mr. Jason Brearley: Communications officers, yes.

Mr. Mike Colle: —avail the committee of that. I'll pass it over to my colleague.

The Chair (Mr. Peter Tabuns): Mr. Anderson.

Mr. Granville Anderson: I also want to thank you for being here, Mr. Brearley, and for your work, keeping us safe and helping those in need of your assistance. As I said, that resonates with me. My daughter is a paramedic, so I know exactly how difficult the job is.

Earlier on, a number of presenters alluded to the fact of how difficult it is to navigate the WSIB system. Hopefully—can you explain—hopefully this bill will help make that easier.

Mr. Jason Brearley: I think so. I think that not only will it make it easier; the perception of my co-workers will be that it is easier, and that will get you more people being honest with the system about the symptoms they're having.

We talk about prevention, and prevention, in my mind, in most of these cases is about early diagnosis of early symptoms. The stigma that we're fighting in our workplace is that people aren't coming forward in a timely fashion. I think they're afraid of the process. They're afraid of the stories they have heard from other co-workers about the interviews they've had to sustain and the process they've had to go through. Any kind of step we can take to make that appear to be more streamlined and appear to be more accepting I think is going to get more people the help they need and maybe less cases where the person is going off work for the rest of their career and more cases where the person is going off work to get treatment and return.

Mr. Granville Anderson: You also mentioned stigma, which has been—the other presenters as well. You're doing some kind of initiative to overcome that stigma. Can you explain what you are doing within your workplace?

Mr. Jason Brearley: Yes. My specific workplace—and this is consistent across the paramedic services that I represent and the people I speak with. You're starting to see mental health show up on our continuing medical education agenda. For those of you who are unaware, paramedics attend regular education throughout the year, and those agendas of those days are starting to talk about mental health. They're starting to talk about support. There are videos about symptoms—and again, we rely heavily on our co-workers to identify those symptoms when we're unable.

My managers see me for a couple of hours a week. The rest of the time I'm not working in the same building or the same place as they are. My family and my co-workers' families aren't highly educated on PTSD, so the education point is very large. The more we can get people helping each other out, the better.

The Chair (Mr. Peter Tabuns): And with that, we come to the end of our time. Thank you very much for your presentation.

Mr. Jason Brearley: You're welcome.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, MENTAL HEALTH DIVISION

The Chair (Mr. Peter Tabuns): Our next and last presenter for the day: Ontario Public Service Employees Union, mental health division, Ed Arvelin. Mr. Arvelin, as you've heard, you have up to 10 minutes to present; then we split 10 minutes between the three parties. If you'd introduce yourself for Hansard, we can proceed.

1710

Mr. Ed Arvelin: Hello. My name is Ed Arvelin. I work at the Lakehead Psychiatric Hospital in Thunder Bay as an RPN. I've worked in mental health for almost 20 years now. But that's not the only thing I've worked in. I've worked in cardiac step-down; I've worked in hospice, acquired brain injuries and pretty much every field in mental health, from crisis response to community health to acute care units to our forensic units—so, been there, done it in health care.

Thank you for this legislation. It's long overdue, but it's a start. It does not go far enough. It needs to go further and it needs to include others: "others" meaning health care providers, front-line workers, other CSA workers, developmental service workers—the stuff where front-line people see and suffer from PTSD all the time.

OPSEU will be giving you an electronic version of our submission, but I wanted to give you a personal story because, working in mental health, I see it and I know it and I live it. Stand beside a nurse when a code is called—a code white, violence; red, yellow, blue, orange, black, pink. You see the reaction: It's a stop to listen and let's get ready to run. That's what we do.

We are first responders; we are first on the scene in the hospitals, in our communities. We're crisis responders. In our communities, we are usually the first ones there, dealing with crises with our patients in the communities. That needs to be addressed.

I'm going to give you a little history on some of the violence that we've seen. I'm sorry, I got a little nervous because this is very passionate to me and I've seen it lots.

A couple of violent situations that I've seen: When I first started, I got called to a code white. You get assigned to a code white—"Attention, assigned staff. Perk up, listen, run to that location." Getting on to the unit—I still remember it as clear as day. I walk in and I see a person, a female, being held by the hair, her hands

in the nurse's hair and her head being swept across the floor like a mop. You don't unsee that. We got on to the situation and got the person secure and the treatment delivered. It was good. Unfortunately, that person has never stepped onto another acute unit ever again. We got to see that.

Another one was another attending-a-code-white situation. "Attention, assigned staff; code white. Perk up, listen, run." Go on to that unit—it was insane. I hadn't ever seen that much blood. A person was on top of one of my buddies, in front of him, pounding his face, his face caving in. We got on top of him, we secured the patient and got him safe. We went after our own and made that he was safe and secure. He ended up with two rods in his nose, which stopped his face from caving in because of the violent attack. Again, that's something that you just can't unsee.

Deaths: You see it all. We have cut-down knives hanging in our office on our psychiatric units. We've had to cut down individuals. You don't unsee that.

I've held a person's arm together because they were very creative in peeling apart a BIC razor. What they did is they pulled the razor and they cut from the wrist up to their elbow—not just once, but they did it several times. They came out in the hall; blood was gushing. We held her arm together. We called the emergency responders. They came, and that person survived. Again, you don't unsee that.

Our community people are walking into people's homes and finding a person dead because they've cheeked their medication enough to the point where they could commit suicide. Our staff are walking into that situation and seeing that; it's stuff you don't unsee.

PTSD, what we do: We call it mental health days in mental health. They're sick days, but we call them mental health days because, do you know what? We just can't listen to it; we can't hear it; we've been through enough; we're shaken.

The lack of support that we feel after incidents: The way I was brought up was, "Okay. You're all right? Good. Next patient." It's slowly evolving. Conversations are happening by the employer. They're realizing they have to provide different services. Small steps; more is needed.

Reporting of PTSD often doesn't happen with people that provide mental health training because we're supposed to be the mental health experts, right? We should know how to take care of ourselves. Good luck. A brother said, "A mom or dad who works in the medical field? You've got to have an arm hanging off or a foot dangling to go." Mental health is the same thing with mental health service providers. That's what we do.

Also, we're bleeding hearts. We work longer hours. We go in with the mentality that if we book off, our patients suffer because a lot of times in our communities there is no backfill. If I book off on the in-patient units or in our institutions, our co-worker suffers because there's no backfill. I've gone home after a shift and needed quiet for at least an hour, just to settle my thoughts. That means I had to shut down my children and my wife because of events that have happened that I've had to deal with.

There are four main points that will help assist front-line service providers: Cover all front-line service providers; strengthen preventative measures; allow doctors to diagnose—physicians; and make sure that benefits are being provided for—wages and treatment. Dealing with WSIB sucks because PTSD is unrecognized. It's an invisible illness, and it happens all the time.

I'm good.

The Chair (Mr. Peter Tabuns): Okay. Thank you for your presentation. We'll start with the third party. Ms. French.

Ms. Jennifer K. French: Thank you so much for coming and reminding us all why we are sitting here: because there are very real people across our communities who are doing very real work. While we've heard that today, I think I've appreciated yours for a different reason, and that is that you are sitting there representing a group that is being left out and providing the care, the mental health support that we're sitting here talking about. So, thank you.

Some of your points that you made—the lack of support that you feel after an incident—I think speak to what we've had a number of other presenters talk to. That is, what happens immediately after a traumatizing incident needs to be part of those plans if this government is going to put in this bill about prevention and in plans—the immediate window after and how our first responders are supported.

Also, as you said, dealing with WSIB sucks. We've been hearing that over and over in terms of the process—reasons why front-line service providers might not report because they don't want to have to go through it again and again or get into family history that may or may not be relevant when you're talking about a workplace injury like PTSD. I think it's very sobering to imagine the work environments that our various first responders wake up and go to every day or every night. So thank you for bringing that to us.

In terms of clear amendments, something that you would like to see, you mentioned four takeaways there at the end. "Cover all": who specifically? How would you word it?

Mr. Ed Arvelin: Wording specific, I think, will come from OPSEU. We have our people looking into that specific language change and amendments. But it's inclusive of all front-line service provider staff—the care providers. You've got the developmental service workers. You have the CAS workers. You have mental health workers. You have our ambulance. Everybody who's providing a human service deals with human values and human problems, and those are the people who should be included because it's real.

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Ms. Jennifer K. French: Anything else that you would like to add?

Mr. Ed Arvelin: You know what? I can go on forever. It's easy. Our psych facilities: We got divested for a

long period now. The problem, or what happened with that, was decentralizing of psychiatric facilities, so we lost that central table. Now we're picking up the pieces of the fragmented services, and we're having to try to get together and bring together solutions to 12, 13, 14 different parties that are all public or private—

The Chair (Mr. Peter Tabuns): I'm sorry to say you're out of time with this questioner. We have to go to the government. Ms. McGarry.

Mrs. Kathryn McGarry: I really appreciate what you had to say today. As a former critical care nurse, I have been witness to a lot of the codes that you were talking about, including code whites.

You mentioned the lack of support and follow-up. I think some workplaces have actually addressed support and treatment better than others. I think I was fortunate. We always had a critical incident debrief team when we needed to be debriefed in hospitals that I was working in. But I know that's not the case across the way, and you've mentioned a few of these things.

I know that Bill 163 has expanded the coverage to include workers in correctional institutions, places of secure custody, those kinds of things. But in terms of prevention, Bill 163 is proposing to give the minister an ability to request and share information to employer prevention plans and programs. How do you feel that would assist mental health in a workplace, going forward?

Mr. Ed Arvelin: Oh, 100%. We found it helped with Bill 168, article 32, under the health and safety act, with the risk assessments, and the violent risk assessments specifically. So, seeing that and having that paralleled in a similar situation, absolutely, because it forces the employer to take notice of a situation that needs to change. I could not advocate for that more.

Mrs. Kathryn McGarry: Do you think that the proposed changes, then, will improve mental health across a workplace?

Mr. Ed Arvelin: If mental health gets included, absolutely. Right now, we're out. We're having trouble streamlining who we talk to, and we have to talk to each and every employer and get them to agree to that change, when you're dealing with 15, 16 different employers, so the tough part is coordinating our efforts. We're getting there. We're fragmented; we're coming back together. But it's a matter of having that voice, and that's where we lack. It would be tougher for us to do that.

Mrs. Kathryn McGarry: The other thing I wanted to ask you about is that you mentioned the stigma of mental health issues in the workplace. Again, some workplaces have a culture that has a larger stigma against admitting that you're having some issues. What do you think is needed to reduce the stigma of PTSD and mental health issues in the workplace?

Mr. Ed Arvelin: Talking. Not myself today, but Jeff Moat—we've brought him in to talk to our mental health people all the time.

It's just as simple as wearing a button saying, "I'm feeling crappy," "I'm feeling angry," "I'm feeling sad," because it promotes the talking and the conversation. It brings it out of the dark. It brings it into light, so people can talk about it, and that's it: It's making people feel okay to do it.

Again, specifically with mental health, that's what we're supposed to be there to provide. So you get a little bit more of the stigma, like, "Okay, if I show weakness, am I that good of a mental health provider, in that I can't even fix myself?" That happens.

Mrs. Kathryn McGarry: Thank you.

The Chair (Mr. Peter Tabuns): Okay. With that, I'm sorry to say we have to go on to the next questioner. We go to the official opposition. Mr. Nicholls.

Mr. Rick Nicholls: Thank you very much, Ed, for coming in this afternoon. One of the things—and I referenced this earlier this afternoon—was September 3, 1999. That was that fatal crash, probably recorded as one of the worst car crashes in Ontario history. There were a lot of heroes that day. We talk about fire, we talk about police, we talk about EMS, and civilians, but you know what? We also need to talk about nurses as well, and what they had to see and what they had to do.

I often wonder. I mean, I was there; I was one of the civilians. It was 17 years ago, and I remember it like it was yesterday. People said, "Rick, maybe you've suffered a little bit of PTSD." Well, I've had to deal with it. Talking about it was a big thing for me—helpful, very, very much.

But I guess my concern is that when you do take a look at it—you talked earlier about the importance of the front line, people on the front line, and what they have to deal with. There are circumstances and situations—and I guess when you talk about front line, the question is, where do you draw the line for front-line people who have to deal with these circumstances and situations day in, day out? They say, "Well, it's part of the job." The old stigma used to be, "Suck it up, buttercup. You're a big boy now." But the fact of the matter is, we're human beings. We have to deal with it. We have families we have to go home to, and sometimes if we shut it in, lock it deep inside, they begin to see behavioural changes that we may not even be aware of.

Again, I appreciate the issue you brought forward today. I can only hope that as we review circumstances and situations, we'll be able to take a closer look at front line and who can be and should be included in that.

Based on your circumstances and situations, what words of advice would you give to someone—earlier, you mentioned talking it out—who is in a similar situation as you?

Mr. Ed Arvelin: What helped us—I grew up in mental health—was mentorship. You have the senior staff who have been there for a while, or people you trust, because when you're in bad situations, you develop a bond. It's a brotherhood and sisterhood. You hear it in the labour movement all the time, but it's actually true on the unit because you expect that person to have your back and you have theirs. Having that person there to talk to is more beneficial than any EAP service that could ever be

provided. Having peer support, specific peer groups—and I know some institutions have that, which I've heard works fantastic—I could see a change, and see how that works.

Mr. Rick Nicholls: I think training is a big thing, too. Making sure that the proper people are qualified to deliver that training is critical. I believe that this bill will also provide funding for additional training.

The Chair (Mr. Peter Tabuns): With that, we're out of time. Thank you very much for your presentation today.

Mr. Ed Arvelin: Thank you.

The Chair (Mr. Peter Tabuns): Members of the committee, this committee stands adjourned until 4 p.m. on Tuesday, March 8, 2016, here in the same room.

The committee adjourned at 1727.

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