national union

report

Post-traumatic Stress Disorder Roundtable

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Guest Speakers: **Enrico Colantoni, National Spokesperson, The Tema Conter Memorial Trust**
Vince Savoia, Executive Director, The Tema Conter Memorial Trust

INTRODUCTION
SPEAKER: JAMES CLANCY, NATIONAL PRESIDENT, NUPGE

The issue of post-traumatic stress disorder (PTSD) has become a very high profile one. Sadly, the increased attention to the issue is primarily as a result of a number of media reports pertaining to tragedies among our military personnel and first responders.

Over the years the issues of workplace trauma and PTSD has been frequently discussed at the Working Session for Correctional Officers and Youth Facility Workers. Serious work on the issue within the corrections setting started almost ten years ago when SGEU started to look at exposure to violence by correctional officers. This was closely followed by the work of Neil Boyd, a criminologist at Simon Fraser University, on behalf of BCGEU.

As a result of this work, and that of other academics, we have seen a considerable amount of research done in the justice sector related to exposure to violence and trauma. All of it indicates that correctional officers experience traumatic events in the workplace at levels basically on a par with military personnel and inner city police forces. Indications are that PTSD rates among correctional officers are among the highest of all professions.

However, the National Union recognizes that this issue is not confined to corrections or justice workers or first responders. We have participated in, and followed, a number of research projects that have looked at exposure to violence and trauma in health care, home care and long term care settings.

In particular, the National Union participated in a large international study on the issue of violence and trauma for workers in long-term care settings. This study found that when comparing Canadian long-term care settings with those in four Scandinavian countries that workers here experienced the highest levels of workplace violence and trauma.

Then, last spring, the topic of PTSD and a health and safety response was the focus of a meeting of the Canadian Health Professionals Secretariat. Many of the same themes covered at that meeting were revisited at the roundtable.

As a union we have an important and unique perspective and focus on issues of workplace trauma and traumatic stress injuries. We look at the entire work environment and not simply the traumatic event or the workers directly involved. As unions we are obligated to take the necessary steps to protect our members in the workplace or ensure that they have all the supports they need should a member be injured.

Looking at the issues from a union perspective also allows us to look at broader political matters and their relationship to traumatic events and mental injuries. We can talk about, for example, how funding cuts and understaffing, are creating unsafe workplaces and resulting in a growing number of our members being exposed to violence and traumatic incidents.

We can also look at how the definition of PTSD that was adopted in the DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) has made it easier for members and their advocates to win leave and compensation for mental injury. However, in some provinces we are still fighting to have chronic and repeated exposure to traumatic events and stressors recognized as leading to PTSD. We have seen some victories in this battle and more are to come.

And, on this issue, we will occasionally find ourselves at odds with those regulatory bodies that govern the work that some of our members do. A situation involving the return to work of paramedics who had been treated for PTSD is a case in point.

For these reasons, the National Union wanted to bring together some of our leaders, staff and activists to look at the diverse threads of the topic — to bring that union and front-line perspective to bear on the topic of PTSD.

While we know that PTSD and mental injury are much more prevalent among first responders we are also seeing growing numbers of others who are reporting traumatic stress disorders.

The National Union also wanted to look at the issue specifically from an occupational health and safety perspective. While the clinical aspects of the issue are important and must be discussed, we feel that there is also a need to look at measures that prevent exposure to traumatic incidents or stressors.

Looking PTSD as an Occupational Health and Safety issue also means discussing legislation and workers' compensation policies that our injured members will face. The National Union sees the adoption of presumptive legislation pertaining to PTSD in some provinces, as well as the new legislation being discussed in Manitoba, as positive developments. However, we need to look at ways to further support our members who are suffering from PTSD and other mental injuries.

The National Union and its Components have often been out front in working on these issues. We are continuing that work with this roundtable.

HEROES ARE HUMAN TOUR

SPEAKER: ENRICO COLANTONI, SPOKESPERSON TEMA CONTER MEMORIAL TRUST

"When simply doing their jobs means sustaining a life-altering trauma themselves, we owe our emergency workers and military personnel the respect and the dignity of first-rate care, understanding and support." Enrico Colantoni

For five years, Canadian actor Enrico Colantoni played a police officer on the popular TV show Flashpoint. In 2011, Mr. Colantoni joined the Tema Conter Memorial Trust (TCMT) as its national spokesperson.

Since then Mr. Colantoni has reached a broad audience on the issue of people who are diagnosed with PTSD. The simple yet powerful slogan, “Heroes Are Human” has spread awareness across the country and beyond.

In 2014, the TCMT conducted the Heroes are Human PTSD Awareness Tour across Canada to great effect. The response from first responders and the public was immense. Hoping to build on that success, a second tour is being planned with more than 48 towns and cities already hosting events.

Another project that Mr. Colantoni is involved in as part of his role with the TCMT is documentary called *The Other Side of the Hero*. Produced and directed by award-winning Canadian film-maker Karen Shopsowitz, the documentary looks at the real life world of the first responder.

It follows the excitement and bravado as real life action heroes head out on a call. Viewers get an inside glimpse of the camaraderie and dark humour back at the station. The intent is for the audience to get to know first responders as people rather than just the uniform that they wear. The documentary also shows the flipside of what can happen when a hero discovers that they are not emotionally immune to all that happens in the course of a shift.

YOU ARE NOT ALONE

SPEAKER: VINCE SAVOIA, EXECUTIVE DIRECTOR TEMA CONTER MEMORIAL TRUST

More than 20 years ago, Vince Savoia, a former paramedic, had to quit his job after a traumatic call that changed his life. He now runs the Tema Conter Memorial Trust, an organization dedicated to working with first responders suffering a little-known side effect of their job: Post-traumatic Stress Disorder.

Savoia started the Tema Conter Memorial Trust in 2001 as a way to bring help to those experiencing PTSD as a consequence of their work as first responders.

The statistics on mental health issues and PTSD demonstrate both the scope and seriousness of the issue:

- 1 in 10 Canadians suffer from a diagnosable mental disorder within any given year.
- 1 in 5 people will experience a mental disorder over the course of their lifetime
- More than half of the people with a psychological health condition do not receive a diagnosis.
- Of those diagnosed, less than half receive treatment that meets the expected standards of practice.
- 15% of Canadian health care expenditures can be attributed to mental health disorders.
- Less than 4% of research funding is dedicated to mental health.

It is estimated that the cost to the Canadian economy of people with mental health problems is $51 billion. These numbers break down into

- costs to the employer: $34.70 billion
- costs to the taxpayer: $16.30 billion

While these figures are not solely related to PTSD, it is an indication of how important mental health issues are both socially and economically in Canada. The data on the incidence of PTSD show that it is a substantial component of this bigger picture:

- Prevalence of PTSD within Canadian general population is approximately 8%.
- Prevalence of PTSD within Emergency Services is 16 to 24%
- Rates of PTSD in the various services in Canada are
    - Corrections: 24 to 26%

- Paramedics: 22 to 24%
- Firefighters: 16.5%
- Police Officers: 10 to 12%
- Canadian Military: 5.3%

Among first responders, the impact of PTSD can be devastating and even fatal:

- 27 first responders died by suicide in 2014 (April 29 to December 31)
- 19 military personnel died by suicide in 2014
- 18 first responders and 5 military members have died by suicide in 2015 (as of May 8)

Unfortunately, the culture of many workplaces has proven to be the biggest barrier to the prevention and treatment of PTSD. In many worksites, in particular those for first responders, there remains a stigma to admitting mental health problems. Often workers who have experienced a traumatic event are not encouraged to seek assistance, rather they are told to "suck it up" or to "be tough."

However, as awareness of traumatic stress injuries and workplace mental health problems increases there is a perceptible move towards greater acceptance of the need for supports. Awareness has also led to more research on the prevention and treatment of mental injury. This in turn has helped organizations like the Tema Conter Memorial Trust develop examples of best practices for workplaces.

Often times it has been discovered that best practices in responding to workers who have been involved in a traumatic incident are at odds with what has traditionally been done. For example, traditionally workplace debriefs involved having the worker recount the incident immediately after the incident. However, research shows that it should be 24 hours later, conducted by a trained mental health professional and does not involve a retelling of the trauma.

All people experience some stress of a general nature every day when going about their lives. Usually, they feel a sense of control over the stress and it does not constitute a traumatic incident.

Then there are the forms of stress that can make a serious impact on an individual's sense of well-being. These are referred to as acute stress, vicarious stress, *cumulative stress* (organizational stress). Research has shown that an individual's sense of how much control they have in a situation is related to whether they will develop a mental injury or PTSD. PTSD is often also referred to as occupational or *operational stress injury* reflecting the workplace origins of the disorder.

The most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5), published by the American Psychiatric Association, has helpfully expanded the criteria for diagnosing PTSD. The DSM 5 identifies the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.

The individual must experience repeated or indirect extreme exposure to details of a traumatic event – usually in the course of one's professional duties.

The DSM-5 proposes four distinct symptom clusters. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal.

- Re-experiencing refers to spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
- Avoidance refers to distressing memories, thoughts, feelings or external reminders of the event.
- Negative cognitions and mood represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.
- Finally, arousal is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance or related problems.

With increased attention and research on the issue, TCMT, and others, have established a set of best practices.

The goals of crisis intervention for any organizations should be to

1. protect our colleagues from any other trauma or additional stress
2. give our colleagues a sense of hope

Workplaces need to implement

- an anti-stigma campaign
- education in the workplace
- peer support
- a process where employers engage with employee assistance program to evaluate and improve upon the supports they offer

THE LEGISLATIVE FRAMEWORK

SPEAKERS: LEN BUSH, NATIONAL REPRESENTATIVE, NUPGE
KRISTA SMITH, SAFETY, HEALTH & ENVIRONMENT, MGEU/NUPGE

There is considerable variation among the provinces with regard to how Workers' Compensation treats workers who have PTSD. There are considerable differences on whether a single traumatic incident is the sole compensable criteria or whether it must be exposure to multiple traumatic events. Similarly, provinces differ on whether only first responders (from a limited list of occupations) are eligible, or if compensation and support is available to everyone.

Len Bush provided a snapshot of each province's legislation or policies regarding PTSD and a general discussion of regional practices. This provided participants an opportunity to see what would constitute better legislation and practices in their jurisdiction.

It is interesting that a number of provinces explicitly exclude changes in the workplace as a stressor that can lead to mental injury.

One of the best approaches to supporting workers with PTSD is referred to as presumption and is, most notably, the case in Alberta. In 2012, amendments to Alberta's *Workers' Compensation Act* somewhat relaxed the eligibility criteria for mental stress claims, in particular for PTSD, for the province's emergency service workers.

Currently, in Alberta, it is assumed that the PTSD claims of emergency medical technicians, firefighters, peace officers and police officers are a result of their exposure to traumatic event(s) that arise as a result of their employment. The claim can be subject to challenge by the employer.

In Alberta, the presumptive approach initially led to an increase in the number of first responders claiming PTSD. Interestingly, it appears that the presumptive approach has prompted employers to adopt better practices to respond to PTSD and, as a result, they are starting to see a decline in claims.

There is legislation in Ontario that promises to significantly improve the ability of first responders to claim PTSD; however, it remains stalled in the legislature despite all-party support. It is hoped that this legislation will be adopted in the near future.

On the legislative front, Manitoba, is in the process of adopting what many see as the most worker-friendly PTSD legislation in Canada. Krista Smith provided some background on how the province's labour movement pushed for the legislation and what is contained in the Act.

In 2015, the province introduced The Worker's Compensation Amendment Act of Manitoba — Bill 35 — which will be Manitoba's legislation covering PTSD. This follows on almost ten years of work by the MGEU/NUPGE responding to problems with the manner in which the WCB of MB was adjudicating claims for psychological injuries.

In the past, there was a different adjudicative standard used for mental injuries. Workers had to meet a higher burden of proof when it came to psychological injuries versus physical injuries. This resulted in a lengthy process to claim mental injury. It also meant a longer appeal procedure, which frequently had an adverse effect on the member.

Despite the MGEU/NUPGE's repeated success with PTSD claims being accepted before the Appeal Commission, the Workers Compensation Board (WCB) still contended there was nothing wrong with their system. Indeed, the WCB seemed unmoved or uninterested in court or appeal board decisions across the country.

In November 2012, a policy on the "Adjudication of Psychological Injuries" was passed by the WCB Board of Directors, supposedly as a way to address the MGEU/NUPGE's concerns.

However, following challenges by the union, the Appeal Commission while responding to a specific case of PTSD ruled that the policy was in conflict with the Act. This led to the MGEU/NUPGE pushing the WCB to rescind the policy. The WCB instead set aside the decision of the Appeal Commission and sent the claim back to the WCB Review Office.

Meanwhile, the union approached the Minister responsible for the Workers Compensation Act and requested changes to the Act to address the issue of psychological injuries. Under the Minister's direction, a stakeholder review of the Act was conducted.

During the stakeholder review the MGEU/NUPGE argued that the legislation should be applicable for all workers, not just first responders, and for all types of psychological injuries, not just PTSD. This has been ultimately reflected in the amendment to the Act.

In a nutshell, the new amendment to the Act is applicable to all workers covered by the *Worker's Compensation Act*. Furthermore,

- PTSD is considered an occupational illness unless the contrary can be proven by the WCB.
- PTSD can be caused by a single event or a series of events.
- PTSD can be diagnosed by a physician or a psychologist.

- If the cause of the PTSD, as outlined in the DSM 5, is a workplace related one, the PTSD is presumed to be an occupational illness.

While this is a positive outcome, there remains work to be done. The new legislation takes effect on January 1, 2016.

The policy supporting the legislative amendment has yet to be developed. Given the WCB's resistance to change in the past, the MGEU/NUPGE believe that they will need to continue to closely monitor the process. Also, the new amendment covers only PTSD and does not address other workplace mental injuries.

Also, WCB has recently developed a new "practice" of accepting the PTSD-related event as an accident, but then disallowing time loss or medical aid benefits.

HEALTH AND SAFETY APPROACHES

SPEAKERS: RAY GELDREICH, HEALTH AND SAFETY ADVISOR, HSAA/NUPGE
TERRI AVERSA, SENIOR HEALTH AND SAFETY OFFICER, OPSEU/NUPGE

Legislation is but one aspect of responding to mental injuries and PTSD in the workplace. Another is the ongoing occupational health and safety work that is done by unions. Indeed, joint occupational health and safety (OH&S) committees likely provide the best forum for addressing many forms of occupationally related mental injuries.

A number of recent developments have significantly increased the standard of what is reasonable and practical around bullying and harassment in the workplace. The changes to the DSM 5 were previously discussed.

Another significant change in Canada is the introduction of the National Standard for Psychological Health and Safety in the Workplace . This is a voluntary standard that is intended to provide systematic guidelines to employers to enable them to foster psychologically safe and healthy work environments for their employees.

Ray Geldreich (HSAA/NUPGE) and Terri Aversa (OPSEU/NUPGE) reviewed two approaches that NUPGE Components have adopted to create psychologically safe and healthy workplaces. In the case of HSAA/NUPGE, they utilize the tools developed in the Guarding Minds at Work project. In Ontario, OPSEU/NUPGE worked with a number of other groups to create the Mental Injury Tool for use in workplaces.

Ray walked through the Guarding Minds at Work (GM@W) approach and its tools and discussed its implementation in Alberta. He explained that the GM@W starts with the assumption that there exists a finite number of workplace factors that play a role in the mental or psychological health, both positively and negatively, of a given worksite.

GM@W is one strategy used to identify these factors with the goal of strengthening those that promote positive mental health in the workplace and reducing those that adversely affect a worker's psychological well-being.

Otherwise stated, GM@W is a method for addressing and supporting certain basic human needs at work so that their lack of fulfilment does not end up presenting risks to mental health.

Ray provided an overview of the various GM@W tools and discussed the program's training process. He explained that any tool used will have strengths and weaknesses. The goal is to continually improve and update the tools used in order to better meet members' needs.

One of the advantages of the tools is that employers have been less resistant to using them in the workplace. This can allow the union to reach members that it might not otherwise due to employer resistance. However, the potential weakness is that the tools will present workplace issues in a manner that is more employer friendly.

Another advantage of the tools is that they have a large body of data that allows for a comparison of the results from a workplace survey with a broad number of other worksites. They help generate good baseline data on workplace factors, which then allows OH&S committees to evaluate the effectiveness of various interventions.

David Durning, staff with HSABC/NUPGE, mentioned that they were using the GM@W tools in British Columbia. The union sent the survey all members around the province and received a good response. The surveys returned well reflected the demographics of the membership.

The intention was to give a general baseline across the province. The data pointed to those worksites and factors that needed close attention. Most worrisome is that the data indicated a lot of problem areas where members where working in some psychologically unsafe worksites. HSABC's work is continuing and they are working closely with three consultant psychologists from Simon Fraser University.

Terri Aversa explained that Ontario's Mental Injury Toolkit was developed as a result of many of the same issues that led to the GM@W tool.

The toolkit project started in 2009 when a group of unions joined with the Occupational Health Clinics for Ontario Workers (OHCOW), University of Waterloo researchers, and representatives from the Office of the Worker Adviser (OWA), and the Workers Health and Safety Centre (WHSC) to look at addressing workplace psychological health and safety issues. The goal of the "Mental Injury Tool" (MIT) Group was to develop tools and resources to help workers deal with these "non-traditional" occupational hazards.

The toolkit was created *for workers by workers*. The concern is that many workers, in particular many first responders, worry about completing a psychological health and safety questionnaire that is sponsored by the employer or an outside party. It is thought that keeping the research and data within the union provides for better response rates and more accurate data.

Terri noted that the Mental Injury Toolkit relied on much of the research and resources contained in the 2010 report by the Canadian Mental Health Commission, written by Dr. Martin Shain, called *Tracking the Perfect Legal Storm*.

The report was responding to legal developments that made it clear that employers have some responsibilities for creating and maintaining a psychologically safe workplace for employees. Shain's work was launched in advance of the voluntary standard for employers.

These tools are not intended as clinical diagnostic tools. They are designed to identify problems that may exist within the workplace and provide possible avenues to address them.

OPSEU/NUPGE uses the COPSOQ II (Copenhagen Psychosocial Questionnaire) as a survey tool to assess a workplace. There are a couple of issues to address before and after a survey of the members on workplace psychological factors. The process should only be embarked upon if there is a sincere commitment (at all levels) to follow-up action based on what is discovered.

Terri reviewed the steps necessary to conduct a significant and useful survey of the membership. She cautioned that survey results should be seen as a tool for dialogue and development — not as a "report card."

OPSEU/NUPGE has circulated the survey in 55 bargaining units and has received back a total of over 2,200 completed surveys (pilot survey in the spring 2012, full launch in spring 2013). The survey was then distributed in 6 additional bargaining units and there were over 200 completed surveys.

A couple of these were “spontaneous units,” where a member obtained a copy of the survey and then copied and distributed it among their members and came to OPSEU/NUPGE for help with the analysis.

There are about another 6 bargaining units in the organizational stage right now.

One example of how COPSOQ II was used is an intervention in Community Nursing. Workers from a community nursing organization used it to identify the top three workplace factors that were statistically shown to be affecting their self-reported health. Then the members (with the assistance of their union and the Joint Health and Safety Committee) collaborated with the employer to

- reduce emotional demands
- address workplace demands
- reduce workplace bullying

In the end, the organization of work was changed to better meet the workers’ workload and the travel and operational demands placed on them. Furthermore, the employer appears to have adopted a collaborative and supportive management style.

Terri argued that the collective agreement should be seen as a health and safety document. Collective agreements set out the terms and conditions of work and usually contain provisions around

- vacation time and other time off
- staffing levels and replacement
- sick leave and other leaves
- health and safety protections, including issues like workplace ergonomics
- human rights language
- workload

Activists can frequently use language in the collective agreement to identify and address psychosocial factors at work. The contract also sets out various workplace committees including those regarding health and safety.

MOVING FORWARD

SPEAKER: JAMES CLANCY, NATIONAL PRESIDENT, NUPGE

The National Union's intention when it organized the roundtable was to bring people together to discuss current provincial legislation regarding PTSD and to start exploring best practices that are in place across the country. The goal was to start a process where Components were learning from each other and implementing what they were learning to benefit our members.

When developing the agenda, NUPGE had considerable discussion about the scope of who should attend. While first responders experience PTSD at a rate disproportionate to that of other workers—and have played a leading role in having the disorder recognized—there is growing recognition that it affects a wide number of the people we represent. Furthermore, very little attention is paid to those workers who develop PTSD and are not first responders.

Again, this is not downplaying the fact that the incidence of PTSD among first responders is at a crisis level. It is about working to best support all workers who have a mental injury as a result of a traumatic workplace event.

The National Union recognizes the importance that education within the union will play in implementing measures that will prevent workers developing PTSD or other mental injury at work. It is particularly important that work is done in our workplaces to combat the stigma still associated with mental health problems.

It is equally important that the union works to educate the public about the issue and create greater awareness among the families, friends, and neighbours of our members.

The educational component of our response will involve more traditional teaching methods, as well as the involvement of Occupational Health and Safety committees in the workplaces. It will also require further research, with the intention of using that research to implement best practices across the country.

Efforts to address mental injury will involve engagement on three fronts: at the bargaining table, in OH&S committees, and in the legislature.

At the bargaining tables—gains made in one Component can be used by others to make progress in their jurisdiction. As has been said, the collective agreement has a significant role in protecting the health of our members.

Occupational Health and Safety Committees need to share the tools and techniques that they have developed to protect the mental health of members and to then support those who experience a mental injury.

On the legislative track, the union needs to compare the legislation and policies from different jurisdictions and identify the best approaches. The legislative front will require engaging both our members and the public. It will require the kind of educational efforts that was discussed earlier.